Final Report: Third Party Evaluation of Texas Behavioral Health Performance Measures, Contract Processes, and Payment Mechanisms

As prepared by
Health Management Associates

In partnership with
National Association of State Mental Health Program Directors Research Institute, Inc.

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Analytics Improving Behavioral Health℠

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Executive Summary

Overview

The State of Texas' Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) [1] engaged Health Management Associates (HMA) and partner National Association of State Program Directors Research Institute (NRI) to evaluate behavioral health performance measures, contract processes, and payment mechanisms in order to bring the HHSC/DSHS behavioral health services into full compliance with Rider 82 of the 84th Regular Legislative Session (See Appendix A.1 for Rider 82). This legislation reflects important nationwide efforts toward measuring behavioral health and quality of care to improve the outcomes of individuals and their families and communities in the United States.[2] The evaluation includes a thorough review of existing mental health, substance use disorder, inpatient and outpatient measures, as well as aligning those performance measures to national norms and industry standards.

The first goal of the evaluation is to provide recommendations of performance measures, contract processes, and payment mechanisms for improvement and alignment with national norms and industry standards. The second goal is to propose a cost-effective web-based dashboard that is accessible to the public in which the performance of HHSC/DSHS operated and contracted behavioral health providers would be reported. The dashboard recommendations are provided in a separate report.

To achieve the first goal, HMA and NRI conducted a broad and deep review of existing measures, including the metrics and methodologies associated with the withholding of allocations made under the DSHS Rider 78 "Mental Health Outcomes and Accountability" of the 83rd Regular Legislative Session. HMA and NRI assessed current measures collected by the State contracted Local Mental Health Authorities[3] (LMHAs, also known as community centers), Substance Use Disorder (SUD) Providers, and the State Mental Health Hospitals (State Hospitals) to create a comprehensive catalogue and crosswalk of the measures and their attributes. We compared existing performance measures to national norms and standards, as well as best practices in other states. These comparisons included Substance Abuse and Mental Health Services Administration (SAMHSA) national outcomes measures (NOMs); requirements of the SAMHSA Certified Community Behavioral Health Clinics (CCBHC); Managed Care Organizations (MCO); and pay for performance and value based purchasing models of four states with performance based contacting approaches well-aligned with HHSC/DSHS' goals (Colorado, Indiana, Oklahoma and Washington State). The evaluation also included statistical analysis to measure the variability in performance across Texas providers.

[1] Note that in 2013 when Rider 78 was enacted, DSHS was a separate division. In 2016, at the direction of the Texas Legislature, the State restructured HHSC. One of the more significant structural changes starting September 1, 2016 was the consolidation of client services into a single division at HHSC, rather than have them exist within several agencies. This Medical and Social Services Division will create a central structure, connecting behavioral, medical, preventive care, disability, developmental and other services into one area to better meet the needs of the whole person. The changes are part of the system's consolidation from five agencies to three. The transformation also includes moving selected programs from the Department of State Health Services to HHSC. DSHS will focus its efforts on core public health functions. In this report, we refer to these entities as HHSC/DSHS.
[2] Substance Abuse and Mental Health Services Administration's Strategic Plan and Health and Human Services' lead public health agency charged with advancing improvements in the behavioral health of the nation.
[3] There are 39 LMHAs in Texas. Of those, 37 are designated LMHAs and two serve as contracted providers in the NorthSTAR service region.

In this report, we provide guiding principles for consideration as the State of Texas transitions to increased use of value based purchasing and pay for performance models in behavioral health. These guiding principles should support the State's efforts to meet the needs of individuals and their families who receive public behavioral health services, and the LMHAs and providers who serve them. The following chapters describe our methodologies, a review of alternative payment models, and the results from this evaluation. Based on our research, review, and analysis, we present two strategies of contract processes and payment mechanisms for the State's consideration. Additionally, we detail our recommendations concerning current performance and contracting measures, suggest new measures for consideration, and make recommendations of measures that could be tied to payment.

To the extent possible, our recommendation is for the State to align incentives in pay for performance systems with quality measures that report on both provider processes (including timely access) and clinical outcomes associated with the services provided. Additionally, we encourage HHSC/DSHS to continue to leverage contracts with LMHAs to monitor and ensure accountability related to access and efficiency.

Results and Recommendations

Contract Payment Mechanisms for LMHAs

The goal of pay for performance payment models is to move away from fee-for-service or other reimbursement methods that incentivize volume but have no ties to quality or value. Given that the goal of Texas' performance based incentive system is to increase quality and value, it is recommended that the State differentiate between data collected to inform compliance with contract (and/or licensure and certification) requirements with those intended to assist with monitoring the outcomes for individuals and families and quality of services being delivered.

We recommend the following seven measures be tied to payment and present two possible pay for performance strategies for the State's consideration.

1. Effective Crisis Response
2. Crisis Follow Up (7 and 30 days)
3. Adult Community Tenure
4. School
5. Follow Up – Face to Face (7 and 30 days)
6. Adult Improvement
7. Child and Youth Improvement

Pay for Performance Strategy #1

The first strategy for HHSC/DSHS' consideration adheres to the principles of linking payment to measures that are within the providers' control, employing measures that reflect clinical behavioral health practices proven to improve positive outcomes, and incentivizing improved quality of care specific to practices that promote recovery. Within this strategy, the Ten Percent Withhold is structured to incentive incremental improvement and utilizes targets that are customized for each provider.

Pay for Performance Strategy #2

The second strategy for consideration adheres to the same principles as Strategy #1, but employs minimum thresholds of performance that must be met to be eligible to earn a portion of the Ten

Percent Withhold. Providers are then eligible to receive a percentage of the Ten Percent Withhold by achieving targets on measures that focus on reduced hospitalization and client improvement.

Measures Recommendations for LMHAs

Of three broad categories of providers of behavioral health services—LMHAs, SUD Providers, and State Mental Health Hospitals—our recommendations to keep, modify or eliminate measures focus primarily on measures required of the LHMAs. Because all ten State Hospitals in Texas are accredited by The Joint Commission and nine are certified by Centers for Medicare and Medicaid Services (CMS) (with the exception of Waco Center for Youth which is not Medicare-certified based on its patient population), the State Hospitals collect and report on identified measures associated with maintenance of their accreditation and certification status. Both of these oversight agencies require the reporting of specific performance measures into a national data set and are not subject to modification by HHSC/DSHS. Therefore, we have no recommendations of current measures to eliminate or modify. Similarly, we have no recommendations of current measures to eliminate or modify for SUD providers because we recognize that the SUD measures are required by federal Block Grant funding and any modification by HHSC/DSHS would require a lengthy and administratively burdensome process with SAMHSA.

Our recommendations for measures HHSC/DSHS should keep, modify, or eliminate in contracts with LMHAs are summarized below. Within the full report, we describe the importance of differentiating among measures that should be kept for pay for performance purposes and those that should be kept in contracts for contract compliance monitoring purposes. We provide details about suggested modifications and rationales for each recommendation. Further, suggested new measures for consideration are described within the full report.

Recommendations for LMHA Measures		
Keep	**Modify**	**Eliminate**
• Adult Community Tenure*	• Access to Crisis Response Services	• Adult Service Target
• Adult Improvement*	• Adult Counseling Target	• Adult Uniform Assessment Completion Rate
• Adult Monthly Service Provision	• ACT Target	• Child and Youth Services Target
• Child and Youth Community Tenure	• Adult Jail Diversion	• Child and Youth Uniform Assessment Completion Rate
• Child and Youth Improvement*	• Child and Youth Community Tenure	• Community Support Plan
• Crisis Follow-Up*	• Community Linkage	• Employment
• Effective Crisis Response*	• Family and Partner Support Services	• Follow-up within 7 Days – Disposition
• Children and Youth Monthly Service Provision	• Follow-up - Face to Face (7 and 30 Days)*	• Life Domain Functioning (Adults)
• Educational or Volunteering Strengths	• Frequent Admissions	• Life Domain Functioning 2 (Youth)
• Employment 2		• Strengths (Adults)
• Family and Living Situation		• Strengths 2 (Youth)
• Hospitalization		
• Juvenile Justice Avoidance		
• Long Term Services and Supports		
• Residential Stability		
• School*		
• TANF Transfer to Title XX Services (Adults)		
• TANF Transfer to Title XX Services 2 (Youth)		
*Indicates Recommendation to Tie Measure to Payment		

Chapter 1: Introduction

The State of Texas' Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) [4] engaged Health Management Associates (HMA) and partner National Association of State Mental Health Program Directors Research Institute (NRI) to evaluate behavioral health performance measures, contract processes, and payment mechanisms in order to bring the HHSC/DSHS behavioral health services into full compliance with Rider 82 of the 84th Regular Legislative Session (See Appendix A.1 for Rider 82). This legislation reflects important nationwide efforts toward measuring behavioral health and quality of care to improve the outcomes of individuals and their families and communities in the United States.[5] The evaluation includes a thorough review of existing mental health, substance use disorder, inpatient and outpatient measures, as well as aligning those performance measures to national norms and industry standards.

The first goal of the evaluation is to provide recommendations of performance measures, contract processes, and payment mechanisms for improvement and alignment with national norms and standards. A second goal of the project is to propose a cost-effective web-based dashboard that is accessible to the public in which the performance of HHSC/DSHS operated and contracted behavioral health providers would be reported. The dashboard recommendations are provided in a separate report.

To achieve the first goal, HMA and NRI conducted a broad and deep review of existing measures, including the metrics and methodologies associated with the withholding allocations made under the DSHS Rider 78 "Mental Health Outcomes and Accountability" of the 83rd Regular Legislative Session (See Appendix A.1 for Rider 78). HMA assessed current measures collected by the state contracted Local Mental Health Authorities[6] (LMHAs, also known as community centers)[7], Substance Use Disorder (SUD) Providers, and the State Mental Health Hospitals (State Hospitals) to create a comprehensive catalogue and crosswalk of the measures and their attributes. We compared existing performance measures to national norms and industry standards, as well as best practices in other states. These comparisons included Substance Abuse and Mental Health Services Administration (SAMHSA) national outcomes measures (NOMs); requirements of the SAMHSA Certified Community Behavioral Health Clinics (CCBHC); Managed Care Organizations (MCO); and pay for performance and value based purchasing models of

[4] Note that in 2013 when Rider 78 was enacted, DSHS was a separate division. In 2016, at the direction of the Texas Legislature, the State restructured HHSC. One of the more significant structural changes starting September 1, 2016 was the consolidation of client services into a single division at HHSC, rather than have them exist within several agencies. This Medical and Social Services Division will create a central structure, connecting behavioral, medical, preventive care, disability, developmental and other services into one area to better meet the needs of the whole person. The changes are part of the system's consolidation from five agencies to three. The transformation also includes moving selected programs from the Department of State Health Services to HHSC. DSHS will focus its efforts on core public health functions. In this report, we refer to these entities as HHSC/DSHS.

[5] Substance Abuse and Mental Health Services Administration's Strategic Plan and Health and Human Services' is the lead public health agency charged with advancing improvements in the behavioral health of the nation.

[6] There are 39 LMHAs in Texas. Of the 39 centers, 37 are designated LMHAs and two serve as contracted providers in the NorthSTAR service region.

[7] Note that although most, but not all, Community Centers are designated LMHAs. Community Centers are independent units of local government established to provide mental health services within their local service area. The State has designated Community Centers across the state as LMHAs to carry out certain responsibilities of the State Authority at the local level.

four states with performance based contacting approaches well-aligned with HHSC/DSHS' goals (Colorado, Indiana, Oklahoma and Washington State).The evaluation also consisted of statistical analysis to measure the variability in performance across Texas providers.

In this report, we provide guiding principles for consideration as the State of Texas transitions to increased use of value based purchasing and pay for performance models in behavioral health. These guiding principles should support the demonstration of the State's efforts to meet the needs of individuals and their families who receive public behavioral health services and the LMHAs and other providers who serve them. The following chapters describe our methodologies, a review of alternative payment models, and the results from this evaluation. Based on our research, review, and analysis, we present for the State's consideration two strategies of contract processes and payment mechanisms. Additionally, we detail our recommendations concerning current performance and contracting measures, suggest new measures for consideration, and make recommendations of measures that could be tied to payment.

To the extent possible, our recommendation is for the State to align incentives in pay for performance systems with quality measures that report on both provider processes (including timely access) and clinical outcomes associated with the services provided. Additionally, we encourage HHSC/DSHS to continue to leverage contracts with LMHAs. The contracts include established minimum standards, clear expectations, and measures of access and efficiency. The LMHAs report regularly on their progress, and the State, through its contract monitoring process, obtains the necessary information to evaluate the LMHAs performance and hold them accountable for their results, requesting corrective action plans and/or utilizing other contract remedies as described below.

We acknowledge that utilizing performance measurement and tying measures to funding represent a sample of the activities HHSC/DSHS uses to monitor and improve quality, access, and the effectiveness and efficiency of services delivered. Additionally, HHSC/DSHS demonstrates its commitment to continuous quality improvement, making available technical assistance to help identify needs and challenges faced by providers statewide, in conjunction with identifying strategies for improvement.

Chapter 2: Guiding Principles

In fulfilling its responsibilities to provide a high-quality public behavioral health system, HHSC/DSHS must identify and report on standardized metrics that are accurate, evidence-based, and create minimal administrative burden. The metrics must measure the quality, access, efficiency, and effectiveness of the overall behavioral health system, inclusive of prevention and promotion, early identification, and treatment services. In publically providing measurement results, the State is able to share with a broad range of stakeholders better information about the ongoing performance of the State's public behavioral health service system. The approach in identifying measures and collecting and analyzing data must be based in a continuous quality improvement framework that supports the data collection and monitoring of the metrics in a standardized way to maintain reliability and validity.

In conducting this evaluation, we have identified key principles intrinsic to identifying behavioral health performance measures, which are tied to value based contracting and support HHSC/DSHS in achieving its goals and fulfilling its responsibility to its citizens. The behavioral health field is achieving consensus on industry standards specific to meaningful, valid, and reliable measures, including those that can be applied to performance-based payment. The following guiding principles informed the review of and recommendations regarding measures utilized by the State for system monitoring and in certain cases, contractor reimbursement.

Align quality measures with Managed Care Organization (MCOs) measures applicable to behavioral health.

Rationale

- MCOs and LMHAs share responsibility for the delivery and reimbursement of publically funded behavioral health services in Texas. Like MCOs, LMHAs are required to plan, administer, coordinate, allocate, and develop resources for behavioral health services within a designated service area. In most cases LMHAs also are a direct provider of services.
- Enhanced alignment between MCO and LMHA provider monitoring activities promotes greater cost effectiveness and efficiency when providers have a uniform set of measures utilized across payers rather than multiple differing reporting requirements.
- Alignment of MCO and LMHA metrics establishes a single set of measures across state agencies for monitoring the same outcomes across Medicaid and non-Medicaid publically funded programs.
- Specialty care providers, such as LMHAs are not required to provide a full array of health services. However, behavioral health providers must consider the total health care of their clients and participate as an integral part of the health care team.

Consider quality measures currently utilized within the HHSC 1115 Transformation Waiver Delivery System Reform Incentive Payment (DSRIP) program.

Rationale

- In the State's implementation of the 1115 waiver it included incentives for innovation, improved access, timeliness, quality, and inclusion of evidence based practices.
- All 39 LMHAs participated in the waiver which established a pay for performance structure and reporting system for identified measures. Where LMHA/provider reporting infrastructure has

been created related to measures applicable to HHSC/DSHS target populations, building on this existing capability could support the collection of additional meaningful data with less provider burden.
- The LMHA projects focused on integrated behavioral health and primary care services, and their associated reported outcomes success, represent the capacity to provide meaningful measures across health care services and should be expanded under HHSC/DSHS as part of broader system integration efforts.

Consideration of measures endorsed by the National Quality Forum (NQF) or other nationally recognized behavioral health entities whose recommendations come with rigor of review and consensus of a cross-section of evaluation experts and stakeholders.

Rationale

- In 2010, the Patient Protection and Affordable Care Act (ACA) charged the U.S. Department of Health and Human Services (HHS) with developing a National Quality Strategy (NQS), the purpose of which is to better meet the promise of providing access to health care that is safe, effective, and affordable.
- Using the NQS as a model, SAMHSA has developed the National Behavioral Health Quality Framework (NBHQF) that includes recommended measures. The NBHQF underwent two phases of review and input, involving the nomination and selection of key quality measures that were endorsed by a panel of stakeholders internal to HHS, and a second panel of external stakeholders composed of researchers, consumers, clinicians, and state agency personnel.
- Consistent with this project, the National Quality Forum (NQF) endorses measures for improving the delivery of behavioral health services, achieving better behavioral health outcomes, and improving the behavioral health of the U.S. population, especially those with mental illness and substance use disorder that were gathered, vetted and recommended after a multi-phase project.
- Alignment with NQS, NQF, and NBHQF allows Texas to leverage measures that withstood extensive vetting and review and are being used by other states and managed care entities.
- Although measures will evolve as more evidence emerges, alignment with national and standardized measures from the aforementioned sources allows HHSC/DSDH to utilize these frameworks/entities for ongoing updates to measures and monitoring strategies.
- The NBHQF may serve to inform future SAMHSA block grant and discretionary grant reporting requirements and current use of these measures may improve competitiveness of future grant proposals for providers and the State.

Recognize that the measurement system must represent a broad stakeholder group and, although there is likely common agreement on many of the measurement domains, there may be less consensus about which metrics optimally represent these domains.

Rationale

- The quality measures include a range of standardized metrics, reported by mental health and SUD providers and aggregated and reported to and by the State.
- Quality measures are based on standardized definitions, numerator and denominator, data source, and quality domain.

- The quality measures should reflect the diverse geography (urban to frontier), variability in population, unmet needs, and health disparities within the state.
- Quality measures benchmarking should be tailored to reflect population served, and be LMHA and provider specific to support the individual LMHA's and provider's continuous quality improvement activities.
- Quality measures provide an opportunity to report and monitor indicators of value, provide information on how the system is operating and are reviewed through a continuous quality improvement process (CQI), which can be used to identify opportunities for improvement, and support realignment and change when indicated.

Measures that capture positive resiliency/recovery outcomes, demonstrate ready access to services, and exhibit cost effectiveness will be leveraged as incentives for value based contracting; and therefore performance on these measures should be under the control of the LMHA/provider.

Rationale

- The measures should incentivize evidenced-based practice, reward innovation, address system gaps and challenges, and encourage providers and systems to consider emerging practices and approaches.
- The allocation method and the percentage at risk for payment tied to a particular measure must have a large enough population, or "N," to be meaningful and not capricious in penalty or loss.
- The measures should reflect "stretch" metrics, e.g. those that present a challenge while at the same time are within successful reach.
- Fee for services (FFS) reimbursement, as opposed to value-based reimbursement, is used to promote volume which may be desirable in circumstances in which the State wishes to incentivize quick adoption of a new practice.

The HHSC/DSHS' approach will continue to utilize a phased-in approach to implement any changes to measurement collection and/or the performance based contracting process.

Rationale

- Changes to the current list of measures may require the collection of new data.
- Changes or enhancements to current measure reporting practices requires additional time, planning, benchmarking, re-alignment of and/or additional resources, and engagement of stakeholders to ensure success.

While changes to either performance measures or reimbursement may require additional resources and significant system effort, all stakeholders are committed to providing the necessary supports to achieve a modern, evidenced-based, recovery-oriented behavioral health system of care in Texas.

Rationale

- To date advocacy, legislative, and provider stakeholders have maintained active participation in measure development and contract mechanisms.
- Consensus exists that whenever possible, new or changed quality measures, should build upon currently available data and reporting infrastructures to reduce cost and administrative burden.

- There is understanding that collection of new data may require changes to information technology systems at both State and LMHA/provider levels.
- Changes in reimbursement methodologies impact budgeting, cash flow, and have additional financial implications at many levels of the system, requiring complex changes in policies and administrative practices. However, the State and LMHAs have succeeded with these changes in the past.

Performance measures provide data for system monitoring. Maintaining accountability of LHMAs/providers can be achieved through both contract compliance enforcement and reimbursement strategies.

- Contract requirements not associated with payment incentives, such as statutory, licensing, or other requirements, are monitored through process measurement and non-compliance is addressed when necessary.
- Funding/reimbursement does not serve as the only lever for contract compliance, i.e. poor performance is addressed through performance improvement plans and other remedies when necessary.

Recommendations related to the development of the web-based, publically accessible dashboard are a resource intensive initiative for HHSC/DSHS. Inclusion of stakeholders throughout the process will help build greater understanding of the effort required to develop dashboard capabilities and report on an agreed upon set of metrics for a broad audience of users.

Rationale

- The development of an interactive dashboard that is cost effective, efficient and provides ready access to identified quality measures will need to be implemented in phases.
- Development should start on a smaller scale and increase and expand the number of domains reported and enhance functionality as additional resources are identified and experience is gained.

Chapter 3: Methodology

The enabling legislation supporting this project, as well as the State of Texas' detailed approach to the scope of work informed the methodology for developing the recommendations found in this report. This methodology included the following steps, and is described in more detail in the sections below:

- Cataloguing and review of the existing performance measures for HHSC/DSHS' statewide behavioral health service delivery systems.
- Identification of existing performance measures currently required by state or federal funders/administrators.
- Incorporation of stakeholder feedback from Texas State Hospital Directors, Association of Substance Use Disorder Providers, the HHSC Behavioral Health Advisory Committee, the Texas Council of Community Centers, select Texas Legislative staff members, and the Meadows Mental Health Policy Institute.
- Cross walking current Texas metrics to nationally recognized measures.
- Comparing current Texas measures and those being utilized by other State Behavioral Health Authorities for similar activities, i.e. both system monitoring and pay for performance.
- Identifying and categorizing measures within framework of process and outcome measures, including access, quality and efficiency.
- Utilizing the cross walk and comparison information to identify opportunities to modify or replace existing measures and be included in HHSC/DSHS' behavioral health contracts.
- Through analysis of information from the aforementioned steps, identifying potential information gaps that could be filled by additional performance measures focusing on new populations.
- Research on multiple reimbursement strategies in pay for performance models.
- Identifying measures to be tied to payment and used in suggested pay for performance strategies; and those that should be kept in contracts for compliance monitoring and accountability purposes.

Catalogue and Review of Existing Measures

At the onset of the project, HMA and NRI reviewed existing legislation, provider contracts, and system goals and created a comprehensive "Crosswalk" spreadsheet of the current measures required by the state contracted LMHAs, substance use disorder (SUD) providers, and mental health hospitals. As a whole, the Crosswalk spreadsheet consists of five separate tabs of measures for the following provider types: Mental Health; SUD; State Hospitals; Medicaid Managed Care; and CCBHCs. It also includes a tab for SAMHSA National Outcome Measures. (See Appendix B.1-6).

Measure attributes for each measure were documented for Mental Health, SUD, and State Hospital measures and to the extent possible include the following information: Measure Title and Description; Provider of Service; Contract Type; Measure Type; 2016 Target; Calculation (includes numerator and denominator); Exclusions; Data Source; Auto Sanction; Sanction Type; Assessment Interval; Sanction Description; and the entity requiring the measure, with slight variation across the three behavioral health provider types.

The Crosswalk also includes columns that enable cross-referencing of whether or not a contractual measure is in alignment with legislative requirements, national norms and industry standards (e.g.

SAMHSA NOMs, Rider 78, Legislative Budget Board, and /or SAMSHA CCBHCs). On the State Hospital tab, it indicates whether a measure is required by The Joint Commission and/or the Center for Medicaid and Medicare Services (CMS). The MCO, CCHBC, and SAMHSA tabs in the Crosswalk are included for reference purposes.

Further, as part of the review, we also assessed the categorization of each measure as a process or outcome measure but did not include this information in the Crosswalk. Both process and outcome measures can be considered quality measures as they can be utilized to gauge or quantify healthcare processes, outcomes, patient perceptions, and organizational structure, including systems that are associated with the ability to provide high-quality health care and that support the goals of a health care system.

Due to the size and complexity of the crosswalk spreadsheets, they are presented only in electronic format.

Data Analysis of Performance of Texas LMHAs, SUD Providers, and State Hospitals

The state contracted LMHAs, SUD Providers, and the State Mental Health Hospitals are partners in the behavioral health continuum of care. These entities work on behalf of the State and the Counties to meet the needs of children, youth and families with serious emotional disorder, and youth, adults and older adults with SUD and serious mental illness (SMI).

HHSC/DSHS delivered provider-level data on the majority of performance measures broken out by mental health providers and SUD providers. All State Hospitals in Texas provide data on a monthly basis to NRI as part of the Behavioral Healthcare Performance Measurement System and HHSC/DSHS granted written permission for NRI to utilize these data to analyze variability among the ten state hospitals on Joint Commission and CMS-required measures.

NRI conducted a quantitative analysis of performance rates for the majority measures to the extent possible with available data to: (1) assess variability in performance across providers; (2) review historical trends in performance rates; (3) determine the number and type of providers that have difficulty meeting measure targets; and (4) determine the measures in which providers less frequently meet the targets. While HHSC provides technical assistance to providers to identify needs or challenges that contribute to the inability to meet a required level of performance, results of the data analysis helped illuminate which measures are consistently problematic for providers. Results of the data analysis (Appendix A.2) were also used to help identify which measures have reached maximum performance over a sustained period, or which demonstrated that providers are regularly struggling to meet the targets, suggesting that the measure should either be modified to support continuous quality improvement efforts or be eliminated.

Analysis of monthly data was completed for performance measures required for Mental Health providers. Only performance measures for which complete data were submitted were included in the analysis. Complete data were defined as data received for all of FY 2015 and for the first half of FY 2016. A Texas state fiscal year is from September 1 thru August 31. Descriptive analysis including analysis of central tendency is presented by month, and aggregated by quarter and by half FY in Appendix A.2 for each LMHA performance measure.

Analysis of six-month time points, broken out by three month quarters following the State FY, was completed for SUD measures to assess variability amongst SUD treatment providers. Performance measures that are required for state hospitals by the Joint Commission and CMS were analyzed. Each hospital and HHSC/DSHS have monthly access to their own performance rates in comparison to NRI and The Joint Commission targets via NRI's Behavioral Healthcare Performance Measurement System (BHPMS); however, the analysis presented in this report presents comparative results among all of Texas' state hospitals which is not available via the BHPMS.

Review of Best Practices and National Norms and Standards

To review best practices in performance measurement, including incentive payments and financial sanctions that are aligned with models utilized by managed care organizations (MCOs) and HHSC, as well as the vision and priorities of SAMHSA and CMS, we conducted a three-step review. First, we reviewed primary and secondary literature on best practices in payment mechanisms. Second, we identified and reviewed model states' performance measures and payment models for comparison. Third, we constructed a payment grid to compare and contrast attributes of various payment models used by MCOs, SAMHSA and CMS, and model states. A description of each of these three methodologies is provided below.

Literature Review

A literature review on best practices in payment mechanism comprised the first step of this task. To do this, a review of published gray literature on emerging best practices in payment mechanisms in August 2016 was completed. The project team conducted research via internet and database searches focusing on documents and database searches from PubMed, Google Scholar, WorldCat, government websites and professional journals and websites. Relevant material was identified through a combination of key word, phrases, and topical searches including:

- Healthcare payment methods
- Purchasing systems
- Payment models
- Pay for performance
- Incentives
- Risk sharing arrangements
- Value based purchasing
- Shared savings
- CMS
- SAMHSA
- Capitation
- Bundled payments
- Contract processes
- Service delivery models
- Alternative payment model

EndNote, a bibliographic reference software, was used to manage citations and references and Nvivo, a qualitative data analysis software, was used to code and identify themes and relationships in found items. Citations to resources are referenced throughout the document and full citations are found in the bibliography at the end of the document. A review and recommendations for payment model for consideration were the result of this effort and are described in detail below.

State Models

The review of payment mechanisms and performance based contracting used by other states provided a foundation for recommendations in best practices in payment mechanisms for Texas to consider. Model states were selected based on their similarity in behavioral healthcare organizational structure to Texas, innovative contractual language for provider contracts, use of the Child and Adolescent Needs and

Strengths Assessment (CANS) and Adult Needs and Strengths Assessment (ANSA) assessments as a basis for performance measures, and creative uses of alternative payment methodologies in both fee-for-service and managed care structures. In selecting eight model states to review, we considered states that had characteristics consistent with the goals of Texas. States in the west, northwest, south and mid-west shared more similarities in regional approaches and authority, urban and frontier areas and moderate funding levels. Model states included California, Colorado, Indiana, Michigan, New York, Oklahoma, Utah, and Washington State. We decided to forgo review of two largely populated states (California and New York) based on California's history of state tax set asides for mental health services that direct resources to the counties and creates a decentralized system. New York has a highly resourced and regulated behavioral health system that also did not align with the state of Texas' resources nor approach to public behavioral health services. Michigan was eliminated because it has developed Prepaid Inpatient Health Plans (PHIPs) that function similar to Medicaid Health Plans and the structure and responsibilities add a level of complexity that makes their system less applicable to Texas. Utah similarly has established a system of multiple plans including Prepaid Mental Health Plans (PMHP, administered by the counties), Prepaid Inpatient Health Plans (PIHP), a Prepaid Ambulatory Health Plan (PAHP), Medicaid Accountable Care Organizations, Dental PAHPs and a Medical and Mental Health Plan. The Plans are tailored to meeting the state's objectives, had limited relevance to Texas and admit the fragmentation between health and behavioral health services is a challenge. We decided the additional complexities made the state less conducive to furthering the goals of Texas. Ultimately, Colorado, Indiana, Oklahoma, and Washington State were found most relevant to this project and they are described below.

Payment Grid

In order to develop recommendations for Texas' payment models, attributes of each type of payment model that were researched in the literature and state models review were aligned in a grid to support ease of comparison (Appendix B.7). Attributes in the grid included Payment Model Name, Risk/Penalties/Sanctions practices, Category within the CMS payment model classification scheme for alternative payment models, Core Elements of the model, Shared Savings/Bonus/Incentives practices, Strengths of the model, Challenges of the model, Strategies typically associated with the model, and Quality Measures. The grid helped us identify various mechanisms that could be useful to HHSC/DSHS and helped shape our recommendations on payment models.

Developing Recommendations

To identify performance measures and other requirements not mandated by state or federal requirements that could be eliminated, we utilized the Crosswalk and the results from the data analysis to assess each measure. The HMA and NRI Project Team conducted at least nine rounds of assessment to thoroughly review the purpose or intent of each measure; its fit within the framework of measures as process or outcome measures; its alignment with national norms and standards; the strength or validity of the measurement calculation and/or the target rates; and a review of the data source used to measure performance. Feedback from HHSC/DSHS staff regarding the interim recommendations provided additional context for consideration in the final recommendations presented.

Several factors were considered when analyzing the State's current measures and considering recommendations for any changes. To support quality monitoring and performance based reimbursement, we made recommendations to maintain a mixture of both process and outcome

measures. Process measures were considered as those that reflected completion of elements that the State requires and support best practices. An example is completion of an assessment or treatment plan within certain timeframes or numbers of individuals served. Process measures provide information on *what* a provider (or the system) is doing. Examples of process measures include those related to access, such as whether a specific appointment was offered or completed within a designated timeframe, or receipt of a certain number of services consistent with an individual's level of care. Outcome measures provide more information on *how* the client is doing. Examples of outcome measures include those that indicate reduction in risk behaviors, inpatient or emergency room contacts, or increased recovery as evidenced by improvement in social connectedness. Also of important consideration was the comprehensiveness of the measures in terms of the populations, continuum of service need, and current challenges facing the State in contributing to wellness and recovery for all Texans.

How process or clinical measures are defined has significant implications for data collection and fairmindedness in reimbursement strategies. While State and Federal oversight has outlined specific areas for measurement, HHSC/DSHS has been given some latitude on what to measure and how to measure it. Current measures were reviewed for consistency of the metric definition with the intention of the measure, i.e. did it provide the intended information and was this information meaningful in assessing provider or system performance. The definition also has implications for ease of capturing, reporting and analyzing the data for providers, the State, and stakeholders. Leveraging existing measures, when possible, was prioritized in order to prevent significant disruption to ongoing monitoring as well as reduce State and provider administrative burden. However, recommendations include increased alignment with models utilized by MCOs contracted by HHSC, as well as national trends, many of which are being led by SAMHSA and CMS.

Lastly, we are sensitive to and inclusive of the State's valued and mandated stakeholder involvement within this review process. To date we have had face-to-face meetings with the HHSC Behavioral Health Advisory Committee, Texas State Hospital Directors, the Texas Council of Community Centers, Texas Legislative Staff involved with the behavioral health review, and the Meadows Mental Health Policy Institute. In these meetings, we described our approach to the evaluation and sought stakeholder recommendations and perspectives. The stakeholders shared common themes and concerns about payment mechanisms that contributed to the establishment of *de facto* "winners" and "losers," depending on the specific measure. Stakeholders expressed concerns about being assessed by measurements of variables that are not within their control as providers of behavioral health care, such as competition for affordable housing, characteristics unique to urban vs frontier area, and lack of bidirectional data from which to make improvements in their service system. They also expressed concern about allocation methodology that dis-incentivized outreach to hard-to-engage individuals, or innovation, because providers could not predict a successful response. Identified measures may not be a good indicator of working relationships and /or barriers within the community and with sister agencies in establishing successful collaboration in serving shared populations. This feedback was incorporated into the evaluation as it sheds additional light on issues relevant to HHSC/DSHS in achieving the goals of the project.

To modify existing and identify new performance measures for the State's consideration, we assessed measures representing best practices and national norms and standards with an eye toward determining whether the data needed to report on the measure is already included in HHSC/DSHS'

behavioral health contracts or could be accessed, collected, and reported on without too much burden if needed. Data and results from above activities was utilized to make recommendations.

Tying Recommended Measures to Performance Payment

The process used to identify measures to link to payment was threefold.

1. Each measure was assessed on whether it was a process measure, linked to researched best practices that leads to positive client outcomes, or an outcome measure which indicates if a client is functioning better;
2. The measures meeting those factors were then assessed on whether providers have reasonable control over the measure's intent; and,
3. The measures that incentivize improved care quality received preferential consideration.

Reviewing each measure carefully through this process resulted in a list of measures to consider linking to payment for meeting performance targets.

Chapter 4: Contract Development and Management

While scope of this report is to review the existing measurement system and make recommendations for any modifications, it is important to clarify the utility and purpose of including measures in contracts for monitoring and accountability purposes at the forefront. Nationally, State Behavioral Health Authorities (SBHAs) have historically focused on process measures such as enrollment data, expenditures and service provision rather than on client outcomes. With the advancement of electronic health records (EHRs) and integrated datasets, the increase in available information and data supports the renewed effort to identify outcome measures rather than only process measures. The shift to outcome measures enhances providers' and clinicians' capacity to evaluate performance and determine opportunities to improve care. Contextually, we offer the following information to provide clarity in terminology used in this report and its focus.

State agencies have an obligation to evaluate the performance of vendors and the adequacy of all agreed-upon services. The government expects the contractor to meet all contract requirements for quality, quantity, access and timeliness. State agencies establish a contract monitoring system as the structure, supported by policies and procedures from which they can evaluate if the objectives of a contract are accomplished and the vendors meet their responsibilities.

A contract monitoring system involves monitoring both the service delivery process, such as units of service or numbers of people served, and performance or outcomes, which assess some aspect of the effect, result, or quality of the service (e.g., improvements in client functioning). A perfectly executed service delivery process is a waste of time and resources if it fails to achieve the effect, result, or quality desired. Contracts for services should focus on achieving desired outcomes that that can be measured (Compassion Capital Fund National Resource Center, 2010).

A strong contract monitoring system includes *performance measurement* and *contract compliance monitoring activities*. Monitoring and measurement are serve the following purposes:

- To validate previous decisions
- To establish direction for activities in order to meet identified system goals
- To present factual evidence to justify a required course of action
- To identify a point of intervention and subsequent changes and corrective actions (Leal, 2015).

Without proper monitoring and measurement, there is not an established method by which to evaluate if the service delivered adds value and complies with the requirements. To make these determinations fairly, the overseeing agency must establish a system that provides a reliable basis to assess performance, reporting on the positive results or requesting corrective actions as needed.

Performance measurement assigns value to something. Outcome measurement is most commonly used in the nonprofit world; performance measurement is used more often in the business and government arenas. Essentially, they mean the same thing. Performance measurement is a systematic way to assess the extent to which a program has achieved its intended results. The main questions addressed in outcome measurement are:

- What has changed in the lives of individuals, families, organizations, or the community as a result of this program?
- Has this program made a difference?

- How are the lives of program participants better as a result of the program?

Performance measurement asks, and attempts to answer, the question "So what?" (Compassion Capital Fund National Resource Center, 2010). For example, these questions could be:

- If your clients are seen face-to-face within one day after a crisis, are they better able to avoid hospitalization? Do they?
- If you train an organization on how to develop a strategic planning process, can the organization effectively perform the steps involved? Do they?
- If your staff works with five faith-based or community organizations on developing partnerships, do the organizations actually follow through and increase their collaboration efforts? Do the efforts result in new partnerships?

There are other circumstances that prompt an organization to choose to measure its performance, including the capacity to:

- Distinguish what appears to be happening from what is actually occurring
- Establish a baseline from which progress and improvements are measured
- Make decisions based on solid evidence
- Demonstrate that changes led to improvements
- Allow performance comparisons across sites
- Monitor process changes to ensure improvements are sustained over time
- Recognize improved performance (HRSA, 2011).

A state agency also needs to monitor contract compliance or outputs. Compliance monitoring refers most often to the contractual arrangement made between a funder and a grantee on the use of funds. Compliance monitoring keeps records on what and how much service a program delivers, the clients it serves, and the money it expends in relation what the provider agreed to with the funder.

A contract compliance monitoring system supports a state agency in meeting its responsibility to the general public that expects the distribution of public funds to public entities and providers that offer services to people with behavioral health conditions. The system must further demonstrate that the services and treatment provided contribute to the person's improved functioning, socially, economically and emotionally, allowing them to participate and live independently in their communities. Additionally, in measuring clients functioning on multiple domains, the state is collecting data that will provide the information on the impact of the initiatives of the state and whether or not they are producing the intended impact in areas such as system access and efficiency.

HHSC/DSHS is accountable to Texas taxpayers for providing quality services that make a positive impact on the individuals being served. By objectively measuring client outcomes, HHSC/DSHS is able to demonstrate effective and efficient use of public dollars to improve the lives of Texans with behavioral health needs.

This report has a primary focus on performance measurement and how HHSC/DSHS can transition from its current approach to performance measurement to one that is more aligned with industry standards and value based purchasing. Activities that can be used to monitor contractual compliance for providers is outside the scope of this report, yet is an important issue. We include a brief discussion of contract

compliance monitoring as a supporting structure that continues to be necessary to assess a vendor's compliance with the requirements and scope of work in the contract, and if they are not, the state must use remedies available to address contract noncompliance. Examples of potential remedies are:

- Notice of contractual violation
- Development of a plan of correction
- Establishment of a referral moratorium until corrections are made
- Withhold of funds until corrections are made
- Probation until corrections are made
- Contract termination
- Application of penalties

A note of caution: It is important to establish a balanced approach between compliance sanctions and performance based reimbursement. Compliance sanctions and remedies may represent a higher fiscal risk for vendors than the performance value based reimbursement incentives and risks, a continued focus on process will be prioritized. A focus on process measures without ties to quality could interfere with the achievement of the benefits of a value based measurement system.

Chapter 5: Performance Payment Mechanisms and Contract Processing Models

The United States healthcare system is rapidly moving toward rewarding value versus only volume. New delivery system and payment approaches authorized in the Affordable Care Act (ACA) and recent legislation, such as the Medicare Access and CHIP Reauthorization Act (MACRA), have placed a growing focus on policymakers to improve the quality and efficiency of the health care system (McGinnis and Houston, 2015). At the core of these efforts is the goal to replace fee-for-service (FFS) payment system with payment methods that reward quality and positive client outcomes. When FFS payment systems are not linked to quality, they incentivize volume and drive up costs, and do not place the provider at risk for client health or costs. Healthcare systems are currently designing, testing, and evaluating new value-based payment models that aim to deliver high quality care at lower costs. As models emerge, providers are being increasingly tasked with implementing services and practices that improve outcomes and reduce costs (Jena et al., 2014). Emerging trends include: alternative payment models, multi-payor alignment efforts, and re-designed managed drug spending (McGinnis and Houston, 2015).

The purpose of this section of the report is to identify and review best practices in payment mechanisms currently in use by states and national insurers for value-based, pay-for-performance reimbursement mechanisms for behavioral health services. In addition, the document includes models not specific to behavioral health due to the fact that there is high emphasis to move toward integrated care models and payment models are continually emerging.

Payment Models

Payment Models[8] serve as the framework for all service delivery models. They are:

1. Fee for Service (FFS)
2. Pay for Performance (P4P)
3. Bundled or Episode of Care Payment (EoC)
4. Capitation (Cap)

The models fall on a continuum of risk which shifts from full risk on the part of the payor to full risk on the part of the provider (Valence Health "Models of Value-based Reimbursements" 2013). Newer service delivery models share savings and risk.

Fee for Service (FFS)

Under the FFS model, the provider is at risk only for unit costs of services; not for client health or total treatment costs. FFS arrangements are prospective and a pre-arranged payment for a discrete service is defined prior to service delivery (Conrad et al., 2013). The FFS's strength is to increase the use and delivery of specific services such as preventative screenings.

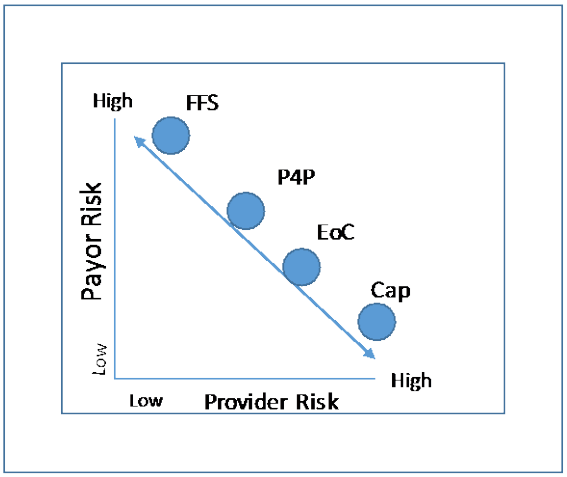
Pay for Performance (P4P)

Providers are reimbursed based on whether they achieve a predetermined set of quality measures for a population. P4P can include sharing in savings and/or penalties. P4P are mostly retrospective in that settlement of final payment is done after services are delivered and it is determined if quality measures

[8] **Payment model** refers to the manner in which a payer reimburses providers.

are met (MedSpan Research (2015). There are numerous variations of P4P models and the strength lies in linking payment to reaching specific quality measures.

Figure 1: Risk Shift by Payment Model



Bundled or Episode of Care Payment (EoC)

Bundled payment arrangements provide a single payment to be shared by a group of providers or professionals for a range of services. Rather than paying each provider separately, a group works collaboratively to provide a more holistic level of care and share payment for the bundled package of services (Whittal, 2016). A bundled payment can be structured in different forms, including a prospective payment arrangement which covers a defined scope of services or in the form of a Case Rate which covers the average cost of all services for a given defined episode of care for an individual over an agreed upon time period (National Council, 2014).

The strength of EoC is reducing cost and variation within episodes. However, the model does nothing to discourage unnecessarily high numbers of episodes of care among clients with a particular condition (Valence Health, 2013). Bundled payment arrangements can also be designed to pay multiple providers, such as team-driven, evidence-based services, for coordinating the total amount of services and has been a popular method for embracing value-based care without fully immersing providers in downside financial risk contracts (Belliveau, 2016). A major challenge with bundled payments is managing costs for a client's treatment that may be out of the provider's control, such as medication adherence or other client behaviors that could lead to adverse outcomes (Belliveau, 2016).

Capitation (CAP)

There are two basic capitation models: "Global" or "Full Capitation" and "Partial" or "Blended Capitation." In Global Capitation, the provider or group of organizations receive a single fixed payment for the entirety of healthcare services a client could receive. Partial Capitation includes a single monthly fee that is paid to the provider and only covers a defined set of healthcare services. Services not covered are usually paid on a fee-for-service basis. For example, it is not uncommon to see a partial capitation model that only includes physician services (primary care and specialty) and laboratory services, but excludes hospital-based care, pharmacy, and mental health benefits. Regardless of whether the capitation is global or partial, the provider is at full risk for the services that are covered. This means that providers reap the rewards of providing care at a cost below the capitated rate, but also bear the risk if the cost of care exceeds the capitated amounts (Valence Health, 2013). Capitation became popular in the 1980s but, at that time, the focus was only on financial savings and quality of care and access to care were not part of the model. This has changed with new models.

Successful capitated payment approaches depend critically on the way in which capitated rates are calculated, which may be especially difficult when establishing payment rates for adults with SMI. Capitation rate calculation typically involves consideration of the case-mix of a population (i.e., demographic and medical characteristics), local costs associated with service provision, and average utilization. The use of average utilization (e.g., as observed within FFS systems) may be inappropriate for

adults with SMI because utilization under FFS may vastly underestimate needed services for the subgroup of adults with SMI who have historically had considerable unmet health care needs in FFS systems. Furthermore, if capitated payments are made to a clinic based on the service utilization of their own consumers over the previous year, the same perverse incentives exist as in FFS arrangements wherein providers benefit from providing a larger quantity of services, regardless of quality or cost-control concerns (Hackbarth, 2015).

Some Community Mental Health Centers (CMHCs) receive a capitated payment (often administered per-member per-month [PMPM]) to cover a set of care coordination services, including services that are not reimbursed in FFS models. Outside of the scope of these coordination services, payment for other services may use a FFS or capitated approach (Hackbarth, 2015).

Capitated payment's real strength is in reducing the number of unnecessary episodes of care for a particular condition or group of people, and it makes sense to use this payment method where there is concern about overuse of procedures or a high rate of preventable hospitalizations. For example, it makes sense to develop a global payment for clients with chronic disease, with a goal of paying for services that help them to manage their conditions more effectively and remain out of the hospital. An annual payment for chronic disease clients can also be thought of as a payment for a "year-long episode of care" (Valence Health, 2013).

Participating in a global payment contract is a challenge because it often requires the ability to coordinate care across multiple sites. It also requires a significant amount of data about a population to stratify clients based on risk, identify variation in treatment patterns, and create new clinical pathways to care for clients. Community Health Centers (CHCs), in particular, lack management and actuarial expertise for managing downside risk as well as experience in how to interpret data and apply it for population health management activities (Burns and Bailit, 2015).

Payment Evolution

Models of reimbursement are moving from a focus on discrete services or type of provider/system toward provider collaboration with emphasis on the whole health[9] of an individual. Healthcare payment reform will likely bring three predominant payment models to behavioral health: Global Payments for providers working in medical homes; Bundled Payments through Prospective Payment Systems for providers that achieve the designation of Certified Community Behavioral Health Clinics; and Case Rates for providers working in specialty behavioral health clinics (National Council, 2014). Implementing and testing payment models is occurring across the nation. Global payment; bundled payment based on medical episodes; and shared savings, with a mixture of upside gain and downside risk-sharing, are all examples of new combinations. So are the mixed models combining care redesign and value-based payment, such as accountable care organizations (Conrad et al., 2013).

Service Delivery Models/Alternative Payment Models

Using the payment models listed previously alone or in combination, numerous **service delivery models (SDM)**[10] are being and have been developed. They are often referred to as **alternative payment models (APMs)**. These SDM/APMs serve as the framework for service systems' reimbursement methods. Examples of these models are Accountable Care Organizations (ACO), Medical or Patient Centered

[9] **Whole health** in this paper is defined as having a healthy mind and body.

[10] **Service delivery model** refers to the manner in which providers organize and deliver care to clients.

Medical Homes (PCMH), and Shared Savings programs (SS). There is continuous morphing of payment and service model combinations. The Center for Medicare and Medicaid Services (CMS) lists on their website, as of August 17, 2016, 75 alternative payment models are in varied stages of testing and implementation (CMS, n.d.). Just as payment models fall on a continuum of risk, SDM/APM models fall on a continuum of combinations of risk and incentives for quality and value.

Value based Payments (VBP)

When payment models and service delivery models are coupled with incentives for quality and efficiency, they are considered '**value-based payment.**' These incentives can be tailored to different market conditions and organizational settings (Conrad, 2015). "Emphasis is on cost savings and services to quality of care and reimbursement. The plethora of terms commonly used (results-based financing, performance-based incentives, pay for performance, performance-based contracting, conditional cash transfers, cash on delivery, and others) can cause confusion. At their heart is a resource transfer which is dependent on some form of performance criteria being met" (Witter et al., 2013). The goal is often referred to as the **Triple Aim**: to provide better health care, advance the population's health, and at a lower cost (Dentzer, 2012). Very few of the value-based payments are pure capitation. New payment models are being designed to provide incentives to increase quality and contain costs along the entire continuum (Arnold, 2016).

Accountable Care Organizations

Accountable care organizations (ACO) are "organizations or structures that assume responsibility for a defined population across a continuum of care through payments linked to value and performance measurements that demonstrate that savings are achieved in conjunction with improvements in care" (Stanek and Takach, 2015). Core components of a Medicaid ACO include:

1. On-the-ground care coordination and management by providers
2. Payment incentives that promote value over volume
3. Provider and community collaboration
4. Robust quality measurement and accountability
5. Data sharing and integration

States have significant flexibility regarding how to structure Medicaid ACOs, including determining the risk-bearing entity, defining care coordination guidelines, and establishing quality reporting and measurement. States can also tailor ACO programs to support population health goals. Additionally, Medicaid ACOs can be aligned with commercial and Medicare ACO models. Such associations could lead to larger and more comprehensive ACOs that cover a more expansive and diverse population and therefore make a larger impact on population health (Crawford et al., 2015).

The payment model generally used by Medicaid ACOs is a FFS plus shared savings payment structure modeled after the Medicare Shared Savings Program. This provides ACOs the incentive to focus resources on high-cost, high-need clients—those most likely to experience short-term health improvements that result in cost savings. Another version is a capitated or Global model that rewards quality, uses no FFS payment and providers are at full risk for client health outcomes. Outcomes

generally focus on population-based health improvements[11] (Crawford et al., 2015). There are challenges in using population health strategies in ACOs as there are multiple pathways and mechanisms that affect a person's health outcomes. This makes it difficult to establish clear cause and effect relationships. In addition, there are currently few models that successfully integrate health care with social, public heath, and community interventions such as food access and housing (Crawford et al., 2015). Using a global budget can motivate an ACO to invest its limited resources in services (including nonclinical services) that maximize health outcomes. Payment and outcomes targets will need to evolve over time, in response to changes in the population's health. Currently, Oregon's CCOs have a global budget with upside and downside risk and are accountable for a wide range of health-related services. (Crawford et al., 2015) Other model combinations include ACOs with shared savings and bundled payments. Although some of these models are fully capitated, the majority include shared savings, partially capitated payments, or other value-based incentives for quality and total cost of care (Arnold, 2016).

The following considerations can help guide states in supporting the integration of services in Medicaid ACOs:

- Acknowledge individual provider capacity to assume downside financial risk when designing financial strategies.
- Invest in Mental Health and SUD provider capacity building activities, including Health Information Technology (HIT) and technical assistance (TA), to enable data-sharing activities.
- Integrate behavioral health and physical health quality measures.
- Consider reorganization at the state agency level to promote integrated oversight and alignment across varied behavioral health initiatives.
- Revise licensure and other regulatory frameworks that can serve as barriers to provider-level integration (Brown and McGinnis).
- Recognize that economic modeling shows that providers who care for vulnerable populations are at a significant disadvantage in terms of personal and practice revenue when payment is based on or adjusted for total health outcomes (Long et al., 2011).

Table 1: ACO Strategies in Review

Payment Model	Opportunities and Obstacles
Global – Fully Capitated	Can motivate an ACO to invest its limited resources in services (including nonclinical services) that maximize health outcomes.
Partial Capitation + Shared Savings	A select group of services is paid through a capitated rate and if performance measures are met, shared savings occurs.
FFS + Capitation	Capitation payment is received and BH services are paid with a FFS payment

[11] While population health management focuses partly on the high-risk client who generate the majority of health costs, it systematically addresses the preventive and chronic care needs of every client. Because the distribution of health risks changes over time, the objective is to modify the factors that make people sick or exacerbate their illnesses. (Institute for Heatlh Technology Transformation, 2012)

Payment Model	Opportunities and Obstacles
FFS + Shared Savings	Can incentivize serving high cost, high need clients. Will need quality measures involved to avoid increased services without cost and value ties.

Medicaid Managed Care (MCO)

In a Medicaid Managed Care organization (MCO) arrangement, the organization is at risk for total member spending, and promotes coordination between medical providers and social service/community-based organizations. If MCOs are given flexibility to pay for social services through an 1115 waiver or other federal authority, opportunities to provide beneficiaries with enhanced care coordination or supporting services such as transportation or temporary housing can be pursued. States can include language in MCO contracts requiring them to pay for behavioral health services or partner with certain service organizations. States must be mindful, however, that provision of non-Medicaid services may impact actuarially sound rate setting processes and result in additional federal scrutiny. Some MCOs have already begun paying for social services using PMPM payment incentives. An Illinois Medicaid managed care organization, IlliniCare/Cenpatico, is paying a mental health and housing services provider, a PMPM fee for its services for high cost homeless individuals. Arizona's Integrated Care Management Pilot, pays an hourly rate for advancing access, quality, and cost-effectiveness in publicly-financed care management services. The rate is based on the estimate of what it would cost the health plan to employ case managers for the same services (Crawford and Houston, 2015).

Many MCO's contract with a behavioral health organization and carve-out the behavioral health services management and payment. The behavioral health services are not covered under the same fixed fee, or administrative oversight, as for medical services. This is being reconsidered due to bringing specialty expertise to address the co-occurring mental health and SUD needs of many of the members, as well as the high co-morbidity with medical conditions, and need for integrated care (Gifford et al., 2011). Another method is to include a contract requirement that MCOs coordinate and share information with behavioral health providers (Gifford et al., 2011). MCOs receive capitated payments from payers, such as Medicaid, and reimburse community mental health centers (CMHCs) through a FFS or CAP arrangement (Hackbarth, 2015).

Table 2: MCO Strategies – Paying for behavioral health/social services

Payment Model	Opportunities and Obstacles
Global/CAP	• Use a 1115 Waiver to pay for enhanced care coordination, transportation, and temporary housing • MCO contract language could require MCO to pay for specific behavioral health services. • MCO contract language requiring MCO to coordinate and share information with behavioral health providers. • PMPM payment incentives for mental health and housing providers. • Cautionary note in that adding these services to medical services in global payment may impact actuarially sound rate setting processes.
FFS to CMHCs	• Pay for case management to increase access, quality, and cost effectiveness. • Estimated fee is based on what it would cost to employ care coordinators.

Medical/Health Homes

Medicaid Health Homes are used to promote better care coordination for beneficiaries with chronic diseases, such as SMI and co-morbid physical health conditions. Health Homes can be designed in many ways.

- Pay a PMPM for care coordination provided by the Health Home and require the client to receive services at least monthly.
- Adjust the rate for case-mix and geography (Hackbarth, 2015).
- Promote investment in data and care delivery infrastructure.
- Require implementation of a uniform, multi-payer model[12] which allows for service delivery redesign costs to be spread across all clients, resulting in lower service costs (Sood and Higgins, 2012).
- Use global payments with risk-adjusted fixed-payments for a defined population. This model has been implemented on a limited basis because of issues of provider readiness (Sood and Higgins, 2012).
- Use a three-layer payment model:
    - Layer one reimburses discrete procedures/services through a FFS model.
    - Layer two adds care management paid with a PMPM for services that do not lend themselves to FFS.
    - Layer three finishes with shared savings that directs a portion of the total healthcare expenditures saved in serving the client population more effectively and rewards the providers if baseline quality measures are met. In most cases, 90% to 95% of the payment in this model remains fee-for-service, and "payment for volume" incentives remain in place (National Council, 2014).
- Use a zero-based budgeting exercise in which the payor works with the provider to complete these items:
    - Identify complexity and severity of client population.
    - Determine number of clinicians needed to support a team-based care model in which the clinic becomes a health and wellness center for those who do not have complex medical conditions.
    - Define infrastructure needed (technology, facilities, support staff, etc.) to support the high performing teams.
    - Specify the price tag associated with creating the clinic and its translation into a per-patient-per-month (PPPM) rate.
    - Standardize PPPM rate for all clinics that can then be risk adjusted for the severity and complexity of the clients within a given medical home.
    - Determine the key performance indicators that will support identification that the services being delivered are "lean," i.e. effective and efficiently provided.
    - Establish the performance metrics that need to be in place to measure whether the clinic is meeting the stated aims and is providing lean services.

[12] Multi-payer models: "To create a stronger economic signal that supports migration from FFS payment systems toward value-based payment systems and to make it easier for providers to participate in APM arrangements, states are seeking to align key parameters of their delivery system and payment reform programs with Medicare and commercial counterparts. For example, states pursuing ACOs and episodes-of-care models for Medicaid are incorporating payment methodologies, including attribution models and quality metrics that are similar to those used in the Medicare Shared Savings Program and commercial programs" (McGinnis and Houston, 2015).

The zero-based budgeting exercise results in a global monthly payment based on the number of clients enrolled multiplied by the PMPM rate. A number of these projects are also adding a shared savings layer that provide a bonus if total healthcare expenditures are reduced more than the extra money paid to the medical home. The behavioral health staff and related infrastructure costs become a line item in the global budget of the medical home. If behavioral health is being provided on a contract, the cost of that contract is built into the global budget. The risk is that the extra staffing and extra infrastructure to achieve the promise of the medical home substantially increases the budget paid through a Global Payment. In this scenario, if a medical home is not able to deliver on outcomes and save enough money through a reduction in emergency room, inpatient, and diagnostic imaging costs, the payors for that medical home will likely move the clinic back to fee for service and take the global payment business elsewhere. Therefore, the focus on an ability to measure and deliver appropriately "lean" services will be a core element (National Council, 2014).

Table 3: Medical/Health Home Strategies to Pay for Behavioral Health Services

Payment Model	Opportunity and Obstacles
PMPM	• Clients must receive services monthly • Adjust for case-mix and geography • Newer models require investments in data and delivery redesign such as the multi-payer approach • Multi-payor approach spreads infrastructure costs across all clients
Global	• 3-layer approach: 1-FFS for discrete services 2-PMPM for care management 3-shared savings if performance measures are met

Shared Savings Programs

Shared savings programs reward providers that reduce total healthcare spending for their clients below an expected level set by the payor. The provider is then entitled to a share of the savings. The idea is that the payor spends less on a client's treatment than it would have otherwise spent, and the provider gets more revenue than it otherwise would have expected. This model often requires upfront spending by the provider to implement the processes or technologies necessary to achieve success. While revenue may increase from such programs, it could be months or years in the future before performance improvement has been assessed (Valence Health, 2013). One model gives providers an annual, risk-adjusted, predicted total-cost-of-care target (TCOC) for a set of clients. Providers that succeed in keeping actual costs below projected costs can keep part of the savings. This approach incentivizes quality and cost improvements across all services included in the total cost and can be effective with PCMH and ACO models. Shared-savings arrangements represent a potentially higher level of reward for providers. While CAP's PMPM payments and FFS rate increases generally cover only the added infrastructure and staff resources, shared-savings can be an enticing incentive because providers offering PCMHs are often challenged to maintain previous productivity levels. Shared saving can be combined with fee-for-service, P4P, bundled payments, global payments, or partial capitation. In one iteration, FFS payments remain in place and the provider is eligible for a portion of savings achieved, or

is at risk for any increase in costs, relative to the projected total cost of care (McGinnis and Houston, 2015).

Shared savings calculations can be complex and potentially place states and CMS at risk if the calculations and trends are inaccurate or if the calculations are not routinely rebased to reflect changes to programs and the efficiencies that have been gained through better coordination and improved quality (CMS, "Medicaid Shared Savings Methodology," 2013). “A shared savings methodology typically comprises four important concepts: 1) a Total Cost of Care (TCOC) benchmark, 2) provider payment incentives to improve care quality and lower TCOC, 3) a performance period that tests the changes, and 4) an evaluation to determine the program cost savings during the performance period compared to the benchmark cost of care and to identify the improvements in care quality. In some instances, the provider payment incentives in the second step will be determined through the evaluation step. As states design shared savings methodologies, key goals should be to ensure that:

- Data analysis is used to determine that benchmark cost, performance period cost and the associated trend rates are accurate.
- Shared savings policies, such as saving thresholds, minimum savings rates, and target populations, work cohesively and that shared savings payments are made only for savings attributable to the program and not for random variations in TCOC.
- Beneficiary access shall not be reduced and quality of care shall be improved”(CMS, "Medicaid Shared Savings Methodology," 2013).

There are some providers that will benefit more from shared savings models than others. Those that are lower performers and are inefficient with resources, have high rates of hospital admissions, and high use of unnecessary procedures will benefit most. In contrast, the best performers—those with relatively low costs and high quality of care—are already saving payors significant amounts of money, and receiving no reward for doing so. Through the shared-savings model, the first group can improve relatively easily, thus becoming eligible for a large reward, while the second group may need to invest significantly more resources to obtain the rewards.

Shared savings do not need to be an all-or-nothing approach. A payor does not need to include all clients who the provider serves in the calculation. There is significant flexibility in how states design the incentive payment calculations. Providers can receive the bonus payment for measureable performance in quality, client satisfaction, resource use, and/or cost. A state could cover coordinating, locating, and monitoring services to all individuals eligible under the Medicaid state plan as an integrated care model and calculate the shared savings incentives based on individuals with high cost and complex care needs. This flexibility assumes that a state has a base methodology in the State Plan with CMS to pay for care coordination with the shared savings payments functioning as a performance bonus. States must monitor that individuals not included within the shared savings calculation have sufficient access to care coordination services (CMS, "Medicaid Shared Savings Methodology," 2013).

Payors will find it difficult to continue making shared savings payments indefinitely based on savings achieved in the past, particularly as the providers and their clients change over time. This may deter providers from making large investments in care improvements that would need to be paid off over a multi-year period.

About half of the studied shared savings models employed risk adjustment. They used four different models: the CMS hierarchical condition categories methodology[13]; the Prometheus payment methodology[14]; or one of two leading commercial risk-adjustment software packages.[15] Models electing not to use risk adjustment were more likely to be medical home initiatives or ones that the risk adjustment was determined not to be imperative. That was the case because the shared-savings model involved comparing the provider's performance to its own past performance. The model also assumed that the client population risk burden would not vary much from year to year (Bailit and Hughes, 2011). States can take additional risk protection steps by retaining some percentage of initial savings before sharing any additional savings with the provider. An example of this would be to make no bonus payments if savings are two (2) percent or less of the value of the estimated budget and only begin to share savings above that level and up to a maximum of five (5) percent (Bailit and Hughes, 2011).

A basic question for any shared-savings model is how to determine whether or not the provider achieved any savings. Savings are typically assessed for a 12-month measurement period and models typically assess savings in two ways:

- Comparison of provider-associated cost to a budget or target.
- Comparison to a control group.

Almost every shared-savings model uses performance measures on access, client experience, quality, and/or service utilization to determine the percentage of savings the provider will receive. The measures most often tend to address preventive and chronic care services, and for ACO-like entities, acute care services.

Gates and ladders. In some models, performance measures serve to define a minimum qualification or "gate." If the provider meets the minimum performance requirement, it is entitled to a fixed percentage of savings. Other models are more complex. They define a gate, and also specify that the provider can increase its savings beyond that amount by performing better relative to a performance measurement set and moving up a "ladder". In such instances, the percentage of savings eligible for meeting the minimum standards—that is, passing through the gate—is typically less than 50 percent. The Medicare Shared-Savings model may be the most complex example of this approach, with 65 measures spread over five performance domains, and providers expelled from the program for not meeting minimum performance standards for one domain for two years. Each measure within a domain is worth a

[13] The CMS HCC model was implemented in 2004 to adjust Medicare capitation payments to private health care plans for the health expenditure risk of their enrollees. CMS uses this model to risk adjust payments to health plans that participate in the Medicare Advantage program. This model uses enrollees' demographics and medical conditions grouped into 70 categories to predict costliness. (CMS, 2013).

[14] PROMETHEUS Payment model centers on packaging payment around a comprehensive episode of medical care that covers all patient services related to a single illness or condition. The costs of treatments are calculated into what is called an "Evidence-informed Case Rate" (ECR®), which creates a patient-specific budget for the entire care episode. It has a strong incentive for clinical collaboration to ensure positive patient outcomes. In addition to earning the base ECR payments, providers are given the opportunity to earn bonuses through a comprehensive quality "scorecard" tied to the reduction of potentially avoidable complications (Robert Wood Johnson Foundation, 2009).

[15] Johns Hopkins' adjusted clinical group's case-mix system and the Verisk Health Sightlines DxCG risk solutions product.

maximum of two points and a minimum of zero points, with points assigned based on performance relative to national Medicare FFS and Medicare Advantage percentiles. An ACO would get a single score for the domain based on the percentage of total points achieved. The average of the five domain scores would be the overall score, which would determine the percentage of the shared savings an ACO receives.

It is common in some models to include utilization measures. These measures typically assess the extent to which the provider is reducing preventable acute care service use including inpatient readmissions, potentially avoidable inpatient admissions, and potentially avoidable emergency department visits. The use of utilization measures has been a topic of debate. The measures can be viewed as both quality measures and as indicators of efficiency and cost savings. Some have argued that their inclusion represents a redundant incentive because, even without these measures, the provider will seek to achieve savings through reduced need for and delivery of these services. Still, some payers insist on their inclusion because of the perceived imperative for the payors to reduce costs associated with utilization of these services.

In one model, quality measures were employed as the qualifying gate, while utilization measures determined the percentage of savings earned above the gate. In other cases, quality, utilization, and other measures are not differentiated for purposes of evaluating performance and determining the percentage of distributed savings.

Benchmarks vs. improvement. Shared-savings models that use performance measures to determine provider savings allocation tend to use three basic approaches. The first involves scoring provider performance relative to a benchmark. Examples include regional Healthcare Effectiveness Data and Information Set (HEDIS) percentiles and payor-defined percentiles, as in the CMS Shared Savings Program. As providers meet or exceed higher benchmarks for each measure or composite measure, they earn more points, which translate into a larger share of savings.

The second approach assesses the extent to which provider performance has improved, compared with the prior year. Some models require the improvement to be statistically significant while others do not.

The third approach is to consider both performance toward benchmarks and performance improvement. One such example is to require annual improvement until such time that the provider reaches a high external benchmark, at which time the provider must only maintain performance at or above the benchmark year-over-year.

There are many variations in the application of the above approaches, including the following:

- The percentage of savings that is contingent on selected performance measures increases over a five-year phase-in period.
- Either reporting measures or maintaining performance is required in the first year, while performance improvement is required in the years that follow.
- Quality cannot be a consideration in a shared-savings distribution and the payor can operate a separate but parallel quality incentive pool.
- Quality scores can be combined into a composite measure for assessment purposes to address the problem of small observation counts for small provider entities.

Shared-savings payment methodologies are often viewed as transitional, with an undefined timeframe. Most providers and payors view their recent forays into shared savings as a learning experience and do not presume to know when they will want or be ready to transition to a risk-based payment arrangement inclusive of a combination of downside risk and greater upside risk. If this approach is seen as a long-term strategy, there will need to be adjustments over time. At least one payor felt that if a shared savings included downside risk, it would never be viable for smaller providers (Bailit and Hughes, 2011).

Figure 2: Typical Shared-Savings Payment Model Cycle

primary care, etc.)

(Valence Health, "Models of Value-based Reimbursements," 2013)

Centers for Medicare and Medicaid Services

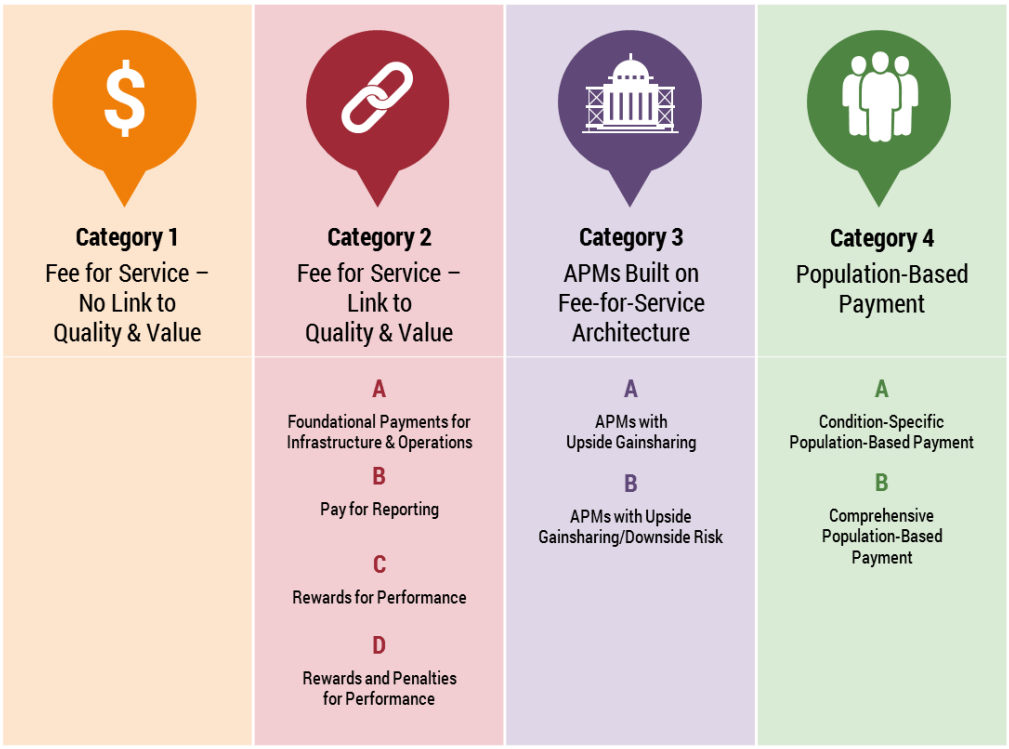
CMS is heavily invested in pursuing payment models and systems that increase value and decrease healthcare dollars by using a multipayor approach. CMS' goal is to tie 30 percent of traditional Medicare payments to quality or value by the end of 2016 and reach 50 percent by the end of 2018. Commercial insurance has set similar goals (Pantano, 2016). Two waivers are mentioned in the literature and use strategies to pay for generally unreimbursable services such as care coordination and support services.

- The 1115 waiver, used for experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs, is a waiver widely used.
- Although section 1332 waivers are not as popular, they can be coordinated with 1115 waivers to provide states the opportunity to coordinate and eliminate some of the differences between Medicaid and Marketplace coverage. Oregon may consider a Section 1332 waiver to expand on its Care Coordination Organizations (CCOs) with incentives to improve health outcomes, or to harmonize value-based purchasing standards in contracts with Medicaid MCOs, state employee plans, and state-based marketplace plans. The number of states interested in exploring 1332 waiver opportunities continues to grow. (McGinnis and Houston, 2015).

The Health Care Payment Learning and Action Network (LAN) was created to drive alignment in payment approaches across the public and private sectors of the United States health care system. The CMS Alliance to Modernize Healthcare (CAMH), the federally funded research and development center operated by the MITRE Corporation, was asked to convene a group to advance this goal. The group was charged with creating an alternative payment model (APM) Framework that could track progress towards payment reform. Composed of diverse health care stakeholders, their work resulted in a

rationale and a pathway for payment reform that is capable of supporting the delivery of person centered care. They began with the payment model classification scheme originally put forward by the CMS, and subsequently reached a consensus on a variety of modifications and refinements. The resulting Framework is subdivided into four Categories and eight subcategories, as illustrated below:

Figure 3: APM Framework



Source: (Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group, 2016)

CMS currently uses three strategies to invite the broader market to participate in transforming payment mechanisms. HHS is actively selecting models demonstrating connections with public sector and private sector payors. This concept is founded in "managing population health and being good stewards of health care resources"(Sood and Higgins, 2012). The three strategies are:

- **CMS as convener** used with the State Innovation Model Initiatives. CMS works with states to "act as convener for multiple payers, clinicians, and health care organizations".
- **Incentivize Clinicians and Organizations** to "bring other payers to the table".
- **State-Level Reforms** where CMS joins in state reform efforts (Rahul Rajkumar et al.).

Medicare Access and CHIP Reauthorization Act

Under the Medicare and CHIP Reauthorization Act (MACRA) CMS is supposed to improve the "relevancy and depth" of Medicare's quality-based payments. CMS introduced the Quality Payment Program, a value-based reimbursement framework that includes two paths to systemic improvement: the **Merit-Based Incentive Payment System (MIPS)** and the **Advanced Alternative Payment Models (APM)** track. Under the MIPS program, clinicians gain more flexibility because they choose measures and activities that are appropriate for the type of healthcare they provide. Health and Human Services (HHS)

proposed two types of Advanced APMs: Advanced APMs and Other Payer Advanced APMs. To be an Advanced APM, an APM is required to use certified Electronic Health Record (EHR) technology, provide payment for covered professional services based on quality measures and be either a Medical Home Model or only have a small amount of financial risk (Sampson, "MACRA Quality Payment Program Promotes Alternative Payment Models " 2016). Both MIPS and APMs are value-based payment models that incentivize providers on quality, outcomes and cost containment. MIPS is a program that streamlines parts of the Physician Quality Reporting System, the Value-based Payment Modifier and the Medicare EHR Incentive Program into one single program called the Quality Payment Program. Under MIPS, eligible professionals will be measured on quality, cost, clinical practice improvement and use of certified EHR technology (Sampson, "Top 5 things to know about MACRA," 2016).

Substance Abuse and Mental Health Administration

The Substance Abuse and Mental Health Administration (SAMHSA) has also ventured into supporting quality and value to purchasing strategies. Their Primary and Behavioral Health Care Integration (PBHCI) grants provide four years of funding to CMHCs to support integrated care for adults with SMI. The intent is to address disparities between physical and behavioral health. Emerging evidence suggests that CMHC-based integration can improve access to physical health care for adults with SMI, and also improve some physical health outcomes (Hackbarth, 2015).

SAMHSA also implemented the Certified Community Behavioral Health Centers (CCBHC) to provide a method to ensure coordination of care and linkages to other systems for behavioral health services. Phase one (planning) began in 2015 with phase two (implementation) scheduled for 2017. The goal is to create a more standardized and high-performing mental health system nationwide (Behavioral Council, 2015).

In this program, there are six required Measures for Quality Bonus Payments:

- Follow-Up after Hospitalization for Mental Illness (adult age groups)
- Follow-Up after Hospitalization for Mental Illness (child/adolescents)
- Adherence to Antipsychotics for Individuals with Schizophrenia
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
- Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

There are two payment methods available:

- CCBHCs receive a fixed daily reimbursement per visit – based on the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) approach used nationally and payment is the same regardless of intensity of services.
- CCBHCs receive a fixed monthly reimbursement for every individual who has at least one visit in the month with payment the same regardless of number of visits per month or intensity of services. CCBHCs do not receive payment in months when the client does not receive any services. This method allows CCBHCs to establish separate reimbursement rates for distinct populations in addition to a base rate – adults with SMI, children and youth with SED, individuals with serious SUD, individuals with a recent history of frequent hospitalizations due to behavioral health conditions (Behavioral Council, 2015).

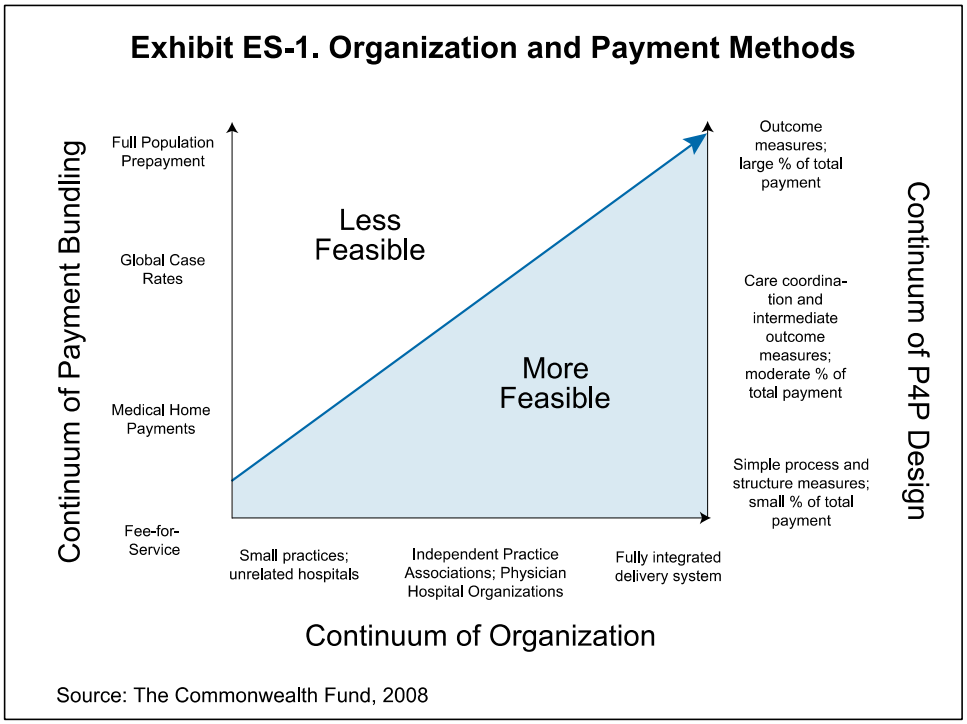
Considerations

Provider System

Whether a provider is small or large is a major factor in determining which payment system and service delivery and payment models can be implemented. A provider's technology capacity determines ability to measure performance outcomes and incorporate multi-payer strategies. The predominance of small practices and the absence of large systems in Salem, Oregon, resulted in a unique pay-for-performance model based on virtual care teams (Conrad et al., 2013).

Figure 4: Relationship Between Type of Organization and Payment Method, graphically represents the degree of feasibility of the type of payment methodolgy, the organization characteristics and alignment with the type of measures included in the P4P design.

Figure 4: Relationship Between Type of Organization and Payment Method



Source: Schoenbaum, Stephen, et al. (2008) "Organizing the US Healthcare Delivery System."Retrieved from http://www.commonwealthfund.org/publications/fund-reports/2008/aug/organizing-the-u-s--health-care-delivery-system-for-high-performance.

The Issue of Risk in System Delivery Models

The level of risk varies by service delivery model and payment model and risk varies for both the payor and the provider. Global capitation is a full risk model on the part of the provider in which the provider bears all financial risk for TCOC. With FFS, the payor bears the risk. Shared risk models involve financial risk-sharing between payors and providers. With shared risk, a target is predetermined to cover all spending on a client during a set time period, and compared to actual spending during that time. If actual spending is lower than the target, this difference is shared between the payor and provider. If the provider can only share in savings, and is not liable for losses, the provider is rewarded if spending is

higher than the target. This is also referred to as **upside risk**. If the provider shares in both losses and savings. This is referred to as **downside risk** (Hackbarth, 2015; Whittal, 2016).

As risk increases, so does the complexity of model. The extent to which risk is shared depends on provider financial and operational readiness to manage effectively downside risk. When risk is shared, it is sometimes defined within very narrow corridors (risk caps) (Burns and Bailit, 2015). Payment systems should be designed and implemented in a manner that manages providers' exposure to risks that are outside of their control and aligns incentives between all parties to achieve the triple aim (Norris and Davenport, 2016). If payment does not adequately account for social, behavioral, and environmental factors of clients, a potential "payment gap" can result. This payment gap occurs when payment systems do not adequately account for these factors. Over time this can lead to providers dis-incentivized to serve vulnerable populations because payment will be too low to cover their actual costs. "This unintended consequence of payment modeling could further limit patient access and, potentially, widen health disparities. P4P incentives and other value-based payment models, if not properly adjusted to account for social and environmental factors in addition to health factors, may actually widen existing health disparities, by dis-incentivizing providers to care for vulnerable populations" (Long, Phillips and Hoyer, 2011). Because the financial rewards or penalties that providers face in a value-based payment model are dependent on the development of accurate cost targets, it is important that cost targets be developed in a rigorous and credible fashion (Colleen Norris and Davenport, 2016). Theory and evidence suggest that small provider organizations are not equipped to assume actuarial risk. Random variation in population health is best borne by insurers. Well-validated, person-level health risk adjustment measures are a critical component of value-based payment, so that all provider organizations are only bearing performance risk (Conrad, 2015).

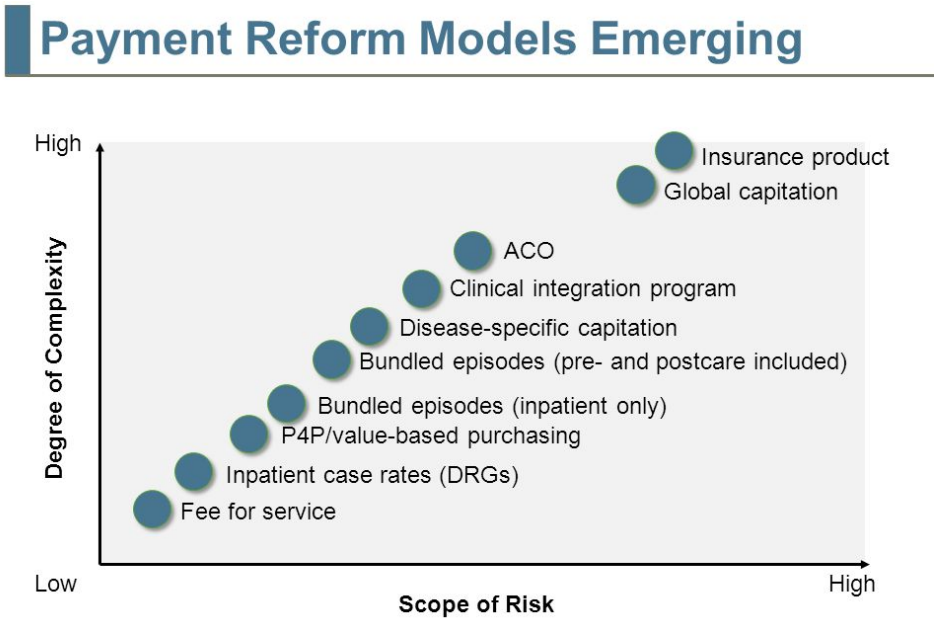
Limiting Risk

In order to maintain the viability of provider organizations and create a positive contractual environment, several techniques can be employed to limit the risk for providers while maintaining the intent of payment being tied to quality and value.

- **Risk adjustment** is an important tool to enhance the accuracy of cost target estimates and reduce exposure risks that are outside of the provider's control. The long-term viability of value-based payment mechanisms is predicated on these payments being fair and accurate for participating providers. An accurate payment is one that minimizes financial exposure to risks a provider cannot meaningfully influence (Norris and Davenport, 2016).
- **Risk corridor** arrangements are an alternate method of limiting risk. Corridors protect from high losses, and also obstruct opportunities for gains. All of these risk limiting strategies increase the likelihood that the payor and the provider organization can reach an agreement (Valence Health, "Models of Value-based Reimbursements," 2013).
- Use of three **"risk tracks".** Track 1 is a shared-risk model with risk corridors and stop-loss provisions. Track 2, the "transitional risk model," is a shared-risk arrangement with risk corridors and greater stop-loss provisions. Track 3 is a shared-savings arrangement (Burns and Bailit, 2015). This tiered system may assist providers in gaining experience with value-based payments.

To support the continued viability of providers, many systems also cap the extent of losses providers must bear to avoid provider exposure to excessive risk (Hackbarth, 2015).

Figure 5: Payment Model Risk Continuum



Adjusting for medical and clinical complexity is an important step in advancing payment models to better meet the realities of members and their need for care. Such adjustment alone is insufficient to address the needs of practices serving predominately individuals and populations who are at high-risk, chronically-ill, or otherwise vulnerable. Concerned that providers could be perversely incented to limit access to populations who are high-risk and chronically-ill and "cherry-pick" individuals or populations who are healthier, some payors developed mechanisms to adjust for clinical complexity in their payment algorithms (Long, Phillips and Hoyer, 2011).

The Issue of Incentives in System Models

The purpose of value-based payment models is to provide incentives or payment based on quality measures with the assumption that improved quality improves health outcomes and reduces costs to the insurer (Milburn and Maurar, 2013). There has been a significant amount of research identifying the factors that result in an effective incentive to achieve desired contractual results. Differing forms of value-based payment (e.g., shared savings and risk, capitation, and bundled payment), coupled with incentives for quality and efficiency, can be tailored to different market conditions and organizational settings (Conrad, 2015). Proven incentive strategies should be considered in designing a service payment system.

- Loss has greater power than gain of equal magnitude. (Kahneman and Tversky, 1979). It is recommended that payors should set the provider share of losses (deficits against the TCOC target) somewhat lower than the provider share of gains (TCOC savings) This incentive design will have a double benefit for payors of increasing participation of risk-averse and loss-averse providers and minimizing size of the required incentive.

- Two-sided models have stronger incentive effects than shared savings alone.
- Identifying a payor's incentive target will help focus incentives. For example, FFS payment for evaluation and management services and evidence-based preventive screening to increase these services support the payor value of prevention, while maintaining TCOC savings incentives.
- Adding outcome and quality-based P4P incentives to shared savings, will result in a stronger effect on value.
- To achieve improved value—better client experience, clinical quality, health outcomes, and lower costs of care—high-powered incentives should directly target improved care processes, enhanced client experience, and create achievable benchmarks for improved outcomes (Conrad, 2015).
- States and other payors are also implementing a variety of P4P initiatives that pay for reporting. This is a relatively low-risk payment approach that may help introduce performance-related goals to providers and organizations. As a first step in payment reform experience, it can lead to shared savings and shared risk arrangements or global capitation (Kaiser Family Foundation, 2015).

Table 5: Incentives-Strategy Summary

Outcome Desired	Strategy
Address small provider factors	• Do not require them to assume actuarial risk as they are not equipped
Add risk and loss-averse providers to system	• Use a 2-sided risk model and set the provider share of loss somewhat lower than their share in gains/savings
Emphasis value and maintain TCOC savings	• Use a FFS payment for evaluation, management, and evidence-based preventative screenings
Increase value	• Add outcome and quality-based P4P incentives to shared savings
Strengthen incentives power	• Select clear, achievable performance targets • Base targets on individual provider or provider organization rankings and do not compare to a group of peers • Rewarded incrementally—rather than based an all-or-none threshold
Strengthen the incentive power in a Global payment structure	• Tie payment size to expected client health benefit (through risk adjustment and incentives for evidence-based practice) and offer a large enough margin over cost to induce providers to attract new clients based on value • Add a P4P quality adjunctive to a base global payment
Increase Provider experience with shared savings and shared risk models	• P4P reward for performance on quality and reporting quality measures with fidelity

It is important to balance the cost of measuring an item with the benefit of the incentive effect on the provider. Clinical quality and client experience (process measures) are more controllable and lower cost than health outcomes.

- Although it is recommended to weight process measures higher in value-based payments, confirm that peer-reviewed evidence supports a strong link between the processes and health outcomes. Process measures must be broad enough to capture clinical behaviors related to positive health outcomes to avoid "treating to the test" (Houle et al., 2012; Conrad, 2015).

Small independent practices are poorly equipped to bear significant actuarial risk for random variation in health status. Consequently, FFS arrangements will be most feasible and need to be linked to P4P incentives based on measures of clinical quality and client experience to incentivize value, not volume. It is also important to avoid linkage of health outcomes or total cost per client over time because the smaller sample size could result in greater random variation in average cost and health outcomes (Conrad, 2015).

A lack of control weakens incentive effects. Financial incentives based on individual provider or individual organization performance has a stronger provider response than incentives compared to a group of peers. Peers' performance is not controllable, whereas the provider's own behavior is directly under his or her influence. Similarly, continuous provider progress toward improved value should be rewarded incrementally—rather than based an all-or-none threshold to qualify for any bonus payments for quality or outcomes. Selecting clear, achievable performance targets strengthens incentives for quality improvement (Conrad, 2015).

Capitation alone typically reduces the volume of services delivered. It does not provide strong incentive for value unless capitation size is tied to expected client health benefit with risk adjustment and incentives for evidence-based practice. It must also offer a large enough margin over cost to induce providers to attract new clients based on value. Use of a P4P quality incentive in addition to the risk-adjusted prospective capitation payment would also mitigate potential withholding in quality of care (Conrad, 2015).

A final item that appears to increase the strength of incentives is to have stable payment methods and levels. These two items were a key to the success of the Massachusetts' Alternative Quality Contact in which the payment level had continuity for five years (Conrad et al., 2013).

The Issue of Quality and Value in System Models

Quality and value drive innovations in payment reform. With the inability to sustain the current and every increasing health care costs, the models are testing numerous ways to achieve better health outcomes for the cost. Value-based reimbursement models have several things in common:

- Based on metrics or measures
- Not based on volume of services (although FFS may still underlie the reimbursement system)
- Frequently include efficiency or cost savings goals
- Include additional payment for achieving set goals or measures.

Value or performance-based contracting maintains existing FFS or capitation payment methods and ties payment increases or other incentives to providers' performance on specific measures of quality and efficiency. Examples of measures or metrics include client satisfaction, chronic disease management, evidence-based care process completion and reduction in costs or at a minimum a slowdown in rise of costs. Payment can be in the form of bonus payments or direct incentives or reimbursement for achieving all or some of the measures. The amounts vary among the programs and are usually above the

FFS reimbursement for services rendered. Some payors offer reimbursement at higher FFS levels and withhold a percentage until cost and quality targets are achieved (Milburn and Maurar, 2013).

P4P and other types of advanced payment models typically rely on clinical and/or claims data to measure quality of care. In all payment models that include clinical quality thresholds or benchmarks, health outcome goals should be based on recognized and evidence-based practices and all practice types should be held accountable for helping all individuals reach these goals. To lower goals for safety net practices could promote, instead of diminish, health disparities. However, practices that serve predominately individuals who are high-risk, complex, and chronically-ill may very well have a more difficult time achieving certain health outcome goals compared to practices that serve healthier and more economically-advantaged patients people (Long, Phillips and Hoyer, 2011).

Examples of general sources for clinical measures include:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- AHRQ Clearinghouse of Clinical Measures
- National Quality Forum
- National Initiative for Children's Healthcare Quality (HHS, 2012)

Policymakers and payors should consider the following as they research and assess the potential impact of payment models on practices that serve vulnerable populations:

1. **Service time:** Clients with complex needs require additional time to assess, monitor, and treat. Payment systems should acknowledge and facilitate this by providing practices with enhanced payment for high-value care delivered to clients with complex conditions.
2. **The value of enabling services:** As payment models continue to evolve towards value-based purchasing and bundled payments, payors should be mindful of the additional enabling services which are necessary for improving the health of vulnerable populations and find ways to support and encourage these services. FQHCs receive enhanced payment, in part to facilitate enabling services (e.g. transportation and housing supports, peer and employment supports).
3. **Adoption of a functional measure of social and environmental risk**: The US does not have a universal measure of social, behavioral, or environmental factors, which makes it difficult to understand or compare risks or outcomes across populations. The United Kingdom has developed indices of "social deprivation" that may provide a useful model for consideration. Safety net practices have historically implemented innovative programs to promote improved health outcomes for vulnerable populations. They regularly provide a variety of adjunctive services such as food, housing assistance, medication management services and most are grant funded. Payors will need to find ways to pay for these practices to care effectively for vulnerable populations. There is much work to be done to design and test payment models that adequately reflect these realities. In the meantime, awareness of the impact of incentives on provider finances, client access, and health disparities is needed.
4. **Refocus measurement**: If payment is tied to outcome measures, it is important to select measures that the practice has a moderate to high-degree of control; and, more importantly, to use reasonable and fair comparisons when developing thresholds and benchmarks". (Long, Phillips and Hoyer, 2011)

The focus on integrating physical and behavioral health services is impacting quality and value measures used. States are requiring payors or providers to report process and outcome measures that are jointly impacted by physical and behavioral health services for individuals with behavioral health conditions. While specific measures may vary from state to state, most Medicaid ACO programs are beginning to make shared savings payments contingent on meeting specific behavioral health-related process and outcome measure targets (Brown and McGinnis). Examples of some measures used include emergency department utilization rates, rates of avoidable hospitalizations, and medication adherence for both physical and behavioral health treatments. Results in one state (Pennsylvania) that used integrated measures showed decreases in psychiatric hospitalizations, all-cause readmissions, and emergency room use for individuals who used those specialty services (McGinnis and Houston, 2015). One quality measure that is effective to use for SUD detox is related to post discharge care. Research shows that a person who receives 90 days of post discharge care after SUD detox is less likely to relapse. Nationally less than 20 percent of detox episodes have subsequent post discharge care (Hicks, 2016).

Oregon's Coordinated Care Organizations have 17 performance measures tied to significant incentive pools. At least seven of these measures can be affected by the performance of specialty behavioral health providers:

- Follow-up after hospitalization for mental illness
- Screening for clinical depression and follow-up plan
- Mental and physical health assessment within 60 days for children in Department of Human Services custody (child welfare)
- Outpatient hospital and emergency department utilization
- Controlling high blood pressure
- Diabetes: HbA1c Poor Control
- Access to Care: Getting Care Quickly (National Council, 2014)

Implementation Recommendations

The following recommendations pertain to activities that payors could provide to aid providers in preparing for and gaining experience in value-based payment systems. These recommendations include:

- Establish a learning community to enable providers to learn about and share best practices for successfully operating under SDM/APMs.
- Develop an educational seminar series on APMs specific to provider chief financial officers.
- Support evaluation of existing data infrastructure and analytics capacity and provide capital support for providers to access and use high-quality data.
- Offer technical assistance on unique situations or challenges identified by particular providers (Burns and Bailit, 2015).

Successful payment reform requires providers and payors to collaborate and coordinate and may be impeded by the many contentious and competitive relationships among stakeholders. Conversely, strong payor-provider relationships appear to facilitate the implementation of payment and system changes (Conrad et al., 2014).

State Models

The four model states described below offer a number of approaches, lessons learned, and better practices which can support Texas in achieving its objectives.

Colorado

For fiscal year (FY) 2015–2016, the Colorado Department of Health Care Policy and Financing (HCPF) contracted with five behavioral health organizations (BHOs) to provide mental health services to Medicaid-eligible recipients. The Department identified a set of performance measures reported by the BHOs for validation for the measurement period of July 1, 2014, through June 30, 2015 (FY 2014–2015). These measures represented HEDIS-like measures and measures developed by the Department and BHOs. Some of these measures were calculated by the Department using data submitted by the BHOs; other measures were calculated by the BHOs. With the exception of Penetration Rates, all measures are calculated using paid claims/encounters data. HCPF requires BHOs to complete and submit annually a Quality Improvement Plan and Annual Quality Report. These reports note findings and opportunities for improvement and list techniques used by the BHOs to improve performance.

Colorado's Office of Behavioral Health (OBH) also contractually requires its providers to collect and report on agreed upon measures. Colorado's behavioral health data systems include the Colorado Client Assessment Record (CCAR) and the Drug Alcohol Coordinated Data Systems (DACODS). The Colorado Client Assessment Record (CCAR) data are required on all admissions and discharges to the Colorado Public Mental Health System. The Drug/Alcohol Coordinated Data System (DACODS) data are a SAMHSA-required source of data in order for states to receive funding to support SUD treatment services. Both systems record client demographics, behavioral health diagnoses, treatment episodes, and treatment outcomes indicators.

Considerations for Texas: Colorado provides an example of performance measurement within a managed care structure as well as utilization of measures developed by the state and managed care entities (as opposed to adoption of HEDIS measures).

Indiana

Each Community Mental Health Center (CMHC) that contracts with Indiana's Division of Mental Health and Addiction (DMHA) receives quarterly payments totaling 90% of their total allocation. The remaining 10 percent of funds are awarded based on how well each provider meets its goals for a given quarter; for each goal met, a certain percentage of the remaining 10 percent is allocated. DMHA also offers bonus incentives for providers that exhibit good performance during the quarter. The majority of measures are based on data from the Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA) tools. This data is reported to the state's performance measurement system, Data Assessment Registry Mental Health and Addiction System (DARMHA). Whether a provider is motivated by these funds largely depends on their access to a variety of other funding sources.

Considerations for Texas: Indiana provides an example of pay for performance utilizing metrics derived from CANS and ANSA data. The state has increased the percentage of dollars at risk for providers over time and may be able to provide implementation insights for Texas. The state has invested time and other resources in maximizing the provider monitoring capabilities of CANS and ANSA, including its data reporting system.

Oklahoma

Oklahoma's State Behavioral Health Authority (SBHA) requires providers to request authorization for service prior to payment. This ensures that the state has high levels of participation from providers. The SBHA also ties payments to provider performance on how well they meet a handful of outcome measures. The SBHA would like to increase the number of measures it uses for incentive payments to ensure that providers focus on improving their services overall, rather than limiting their focus to a few areas based on payment. The SBHA allows providers to review other providers' outcomes. In the past, the SBHA has received calls from providers wanting to know why other providers have done so well in certain areas, which leads to a review of the data. This transparency helps ensure that none of the providers are gaming the system.

Washington State

As directed by the Legislature in statute, and as a key strategy under Healthier Washington, Washington State's Health Care Authority (HCA) has pledged that 80 percent of HCA provider payments under State-financed health care programs—Apple Health (Medicaid) and the Public Employees Benefits Board (PEBB) program—will be linked to quality and value by 2019. The state is leveraging an 1115 Medicaid transformation waiver to accelerate payment and delivery service reforms and reward "regionally-based care redesign approaches that promote clinical and community linkages through State-purchased programs." Within the waiver application Washington committed to having 90 percent of its provider payments under state-financed health care linked to quality and value by 2021.

This transition to value-based payment coincides with the states movement to a fully integrated Medicaid Managed Care across its regions. The integration initiative began in 2014 with Senate Bill directing the Department of Social and Health Services (DSHS) to integrate funding and oversight for behavioral health (mental health and substance use) treatment services. At that time the state purchased behavioral health services from two separate systems: Regional Support Networks and counties. In April 2016, administration of these services transferred to regionally operated Behavioral Health Organizations (BHOs), many of whom served as the Regional Support Networks and now operate under the new managed care structure. BHO contracts include inpatient and outpatient treatment, involuntary treatment and crisis services, jail proviso services, and services funded by the federal block grants. The State's long term goal is to integrate the BHOs into the State's Apple Health Managed Care Organizations by 2020.

Washington plans to fully integrate behavioral health and implement value based payments draws on components of Healthier Washington (Payment Redesign Model Tests, Statewide Common Measure Set and Accountable Communities of Health), the Medicaid transformation waiver, and the Bree Collaborative care transformation recommendations and bundled payment models.

Considerations for Texas: Washington like Texas has most behavioral health benefits within managed care and can provide examples of alternative payment methodologies under these arrangements. Washington is bold in its plans for large percentages of funding "at risk" to BHOs and health plans and may serve as a future model for not only behavioral health but also Medicaid managed care contracting in Texas.

Current Contract Payment Mechanisms in Texas

Public behavioral health services in Texas are dispersed among many programs and agencies. Individuals in need of treatment may receive care through a variety and combination of state agencies, including:

- Health and Human Services Commission
- Department of State Health Services
- Department of Family and Protective Services
- Department of Aging and Disability Services
- Department of Assistive and Rehabilitative Services
- Texas Department of Criminal Justice
- Texas Department of Juvenile Justice
- Texas Education Agency
- Texas Department of Housing and Community Affairs
- Texas Veterans Commission

In addition to state entities, behavioral health services are provided at the local level in a variety of settings (Hogg Foundation, 2014).

Coordinated Statewide Behavioral Health Expenditure Proposal for Fiscal Year 2017

In an effort to enhance cross-agency behavioral health service coordination, Article IX, Section 10.04, created the Statewide Behavioral Health Coordinating Council for the purpose of working collectively to develop a five-year Statewide Behavioral Health Strategic Plan and a Coordinated Statewide Behavioral Health Expenditure Proposal for fiscal year 2017. The Coordinated Statewide Behavioral Health Expenditure Proposal provides information regarding $1.8 billion in behavioral health expenditures for Fiscal Year 2017. Expenditures, shown in the below table, are linked to applicable goals in the strategic plan to demonstrate how State appropriations will be spent in accordance with, and further the goals of the plan (Texas Statewide Behavioral Health Coordinating Council, 2016).

Summary by Service Type Category	Proposed FY 17 Expenditures – All Funds
Education and Training	$ 4,000,000
Information Technology	$ 1,882,365
Infrastructure	$ 2,882,062
Intervention and Treatment Services	$ 1,657,002,029
Prevention	$ 98,976,583
Research	$ 6,000,000
Staff	$ 16,963,628

Department of State Health Services Funding

Texas entered the 83rd legislative session ranking 49th in per capita mental health spending. According to the Hogg Foundation for Mental Health, “realizing that transformative actions were imperative to expand access to mental health services, nearly $350 million more was appropriated for FY 2014 and 2015 than was allotted in the previous biennium. This increase put an end to a decade of flat funding for behavioral health. The FY 2014–2015 DSHS budget contains an unprecedented $2.6 billion for the public mental health system, with $1.7 billion from the state general revenue” (Hogg Foundation, 2014).

Contracted Service Providers

LMHAs

Designated Local Mental Health Authorities (LMHAs) primarily provide public mental health services in Texas. HHSC/DSHS contracts with and oversees 39 LMHAs to provide or arrange for the delivery of community mental health crisis and ongoing services for children, adolescent and adults who are medically indigent, individuals with a priority population diagnosis as well as those eligible for Medicaid residing in specific geographic areas. The LMHAs are required to plan, develop and coordinate local policy, resources and services for mental health care as well as develop external provider networks and serve as a provider of last resort (Hogg Foundation, 2014).

Sanctions, Withholds, and Liquidated Damages

Currently, LHMAs are contractually obligated to meet the service targets, performance measures, and outcomes outlined below and described in detail in Appendix A.3. The existing payment system used with the LMHA contracts is an allocation model with 10 percent of general revenue funds withheld to use in a performance based incentive system for adult, child, and crisis mental health services. LMHAs have an opportunity for a release from the Ten Percent Withhold and payment of these funds if performance targets are met. Each target represents a percentage of the overall withhold. Contract requirements and performance measures not tied to the Ten Percent Withhold are enforced through standard contract remedies and sanctions. There are currently 29 measures tied to LMHA financial implications, including the 13 measures tied to the Ten Percent Withhold.

Ten Percent Withheld General Revenue Measures: Rider 78, Mental Health Outcomes and Accountability, requires Ten Percent Withhold of funds in strategies B.2.1, B.2.2 and B.2.3 with payment contingent upon achievement of outcome performance. Performance assessed and payments are made on a six-month interval. For each outcome target met, the Contractor will receive a percentage of withheld general revenue allocation in proportion to the number of outcome targets met. For each individual outcome measure met, the Contractor may be eligible for redistribution of general revenue funds that are withheld from Centers that did not meet outcome targets:

- Resilience and recovery outcomes – adult mental health services
    - Employment
    - Adult community tenure
    - Adult improvement
    - Adult monthly service provision
- Resilience and recovery crisis outcomes – applicable for adult and children's mental health services
    - Hospitalization
    - Effective crisis response
    - Frequent admissions
    - Access to crisis services
    - Adult jail diversion
- Resilience and recover outcomes – children's services
    - Juvenile justice avoidance
    - Child and youth community tenure
    - Child and youth improvement
    - Child and youth monthly service provision

Benchmarking Measures: As a result of the Sunset Committee recommendations in 2014, HHSC/DSHS conducted an internal evaluation and engaged stakeholders in a process to identify potential changes, with particular focus on measures associated with the Ten Percent Withhold. This process resulted in a recommendation to replace some of the existing adult and child measures with revised or alternative measures. These proposed new measures were added to the LMHA contract in fiscal year 2016 for benchmarking purposes, but are not currently associated with any penalty or sanction. After further work, stakeholders recommended changes to the crisis measures, but those recommendations have not yet been incorporated into the contract for benchmarking. While the proposed measures were meant to go into effect in fiscal year 2017, the process was suspended pending the mandated evaluation of measures by a third-party evaluation and feedback (i.e. this report). As such the proposed adult and child measures remain in the fiscal year 2017 contract as benchmarking measures with no associated sanctions.

- Employment
- Residential Stability
- Strengths
- Life Domain Functioning
- Educational or Volunteering Strengths
- School
- Living and family situation

Substance Use Disorder Providers

HHSC/DSHS provides substance use disorder (SUD) services for eligible youth and adults and contracts with service providers to deliver treatment. In Texas during FY 2013, 54,914 (three percent) of the 1,776,671 adults and 6,928 (four percent) of the 187,837 youth with chemical dependence and medical indigence were served by HHSC/DSHS-funded SUD providers, including the NorthSTAR program. HHSC/DSHS has attempted to address funding concerns by expanding the capacity of the SUD treatment delivery system beyond the level established by the Legislative Budget Board (LBB). HHSC/DSHS serves an average of 9,306 individuals monthly, exceeding the LBB's target goal of 8,851 individuals per month (Hogg Foundation, 2014).

According to the Hogg Foundation, SUD funding was increased by over $25 million in the 83rd legislative session, including nearly $11 million to increase provider reimbursement rates for SUD services in an attempt to attract new and competitive providers into the service system. The legislature also approved an appropriation of $10 million to create additional service capacity for parents whose children are in Department of Family and Protective Services' custody due to parental SUD issues (Hogg Foundation, 2014).

Sanctions/Liquidated Damages

SUD measures have no automatic sanctions. If a sanction was imposed it would be in the form of the following Liquidated Damages: $500 for the first occurrence of noncompliance during a fiscal year; $750 for the second occurrence of noncompliance with the same requirement during the same fiscal year, and $1,000 for the third and subsequent occurrence(s) of noncompliance with the same requirement during the same fiscal year.

State Hospitals

For the FY 2012 – 2013 biennium, the 82nd Legislature appropriated approximately $783.4 million in all funds and 7,974 full-time-equivalent (FTE) employees for state hospitals. In the 83rd Legislative Session for the FY 2014-2015 biennium, appropriations increased by over $52 million (Hogg Foundation, 2014). The table below displays contracted community hospitals, state allocated funds and the number of hospital beds available.

Community Hospital	Annual Funds	Number of Beds
Montgomery County	$15,000,000	100
Harris County	$31,893,696	179
Gulf Coast Center	$3,726,006	18
Sunrise Canyon	$4,126,274	30
Hill Country MHMR	$2,357,120	16
Tri County MHMR	$1,104,125	5
Center for Health Care Services	$5,520,625	25
UTHSC-Tyler	$4,635,940	30
Tropical South Texas Behavioral	$2,208,250	10
MHMR of Tarrant County	$4,031,060	20
Total	$74,603,096	433

Source: Hogg Foundation for Mental Health. (Month, 2014). A guide to understanding mental health systems and services in Texas. Retrieved from http://www.hogg.utexas.edu

Sanctions/Liquidated Damages

As DSS operates State Hospitals, they are not under contract and are not subject to sanctions.

The Changing Environment

Recent changes impacting behavioral services in the State include the following:

- **1115 Waiver:** The CMS 1115 waiver creates two different funding pools—the Uncompensated Care (UC) and the Delivery System Reform Incentive Payment (DSRIP) pool—with funds totaling $29 billion over the five-year period from 2011 to 2016. The goal of the 1115 waiver is to develop innovative care models focused on improving care for individuals, overall health and the efficiency of healthcare service delivery in the State. Of the over 1,400 DSRIP projects over 25 percent have a behavioral health focus.
- **Senate Bill 58:** In Texas, the providers eligible to receive Medicaid reimbursement for rehabilitation and targeted case management services have historically been limited to LMHAs. However, because of SB 58, effective September 1, 2014, targeted case management and mental health rehabilitative services for individuals with mental health conditions who are eligible to receive Medicaid benefits are now delivered through state managed care programs (STAR and STAR+PLUS), with the goal of better care coordination. HHSC will contract with the various health plans to oversee delivery of these services. Initially, the health plans will primarily be contracting with the LMHAs to provide these services throughout Texas. HHSC has indicated that this initiative will later broaden the provider base.

Chapter 6: Contract Performance Payment Mechanism Recommendations

A described above, the existing payment system used with the LMHA contracts is an allocation/capitation model with 10% of general funds withheld to use in a performance based incentive system for adult, child, and crisis mental health services. LMHAs have an opportunity for a release from the Ten Percent Withhold and payment of these funds if performance targets are met. Each target represents a percentage of the overall withhold. There are currently twenty-nine measures tied to LMHA financial sanctions or liquidated damages; thirteen measures are specifically tied to the Ten Percent Withhold.

The purpose of VBP models is to provide incentives or payment based on successful achievement of process and outcome measures with the assumption that this success translates to improved quality of care and improvement in health outcomes and reduces costs to the payor.

The goal of P4P payment models is to move from FFS services or other reimbursement methods that incentivize volume and do not tie to quality or value. Given that the goal of Texas' performance based incentive system is to increase quality and value, it is recommended that the State maintain a clear differentiation between data collected to inform compliance with contract (and/or other statutory or regulatory) requirements with those outcome and quality measures that are part of a pay-for-performance system. Performance measures and other contract requirements not tied to payment should be monitored, with corrective action plans and/or other remedies used to address performance issues when needed.

Building upon research, Texas system review, analysis of results, and multiple meetings with stakeholders, the following recommendations and strategies are offered for the State's consideration.

Overarching Performance Contract Payment Mechanism Recommendations

The overarching recommendation is to establish individualized incentive targets based on the provider's performance and their capability to engage in continuous quality improvement rather than establishing system wide performance targets. Data analysis shows that some providers consistently struggle more than others in their ability to meet performance targets and are therefore differentially affected by financial sanctions. By focusing on individual provider performance improvement and application of individualized targets rather than a group of peers, the incentive power is strengthened. In tying reimbursement to meeting individualized targets, Texas would reward continuous provider progress and incremental improved value–rather than base payment on an all-or-nothing threshold.

For providers maximizing their measure targets, it is critical for them to maintain this achievement. Maintenance of performance is an appropriate goal in these circumstances. Maintaining requirements for these targets also sustains attention on the focus areas of these measures.

The second overarching recommendation is that the State delay for one year tying payment to new or modified measures to allow providers to develop necessary data collection and reporting infrastructure, as well as determine LMHA baselines. HHSC/DSHS has used this approach with previous measure changes.

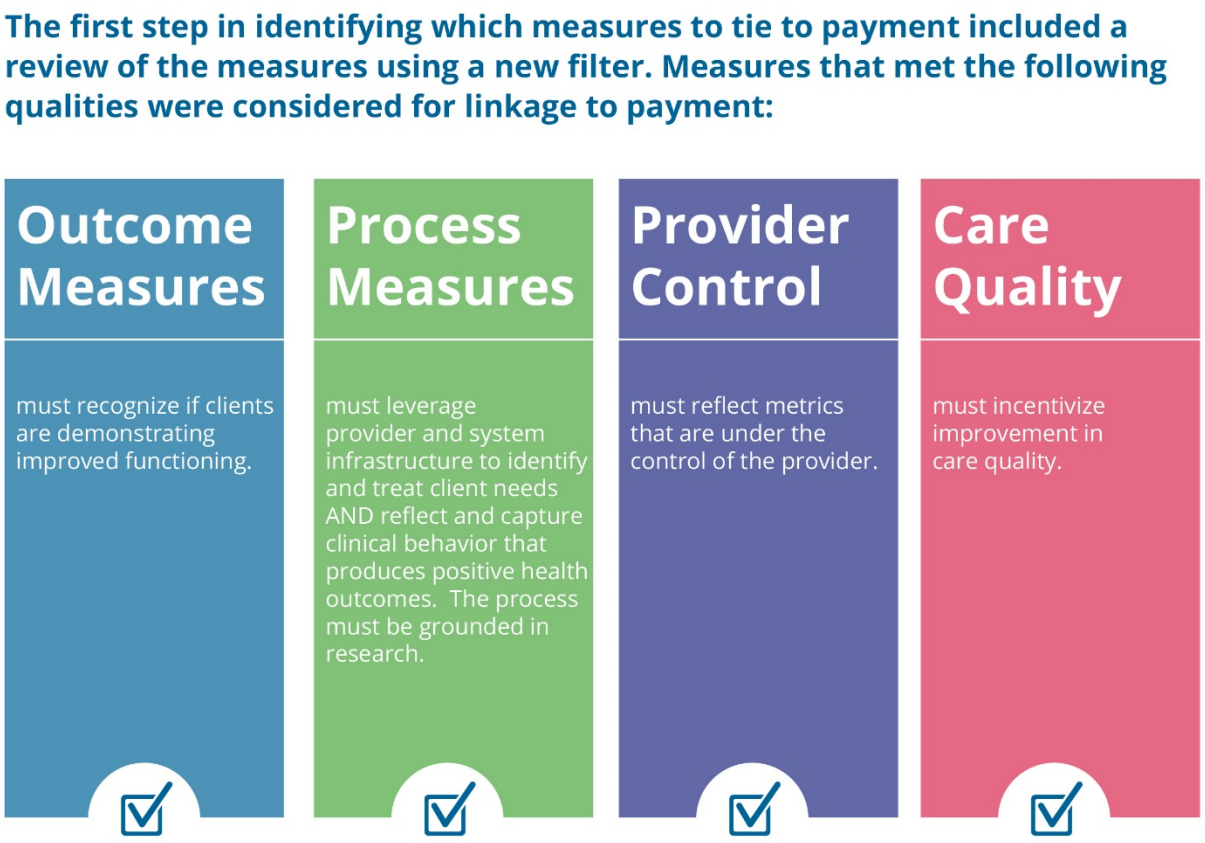
Consideration of Specific Incentive System Strategies for Performance Measurement

A review of the literature revealed several incentive strategies currently under use, as well as emerging models for value based payment. The following items highlight three of these strategies that are feasible in a public behavioral health system of care.

- Applying a **bonus payment** for achieved measures or metrics tied to client satisfaction, chronic disease management, evidence-based care process completion, and reduction in costs or at a minimum a slowdown in the rise of costs are several options to consider.
- Implementing a **shared savings** approach for specific populations or a subset of populations such as individuals with SMI, individuals who are homeless or in unstable housing, areas wherein the data show high utilization of hospitalization or emergency room use to incentivize providers to serve the hard to reach and potentially begin to control the high cost service utilization.
- Applying a bonus payment or making sure the allocation algorithm includes **enhanced funding** to facilitate initiatives to serve individuals who are hard to reach, allows providers' payment for activities of engagement and outreach which are generally not reimbursable. This type of incentive would also stimulate transformative services for populations that are harder to serve.

The first step in identifying which measures to tie to payment included a review of the measures using a new filter. Measures that met the following qualities were considered for linkage to payment (See Figure 6 below).

Figure 6: Steps to Consider Linking Measure to Payment



The current Texas system uses withholds, reduction of allocations, and liquidated damages as strategies.[16] Two funding options for LMHA contracting that utilize P4P strategies are presented below for consideration. Both P4P strategies take advantage of existing data sources, continue to use the Ten Percent Withhold, and reduce the number of measures tied to performance based reimbursement and the 29 measures that are currently tied to financial sanctions. Both recommended strategies add positive incentives to increase incentive power. Further, both P4P strategies utilize the same seven performance measures to be tied to payment, but within different incentive structures.

Performance Measures Recommended to be Tied to Payment

Measures Tied to Payment

1. **Effective Crisis Response**
2. **Crisis Follow Up (7 and 30 days)**
3. **Adult Community Tenure**
4. **School**
5. **Follow Up – Face to Face (7 and 30 days)**
6. **Adult Improvement**
7. **Child and Youth Improvement**

We recommend a decrease in the number of measures tied to the Ten Percent Withhold from 13 to seven (7). The seven measures selected have a far-reaching impact when targets are met, as they reflect and measure an individual's improvement based on six broadly defined domains. Recommended measures one through five (1-5) broadly focus on crisis response and follow-up. Measures six (6) and seven (7) are improvement measures that have the capacity to leverage a total of thirteen domains of recovery and resilience from the CANS and ANSA tool. We have structured the P4P strategies so that the weighted distribution of incentives is evenly balanced between the five crisis and two improvement measures. Specifically, fifty percent, or half, of the Ten Percent Withhold is tied to the crisis measures, and the other fifty percent of the Ten Percent Withhold is tied to the improvement measures.

In order for adult improvement scores to demonstrate improvement, individuals must will show improvement in one or more of the six domains listed below:

- Risk behaviors
- Behavioral health needs
- Life domain functioning
- Strengths
- Substance use
- Adjustment to trauma

And in order for children and youth served in the system to demonstrate improvement, they will

[16] Note: Currently there are 13 measures tied to 10% Pay for Performance withhold, 11 are subject to liquidated damages, and five have a percent of adult/child allocation as sanctions.

improvement within one or more of these seven family and educational domains:

- Child strengths
- Behavioral and emotional needs
- Life domain functioning
- Child risk behaviors
- Adjustment to trauma
- School performance
- Substance use

With providers focused on fewer targets, service impact to clients could continue to be broad and far-reaching. This recommended approach will also allow providers to monitor outcomes at individual and population levels. Attention was paid to ensuring the measures are within the control of the providers, and should have LMHA-specific targets. The shift to more outcome verses process measures enables providers to determine services and supports that achieve the best outcomes for the target populations. For example, providers' efforts could be more focused on practices resulting in increased recovery and resiliency rather than frequency of contact. Targeting fewer measures under the withhold strengthens the focus on the remaining measures, increasing the positive impact in those areas.

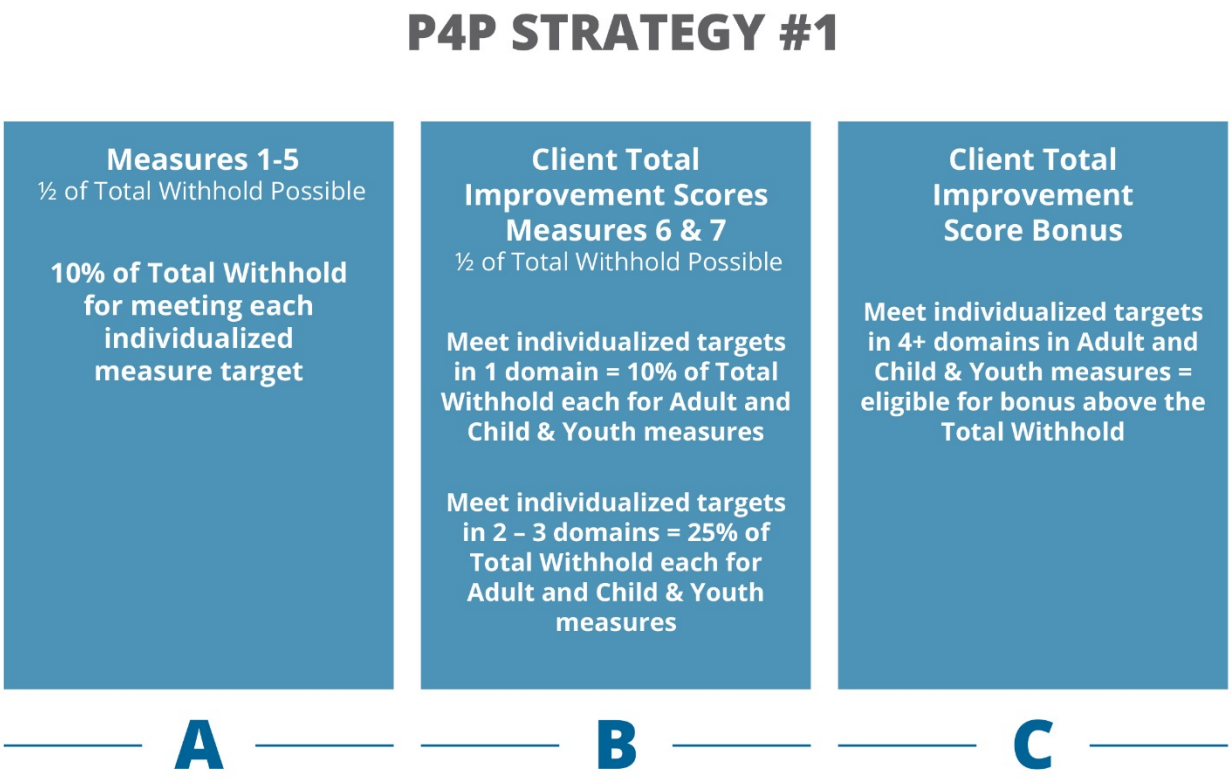
Performance Based Payment Strategy #1

The strategy has three sections: Sections A, B, and C.

Section A	Measures 1-5: One point can be earned for each target met for measures 1 – 5. Provider can receive up to ½ of total Ten Percent Withhold. *Example: $1,000,000 withhold. $500,000 possible for Section A. $100,000 for each target met.*
Section B	Measures 6-7: *Adult/Child Improvement* – Measures with multiple CANS/ANSA domain targets. 1. Meet one CANS/ANSA domain target = $^{1}/_{10}$ of total withhold 2. Meet two – three CANS/ANSA domain targets = ½ of total withhold *Example: $1,000,000 withhold. $500,000 possible for section B.* • *One specified ANSA/CANS target = $100,000* • *Two-three specified ANSA/CANS targets = $500,000* ***Calculation:*** • **Adult Improvement:** Percent of adults authorized into a facility level of care (FLOC) will show reliable improvement in at least **one or more** of the following ANSA domains/modules: Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Strengths, SUD, and/or Adjustment to Trauma. Reliable Improvement is defined as a calculated value of the Reliable Change Index (RCI) that exceeds a

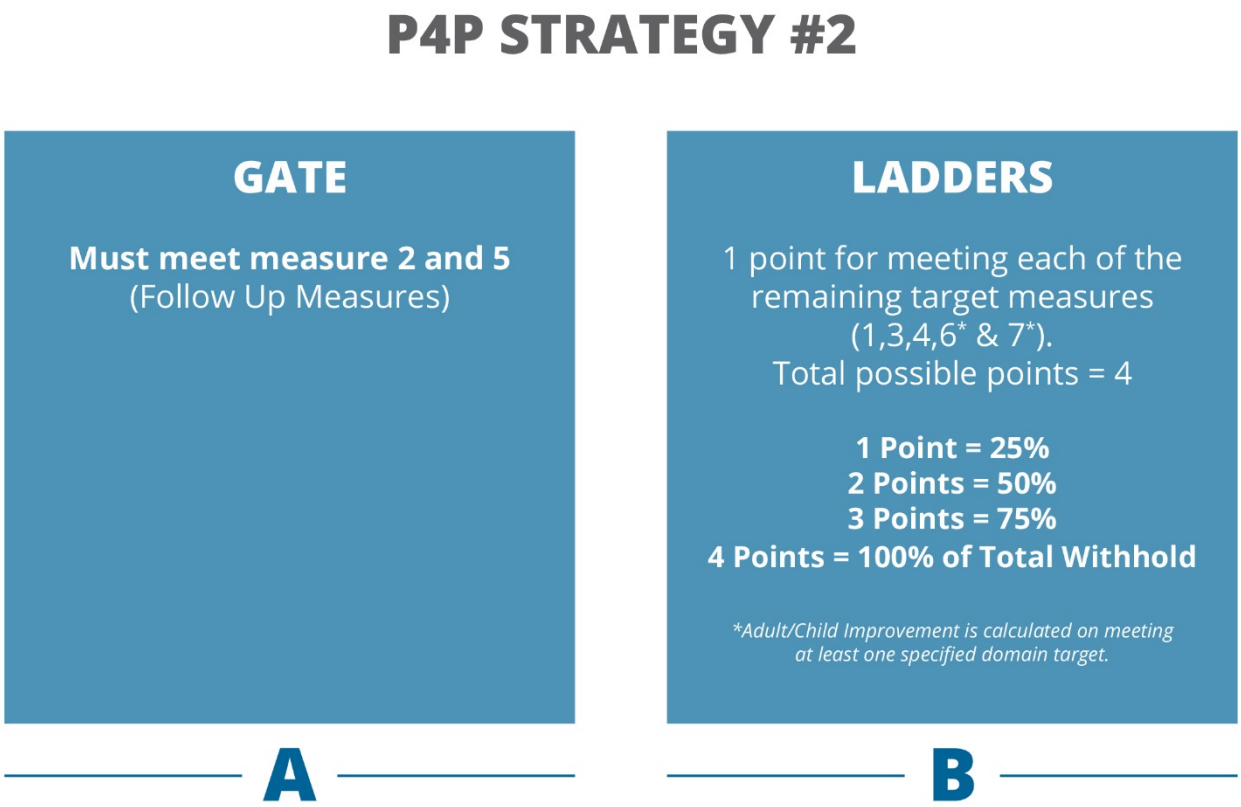
	benchmark value lower than 1.645 (indicating fewer problematic symptoms) over the measurement period. 1. Numerator: Number of adults enrolled in a FLOC meeting or exceeding the RCI in one of the identified ANSA domains/modules and the first and last Uniform Assessments are at least 90 days apart. 2. Denominator: All adults enrolled in a FLOC whose first and last Uniform Assessments, including ANSA domains/modules, are at least 90 days apart. • **Child and Youth Improvement**: Percent of children/adolescents authorized into a FLOC will show reliable improvement in at least **one or more** of the following CANS domains/modules: Child Strengths, Behavioral and Emotional Needs, Life Domain Functioning, Child Risk Behaviors, Adjustment to Trauma, School Performance, and/or SU. Reliable Improvement is defined as a calculated value of the RCI that exceeds a benchmark value of -1.645 in the negative direction (indicating fewer problematic symptoms) over the measurement period. 1. Numerator: Number of children/youth enrolled in a FLOC meeting or exceeding the RCI in one of the identified CANS domains/modules and the first and last Uniform Assessments are at least 75 days apart. 2. Denominator: All children/youth enrolled in a FLOC whose first and last Uniform Assessments, including CANS domains/modules, are at least 75 days apart.
Section C	Meet 4 or more CANS/ANSA domain targets within measures 6 and 7 and become eligible for bonus payment above the Ten Percent Withhold. Bonus funding source will come from funds withheld from providers not meeting targets. A risk corridor for the bonus payment could be implemented to increase comfort level of providers and the State.

Figure 7: P4P Strategy #1



P4P Strategy #1 has the advantage of a possible bonus payment. The State could also customize the ANSA/CANS domains eligible for points in a contract period to emphasis priorities and direct provider focus. The strategy uses an incremental incentive design, strengthens incentive power by adding positive reinforcement, and individualizes measure targets. While it reimburses for process measures, the processes are tied to research and the major incentive is based in client improvement.

Performance Based Payment Strategy #2



Strategy #2 requires meeting a minimum performance qualification in Step A (meeting two LMHA targets) to be eligible for the Ten Percent Withhold. It also uses an incremental incentive design in Step B. Incentives in this strategy focus on reduced hospitalization and client improvement.

Additional Recommendations

In addition to the two P4P strategies described above, additional considerations are provided throughout the report. In areas where the State wishes to increase volume, such as specific evidenced-based practices, applying a FFS reimbursement strategy which incentivizes volume could be considered. The State could take a portion of the funding outside the ten percent general fund set aside for performance measurement strategies. This approach could be included in the contract requirements. Using the zero-based budgeting exercise cited earlier in this report would help set the allocation level for this set aside.

It is further recommended that technical assistance dollars should continue to be focused to providers who are challenged in achievement of their individualized targets. Rider 78 states that, “Funds that have been withheld for failure to achieve outcome targets will be used for technical assistance and redistributed as an incentive payment according to a methodology developed by the department.”

P4P: SUD Measures

Since SUD measures are not currently tied to payment, if Texas plans to include them in the performance based incentive system at a later date, it is recommended that the State assist providers in

preparing and establishing individual targets for SUD treatment measures. Focusing on continuous improvement and maintenance of the target if they maximize the measure is the recommended approach. The measures that meet the qualities listed earlier for the LMHA measures (outcome, process, control, and quality) are the SUD measures that could be tied to payment. Several SUD treatment measures that demonstrate these qualities are:

- Community Support Referrals
- Detoxification (any setting) plus referral
- Number of Motivational Sessions per Client with Multiple Residential Detoxification Episodes
- Receive reproductive health visits

Implementing the ANSA/CANS into the SUD system would provide a powerful tool to leverage across systems, provide common behavioral health system language, offer a method to assess for cross system client improvement, and allow for performance based strategies for client improvement are SUD treatment system based. As Texas established a mental health block grant goal to increase fidelity training for the ANSA/CANS, incrementally including the SUD system could be a companion goal. This recommendation is not intended to replace use of the American Society of Addiction Medicine (ASAM) criteria in determining level of care need within the SUD continuum.

Chapter 7: Measure Recommendations

Measurement and monitoring of outcomes is an important tool assisting HHSC/DSHS monitor the quality and effectiveness of services, value of public funds allocated to those services, as well as the performance and compliance of provider contractors. Capturing meaningful information in all of these areas requires measurement of both clinical and administrative functions across the populations, programs, and providers of the HHSC/DSHS system of care.

The following recommendations are provided to HHSC/DSHS and stakeholders for consideration. For mental health measures, we make recommendations to keep, eliminate, or modify existing measures, as well as suggest additional measures for consideration. For each mental health measure, we offer a summary recommendation, a detailed recommendation, and brief rationale that includes the reasoning behind our recommendation, any suggested changes or modifications (including downstream recommendations for consideration in future phases of measure reform), and in some cases, suggested replacement measures. For the most part, these recommendations are intended to inform the nearest cycle of contracting. For the measures we recommend to keep, we often suggest keeping the measure but modifying the targets, or keeping the measure for contracting and monitoring purposes, but not for pay for performance purposes. In cases of a recommendation to modify a measure, we recommend replacing the measure with a more meaningful measure and, when possible, suggest a replacement measure. A brief summary regarding the review of SUD and State Hospital measures is also provided, and in the case of SUD, we suggest new measures for consideration.

We are sensitive to the burden placed on HHSC/DSHS and providers when measurement strategies are modified. Our measure recommendations represent a balance between data that are already being collected by HHSC/DSHS and future alignment with national norms and standards. Although some of our recommendations would require HHSC/DSHS to compute individualized performance targets for LMHAs, the methods to calculate performance rates remain consistent with prior definitions. Some additional recommendations modify the way performance rates are computed using existing data, to further incentivize quality improvement. Last, the brand new measures we present for HHSC/DSHS' consideration based on gaps that were identified in the existing measure set were selected based on scientifically-validated national standards in measurement. Recognizing that *any* change to the existing structure will place a demand on resources at the State and/or provider levels, we maintain that an upfront investment will produce downstream benefits to align with best practices in performance measurement and contracting.

During our review, we noted that some of the measure names were not an accurate reflection of the measurement construct. For example, the "Effective Crisis Response" measure reflects hospitalization avoidance; however, not all crisis episodes require hospitalization, therefore effective interventions may span a variety of services. Within the rationale, where pertinent, we have suggested modifications to measure names to describe more accurately what is being measured. Assigning descriptive measure names is particularly important when the measures are publically posted as some individuals may not be familiar with behavioral healthcare terminology and will be seeking information on providers.

Finally, data analysis results were reviewed for each measure and considered as one factor to inform our recommendation of whether the measure should be kept, modified, or eliminated. In instances in which every provider exceeded the targeted rate for a prolonged period of time, we considered if the care practices reflected in the measure had become a part of routine care, then the measure was no longer

necessary. Alternatively, the data may have reflected that the measure was still pertinent, and the targets required adjustment to incentivize further quality improvement. When multiple providers struggled to achieve a target over multiple time period, we considered if the measure was an accurate reflection of the desired care practices, if performance rates are under the control of the provider, and if there was perhaps a superior measure which could be recommended for replacement.

Recommendations for Mental Health Measures

Measure Name	Description	Summary Recommendation	Detailed Recommendation	Rationale
Adult Improvement	The percentage of adults authorized into a FLOC show reliable improvement in at least one of the following domain as compared to the Reliable Change Index: risk behaviors, behavioral health needs, life domain functioning, strengths, substance use, and trauma. 20.0% or more of all adults authorized into a FLOC shall show reliable improvement in at least one of the following ANSA domains/modules: Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Strengths, Substance Use, and Adjustment to Trauma. Reliable Improvement is defined as a calculated value of the Reliable Change Index (RCI) that exceeds a benchmark value of -1.645 in the negative direction (indicating fewer problematic symptoms) over the measurement period.	Keep	Keep; modify target; tie to payment	**Comments:** This measure captures improvement in any one of six ANSA domains and fulfills a SAMHSA NOMs requirement. **Data:** Data analysis shows that most LMHAs are meeting target benchmark of 20% and that this has remained the same over three, six-month time points in 2015-2016. **Recommendation:** We recommend more individualized improvement targets for each LMHA, as well as tying the total score to payment and reporting individual area scores for contracting purposes.
Life Domain Functioning (Adults)	Description The percentage of adults authorized in a FLOC with acceptable or improved life functioning.	Eliminate	Eliminate	**Comments:** This is an outcome measure that utilizes existing data from the uniform assessment and can provide client level outcomes for providers. **Recommendation:** Although this measure may be important for internal LMHA monitoring and performance activities, it is not a strong indicator for overall LHMA performance and is included in the Adult Improvement measure.
Strengths (Adults)	The percentage of adults authorized in a FLOC with acceptable or improved strengths.	Eliminate	Eliminate	**Comments:** This is a recovery outcome measure utilizes existing data from uniform assessment and can provide client level outcomes for providers. **Recommendation:** Although this measure may be important for internal LMHA monitoring and performance activities, it is not a strong indicator for overall LHMA performance and is included in the Adult Improvement measure. It may be useful for the State to monitor performance in this domain specifically to inform efforts to support and promote a more recovery-oriented system of care.

Measure Name	Description	Summary Recommendation	Detailed Recommendation	Rationale
Child and Youth Improvement	The percentage of population meeting or exceeding the Reliable Change Index (RCI) in one or more domains on the CANS. 25.0% or more of all children/adolescents authorized into a FLOC will show reliable improvement in at least one of the following CANS domains/modules: Child Strengths, Behavioral and Emotional Needs, Life Domain Functioning, Child Risk Behaviors, Adjustment to Trauma, School Performance, Substance Use. Reliable Improvement is defined as a calculated value of the Reliable Change Index (RCI) that exceeds a benchmark value of -1.645 in the negative direction (indicating fewer problematic symptoms) over the measurement period.	Keep	Keep; modify target; continue to tie to payment	**Comments:** Captures improvement in any one of seven CANS domains and fulfills a SAMHSA NOMs requirement. **Data:** Data analysis shows that most LMHAs are meeting target benchmark of 25% and that this has remained the same over three, six-month time points in 2015-2016, with the average performance being 55%. **Recommendation:** We recommend more individualized improvement targets for each LMHA, as well as tying the total score to payment and reporting individual area scores for contracting purposes.
Life Domain Functioning 2 (Youth)	The percentage of children and youth authorized in a FLOC with acceptable or improved life functioning.	Eliminate	Eliminate	**Comments:** This measure measures improvement on a fundamental component of stabilization and recovery—the ability to be successful in activities of daily life. This is an outcome measure that utilizes existing data from uniform assessment and can provide client level outcomes for providers. **Recommendation:** Although this measure may be important for internal LMHA monitoring and performance activities, it is not a strong indicator for overall LHMA performance and is included in the Child and Youth Improvement measure.
Strengths 2 (Youth)	The percentage of children and youth authorized in a FLOC with acceptable or improved strengths.	Eliminate	Eliminate	**Comments:** This is a recovery outcome measure utilizes existing data from uniform assessment and can provide client level outcomes for providers. **Recommendation:** Although this measure may be important for internal LMHA monitoring and performance activities, it is not a strong indicator for overall LHMA performance and is already included in the Child and Youth Improvement measure.

Measure Name	Description	Summary Recommendation	Detailed Recommendation	Rationale
Adult Community Tenure	The percent of adults in a FLOC that avoid hospitalization in a DSHS Purchased Inpatient Bed after authorization into a FLOC	Keep	Keep; modify target; continue to tie to payment	**Comments:** Community Tenure is a SAMHSA NOM required for block grant reporting, as well as a worthwhile measure to monitor the effectiveness of services in preventing hospitalizations. Continued engagement in clinically appropriate levels of care should minimize the need for inpatient services. **Recommendation:** We recommend that LMHA targets for this measure be individualized. Tie to payment.
Child and Youth Community Tenure	The percentage of children and youth in a FLOC avoiding psychiatric hospitalization in a DSHS Purchased Inpatient Bed after authorization into a FLOC.	Keep	Keep as a contract compliance measure; modify target; do not tie to payment	**Comments:** Community Tenure is a SAMHSA NOM required for block grant reporting, as well as a worthwhile measure to monitor the effectiveness of services in preventing hospitalizations. **Data:** Data analysis shows that this is topped out at a mean of 99 for three reporting periods. **Recommendation:** We recommend that LMHA targets for this measure be individualized. Keep as a contract compliance indicator but do not tie to payment. In the future, consider replacing with a more meaningful measure such as readmission rates.
Educational or Volunteering Strengths	The percentage of adults authorized in a FLOC with acceptable or improved employment-preparatory skills as evidenced by Educational or Volunteering Strengths.	Keep	Keep; modify target; do not tie to payment	**Comments:** The measure utilizes client-level data from the ANSA that can also be leveraged by providers. It is applicable to the adult population. **Data:** Data analysis shows that all LMHAs met and are exceeding benchmark of 1.6%. **Recommendation:** The target could be modified to incentivize the LMHAs to maintain stability or improve over time, rather than just meet the benchmark.

Measure Name	Description	Summary Recommendation	Detailed Recommendation	Rationale
Employment 2 (Recently renamed to Employment Improvement)	The percentage of adults authorized in a FLOC with acceptable or improved employment performance. Note: This measure was proposed to replace the current Employment Status measure and is currently included in the contract for benchmarking purposes only.	Keep	Keep as a contract compliance measure; modify target; do not tie to payment	**Comments:** This metric measures changes in employment rather than representing a point in time measure of individuals employed. It is part of a SAMHSA required domain. **Data**: All LMHAs are meeting the benchmark of 9.8, with a mean of 20. **Recommendation:** We recommend changing this target. This measure could be modified as an individualized target for each LMHA.
Employment (Recently renamed Employment Status)	The percentage of adults served with an Adult Uniform Assessment Community Data Section 4. B. Paid Employment Type score of 1 (Independent/Competitive/Supported/Self Employment) shall be ≥9.8% per measurement period.	Eliminate	Eliminate; replace with Employment 2 (Employment Improvement)	**Comments:** More meaningful measures are available. **Recommendation:** We recommend eliminating and replacing as planned with Employment 2 (Employment Improvement).
Family and Living Situation	The percentage of children and youth authorized in a FLOC with acceptable or improved family and living situations.	Keep	Keep as a contract compliance measure; modify target; do not tie to payment	**Comments:** The metric measures positive or negative changes an area critical to stability and recovery. This relates to one of the required SAMHSA NOM domains. **Recommendation:** If the State were to modify to reflect each individual LMHA, the metric would be more representative. RCI is an individualized/person indicator of change.
Residential Stability	The percentage of adults authorized in a FLOC with acceptable or improved residential stability.	Keep	Keep as a contract compliance measure; do not tie to payment	**Comments:** This is an outcome measure that utilizes existing data from uniform assessment and can provide client level outcomes for providers in the area of housing, a key factor in ongoing stability and recovery. It is also a SAMHSA required domain. **Recommendation:** It is recommended that the measure be modified to establish an individualized target for each LMHA. In addition, the State could consider adding a measure later that examines percent of adults in need who receive fidelity-based Permanent Supported Housing (PSH).

Measure Name	Description	Summary Recommendation	Detailed Recommendation	Rationale
School	The percentage of children and youth authorized in a FLOC with acceptable or improved school performance.	Keep	Keep; modify target; tie to payment	**Comments:** This is an outcome measure of educational engagement that utilizes existing data from the uniform assessment and can provide the client-level outcomes for providers. It is a SAMHSA required domain. **Recommendation:** This measure could be modified to implement individualized targets for each LMHA. **Name:** Consider renaming this measure "School Improvement."
Adult Jail Diversion	The equity-adjusted percentage of valid adult TLETS bookings with a match in CARE shall be ≤ 10.46% for each local service area. The equity-adjusted number of valid TLETS bookings in the local service area with a CARE match divided by the number of valid TLETS bookings in the local service area.	Modify	Modify; consider replacing with a more meaningful measure; do not tie to payment	**Comments:** Jail diversion is not captured by counting arrests; what is measured in the current calculation is a match in data sets, not service provision. As such, this measure does not demonstrate the provider's ability to effect change, and the three-year period within which someone is arrested does not reflect accurately a LMHA's performance. An individual's contact with the LMHA system over a three-year period can be influenced by many variables not under the control of the provider/LMHA. This measure may create a disincentive for LMHAs to serve clients who may be more likely to go to jail. **Recommendation**: Consider modifying and capturing improvement of individuals in LOC 3 and 4 across ANSA Criminal Behavior module. **Name:** Consider renaming this measure "Reduced Adult Criminal Justice Involvement" if any recommendations are adopted.
Juvenile Justice Avoidance	95.0% of children/youth enrolled in a FLOC showing no arrests (acceptable) or a reduction of arrests (improving) from time of first assessment to time of last assessment within the measurement period (with assessments occurring at least 75 days apart).	Keep	Keep; modify target; do not tie to payment	**Comments:** Recommended focus area by stakeholders; meaningful measure of system performance. It is also a required SAMHSA NOMs domain. **Data:** Data analysis shows that every LHMA has met benchmark at 3 time points. **Recommendation:** Consider individualizing target for LMHAs to focus on improvement.

Measure Name	Description	Summary Recommendation	Detailed Recommendation	Rationale
Adult Monthly Service Provision	The percentage of individuals authorized in a FLOC receiving at least one Mental Health (MH) Hourly Service per month. Excludes individuals with a LOC-R = A1S & LOC-A = A1S. The percentage of adults authorized in a FLOC receiving at least one face to face, telehealth, or telemedicine encounter of any service per month of any length of time shall be ≥ 65.6% per measurement period. FLOCs included in this measure are LOC-1S, LOC-2, LOC-3, and LOC-4. Individuals both recommended and authorized for LOC-A1S are excluded from this measure. Encounters must be delivered face-to-face or via telehealth or telemedicine.	Keep	Keep as a contract compliance measure; modify target; do not tie to payment	**Comments:** A general process measure of ongoing engagement with services. Comprehensive service penetration measure across the adult population is required by SAMHSA. **Data:** Data analysis shows sustained improvement over 3 measurement periods when the benchmark target was 54.1 and when changed to 65.6%. **Recommendation:** As the State continues to expand measurement and reporting capabilities, future measures may include LOC specific targets that ensure individuals are receiving the right intensity of services for their identified need, as opposed to at least one service per month. May want to consider individualized targets based on LMHA historical performance.
Adult Service Target	The percent of adults in a FLOC who meet their service target. The statewide performance level for the adult service target is 100%.	Eliminate	Eliminate	**Comments:** This measures volume rather than quality or outcome of care. **Data:** Data analysis shows that that there is not much variation among providers of this measure and such a metric does not contribute in a meaningful way to opportunities for improvement. **Recommendation:** This is a required state reporting measure for the Legislative Budget Board and could be maintained for reporting purposes. However, we recommend to eliminate the measure and encourage the State to consider other measures to monitor access to services. Examples used in other systems include penetration rates and time between request for services and intake. If there are concerns about LMHAs proving adequate intensity of service, it is recommended that measures focus on specific gaps by population, service type or other related variables.

Measure Name	Description	Summary Recommendation	Detailed Recommendation	Rationale
ACT Target	The monthly average of all adults recommended for LOC 4 and authorized into LOC-3 or LOC-4 is greater than or equal to 54.0%.	Modify	Modify; consider replacing with a more meaningful measure; do not tie to payment	**Comments:** There is overlap or duplication in this measure with the Adult Monthly Service Provision measure. **Recommendation:** If the State is interested in practice guidelines specific to assertive community treatment (ACT) or intensive community based supports, the State should consider modifying the measure. The new measure could tie fidelity of service delivery to the ACT model or replace with an outcome measure associated with a higher level of intervention.
Adult Counseling Target	The monthly average of all adults authorized into LOC-2 is greater than or equal to 12% of adults recommended for LOC-2.	Modify	Modify; consider replacing with a more meaningful measure; do not tie to payment	**Comments:** This measure is intended to monitor use of an evidenced based approach for LOC2, i.e. use of cognitive behavioral therapy (CBT). Identifying specific EBPs to LOCs incentivizes individualized application of EBPs within the continuum of care. **Recommendation:** The State is encouraged to measure the outcome of this targeted use of CBT, rather than a focus on volume. For example, adopt a new measure that tracks change in ANSA domains over time related to depression.
Children and Youth Monthly Service Provision	The percentage of children and youth authorized in a FLOC receiving at least one Mental Health (MH) Hourly Service per month The percentage of children and youth authorized in a FLOC or LOC-Y (Yes Waiver) receiving at least one face to face, telehealth or telemedicine encounter of any service per month of any length of shall be > 65 % the target for the measurement period. LOCs included in this measure are LOC-1, LOC-2, LOC-3, LOC-4, LOC-YC and LOC-Y. An encounter must be delivered face-to-face or via telehealth or telemedicine.	Keep	Keep as a contract compliance measure; do not tie to payment	**Comments:** A general process measure of ongoing engagement with services. A comprehensive service penetration measure across the child/youth population is required by SAMHSA. **Recommendation:** As the State continues to expand measurement and reporting capabilities, future measures may include LOC specific targets that ensure individuals are receiving the right intensity of services for their identified need, as opposed to at least one service per month. Such an approach allows a targeted alignment with individual needs and service frequency, and contributes to a more meaningful measure. May want to consider individualized targets based on LMHA historical performance.

Measure Name	Description	Summary Recommendation	Detailed Recommendation	Rationale
Child and Youth Services Target	The statewide performance level for the child and youth service target is 100% of given targets.	Eliminate	Eliminate	**Comments:** There is overlap or duplication in the metric with the Children and Youth Monthly Service Provision measure. **Data:** Data analysis shows that that there is not much variation among providers and such a metric does not contribute in a meaningful way to opportunities for improvement. **Recommendation:** This measures volume rather than quality or outcome of care. It is a required state reporting measure and could be maintained for reporting purposes. However, we recommend to eliminate the measure and encourage the State to consider other measures to monitor access to services. Examples used in other systems include penetration rates and time between request for services and intake.
Family and Partner Support Services	10% or more of children and youth authorized to receive LOC 2, 3, 4 and YC shall receive Family Partner support services each client month, as defined by Engagement (H0025HATS), Family Partner (H0038HA), and Parent Support Group (H0025HAHQ) procedure codes, or other services identified by SERVER_TYPE_CD = K.	Modify	Modify; consider replacing with a more meaningful measure	**Comments:** This measure overlaps or duplicates the Children and Youth Monthly Service Provision measure. **Data:** Data analysis shows that the mean is 18. LMHAs generally exceed target of 10% of children and youth; there two LMHAs that do not meet the target in some reporting periods. **Recommendation:** Consider modifying to measure fidelity to the SOC model or an outcome measure associated with higher level of care (LOC) intervention rather than service penetration following assessment and LOC assignment. Measurement is associated with procedure codes that may not even be recorded, particularly if they are bundled or capitated payment codes. If fidelity audit is too resource intensive, engage in technical assistance to understand LMHA experience, better practices and potential alternative measures.

Measure Name	Description	Summary Recommendation	Detailed Recommendation	Rationale
Effective Crisis Response	The percentage of individuals receiving crisis services who avoid admission to a DSHS Operated or Contracted Inpatient Bed within 30 days of the start of the crisis episode shall be > 75.1% per measurement period.	Keep	Keep; modify target; tie to payment	**Comments:** Outcome measure specific to individuals actively engaged in crisis service, measuring success with admission avoidance. **Data:** All LMHAs but one have met the 75% target for 2 measurement periods out of 3. **Recommendation:** Consider adjusting the target (higher) as the current mean is 90%. **Name:** Suggest renaming measure to "Inpatient Diversion by Crisis Services."
Follow-up within 7 Days - Face to Face	The statewide face-to-face follow-up performance level for adults, children, and youths discharged from a state facility or including the Montgomery County Mental Health Treatment Facility. The statewide follow-up performance level for adults, children, and youth discharged from a state facility, privately operated and state funded facility (i.e., Montgomery County Mental Health Treatment Facility and University of Texas Health Science Center at Tyler), or private psychiatric hospital funded through a Private Psychiatric Bed (PPB) or Community Mental Health Hospital (CMHH) contract is 75% for face-to-face follow-up.	Modify	Modify, consider modifying with the addition of the 30-day measurement, tie to payment	**Comments:** This aligns with a managed care measure and is a nationally accepted and utilized measure. **Data**: Most LMHAs (32 of 39) currently meeting target. **Recommendation:** The State should consider adding the 30-day reporting to this measure, to align with the HEDIS measure. Targets should be individualized by LMHA. **Name:** Follow-up After Hospitalization for Mental Illness, 7 and 30 Days (Face to Face).
Follow-up within 7 Days - Disposition	The statewide follow-up performance level for adults, children, and youth discharged from a state facility, privately operated and state funded facility (i.e., Montgomery County Mental Health Treatment Facility and University of Texas Health Science Center at Tyler), or private psychiatric hospital funded through a Private Psychiatric Bed (PPB) or Community Mental Health Hospital (CMHH) contract is 95% with any follow-up disposition.	Eliminate	Eliminate	**Comment:** The measure aligns with the managed care measure which is a nationally accepted and utilized measure. **Recommendation:** We recommend eliminating measure because it is tracked in Follow-up Face to Face measure, which is a HEDIS measure.

Measure Name	Description	Summary Recommendation	Detailed Recommendation	Rationale
Community Support Plan	The statewide performance level for adults, children, and youth discharged from state facilities with a community support plan is 95%.	Eliminate	Eliminate	**Comments:** The state already measures Follow-up after Hospitalization for Mental Illness. While this measure also assists in monitoring continuity of care, the recommended replacement measures can also provide this assurance through action rather than a plan that may not be activated. **Data:** Historical data show providers generally exceed the 95% target and most reflect 100% performance on this measure. **Recommendation:** Eliminate
Crisis Follow-Up	The percentage of persons with a mental health community LOC-A = 5 who receive a Crisis Follow-Up service encounter within 30 days shall not be less than 90%.	Keep	Keep; modify target; combine with Community Linkage; tie to payment	**Comments:** This process is intended to measure whether individuals authorized into LOC 5 (a 90-day transitional level of care) after a crisis episode receive follow-up services (LMHA services or other community services). **Recommendation:** This is a population at high risk and intervention/transitional services are key. LOC 5 represents only about 1% of clients and a significant number of LMHAs have fewer than 10 clients in LOC 5 at any one time. Recommend combining with Community Linkage to provide a single measure that addresses timely follow-up and/or linkage for all clients entering the service system through a crisis episode.
Community Linkage	No less than 23% of LOC-A = 0 shall be followed by a mental health community LOC-A = 1M and 1S through 5 and/or a contact at a DSHS-funded substance abuse treatment facility, or an Outreach, Screening, Assessment and Referral (OSAR) provider within 14 days of closure from Level of Care 0.	Modify	Modify, combine with Crisis Follow-up, tie to payment	**Comments:** This measure is not required by any state or federal authority. Measures are already in place that measure preventable admissions and engagement into outpatient care which more strongly reflect an individual's connection to services. **Recommendation:** Modify and combine with Crisis Follow-up to provide a single measure that addresses timely follow-up and/or linkage for all clients entering the service system through a crisis episode.

Measure Name	Description	Summary Recommendation	Detailed Recommendation	Rationale
Access to Crisis Response Services	The percentage of crisis hotline calls (with CARE ID) that result in face to face encounters within one day shall be > 52.2% per measurement period.	Modify	Modify; consider replacing with a more meaningful measure; do not tie to payment	**Comments:** Current measure may unintentionally incentivize unnecessary face to face encounters. **Recommendation:** May want to consider a measure that captures compliance with access standard such as timeliness of response. A modification could also indirectly capture number of hotline calls resulting in face to face contacts to assist in accessing network adequacy for crisis services.
Long Term Services and Supports	Contractor shall act upon referrals within 15 calendar days of receipt from the Long-term Services and Supports (LTSS) Screen. Contractor shall demonstrate successful action a referral by utilizing the H0023 procedure code (grid code 100) for adults and the H0023HA procedure code (grid code 200) for children. 3. Allowable Server Types: All (A-R) 4. Contact Type: Contractor coding T (telephone), F (face-to-face), or D (documentation) on the procedure code will be demonstrating successful action the referral.	Keep	Keep as a contract compliance measure; do not tie to payment	**Comments:** A process measure to monitor whether the LMHA is acting promptly to follow-up on referrals. **Data:** Data analysis shows that 5 LMHAs meet target at 100%, with 6 LMHSAs reporting 0; it is not clear if they are not reporting or not making referrals. This measure calculation is tied to procedure code which can be problematic, and its target establishes a low bar. **Recommendation:** The data are collected for contract compliance monitoring purposes and should be indicated as such and should not be included as part of outcome and quality measurement system. If it is viewed as important, it should be tied to payment.

Measure Name	Description	Summary Recommendation	Detailed Recommendation	Rationale
Hospitalization	The equity-adjusted rate of adult and child inpatient DSHS Operated or Contracted Psychiatric Inpatient Beds for the population of the local service area shall be ≤ 1.9% per measurement period.	Keep	Keep as a contract compliance measure; do not tie to payment	**Comments:** This measure provides information about the utilization of bed days by the population in the local service area. The information reports on efficient and clinically-indicated use of inpatient services and the ability of the LMHA to balance access to the continuum of care for its population, including active outreach to high risk individuals, diversion into community-based alternatives when appropriate and community collaboration. It provides meaningful information in combination with other measures identified. **Recommendation:** We recommend to continue to require reporting of this data for contract monitoring rather than as a required performance measure. **Name:** Consider renaming the measure "Inpatient Bed Days/Utilization."
Frequent Admissions	The percentage of adults and children authorized in a FLOC who are admitted 3 or more times within 180 days to a DSHS Operated or Contracted Inpatient Psychiatric Bed shall be < 0.3% per measurement period.	Modify	Modify; consider replacing with a more meaningful measure	**Comments:** The State is interested in tracking individuals with frequent admissions, especially those who are readmitted within a short period of time. **Recommendation:** If the State were willing to consider a measure that captures frequent admissions and readmissions they would make stronger measures, rather than a count of those with three or more admissions or readmissions. For example, 2 or more admissions with 90 days.

Measure Name	Description	Summary Recommendation	Detailed Recommendation	Rationale
Adult Uniform Assessment Completion Rate	The percentage of adults served or authorized for services during the six-month period with a completed and current Uniform Assessment (UA) will be ≥ 95%. Targets will be reviewed semi-annually.	Eliminate	Eliminate	**Comments:** This measure was initially created to monitor and address concerns with individuals being served without full assessment. The system currently has incentives in place for completion of the uniform assessments, i.e. access to reimbursement for service package. **Data:** Although data analysis shows some variation among LMHAs, most are exceeding benchmark. Individual outliers with service volume concerns could be individually monitored and provided engagement and outreach technical assistance. **Recommendation:** Eliminate
Child and Youth Uniform Assessment Completion Rate	The percent of children and youth served or authorized for services during the six-month period who have a completed and current UA.	Eliminate	Eliminate	**Comments:** This measure was initially created to monitor and address concerns with individuals being served without a full assessment. The system currently has incentives in place for completion of the uniform assessments, i.e. access to reimbursement for service package. **Data:** Although data analysis shows some variation among LMHAs, most are exceeding benchmark. Individual outliers with service volume concerns could be individually monitored and provided engagement and outreach technical assistance. **Recommendation:** Eliminate
TANF Transfer to Title XX Services (Adults)	Contractor shall meet the minimum annual service target levels for TANF Transfer to Title XX and Base Title XX services as outlined in the table below. Services are defined as those provided within the contract guidelines as outlined in Section 1.B. of the Performance Contract Notebook. Targets were developed using the dollar amount allocated for each center divided into the estimated cost per person ($16,688) for intensive services.	Keep	Keep as a contract compliance measure; do not tie to payment	**Comments:** To monitor compliance with funding requirements. **Recommendation:** Keep for contracting purposes only. The data are collected for contract compliance monitoring purposes and should be indicated as such and not included as part of the outcome and quality measurement system.

Measure Name	Description	Summary Recommendation	Detailed Recommendation	Rationale
TANF Transfer to Title XX Services 2 (Youth)	Unique count of clients served with TANF Transfer to Title XX and Base Title XX funds.	Keep	Keep as a contract compliance measure; do not tie to payment	**Comments:** To monitor compliance with funding requirements. **Recommendation:** Keep for contracting purposes only. The data are collected for contract compliance monitoring purposes and should be indicated as such and not included as part of the outcome and quality measurement system.

Additional Measures for Consideration

After a thorough and careful review of the current list of measures and recommendations for keeping, eliminating or modifying those measures, some gaps in measurement areas were identified. Therefore, a list of recommended new and additional measures is provided below for HHSC/DSHS' consideration. The measures were selected from nationally recognized and endorsed measures, and are currently in use by some Texas MCOs and part of the National Center for Quality Assessment Healthcare Effectiveness Data and Information Set (HEDIS) measure set, one of the most widely used sets of health care performance measure in the United States.

While some of the new measures presented for consideration may require significant effort to put into place, consistent with our guiding principles these measure promote adherence to evidenced-based practice, promote recovery, and address health disparities for individuals with chronic behavioral health disorders. These recommendations further encourage HHSC/DSHS to consider established and emerging measures in the behavioral health field. It is understood that data collection and reporting on these measures may present challenges; however, overcoming these barriers will result in a long term investment. Collaboration across state agencies to gain access to necessary data, or changes to encounter reporting within the behavioral health system, along with financial resources to the state to modify information technology systems may be required.

Measure Name	Description	Rationale	Data Source
Follow-up care for children prescribed ADHD Medication (ADD)	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who have at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed. Two rates are reported. 1. Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. 2. Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	Provides state with opportunity to encourage both specialty and primary care providers to maintain use of nationally recognized practice guidelines. Currently a measure required in Texas Medicaid managed care contracts. NCQA measure.	Encounter data

Measure Name	Description	Rationale	Data Source
NQF #105: Antidepressant Medication Management	The percentage of patients 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. • Effective Acute Phase Treatment. The percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 84 days (12 weeks). • Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 180 days (6 months).	Provides state with opportunity to encourage both specialty and primary care providers to maintain use of nationally recognizes practice guidelines	Encounter data, pharmacy claims
NQF #710 and 711 Depression Remission at 6 and 12 months	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.	Important outcome measure for patients with diagnosis of Major Depression or Persistent Depressive Disorder that is gaining in use nationwide	PHQ-9 scores; chart review
NQF #1932: Diabetes Screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD)	The percentage of individuals 25 – 64 years of age with schizophrenia or bipolar disorder, who were prescribed any antipsychotic medication, and who received a diabetes screening during the measurement year.	This is one of several measures the National Quality Forum endorsed that focus on a wide range of care processes and services, including medical treatment for individuals with serious mental illness (SMI). This measure can enable the state to monitor efforts with integration of physical health and mental health care as well as reducing the health disparities among individuals with SMI.	PHQ-9 scores; chart review

Measure Name	Description	Rationale	Data Source
NQF #1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia.	The measure calculates the percentage of individuals 18 years of age or greater with schizophrenia who are prescribed an oral antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC) of at least 0.8 during the measurement period (12 consecutive months).	While the state has multiple measures monitoring use of inpatient beds, they are based on utilization rather than use of interventions that may prevent an inpatient stay. This measure may serve as a way to measure proactive activities and paired with emergency room, crisis, inpatient utilization data may give a fuller picture of cause and effect.	Encounter data, pharmacy claims
CMS Outcome Measure: 30-day Risk-standardized Hospital Readmission	The percentage of Adults and Youth discharged from a state hospital, DSHS-contracted Private Psychiatric beds (PPBs) and DSHS-contracted Community Mental Health Hospital (CMHH) beds who are readmitted within 30 days of discharge.	30 day readmissions are potentially avoidable and efforts to prevent this are a part of effective discharge planning and appropriate follow-up.	Encounter data
Consumer Perception of Care Survey	Domains measures by the survey include: General satisfaction, access, quality & appropriateness, participation in treatment, outcomes, functioning, social connectedness. The survey is specifically designed for adults.	Nearly half of all State Behavioral Health Agencies include consumer's perceptions of care in their performance measurement systems. The MHSIP Consumer Survey is the most commonly used instrument to collect these data.	MHSIP Consumer Survey

Recommendations for Substance Use Disorder Measures

SUD treatment and prevention measures are tightly connected to the required SAMHSA block grant NOMS. Texas currently collects and reports data across its substance use disorder system which includes numerous programs and providers for prevention, intervention, treatment and recovery. Due to the extensive and specific requirements from SAMHSA, modifying or eliminating any SUD measures is not recommended and our analysis confirms the block grant metrics provide a strong foundation from which to consider future enhancements.

For future consideration, the following observations and recommendations to strengthen the SUD performance measurement reporting program are offered.

- Measures focused on a common domain, for example, detoxification services, should be defined uniformly across provider types to enable comparisons across treatment settings. The same is true of measures that apply across different target populations e.g. youth, adult, women. Standardizing definitions and rate calculations eases burden of reporting for providers that offer multiple types of services to various target populations.
- We recommend that measures with common definitions be streamlined and the focus be placed on the desired outcomes versus the location a service is delivered. For example, the current SUD treatment measures include three for detoxification (ambulatory detoxification, residential initial, and residential multiple detoxification) and the outcome desired for each is a referral for continued services after detoxification. A standardized measure could be implemented requiring that a referral to ongoing treatment must be made regardless of what type of detox is provided.
- Consider supplementing process measures tied to researched best practices along with outcomes measures where possible. For example, research shows that when a person receives 90 days of post discharge care after detox, they are less likely to relapse. Adding a measure indicating post-discharge care received attaches a proven quality and value to the measurement program.
- Reporting timelines for measurement data may have to be program-specific to be cognizant of variations among programs and populations being served, but it is likely to be beneficial for both providers and the State, if a report be developed to capture admission, discharge, and program type/name. The data could then be sorted by program at the State level, eliminating the need for multiple measures.

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Abstinence - Adult	SA Intervention	Parenting Awareness and Drug Risk Education (PADRE)		Number of adult clients with open cases who reported to be abstinent from alcohol and other drugs during the reporting month	Keep
Abstinence - Youth	SA Intervention	Parenting Awareness and Drug Risk Education (PADRE)		Number of youth clients with open cases who reported to be abstinent from alcohol and other drugs during the reporting month	Keep
Abstinence at six-months of services	SA Treatment	Adult Treatment Services (TRA)	Opioid Substitution Therapy	Abstinence at six-months of service	Keep
Adult participation in meetings or presentations with schools and community organization representatives to collect data	SA Prevention	Prevention Resource Center (PRC)		Number of adults participating in meetings or presentations conducted with schools or community organization representatives regarding participation in surveys to collect local, county, or regional data	Keep
Adults attending AOD presentations	SA Prevention	Community Coalition Partnership (CCP)		Number of adults attending alcohol and other drugs (AOD) presentations focused on the state's three prevention priorities of alcohol (underage drinking), marijuana, and prescription drugs	Keep
Adults attending AOD presentations	SA Prevention	Youth Prevention Indicated (YPI)		Number of adults attending alcohol and other drugs (AOD) presentations	Keep
Adults attending AOD presentations	SA Prevention	Youth Prevention Selective (YPS)		Number of adults attending alcohol and other drugs (AOD) presentations	Keep
Adults attending AOD presentations	SA Prevention	Youth Prevention Universal (YPU)		Number of adults attending alcohol and other drugs (AOD) presentations	Keep
Adults attending minors and tobacco presentations	SA Prevention	Youth Prevention Indicated (YPI)		Number of adults attending minors and tobacco presentations	Keep
Adults attending minors and tobacco presentations	SA Prevention	Youth Prevention Selective (YPS)		Number of adults attending minors and tobacco presentations	Keep
Adults attending minors and tobacco presentations	SA Prevention	Youth Prevention Universal (YPU)		Number of adults attending minors and tobacco presentations	Keep
Adults involved in AOD alternative activities	SA Prevention	Youth Prevention Indicated (YPI)		Number of adults involved in alcohol and other drugs (AOD) alternative activities (Do Not Include Tobacco Specific Activities)	Keep
Adults involved in AOD alternative activities	SA Prevention	Youth Prevention Selective (YPS)		Number of adults involved in alcohol and other drugs (AOD) alternative activities (Do Not Include Tobacco Specific Activities)	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Adults involved in AOD alternative activities	SA Prevention	Youth Prevention Universal (YPU)		Number of adults involved in alcohol and other drugs (AOD) alternative activities (Do Not Include Tobacco Specific Activities)	Keep
Adults involved in tobacco alternative activities	SA Prevention	Youth Prevention Indicated (YPI)		Number of adults involved in tobacco alternative activities	Keep
Adults involved in tobacco alternative activities	SA Prevention	Youth Prevention Selective (YPS)		Number of adults involved in tobacco alternative activities	Keep
Adults involved in tobacco alternative activities	SA Prevention	Youth Prevention Universal (YPU)		Number of adults involved in tobacco alternative activities	Keep
Adults participating in meetings or presentations	SA Prevention	Prevention Resource Center (PRC)		Number of adults participating in meetings or presentations with schools, higher education, or other organizations regarding collaboration to collect or share local, county, or regional data	Keep
Adults receiving prevention education	SA Prevention	Youth Prevention Universal (YPU)		Number of adults receiving prevention education/skills training (approved evidence-based family-focused curriculum only)	Keep
Adults receiving AOD information	SA Prevention	Community Coalition Partnership (CCP)		Number of adults receiving alcohol and other drugs (AOD) information focused on the state's three prevention priorities of alcohol (underage drinking), marijuana, and prescription drugs	Keep
Adults receiving ATOD information	SA Prevention	Youth Prevention Indicated (YPI)		Number of adults receiving alcohol, tobacco and other drugs (ATOD) information	Keep
Adults receiving ATOD information	SA Prevention	Youth Prevention Selective (YPS)		Number of adults receiving alcohol, tobacco and other drugs (ATOD) information	Keep
Adults receiving ATOD information	SA Prevention	Youth Prevention Universal (YPU)		Number of adults receiving alcohol, tobacco and other drugs (ATOD) information	Keep
Adults receiving local, county, or regional data	SA Prevention	Prevention Resource Center (PRC)		Number of adults receiving local, county, or regional data	Keep
Adults receiving prevention education	SA Prevention	Youth Prevention Indicated (YPI)		Number of adults receiving prevention education/skills training (for programs implementing approved evidence-based family-focused curriculum)	Keep
Adults receiving prevention education	SA Prevention	Youth Prevention Selective (YPS)		Number of adults receiving prevention education/skills training (approved evidence-based family-focused curriculum only)	Keep
Adults successfully referred to other support services	SA Prevention	Youth Prevention Indicated (YPI)		Number of adults successfully referred to other support services (for programs implementing approved evidence-based family-focused curriculum)	Keep
Alternative activities - Adult	SA Intervention	Rural Border Intervention (RBI)		Number of Adults Involved in Alternative Activities	Keep
Alternative activities - Youth	SA Intervention	Rural Border Intervention (RBI)		Number of Youth Involved in Alternative Activities	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
AOD presentations	SA Prevention	Community Coalition Partnership (CCP)		Number of alcohol and other drugs (AOD) presentations focused on the state's three prevention priorities of alcohol (underage drinking), marijuana, and prescription drugs	Keep
AOD presentations	SA Prevention	Partnerships for Success (PFS)		Number of Presentations Focused On the PFS Prevention Priorities of Alcohol (Underage Drinking) and Prescription Drug Misuse and Abuse	Keep
AOD presentations	SA Prevention	Youth Prevention Indicated (YPI)		Number of alcohol and other drugs (AOD) presentations	Keep
AOD presentations	SA Prevention	Youth Prevention Universal (YPU)		Number of alcohol and other drugs (AOD) presentations	Keep
AOD presentations	SA Prevention	Youth Prevention Selective (YPS)		Number of alcohol and other drugs (AOD) presentations	Keep
Average abstinence rates for each recovery home	SA Recovery	Substance Abuse Texas Group Homes- Oxford House		Report monthly the average abstinence rates for each house-calculated by dividing total abstainers by total residents for the month.	Keep
Average number of community and social referrals	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Intensive Residential Services	Average number of community and social support referrals	Keep
Average number of community and social referrals	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Supportive Residential Services	Average number of community and social support referrals	Keep
Average number of community and social referrals	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Intensive Residential Services	Average number of community and social support referrals	Keep
Average number of community and social referrals	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Supportive Residential Services	Average number of community and social support referrals	Keep
Average number of community and social referrals	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Intensive Residential Services	Average number of community and social support referrals	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Average number of community and social referrals	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Outpatient Services	Average number of community and social support referrals	Keep
Average number of community and social referrals	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Supportive Residential Services	Average number of community and social support referrals	Keep
Case management and Outreach efforts	SA Intervention	HIV Outreach Services (HIV)		Number of Participants Enrolled in HIV Early Intervention (HEI) Case Management as a Result of Outreach Efforts	Keep
Client engagement	SA Treatment	Treatment Co-Occurring Services (TCO)	Co-Occurring Psychiatric and Substance Use Disorders (COPSD)	Client engagement	Keep
Coalition meetings	SA Prevention	Community Coalition Partnership (CCP)		Number of coalition meetings conducted	Keep
Coalition meetings	SA Prevention	Partnerships for Success (PFS)		Number of Coalition Meetings	Keep
Coalition members	SA Prevention	Community Coalition Partnership (CCP)		Number of coalition members attending coalition meetings	Keep
Coalition members	SA Prevention	Partnerships for Success (PFS)		Number of Active Coalition Members	Keep
Coalition recruitment	SA Prevention	Community Coalition Partnership (CCP)		Number of coalition recruitment efforts	Keep
Coalition recruitment	SA Prevention	Partnerships for Success (PFS)		Number of Coalition Recruitment Efforts	Keep
Community meetings or presentations regarding data collection	SA Prevention	Prevention Resource Center (PRC)		Number of meetings or presentations conducted with schools, high education, or other organizations regarding collaboration to collect or share local, county, or regional data	Keep
Community stakeholder meetings focused on data collection efforts	SA Prevention	Prevention Resource Center (PRC)		Number of meetings conducted with community stakeholders focused on data collection efforts in the region	Keep
Continued involvement in recovery activities	SA Recovery	Recovery Support Services-All settings		% of individuals involved in any of the following recovery activities during the past 30 days at 12-Month Follow-Up Interview: self-help groups, meetings with sponsor, met with	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
				or served as recovery coach, served as peer volunteer or sponsor	
Continuous HIV care	SA Intervention	HIV Early Intervention (HEI)		Total Number of Clients Who Are Maintained in Continuous HIV Medical Care	Keep
Education - Adult	SA Intervention	Rural Border Intervention (RBI)		Number of Adults Receiving Prevention Education/Skills Training	Keep
Education - Youth	SA Intervention	Rural Border Intervention (RBI)		Number of Youth Receiving Prevention Education/Skills Training	Keep
Employed or enrolled in school - Adult	SA Intervention	Parenting Awareness and Drug Risk Education (PADRE)		Number of adult clients with open cases who are employed and/or enrolled in school during the reporting month	Keep
Employed or enrolled in school - Youth	SA Intervention	Parenting Awareness and Drug Risk Education (PADRE)		Number of youth clients with open cases who are employed and/or enrolled in school during the reporting month	Keep
Environmental, regulatory, or legal strategies	SA Prevention	Community Coalition Partnership (CCP)		Number of environmental, regulatory, or legal strategies implemented or changed focused on the state's three prevention priorities of alcohol (underage drinking), marijuana, and prescription drugs	Keep
Follow-up visits to retail merchants	SA Prevention	Prevention Resource Center (PRC)		Number of follow-up visits to retail merchants	Keep
Follow-up visits to retail merchants that are not in compliance with the tobacco laws	SA Prevention	Prevention Resource Center (PRC)		Number of follow-up visits to retail merchants that are not in compliance with the Texas Tobacco Laws	Keep
Follow-ups	SA Intervention	HIV Outreach Services (HIV)		Number of Participants Follow-ups	Keep
High risk for HIV	SA Intervention	HIV Outreach Services (HIV)		Number of Individuals Identified Through Targeted Outreach as Being at High Risk for HIV Infection	Keep
Increased Recovery Capital	SA Recovery	Recovery Support Services		% of individuals achieving higher total scores on the Assessment of Recovery Capital (ARC) scale at 12-Month Follow-Up	Keep
Individuals attending AOD Presentations	SA Prevention	Partnerships for Success (PFS)		Number of Individuals Attending Presentations Focused on the PFS Prevention Priorities of Alcohol (Underage Drinking) and Prescription Drug Misuse and Abuse	Keep
Individuals Receiving Information	SA Prevention	Partnerships for Success (PFS)		Number of Individuals Receiving Information Focused On the PFS Prevention Presentations of Alcohol (Underage Drinking) and Prescription Drug Misuse and Abuse	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Maintain specific number of outreach workers to perform specified duties	SA Recovery	Substance Abuse Texas Group Homes- Oxford House		Report monthly activities performed by outreach workers	Keep
Media awareness activities	SA Prevention	Community Coalition Partnership (CCP)		Number of media awareness activities focused on the state's three prevention priorities of alcohol (underage drinking), marijuana, and prescription drugs	Keep
Media awareness activities	SA Prevention	Partnerships for Success (PFS)		Number of Media Awareness Activities Successfully Conducted Focused On the PFS Prevention Priorities of Alcohol (Underage Drinking) and Prescription Drug Misuse and Abuse	Keep
Media awareness activities	SA Prevention	Prevention Resource Center (PRC)		Number of media awareness activities focused on the state's three prevention priorities of alcohol (underage drinking), marijuana, and prescription drugs	Keep
Media contacts	SA Prevention	Community Coalition Partnership (CCP)		Number of media contacts focused on the state's three prevention priorities of alcohol (underage drinking), marijuana, and prescription drugs	Keep
Media Contacts	SA Prevention	Partnerships for Success (PFS)		Number of Media Contacts Focused on the PFS Prevention Priorities of Alcohol (Underage Drinking) and Prescription Drug Misuse and Abuse	Keep
Media contacts	SA Prevention	Prevention Resource Center (PRC)		Number of media contacts focused on the state's three prevention priorities of alcohol (underage drinking), marijuana, and prescription drugs.	Keep
Meetings or presentations conducted with college or university representatives to collect data	SA Prevention	Prevention Resource Center (PRC)		Number of meetings or presentations conducted with college or university representatives regarding participation in surveys to collect local, county, or regional data	Keep
Mental Health treatment at discharge	SA Treatment	Treatment Co-Occurring Services (TCO)	Co-Occurring Psychiatric and Substance Use Disorders (COPSD)	Mental Health Treatment Status at discharge	Keep
Minimum average annual occupancy rate for each recovery home	SA Recovery	Substance Abuse Texas Group Homes- Oxford House		Report monthly the occupancy rates for each house	Keep
Minimum number of houses opened during fiscal year.	SA Recovery	Substance Abuse Texas Group Homes- Oxford House		Report monthly the number of newly opened houses	Keep
Motivational Interviewing - Adult	SA Intervention	Rural Border Intervention (RBI)		Number of Adults Receiving Interventions Using Motivational Interviewing Techniques	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Motivational Interviewing - Adult	SA Intervention	Rural Border Intervention (RBI)		Number of Youth Receiving Interventions Using Motivational Interviewing Techniques	Keep
New Coalition members	SA Prevention	Community Coalition Partnership (CCP)		Number of new coalition members recruited	Keep
New Community Agreements	SA Intervention	HIV Early Intervention (HEI)		Number of New Written Community Agreements	Keep
New Community Agreements	SA Intervention	HIV Outreach Services (HIV)		Number of New Written Community Agreements	Keep
New Community Agreements	SA Intervention	Rural Border Intervention (RBI)		Number of New Written Community Agreements	Keep
Not Arrested - Adult	SA Intervention	Parenting Awareness and Drug Risk Education (PADRE)		Number of adult clients with open cases who were not arrested during the reporting month	Keep
Not Arrested - Youth	SA Intervention	Parenting Awareness and Drug Risk Education (PADRE)		Number of youth clients with open cases who were not arrested during the reporting month	Keep
Number of motivational sessions per client with multiple detoxification episodes	SA Treatment	Adult Treatment Services (TRA)	Adult Residential Detoxification Services	Number of motivational sessions per client with multiple detoxification episodes (average count)	Keep
Number of motivational sessions per client with multiple detoxification episodes	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Residential Detoxification Services	Number of motivational sessions per client with multiple detoxification episodes (average count)	Keep
Number of newly written Memorandums of Understanding (MOUs)	SA Recovery	Recovery Support Services-Community Based Organization- (was RSSCBO)		Report monthly the number of newly written Memorandums of Agreement that are developed by your organization each month.	Keep
Number of newly written Memorandums of Understanding (MOUs)	SA Recovery	Recovery Support Services-Recovery Community Organization (was RSSCO)		Report monthly the number of newly written Memorandums of Agreement that are developed by your organization each month.	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Number of newly written Memorandums of Understanding (MOUs)	SA Recovery	Recovery Support Services-Treatment Organization (was RSSTO)		Report monthly the number of newly written Memorandums of Agreement that are developed by your organization each month.	Keep
Number of Peer Recovery Advisory Council meetings.	SA Recovery	Recovery Support Services-Community Based Organization- (was RSSCBO)		Report the number of Peer Recovery Advisory Council meetings held by your organization during the reporting month	Keep
Number of Peer Recovery Advisory Council meetings.	SA Recovery	Recovery Support Services-Recovery Community Organization (was RSSCO)		Report the number of Peer Recovery Advisory Council meetings held by your organization during the reporting month	Keep
Number of Peer Recovery Advisory Council meetings.	SA Recovery	Recovery Support Services-Treatment Organization		Report the number of Peer Recovery Advisory Council meetings held by your organization during the reporting month	Keep
Number of persons who received education services.	SA Recovery	Recovery Support Services-Community Based Organization-		Report the number of new and ongoing participants who attended any type of education services during the reporting month.	Keep
Number of persons who received education services.	SA Recovery	Recovery Support Services-Community Based Organization- (was RSSCBO)		Report the number of new (unduplicated) individuals who attend any type of education services during the past month.	Keep
Number of persons who received education services.	SA Recovery	Recovery Support Services-Recovery Community Organization (RSSCO)		Report the number of new (unduplicated) individuals who attend any type of education services during the past month.	Keep
Number of persons who received education services.	SA Recovery	Recovery Support Services-Recovery Community Organization (was RSSCO)		Report the number of new and ongoing participants who attended any type of education services during the reporting month.	Keep
Number of persons who received education services.	SA Recovery	Recovery Support Services-Treatment Organization		Report the number of new (unduplicated) individuals who attend any type of education services during the past month.	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Number of persons who received education services.	SA Recovery	Recovery Support Services-Treatment Organization		Report the number of new (unduplicated) individuals who attend any type of education services during the past month.	Keep
Number of persons who received education services.	SA Recovery	Recovery Support Services-Treatment Organization (was RSSTO)		Report the number of new and ongoing participants who attended any type of education services during the reporting month.	Keep
Number of persons who received recovery support services.	SA Recovery	Recovery Support Services-Community Based Organization- (was RSSCBO)		Report the number of individuals who received any type of direct recovery services during the reporting month.	Keep
Number of persons who received recovery support services.	SA Recovery	Recovery Support Services-Community Based Organization- (was RSSCBO)		Report the number of new and ongoing participants who received any type of direct recovery services during the reporting month.	Keep
Number of persons who received recovery support services.	SA Recovery	Recovery Support Services-Community Based Organization- (was RSSCBO)		Report the number of new (unduplicated) individuals who received any type of indirect recovery services during the reporting month.	Keep
Number of persons who received recovery support services.	SA Recovery	Recovery Support Services-Community Based Organization- (was RSSCBO)		Report the number of new and ongoing participants who received any type of indirect recovery support services during the reporting month.	Keep
Number of persons who received recovery support services.	SA Recovery	Recovery Support Services-Recovery Community Organization (was RSSCO)		Report the number of individuals who received any type of direct recovery services during the reporting month.	Keep
Number of persons who received recovery support services.	SA Recovery	Recovery Support Services-Recovery Community Organization (was RSSCO)		Report the number of new and ongoing participants who received any type of direct recovery services during the reporting month.	Keep
Number of persons who received recovery support services.	SA Recovery	Recovery Support Services-Recovery Community		Report the number of new (unduplicated) individuals who received any type of indirect recovery services during the reporting month.	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
		Organization (was RSSCO)			
Number of persons who received recovery support services.	SA Recovery	Recovery Support Services-Recovery Community Organization (was RSSCO)		Report the number of new and ongoing participants who received any type of indirect recovery support services during the reporting month.	Keep
Number of persons who received recovery support services.	SA Recovery	Recovery Support Services-Treatment Organization (was RSSTO)		Report the number of individuals who received any type of direct recovery services during the reporting month.	Keep
Number of persons who received recovery support services.	SA Recovery	Recovery Support Services-Treatment Organization (was RSSTO)		Report the number of new (unduplicated) individuals who received any type of indirect recovery services during the reporting month.	Keep
Number of persons who received recovery support services.	SA Recovery	Recovery Support Services-Treatment Organization (was RSSTO)		Report the number of new and ongoing participants who received any type of indirect recovery support services during the reporting month.	Keep
Number of Pregnant clients with open cases prior to 28 weeks through delivery - Adult	SA Intervention	Pregnant and Postpartum Intervention (PPI)		Number of Pregnant Adults with a PPI Open Case Prior to 28 Weeks Gestation and Through the Delivery	Keep
Number of Pregnant clients with open cases prior to 28 weeks through delivery - Youth	SA Intervention	Pregnant and Postpartum Intervention (PPI)		Number of Pregnant Youth with a PPI Open Case Prior to 28 Weeks Gestation and Through the Delivery	Keep
Number of referrals made to services outside the program.	SA Recovery	Recovery Support Services-Community Based Organization- (was RSSCBO)		Report the total number of referrals made to services outside the program during the reporting month.	Keep
Number of referrals made to services outside the program.	SA Recovery	Recovery Support Services-Recovery Community Organization (was RSSCO)		Report the total number of referrals made to services outside the program during the reporting month.	Keep
Number of referrals made to services outside the program.	SA Recovery	Recovery Support Services-Treatment Organization		Report the total number of referrals made to services outside the program during the reporting month.	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Number served	SA Treatment	Adult Treatment Services (TRA)	Adult Ambulatory Detoxification Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Adult Treatment Services (TRA)	Adult Intensive Residential Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Adult Treatment Services (TRA)	Adult Outpatient Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Adult Treatment Services (TRA)	Adult Residential Detoxification Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Adult Treatment Services (TRA)	Adult Supportive Residential Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Adult Treatment Services (TRA)	Human Immunodeficiency Virus (HIV) Residential Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Adult Treatment Services (TRA)	Opioid Substitution Therapy	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Ambulatory Detoxification Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Intensive Residential Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Outpatient Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Residential Detoxification Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Number served	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Supportive Residential Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Intensive Residential Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Supportive Residential Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Intensive Residential Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Outpatient Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Supportive Residential Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Treatment Co-Occurring Services (TCO)	Co-Occurring Psychiatric and Substance Use Disorders (COPSD)	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Youth Treatment Services (TRY)	Youth Intensive Residential Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Youth Treatment Services (TRY)	Youth Outpatient Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep
Number served	SA Treatment	Youth Treatment Services (TRY)	Youth Supportive Residential Services	The unduplicated number of clients served (with a claim submitted and paid by DSHS)	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Number served - Adult	SA Intervention	Rural Border Intervention (RBI)		Number of Adults Served in the RBI Program	Keep
Number served - Youth	SA Intervention	Rural Border Intervention (RBI)		Number of Youth Served in the RBI Program	Keep
Numbers tested for HIV	SA Intervention	HIV Outreach Services (HIV)		Number of Participants Tested for HIV Through Outreach Efforts	Keep
Numbers tested positive for HIV	SA Intervention	HIV Outreach Services (HIV)		Number of Participants Testing Positive for HIV Through Outreach Efforts	Keep
Open Case - Adult	SA Intervention	HIV Early Intervention (HEI)		Number of Clients with an Open Case in HEI Program	Keep
Open Case - Adult	SA Intervention	Parenting Awareness and Drug Risk Education (PADRE)		Total number of adult clients with open cases in the reporting month	Keep
Open Case - Youth	SA Intervention	Parenting Awareness and Drug Risk Education (PADRE)		Total number of youth clients with open cases in the reporting month	Keep
Organizations contacted to obtain data	SA Prevention	Prevention Resource Center (PRC)		Number of organizations contacted to obtain local, county, or regional data	Keep
Organizations receiving local, county, or regional data	SA Prevention	Prevention Resource Center (PRC)		Number of organizations receiving local, county, or regional data	Keep
Percent able to access medication and medical care	SA Treatment	Adult Treatment Services (TRA)	Human Immunodeficiency Virus (HIV) Residential Services	Percent able to access medication and medical care	Keep
Percent abstinent at discharge	SA Treatment	Adult Treatment Services (TRA)	Adult Intensive Residential Services	Percent abstinent at discharge	Keep
Percent abstinent at discharge	SA Treatment	Adult Treatment Services (TRA)	Adult Outpatient Services	Percent abstinent at discharge	Keep
Percent abstinent at discharge	SA Treatment	Adult Treatment Services (TRA)	Adult Supportive Residential Services	Percent abstinent at discharge	Keep
Percent abstinent at discharge	SA Treatment	Adult Treatment Services (TRA)	Human Immunodeficiency Virus (HIV)	Percent abstinent at discharge	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
			Residential Services		
Percent abstinent at discharge	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Intensive Residential Services	Percent abstinent at discharge	Keep
Percent abstinent at discharge	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Outpatient Services	Percent abstinent at discharge	Keep
Percent abstinent at discharge	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Supportive Residential Services	Percent abstinent at discharge	Keep
Percent abstinent at discharge	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Intensive Residential Services	Percent abstinent at discharge	Keep
Percent abstinent at discharge	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Supportive Residential Services	Percent abstinent at discharge	Keep
Percent abstinent at discharge	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Intensive Residential Services	Percent abstinent at discharge	Keep
Percent abstinent at discharge	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Outpatient Services	Percent abstinent at discharge	Keep
Percent abstinent at discharge	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Supportive Residential Services	Percent abstinent at discharge	Keep
Percent abstinent at discharge	SA Treatment	Youth Treatment Services (TRY)	Youth Intensive Residential Services	Percent abstinent at discharge	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Percent abstinent at discharge	SA Treatment	Youth Treatment Services (TRY)	Youth Outpatient Services	Percent abstinent at discharge	Keep
Percent abstinent at discharge	SA Treatment	Youth Treatment Services (TRY)	Youth Supportive Residential Services	Percent abstinent at discharge	Keep
Percent admitted to/involved in ongoing treatment/recovery episodes	SA Treatment	Adult Treatment Services (TRA)	Adult Intensive Residential Services	Percent admitted to/involved in ongoing treatment/recovery episode (supportive residential, outpatient, 12-step groups, and other recovery support services)	Keep
Percent admitted to/involved in ongoing treatment/recovery episodes	SA Treatment	Adult Treatment Services (TRA)	Adult Outpatient Services	Percent admitted to/involved in ongoing treatment/recovery episode (supportive residential, outpatient, 12-step groups, and other recovery support services)	Keep
Percent admitted to/involved in ongoing treatment/recovery episodes	SA Treatment	Adult Treatment Services (TRA)	Adult Supportive Residential Services	Percent admitted to/involved in ongoing treatment/recovery episode (supportive residential, outpatient, 12-step groups, and other recovery support services)	Keep
Percent admitted to/involved in ongoing treatment/recovery episodes	SA Treatment	Adult Treatment Services (TRA)	Human Immunodeficiency Virus (HIV) Residential Services	Percent admitted to/involved in ongoing treatment/recovery episode (supportive residential, outpatient, 12-step groups, and other recovery support services)	Keep
Percent admitted to/involved in ongoing treatment/recovery episodes	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Intensive Residential Services	Percent admitted to/involved in ongoing treatment/recovery episode (supportive residential, outpatient, 12-step groups, and other recovery support services)	Keep
Percent admitted to/involved in ongoing treatment/recovery episodes	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Outpatient Services	Percent admitted to/involved in ongoing treatment/recovery episode (supportive residential, outpatient, 12-step groups, and other recovery support services)	Keep
Percent admitted to/involved in ongoing treatment/recovery episodes	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Supportive Residential Services	Percent admitted to/involved in ongoing treatment/recovery episode (supportive residential, outpatient, 12-step groups, and other recovery support services)	Keep
Percent admitted to/involved in ongoing treatment/recovery episodes	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Intensive Residential Services	Percent admitted to/involved in ongoing treatment/recovery episode (supportive residential, outpatient, 12-step groups, and other recovery support services)	Keep
Percent admitted to/involved in ongoing treatment/recovery episodes	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Supportive	Percent admitted to/involved in ongoing treatment/recovery episode (supportive residential, outpatient, 12-step groups, and other recovery support services)	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
			Residential Services		
Percent admitted to/involved in ongoing treatment/recovery episodes	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Intensive Residential Services	Percent admitted to/involved in ongoing treatment/recovery episode (supportive residential, outpatient, 12-step groups, and other recovery support services)	Keep
Percent admitted to/involved in ongoing treatment/recovery episodes	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Outpatient Services	Percent admitted to/involved in ongoing treatment/recovery episode (supportive residential, outpatient, 12-step groups, and other recovery support services)	Keep
Percent admitted to/involved in ongoing treatment/recovery episodes	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Supportive Residential Services	Percent admitted to/involved in ongoing treatment/recovery episode (supportive residential, outpatient, 12-step groups, and other recovery support services)	Keep
Percent admitted to/involved in ongoing treatment/recovery episodes	SA Treatment	Youth Treatment Services (TRY)	Youth Intensive Residential Services	Percent admitted to/involved in ongoing treatment/recovery episode (supportive residential, outpatient, 12-step groups, and other recovery support services)	Keep
Percent admitted to/involved in ongoing treatment/recovery episodes	SA Treatment	Youth Treatment Services (TRY)	Youth Outpatient Services	Percent admitted to/involved in ongoing treatment/recovery episode (supportive residential, outpatient, 12-step groups, and other recovery support services)	Keep
Percent admitted to/involved in ongoing treatment/recovery episodes	SA Treatment	Youth Treatment Services (TRY)	Youth Supportive Residential Services	Percent admitted to/involved in ongoing treatment/recovery episode (supportive residential, outpatient, 12-step groups, and other recovery support services)	Keep
Percent attending school or vocational training	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Intensive Residential Services	Percent attending school or vocational training	Keep
Percent attending school or vocational training	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Outpatient Services	Percent attending school or vocational training	Keep
Percent attending school or vocational training	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Supportive Residential Services	Percent attending school or vocational training	Keep
Percent attending school or vocational training	SA Treatment	Youth Treatment Services (TRY)	Youth Intensive Residential Services	Percent attending school or vocational training	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Percent attending school or vocational training	SA Treatment	Youth Treatment Services (TRY)	Youth Outpatient Services	Percent attending school or vocational training	Keep
Percent attending school or vocational training	SA Treatment	Youth Treatment Services (TRY)	Youth Supportive Residential Services	Percent attending school or vocational training	Keep
Percent discharging to stable housing	SA Treatment	Adult Treatment Services (TRA)	Adult Intensive Residential Services	Percent discharging to stable housing	Keep
Percent discharging to stable housing	SA Treatment	Adult Treatment Services (TRA)	Adult Outpatient Services	Percent discharging to stable housing	Keep
Percent discharging to stable housing	SA Treatment	Adult Treatment Services (TRA)	Adult Supportive Residential Services	Percent discharging to stable housing	Keep
Percent discharging to stable housing	SA Treatment	Adult Treatment Services (TRA)	Human Immunodeficiency Virus (HIV) Residential Services	Percent discharging to stable housing	Keep
Percent discharging to stable housing	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Intensive Residential Services	Percent discharging to stable housing	Keep
Percent discharging to stable housing	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Outpatient Services	Percent discharging to stable housing	Keep
Percent discharging to stable housing	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Supportive Residential Services	Percent discharging to stable housing	Keep
Percent discharging to stable housing	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Intensive Residential Services	Percent discharging to stable housing	Keep
Percent discharging to stable housing	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Supportive Residential Services	Percent discharging to stable housing	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Percent discharging to stable housing	SA Treatment	Treatment Co-Occurring Services (TCO)	Co-Occurring Psychiatric and Substance Use Disorders (COPSD)	Percent discharging to stable housing	Keep
Percent employed at discharge	SA Treatment	Adult Treatment Services (TRA)	Adult Intensive Residential Services	Percent employed at discharge	Keep
Percent employed at discharge	SA Treatment	Adult Treatment Services (TRA)	Adult Outpatient Services	Percent employed at discharge	Keep
Percent employed at discharge	SA Treatment	Adult Treatment Services (TRA)	Adult Supportive Residential Services	Percent employed at discharge	Keep
Percent employed at discharge	SA Treatment	Adult Treatment Services (TRA)	Human Immunodeficiency Virus (HIV) Residential Services	Employed at discharge	Keep
Percent employed at discharge	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Intensive Residential Services	Percent employed at discharge	Keep
Percent employed at discharge	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Outpatient Services	Percent employed at discharge	Keep
Percent employed at discharge	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Supportive Residential Services	Percent employed at discharge	Keep
Percent employed at discharge	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Intensive Residential Services	Percent employed at discharge	Keep
Percent employed at discharge	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Supportive Residential Services	Employed at discharge	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Percent of claims submitted to DSHS with matching Medicaid Residential claim	SA Treatment	Adult Treatment Services (TRA)	Adult Human Immunodeficiency Virus (HIV) Residential Wraparound Services (Medicaid Adult-21 and Over)	Percent of claims submitted to DSHS with matching Medicaid Residential claim	Keep
Percent of claims submitted to DSHS with matching Medicaid Residential claim	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Intensive Residential Wraparound Services (Medicaid Adult)	Percent of claims submitted to DSHS with matching Medicaid Residential claim	Keep
Percent of claims submitted to DSHS with matching Medicaid Residential claim	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Intensive Residential Wraparound Services (Medicaid Youth)	Percent of claims submitted to DSHS with matching Medicaid Residential claim	Keep
Percent of claims submitted to DSHS with matching Medicaid Residential claim	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Intensive Residential Wraparound Services – Room & Board (Medicaid Youth)	Percent of claims submitted to DSHS with matching Medicaid Residential claim	Keep
Percent of claims submitted to DSHS with matching Medicaid Residential claim	SA Treatment	Youth Treatment Services (TRY)	Youth Intensive Residential Wraparound Services-Room & Board (Medicaid Youth)	Percent of claims submitted to DSHS with matching Medicaid Residential claim	Keep
Percent of clients presenting for recovery support services.	SA Intervention	Outreach, Screening, Assessment and Referral (OSAR)		Percent of clients referred that presented for recovery support services	Keep
Percent of clients presenting for treatment	SA Intervention	Outreach, Screening,		Percent of clients referred that presented to treatment	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
		Assessment and Referral (OSAR)			
Percent of clients reporting abstinence at delivery - Adult	SA Intervention	Pregnant and Postpartum Intervention (PPI)		Percentage of Pregnant Adults Reporting Abstinence from Date of Open Case to Delivery	Keep
Percent of clients reporting abstinence at delivery - Youth	SA Intervention	Pregnant and Postpartum Intervention (PPI)		Percentage of Pregnant Youth Reporting Abstinence from Date of Open Case to Delivery	Keep
Percent of Methadone clients who length of stay is at least one year	SA Treatment	Adult Treatment Services (TRA)	Opioid Substitution Therapy	Percent of Methadone clients whose length of stay is at least one year	Keep
Percent of referral to another level of care for clients in an initial detoxification episode	SA Treatment	Adult Treatment Services (TRA)	Adult Residential Detoxification Services	Percent of referral to another level of care for clients in an initial detoxification episode	Keep
Percent of referral to another level of care for clients in an initial detoxification episode	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Residential Detoxification Services	Percent of referral to another level of care for clients in an initial detoxification episode	Keep
Percent of referral to another level of care for clients with multiple detoxification episode	SA Treatment	Adult Treatment Services (TRA)	Adult Residential Detoxification Services	Percent of referral to another level of care for clients with multiple detoxification episodes	Keep
Percent of referral to another level of care for clients with multiple detoxification episode	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Residential Detoxification Services	Percent of referral to another level of care for clients with multiple detoxification episodes	Keep
Percent reporting reduction in risk behavior	SA Treatment	Adult Treatment Services (TRA)	Human Immunodeficiency Virus (HIV) Residential Services	Percent reporting reduction in risk behavior	Keep
Percent successfully completing	SA Treatment	Adult Treatment Services (TRA)	Adult Intensive Residential Services	Percent who successfully complete treatment services	Keep
Percent successfully completing	SA Treatment	Adult Treatment Services (TRA)	Adult Outpatient Services	Percent who successfully complete treatment services	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Percent successfully completing	SA Treatment	Adult Treatment Services (TRA)	Adult Supportive Residential Services	Percent who successfully complete treatment services	Keep
Percent successfully completing	SA Treatment	Adult Treatment Services (TRA)	Human Immunodeficiency Virus (HIV) Residential Services	Percent who successfully complete treatment services	Keep
Percent successfully completing	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Intensive Residential Services	Percent who successfully complete treatment services	Keep
Percent successfully completing	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Outpatient Services	Percent who successfully complete treatment services	Keep
Percent successfully completing	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Supportive Residential Services	Percent who successfully complete treatment services	Keep
Percent successfully completing	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Intensive Residential Services	Percent who successfully complete treatment services	Keep
Percent successfully completing	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Supportive Residential Services	Percent who successfully complete treatment services	Keep
Percent successfully completing	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Intensive Residential Services	Percent who successfully complete treatment services	Keep
Percent successfully completing	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Outpatient Services	Percent who successfully complete treatment services	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Percent successfully completing	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Supportive Residential Services	Percent who successfully complete treatment services	Keep
Percent successfully completing	SA Treatment	Youth Treatment Services (TRY)	Youth Intensive Residential Services	Percent who successfully complete treatment services	Keep
Percent successfully completing	SA Treatment	Youth Treatment Services (TRY)	Youth Outpatient Services	Percent who successfully complete treatment services	Keep
Percent successfully completing	SA Treatment	Youth Treatment Services (TRY)	Youth Supportive Residential Services	Percent who successfully complete treatment services	Keep
Percent who complete detoxification services	SA Treatment	Adult Treatment Services (TRA)	Adult Ambulatory Detoxification Services	Percent who complete detoxification services	Keep
Percent who complete detoxification services	SA Treatment	Adult Treatment Services (TRA)	Adult Residential Detoxification Services	Percent who complete detoxification services	Keep
Percent who complete detoxification services	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Ambulatory Detoxification Services	Percent who complete detoxification services	Keep
Percent who complete detoxification services	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Residential Detoxification Services	Percent who complete detoxification services	Keep
Percent with concurrent admission to outpatient treatment services	SA Treatment	Adult Treatment Services (TRA)	Adult Ambulatory Detoxification Services	Percent of clients with concurrent admission to outpatient treatment services	Keep
Percent with concurrent admission to outpatient treatment services	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Ambulatory Detoxification Services	Percent of clients with concurrent admission to outpatient treatment services	Keep
Percent with no arrest since admission	SA Treatment	Adult Treatment Services (TRA)	Adult Intensive Residential Services	Percent with no arrest since admission	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Percent with no arrest since admission	SA Treatment	Adult Treatment Services (TRA)	Adult Outpatient Services	Percent with no arrest since admission	Keep
Percent with no arrest since admission	SA Treatment	Adult Treatment Services (TRA)	Adult Supportive Residential Services	Percent with no arrest since admission	Keep
Percent with no arrest since admission	SA Treatment	Adult Treatment Services (TRA)	Human Immunodeficiency Virus (HIV) Residential Services	Percent with no arrest since admission	Keep
Percent with no arrest since admission	SA Treatment	Adult Treatment Services (TRA)	Opioid Substitution Therapy	Percent with no arrest since admission	Keep
Percent with no arrest since admission	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Intensive Residential Services	Percent with no arrest since admission	Keep
Percent with no arrest since admission	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Outpatient Services	Percent with no arrest since admission	Keep
Percent with no arrest since admission	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Specialized Female Supportive Residential Services	Percent with no arrest since admission	Keep
Percent with no arrest since admission	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Intensive Residential Services	Percent with no arrest since admission	Keep
Percent with no arrest since admission	SA Treatment	Specialized Female Treatment Services – Adult (TRF)	Adult Women and Children Supportive Residential Services	Percent with no arrest since admission	Keep
Percent with no arrest since admission	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Intensive Residential Services	Percent with no arrest since admission	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Percent with no arrest since admission	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Outpatient Services	Percent with no arrest since admission	Keep
Percent with no arrest since admission	SA Treatment	Specialized Female Treatment Services – Youth (TYF)	Youth Specialized Female Supportive Residential Services	Percent with no arrest since admission	Keep
Percent with no arrest since admission	SA Treatment	Youth Treatment Services (TRY)	Youth Intensive Residential Services	Percent with no arrest since admission	Keep
Percent with no arrest since admission	SA Treatment	Youth Treatment Services (TRY)	Youth Outpatient Services	Percent with no arrest since admission	Keep
Percent with no arrest since admission	SA Treatment	Youth Treatment Services (TRY)	Youth Supportive Residential Services	Percent with no arrest since admission	Keep
Percentage whose children received All Recommended Well-Child Visits - Adult	SA Intervention	Pregnant and Postpartum Intervention (PPI)		Percentage of All Adult Clients Whose Children Received All Recommended Well-Child Visits During the Time the Client's Case Was Open	Keep
Percentage whose children received All Recommended Well-Child Visits - Youth	SA Intervention	Pregnant and Postpartum Intervention (PPI)		Percentage of All Youth Clients Whose Children Received All Recommended Well-Child Visits During the Time the Client's Case Was Open	Keep
Percentage of clients delivering healthy weight babies - Adult	SA Intervention	Pregnant and Postpartum Intervention (PPI)		Percentage of Pregnant Adults Delivering Healthy Weight Baby	Keep
Percentage of clients delivering healthy weight babies - Youth	SA Intervention	Pregnant and Postpartum Intervention (PPI)		Percentage of Pregnant Youth Delivering Healthy Weight Baby	Keep
Percentage of Pregnant Clients delivering full-term - Adult	SA Intervention	Pregnant and Postpartum Intervention (PPI)		Percentage of Pregnant Adults Delivering at Full-Term	Keep
Percentage of Pregnant Clients delivering full-term - Youth	SA Intervention	Pregnant and Postpartum Intervention (PPI)		Percentage of Pregnant Youth Delivering at Full-Term	Keep
Percentage that received reproductive health visits - Adult	SA Intervention	Pregnant and Postpartum Intervention (PPI)		Percentage of All Adult Clients Receiving Reproductive Health Visit (Prenatal visit, Postpartum visit, Interconception Visit)	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Percentage that received reproductive health visits - Youth	SA Intervention	Pregnant and Postpartum Intervention (PPI)		Percentage of All Youth Clients Receiving Reproductive Health Visit (Prenatal visit, Postpartum visit, Interconception Visit)	Keep
Pregnant or Postpartum clients screened for substance abuse risk factors - Adult	SA Intervention	Pregnant and Postpartum Intervention (PPI)		Number of Pregnant or Postpartum Adults Screened for Substance Abuse Risk Factors	Keep
Pregnant or Postpartum clients screened for substance abuse risk factors - Youth	SA Intervention	Pregnant and Postpartum Intervention (PPI)		Number of Pregnant or Postpartum Youth Screened for Substance Abuse Risk Factors	Keep
Prevention presentations that include minors and tobacco information	SA Prevention	Youth Prevention Indicated (YPI)		Number of prevention presentations that include minors and tobacco information	Keep
Prevention presentations that include minors and tobacco information	SA Prevention	Youth Prevention Selective (YPS)		Number of prevention presentations that include minors and tobacco information	Keep
Prevention presentations that include minors and tobacco information	SA Prevention	Youth Prevention Universal (YPU)		Number of prevention presentations that include minors and tobacco information	Keep
Priority for housing admission maintained for DSHS-MHSA funded treatment program completers.	SA Recovery	Substance Abuse Texas Group Homes- Oxford House		Report monthly number of DSHS/MHSA funded treatment program completers admitted to each recovery house	Keep
Problem ID - Adult	SA Intervention	Rural Border Intervention (RBI)		Number of Adults Receiving Problem Identification and Referral	Keep
Problem ID - Youth	SA Intervention	Rural Border Intervention (RBI)		Number of Youth Receiving Problem Identification and Referral	Keep
Recovery Coaching 12 Month Follow Up interview	SA Recovery	Recovery Support Services-All settings		% of 12-Month Follow-Up Interviews successfully completed.	Keep
Recovery coaching Enrollment	SA Recovery	Recovery Support Services- All settings		# of participants in long-term Recovery Coaching, develop individualized strength-based Recovery Plans, and provide regular Recovery Check-Ups.	Keep
Recovery Support Service Provision	SA Recovery	Recovery Support Services-All settings		# individuals entering program and receiving Direct and Indirect Recovery Support Services and Educational Services based on individualized needs.	Keep
Reduced and/or abstinence from substance use	SA Recovery	Recovery Support Services-All settings		% individuals with reduced and/or abstinence from substance use during the past 30 days at 12-Month Follow-Up Interview compared to their past 30-day substance use at	Keep
Referral rate	SA Intervention	HIV Early Intervention (HEI)		Number of Client Referrals Resulting in Initial Contact with Service Provider by the Client within 14 days	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Referral to Community Supports - Adult	SA Intervention	Outreach, Screening, Assessment and Referral (OSAR)		Number of adults referred to recovery support services	Keep
Referral to Community Supports - Youth	SA Intervention	Outreach, Screening, Assessment and Referral (OSAR)		Number of youth referred to recovery support services	Keep
Referral to SA treatment	SA Intervention	HIV Outreach Services (HIV)		Number of Participants Referred for Substance Abuse Services as a Result of HIV Outreach Efforts	Keep
Referral to SA treatment - Adult	SA Intervention	Outreach, Screening, Assessment and Referral (OSAR)		Number of adults referred to substance abuse treatment	Keep
Referral to SA treatment - Youth	SA Intervention	Outreach, Screening, Assessment and Referral (OSAR)		Number of youth referred to substance abuse treatment	Keep
Regional Prevention Trainings	SA Prevention	Prevention Resource Center (PRC)		Number of prevention trainings coordinated for the region	Keep
Renewed written community agreements	SA Prevention	Community Coalition Partnership (CCP)		Number of renewed written community agreements	Keep
Renewed Community Agreements	SA Intervention	HIV Early Intervention (HEI)		Number of Renewed Written Community Agreements	Keep
Renewed Community Agreements	SA Intervention	HIV Outreach Services (HIV)		Number of Renewed Written Community Agreements	Keep
Renewed Community Agreements	SA Intervention	Rural Border Intervention (RBI)		Number of Renewed Written Community Agreements	Keep
Renewed written community agreements	SA Prevention	Prevention Resource Center (PRC)		Number of renewed written community agreements	Keep
Retailers contacted to comply with Texas Tobacco Laws	SA Prevention	Prevention Resource Center (PRC)		Number of retailers contacted to comply with the Texas Tobacco Laws	Keep
SA active clients	SA Intervention	HIV Early Intervention (HEI)		Total Number of Clients who are Actively Participating in Substance Abuse Services	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Schools contacted to promote the Texas School Survey	SA Prevention	Prevention Resource Center (PRC)		Number of schools contacted to promote the Texas School Survey	Keep
Screening for SA risk factors - Adult	SA Intervention	Parenting Awareness and Drug Risk Education (PADRE)		Number of adult clients screened for substance abuse risk factors	Keep
Screening for SA risk factors - Youth	SA Intervention	Parenting Awareness and Drug Risk Education (PADRE)		Number of youth clients screened for substance abuse risk factors	Keep
Social media messages	SA Prevention	Community Coalition Partnership (CCP)		Number of social media messages focused on the state's three prevention priorities of alcohol (underage drinking), marijuana, and prescription drugs	Keep
Stable Housing - Adult	SA Intervention	Parenting Awareness and Drug Risk Education (PADRE)		Number of adult clients with open cases who report to have stable housing during the reporting month	Keep
Stable Housing - Youth	SA Intervention	Parenting Awareness and Drug Risk Education (PADRE)		Number of youth clients with open cases who report to have stable housing during the reporting month	Keep
Substance Abuse Screening - Adult	SA Intervention	Outreach, Screening, Assessment and Referral (OSAR)		Number of adults screened for substance abuse	Keep
Substance Abuse Screening - Youth	SA Intervention	Outreach, Screening, Assessment and Referral (OSAR)		Number of youth screened for substance abuse	Keep
Substance abuse treatment at discharge	SA Treatment	Treatment Co-Occurring Services (TCO)	Co-Occurring Psychiatric and Substance Use Disorders (COPSD)	Substance Abuse Treatment Status at discharge	Keep
Written Community Agreements or MOUs	SA Prevention	Community Coalition Partnership (CCP)		Number of new written community agreements	Keep
Written Community Agreements or MOUs	SA Prevention	Partnerships for Success (PFS)		Number of Active Written Community Agreements (Cas) or Memorandums of Understanding (MOUs)	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Written Community Agreements or MOUs	SA Prevention	Prevention Resource Center (PRC)		Number of new written community agreements	Keep
Written Community Agreements or MOUs	SA Prevention	Youth Prevention Indicated (YPI)		Number of written Community Agreements (CAs) or Memorandum of Understanding (MOUs)	Keep
Written Community Agreements or MOUs	SA Prevention	Youth Prevention Selective (YPS)		Number of written Community Agreements (CAs) or Memorandum of Understanding (MOUs)	Keep
Written Community Agreements or MOUs	SA Prevention	Youth Prevention Universal (YPU)		Number of written Community Agreements (CAs) or Memorandum of Understanding (MOUs)	Keep
Youth attending AOD Presentations	SA Prevention	Community Coalition Partnership (CCP)		Number of youth attending alcohol and other drugs (AOD) presentations focused on the state's three prevention priorities of alcohol (underage drinking), marijuana, and prescription drugs	Keep
Youth attending AOD Presentations	SA Prevention	Youth Prevention Indicated (YPI)		Number of youth attending alcohol and other drugs (AOD) presentations	Keep
Youth attending AOD presentations	SA Prevention	Youth Prevention Selective (YPS)		Number of youth attending alcohol and other drugs (AOD) presentations	Keep
Youth attending AOD Presentations	SA Prevention	Youth Prevention Universal (YPU)		Number of youth attending alcohol and other drugs (AOD) presentations	Keep
Youth attending minors and tobacco presentations	SA Prevention	Youth Prevention Indicated (YPI)		Number of youth attending minors and tobacco presentations	Keep
Youth attending minors and tobacco presentations	SA Prevention	Youth Prevention Selective (YPS)		Number of youth attending minors and tobacco presentations	Keep
Youth attending minors and tobacco presentations	SA Prevention	Youth Prevention Universal (YPU)		Number of youth attending minors and tobacco presentations	Keep
Youth involved in AOD alternative activities	SA Prevention	Youth Prevention Indicated (YPI)		Number of youth involved in alcohol and other drugs (AOD) alternative activities (Do Not Include Tobacco Specific Activities)	Keep
Youth involved in AOD alternative activities	SA Prevention	Youth Prevention Selective (YPS)		Number of youth involved in alcohol and other drugs (AOD) alternative activities (Do Not Include Tobacco Specific Activities)	Keep
Youth involved in AOD alternative activities	SA Prevention	Youth Prevention Universal (YPU)		Number of youth involved in alcohol and other drugs (AOD) alternative activities (Do Not Include Tobacco Specific Activities)	Keep
Youth involved in tobacco alternative activities	SA Prevention	Youth Prevention Indicated (YPI)		Number of youth involved in tobacco alternative activities	Keep
Youth involved in tobacco alternative activities	SA Prevention	Youth Prevention Selective (YPS)		Number of youth involved in tobacco alternative activities	Keep
Youth involved in tobacco alternative activities	SA Prevention	Youth Prevention Universal (YPU)		Number of youth involved in tobacco alternative activities	Keep

Name	Construct	Program	Sub-program	Description of Measure	Rec.
Youth receiving AOD information	SA Prevention	Community Coalition Partnership (CCP)		Number of youth receiving alcohol and other drugs (AOD) information focused on the state's three prevention priorities of alcohol (underage drinking), marijuana, and prescription drugs	Keep
Youth receiving ATOD information	SA Prevention	Youth Prevention Indicated (YPI)		Number of youth receiving alcohol, tobacco and other drugs (ATOD) information	Keep
Youth receiving ATOD information	SA Prevention	Youth Prevention Selective (YPS)		Number of youth receiving alcohol, tobacco and other drugs (ATOD) information	Keep
Youth receiving ATOD information	SA Prevention	Youth Prevention Universal (YPU)		Number of youth receiving alcohol, tobacco and other drugs (ATOD) information	Keep
Youth receiving indicated prevention counseling	SA Prevention	Youth Prevention Indicated (YPI)		Number of youth receiving indicated prevention counseling	Keep
Youth receiving prevention education	SA Prevention	Youth Prevention Indicated (YPI)		Number of youth receiving prevention education/skills training (approved evidence-based curriculum)	Keep
Youth receiving prevention education	SA Prevention	Youth Prevention Selective (YPS)		Number of youth receiving prevention education/skills training (approved evidence-based curriculum)	Keep
Youth receiving prevention education	SA Prevention	Youth Prevention Universal (YPU)		Number of youth receiving prevention education/skills training (approved evidence-based curriculum)	Keep
Youth successfully referred to other support services	SA Prevention	Youth Prevention Indicated (YPI)		Number of youth successfully referred to other support services	Keep

Additional SUD Measures for Consideration

Measure Name	Description	Rationale
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (HEDIS)	This measure assesses the percentage of adolescents and adults with a new episode of AOD dependence who received the following care. Initiation of AOD Treatment: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. Engagement of AOD Treatment: The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	AOD dependence is common across many age groups and a cause of morbidity, mortality and decreased productivity. There is strong evidence that treatment for AOD dependence can improve health, productivity and social outcomes, and can save millions of dollars on health care and related costs.
NQF #2605 Follow-up After Emergency Room Visit for Alcohol or Other Drug Use	The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge. Four rates are reported: • The percentage of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge. • The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge. • The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge. • The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge.	Proposed 2017 HEDIS measure – follow-up 7 and 30 days after emergency room visit for SUD.
Initiation of Pharmacotherapy upon New Episode of Opioid Dependence (American Society of Addiction Medicine criteria)	Number of individuals with index visit associated with an opioid dependence diagnosis after 60-day clean period with no SUD claims.	Adds a measure that monitors use of evidenced based practice by SUD treatment providers.

Review of State Hospital Measures

All ten State Hospitals in Texas are accredited by the Joint Commission and nine are certified by CMS (Waco Center for Youth is not Medicare certified based on its patient population). Both of these oversight agencies require the reporting of specific performance measures into a national data set and are not subject to modification by HHSC/DSHS. Therefore, we have no recommendations of current measures to eliminate or modify.

The Joint Commission

The Joint Commission (TJC) is a not for profit organization that accredits healthcare organizations and requires freestanding inpatient psychiatric hospitals to report performance data via an intermediary vendor. NRI serves as the vendor for all of the Texas State Hospitals, as well as the majority of other state hospitals across the United States. NRI's large and comprehensive national data set allows for the calculation of comparison rates specifically for state hospitals. TJC's targets are comprised of all freestanding psychiatric hospitals (public and private) across the country, which represents a different comparison group.

Performance rates are monitored by TJC on a quarterly basis in comparison to TJC target rates, and Joint Commission surveyors use these data to as part of their triennial survey reviews. Quantitative results of the data analysis for each of the required TJC measures are presented in Appendix A.2.

Centers for Medicare and Medicaid Services

Beginning in 2012, CMS required all facilities to report performance rates for patients served on inpatient psychiatric units that are certified by CMS. Thirty-five of the 121 units in nine Texas State Hospitals fall into this category.

The CMS program is currently a pay for reporting program, which means that failure to report data (regardless of performance rate) will result in a 2% loss of the of the annual Medicare payment update. Hospital level performance rates are posted publicly on the CMS Hospital Compare website. While there are no national benchmarks for the CMS measures, NRI provides feedback to each Texas State Hospital on their rates compared to all other state hospital CMS certified units. In the future, the CMS reporting program will move towards a pay for performance program. Hospitals will then need to achieve CMS-established targets to avoid losing 2% of Medicare payment updates.

Performance rates on the CMS measures are computed by NRI and submitted to CMS on behalf of Texas State Hospitals annually. It is important to note that CMS updates the list every year which poses a burden on the hospitals and HHSC/DSHS staff to update the clinical, administrative, and IT infrastructure to support new measures. Quantitative results of the data analysis of CMS-required measures are presented in Appendix A.2.

Chapter 8: Conclusion

The State of Texas' HHSC/DSHS implemented as directed appropriated funds to a ten percent allocation from each LMHA for use as a performance based incentive payment. They established process measures and targets that the LMHAs and providers must achieve to receive payment of the funds withheld, in support of accomplishing the State's goal of demonstrating improvement of the quality of behavioral health and reporting on metrics reflective of the systems' performance. The HMA/NRI team commends HHSC/DSHS for executing its structured approach inclusive of defined measures, contract processes, and payment mechanisms as required by Rider 82 of the 84th Regular Legislative Session. HHSC/DSHS established a "stake in the ground," based on the information, data, and reporting capabilities, and infrastructure and resources at hand.

The State's release of the Request for Proposal for a Third Party Evaluation of Behavioral Health and selection of a vendor in July 2016 continues HHSC/DSHS' commitment to complete a review and assessment of its current efforts, and determine strengths and opportunities for improvement to meet the State's objectives. The evaluation of existing mental health, SUD, inpatient and outpatient measures, and consideration of their alignment with national norms and standards is fundamental to Texas achieving its goals of paying for value and performance and fulfilling its responsibilities to provide a high quality, accessible, effective, and efficient public behavioral health system.

Integral to this approach, HHSC/DSHS also is aware of its responsibility to report the measures and results publicly, sharing with a broad range of stakeholders better information about the ongoing performance of the State's public behavioral health system. The development of a publically accessible, web-based dashboard which displays key measures of performance has the potential to contribute to stakeholders' sense of greater HHSC/DSHS transparency. The State will be fulfilling its responsibility to provide easily accessible and publically available information to its citizens.

Texas' decision to move to a system of value based payment tied to performance is significant in fulfilling its fiduciary and public responsibility to its citizens, and is aligned with national efforts. In light of the goals the State of Texas has identified, HHSC/DSHS should consider establishing a transition plan that identifies the steps needed to build a robust infrastructure to support this endeavor. For providers, an infrastructure can increase capacity to establish, expand, and conduct performance based payment reporting based in industry standards and performance based contacting. The State will need to re-align resources as it includes recommendations supportive of their and stakeholders' interests. Furthermore, HHSC/DSHS will enhance the success of its approach and plan through embarking on additional engagement of stakeholder representatives of the LMHAs, providers, legislators, advocates, consumers and family members, and others. The opportunity to discuss priorities and develop a joint plan of action, anchored in shared vision and shared understanding of needs, can more effectively promote the transformation in behavioral health.

We believe HHSC/DSHS and the State of Texas are well positioned to leverage its current efforts, engage stakeholders, and create momentum that will transform the behavioral health system. Such transformation can occur in a thoughtful and timely way as HHSC/DSHS conducts its evaluation of the recommendations and weighs considerations with stakeholders to effectuate successful execution of the plan.

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Appendices

Appendix A

A.1 Legislation
A.2 Data Analysis: MH, SUD, and State Hospitals
A.3 Mental Health Contract Measures Tied to Payment FY2016

Appendix B

B.1-3 Crosswalks
B.4 Medicaid Managed Care Measures
B.5 Certified Community Behavioral Health Clinic Measures
B.6 SAMHSA National Outcome Measures
B.7 Payment Models

Appendix A.1: Legislation

GENERAL APPROPRIATIONS ACT FOR THE 2016-17 BIENNIUM

Eighty-fourth Texas Legislature, Regular Session, 2015

Rider 58. Mental Health Outcomes and Accountability. Out of funds appropriated above in Goal B, Community Health Services, Strategies B.2.1, Mental Health Services for Adults, B.2.2, Mental Health Services for Children, and B.2.3, Community Mental Health Crisis Services, the Department of State Health Services shall withhold ten percent (10%) of the General Revenue quarterly allocation from each Local Mental Health Authority (LMHA) for use as a performance based incentive payment. The payment of the funds withheld shall be contingent upon the achievement of outcome targets set by the department. Performance shall be assessed and payments made on a six-month interval. Funds that have been withheld for failure to achieve outcome targets will be used for technical assistance and redistributed as an incentive payment according to a methodology developed by the department.

Rider 82. Behavioral Health Services Provider Contracts Review. Out of funds appropriated above, the Department of State Health Services (DSHS), in collaboration with the Health and Human Services Commission (HHSC), shall conduct a review to identify improvements to performance measurement, contract processing, and payment mechanisms for behavioral health services contracts with DSHS. In conducting the review, DSHS shall solicit stakeholder input and may use funds appropriated above to seek the assistance of a third party with expertise in health purchasing. DSHS shall complete the review and report findings no later than December 1, 2016 to the Legislative Budget Board, the Office of the Governor, and the permanent standing committees in the House of Representatives and the Senate with jurisdiction over health and human services. The review and report must include:

a. identification of performance measures and other requirements not necessary by a state or federal requirement that could be eliminated from contracts;

b. a review of the metrics and methodology associated with the withholding of allocations made under DSHS Rider 58, Mental Health Outcomes and Accountability;

c. consideration of performance measures and contracting strategies similar to those used for managed care organizations;

d. consideration of best practices in performance measurement and contracting, including incentive payments and financial sanctions that are aligned with the models used by the Health and Human Services Commission for purchasing health care services; and

e. a proposal for a publicly available web-based dashboard to compare performance of behavioral health services providers contracted with DSHS.

GENERAL APPROPRIATIONS ACT FOR THE 2014-15 BIENNIUM

Eighty-third Texas Legislature, Regular Session, 2013

Rider 78. Mental Health Outcomes and Accountability. Out of funds appropriated above in Goal B, Community Health Services, Strategies B.2.1, Mental Health Services for Adults, B.2.2, Mental Health Services for Children, and B.2.3, Community Mental Health Crisis Services, the Department of State Health Services shall withhold ten percent (10%) of the General Revenue quarterly allocation from each Local Mental Health Authority (LMHA) for use as a performance based incentive payment. The payment of the funds withheld shall be contingent upon the achievement of outcome targets set by the department. Initial outcome targets shall be set by the department not later than September 1, 2013. Performance shall be assessed and payments made on a six-month interval. Funds that have been withheld for failure to achieve outcome targets will be used for technical assistance and redistributed as an incentive payment according to a methodology developed by the department.

Appendix A.2: Performance Rates of Texas Behavioral Healthcare Providers on Select Performance Measures

Introduction

This report contains the data analysis performed for the Texas Behavioral Healthcare Providers as part of Task 2, of the Business Proposal to Provide Third Party Evaluation for Behavioral Health Services for Texas Health and Human Services Commission. The report presents an assessment of trends over time in measure variability across Texas reporting providers and for the overall sample. For section III of the report, national data is also provided for comparison purposes. The report is divided in three main sections for which data analysis was performed: (1) local mental health agencies, (2) substance use providers, and (3) state hospitals. Each section provides information related to the performance measures included for analysis, the list of providers included in the data analysis, and the results.

The results section is also divided in two parts. First, descriptive analysis including analysis of central tendency by half fiscal year (FY) for each performance measure is provided. Texas FY runs from September thru August. When feasible, data analysis was also conducted by month, and aggregated by quarter. Quarter 1 includes data for the months of September thru November, Quarter 2 includes data for the months of December thru February, Quarter 3 includes data for the months of March thru May, and Quarter 4 includes data for the months of June thru August. Second, variability analysis is presented by entity (mental health provider, substance use provider, or state hospital) in six-month intervals. Performance level for each entity was rounded to the next integer at .5. For the local mental health agencies, data analysis was performed for 1st half FY 2015, 2nd half FY 2015, and 1st half FY 2016. For the substance use providers, data analysis was conducted for 1st half FY 2015 and 2nd half FY 2015. And, for state hospitals, data analysis data analysis included 2nd half FY 2015 and 1st half FY 2016.

Section I. Local Mental Health Agencies

A. Performance measures – *DSHS Measures*

The tables below present the mental health performance measure included for analysis for the local mental health agencies (LMHAs). Two types of performance measures were analyzed both associated with financial sanctions: (1) DSHS measures, and (2) measures that relate to the SAMHSA National Outcome Measures [NOMs] domains).

List of mental health performance measures – *DSHS Measures*				
Code	**Measure Name (Target)**	**Measure Description**	**Measure Numerator**	**Measure Denominator**
MH1	Service Target Adult (>=100%)	The percent of adults in a FLOC compared to LMHA target.	The total number of clients authorized in a FLOC in the last month of Quarter 2.	The target assigned to the contractor.
MH2	Service Target Child (>=100%)	The percent of children and youth in a FLOC compared to LMHA target.	The total number of clients authorized in a FLOC in the last month of Quarter 2.	The target assigned to the contractor.
MH3	Uniform Assessment Completion Rate Adult (>=95%)	The proportion of adults served or authorized for services during the six month period who have a completed and current UA.	Total number of registered adults registered in CARE with a completed UA.	Unduplicated number of adults with a completed UA or a service encounter.
MH4	Uniform Assessment Completion Rate Child (>=95%)	The percent of children and youth served or authorized for services during the six month period who have a completed and current UA.	Total number of children and youths with a completed UA.	Unduplicated number of registered children and youths with a completed UA or a service encounter.
MH5	Adult Counseling Target (>= 12%)	The monthly average of all adults authorized into LOC-2 during the fiscal year is greater than or equal to 12% of adults recommended for LOC-2.	The number of adults recommended and authorized into LOC-2 during the fiscal year.	The number of adults recommended for LOC-2 during the fiscal year.
MH6	Assertive Community Treatment (ACT) (>=54%)	The monthly average of all adults recommended for LOC 4 and authorized into LOC-3 or LOC-4 during the fiscal year is greater than or equal to 54.0%.	The number of adults recommended for LOC-4 and authorized into LOC-3 or LOC-4 during the fiscal year.	The number of adults recommended for LOC-4 during the fiscal year.

MH7	Access to Crisis Response Services (>=52.2%)	The percentage of crisis hotline calls that result in face to face encounter.	The number of face-to-face services occurring on the same day or within one day of a hotline call.	The total number of hotline calls.
MH8	Family Partner Supports Target for LOCs 2, 3, and YC (>=10%)	The proportion of full client months for children and youths authorized to receive LOC 2, 3, or YC in which at least 1 minutes of Family Partner Supports is reported.	The number of unique Clients Months where at least 1minute of Family Partner Supports identified by Procedure Code H0038HA is reported.	All unique client months for children and youths authorized to LOC 2, 3, or YC.
MH9	Community Linkage % (>=23% Annual Measure)	The proportion of LOC-A = 0 that is followed by a mental health community LOC-A = 1M and 1S through 5 and/or a contact at a DSHS-funded substance abuse treatment facility, or an Outreach, Screening, Assessment and Referral (OSAR) provider within 14 days of closure from Level of Care 0.	The number of LOC-A = 0 that is followed by a mental health community LOC-A = 1M and 1S through 5) and/or a contact at a DSHS-funded substance abuse treatment facility, or an Outreach, Screening, Assessment and Referral (OSAR) provider within 14 days of closure from Level of Care 0.	The number of LOC-A = 0.
MH10	Crisis Follow-Up Within 30 Days (>=90%)	Percentage of persons with a mental health community LOC-A = 5 who receive a Crisis Follow-Up service encounter within 30 day	The number of persons with a mental health community LOC-A = 5, who receive an authorized service encounter or are authorized to a FLOC within 30 days.	The number of persons with a mental health community LOC-A = 5.

A. Performance measures related to SAMHSA NOMS– *Federal Measures*

List of mental health performance measures – *NOMS Measures*				
Code	**Measure Name (Target)**	**Measure Description**	**Measure Numerator**	**Measure Denominator**
NOM1	Employment (>=9.8%)	The percentage of adults served with an Adult Uniform Assessment Community Data Section 4. B. Paid Employment Type score of 1.	The number of adults recommended and authorized for a FLOC with an Adult Uniform Assessment Community Data Section 4. B. Paid Employment Type score of 1.	All adults recommended and authorized for a FLOC.

NOM2	Adult Improvement (>=20%)	The percentage of adults authorized into a FLOC show reliable improvement in at least one of the following domain as compared to the Reliable Change Index: risk behaviors, behavioral health needs, life domain functioning, strengths, substance use, and trauma.	Number of adults enrolled in a FLOC meeting or exceeding the RCI in one of the identified ANSA domains/modules whose first and last Uniform Assessments are at least 90 days apart.	All adults enrolled in a FLOC whose first and last Uniform Assessments, including ANSA domains/modules, are at least 90 days apart.
NOM3	Child and Youth Improvement (>=25%)	The percentage of population meeting or exceeding the Reliable Change Index (RCI) in one or more domains on the CANS.	Number of children/youth enrolled in a FLOC meeting or exceeding the RCI in one of the identified CANS domains/modules whose first and last Uniform Assessments are at least 75 days apart.	All children/youth enrolled in a FLOC whose first and last Uniform Assessments, including CANS domains/modules, are at least 75 days apart.
NOM4	Community Tenure Adult (>=96.4%)	The percent of adults in a FLOC that avoid hospitalization in a DSHS Purchased Inpatient Bed after authorization into a FLOC	All adults authorized in a FLOC during the measurement period who avoid hospitalization in a DSHS Operated or Contracted Inpatient Bed after authorization into a FLOC.	All adults authorized in a FLOC during the measurement period.
NOM5	Community Tenure Child & Youth (>=96.4%)	The percentage of children and youth in a FLOC avoiding psychiatric hospitalization in a DSHS Purchased Inpatient Bed after authorization into a FLOC.	The number of children and youth authorized in a FLOC who avoided hospitalization in a DSHS Purchased Inpatient Bed after authorization into a FLOC.	All children and youth authorized in a FLOC during the measurement period.
NOM6	Effective Crisis Response (75.1%)	The percentage of individuals receiving crisis services who avoid admission to a DSHS Operated or Contracted Inpatient Bed within 30 days of the start of the crisis episode shall be > 75.1% per measurement period.	The number of persons with crisis episodes that avoid admission into DSHS Operated or Contracted Inpatient Beds within 30 days of the first day of the crisis episode.	The number of crisis episodes
NOM7	Adult Monthly Service Provision (>=54.1%)	The percentage of adults authorized in a FLOC receiving at least one mental health hourly service per month.	Total number of adults authorized in a FLOC receiving at least one face to face, telehealth, or telemedicine encounter of any service per month of any length of time.	Total number of persons authorized in a FLOC that month.

NOM8	Children and Youth Monthly Service Provision (>=65%)	The percentage of children and youth authorized in a FLOC receiving at least one mental health hourly service per month.	Total number of children and youth authorized in a FLOC or LOC-Y (Yes Waiver) receiving at least one face to face, telehealth or telemedicine encounter of any service per month of any length of time.	Total number of children and youth authorized in a FLOC or LOC-Y that month.
NOM9	Hospitalization (<=1.9%)	The equity-adjusted rate of adult and child inpatient DSHS Operated or Contracted psychiatric Inpatient Beds for the population of the local service area shall be ≤ 1.9% per measurement period.	The number of DSHS Operated or Contracted Inpatient Bed Days for the population in the local service area multiplied by the LMHA's equity factor.	Total population of the local service area.
NOM10	Adult Jail Diversion (<=10.46%)	The equity-adjusted percentage of valid adult TLETS bookings with a match in CARE for each local service area.	The number of valid TLETS bookings in the local service area with a CARE match multiplied by the LMHA's equity factor.	The number of valid TLETS bookings in the local service area.
NOM11	Juvenile Justice Avoidance (>=95%)	Children/youth enrolled in a FLOC showing no arrests (acceptable) or a reduction of arrests (improving) from time of first assessment to time of last assessment within the measurement period (with assessments occurring at least 75 days apart).	The number of children and youth recommended and authorized for a FLOC, whose latest number of arrests is 0 and whose previous number of arrests is 0.	All children and youth recommended and authorized for a FLOC who have at least two number of arrests ratings.
NOM12	Frequent Admissions (<=0.3)	The percentage of adults and children authorized in a FLOC who are admitted 3 or more times within 180 days to a DSHS Operated or Contracted Inpatient psychiatric bed.	The number of adults and children authorized in a FLOC admitted to a DSHS Operated or Contracted psychiatric Inpatient Bed 3 or more times in 180 days.	The total number of clients authorized to a FLOC.

B. Local mental health agencies

The table below presents the LMHAs included for analysis.

Code	Name of LMHA
010	BETTY HARDWICK CENTER
020	TEXAS PANHANDLE CENTERS
030	AUSTIN-TRAVIS CO INTEGRAL CARE
040	CENTRAL COUNTIES SERVICES
050	THE CENTER FOR HEALTH CARE SERVICES
060	CENTER FOR LIFE RESOURCES
070	CENTRAL PLAINS CENTER
090	EMERGENCE HEALTH NETWORK
100	THE GULF COAST CENTER
110	GULF BEND MHMR CENTER
130	TROPICAL TEXAS BEHAVIORAL HEALTH
140	SPINDLETOP CENTER
150	STARCARE SPECIALTY HEALTH SYSTEM
160	MHMR SERVICES FOR THE CONCHO VALLEY
170	PERMIAN BASIN COMMUNITY CENTERS FOR
180	BEHAVIORAL HEALTH CENTER OF NUECES COUNTY
190	ANDREWS CENTER
200	MHMR OF TARRANT COUNTY
220	HEART OF TEXAS REGION MHMR CENTER
230	HELEN FARABEE CENTERS
240	COMMUNITY HEALTHCORE
250	MHMR AUTH.OF BRAZOS VALLEY
260	BURKE CENTER
280	MHMR AUTHORITY OF HARRIS COU
290	TEXOMA COMMUNITY CENTER
350	PECAN VALLEY CENTERS
380	TRI-COUNTY MHMR SERVICES
400	DENTON COUNTY MHMR CENTER
430	TEXANA COMMUNITY MHMR CENTER
440	ANDERSON/CHEROKEE
450	WEST TEXAS CENTERS
460	BLUEBONNET TRAILS COMMUNITY SERVICES
470	HILL COUNTRY COMMUNITY MHDD CENTER
475	COASTAL PLAINS COMMUNITY CENTER
480	LAKES REGIONAL MHMR CENTER
485	BORDER REGION BEHAVIORAL HEALTH CENTER
490	CAMINO REAL COMMUNITY SERVICES

C. Results- *DSHS Measures*

MH1: Service Target Adult

The performance level for MH1 represents the percent of adults in a FLOC compared to LMHA target.

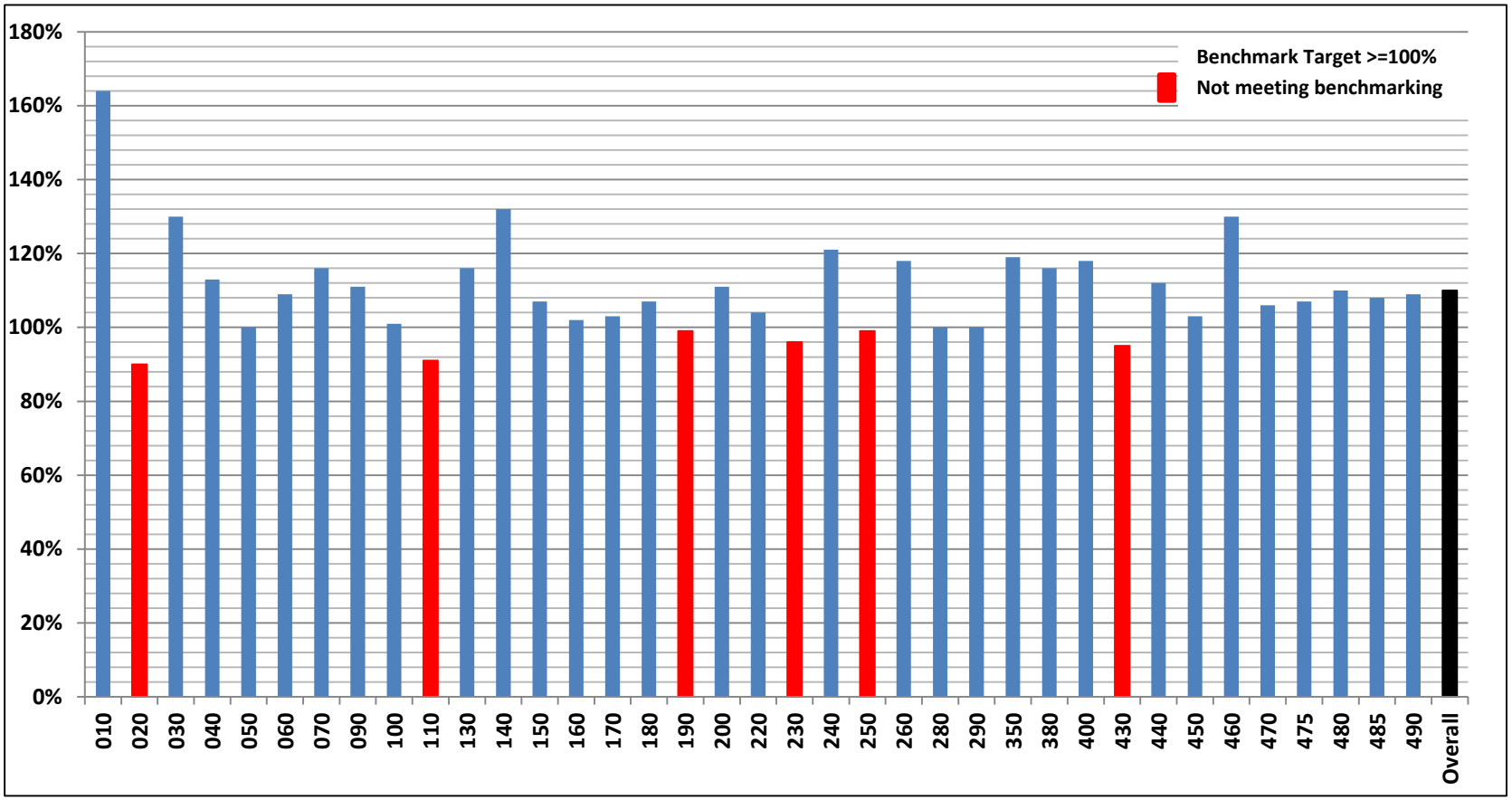
Variation across LMHAs

Performance level (%) for the overall MH1 (n=37)									
	Mean	**SD**	**Min**	**Max**	**IQT***	**25th**	**50th**	**75th**	**# LMHAs not meeting benchmarking**
QT115	**110**	**13**	**89**	**159**	**12**	**101**	**109**	**113**	
092014	109	12	92	154	12	101	108	113	
102014	110	13	89	160	13	101	109	114	
112014	110	14	87	163	15	100	107	115	
QT215	**110**	**15**	**89**	**169**	**19**	**100**	**109**	**119**	
122014	110	14	88	164	17	100	108	117	
012015	111	15	89	170	19	101	109	120	
022015	111	15	90	172	18	100	109	119	
1st Half FY 2015	**110**	**14**	**90**	**164**	**16**	**101**	**108**	**116**	**6**
QT315	**111**	**15**	**92**	**172**	**14**	**103**	**107**	**116**	
032015	112	15	90	173	16	103	108	118	
042015	111	15	91	172	13	103	108	117	
052015	111	14	91	170	13	102	108	116	
QT415	**112**	**15**	**92**	**169**	**13**	**103**	**109**	**117**	
062015	111	15	92	170	13	103	109	116	
072015	112	15	91	170	14	103	109	117	
082015	112	15	92	168	13	104	110	117	
2nd Half FY 2015	**112**	**15**	**92**	**171**	**14**	**103**	**108**	**116**	**5**
QT116	**106**	**14**	**86**	**160**	**11**	**98**	**102**	**109**	
092015	106	14	87	159	10	98	101	108	
102015	106	14	86	160	11	98	102	109	
112015	106	14	85	162	12	98	103	110	
QT216	**108**	**14**	**86**	**160**	**11**	**99**	**103**	**114**	
122015	107	14	84	158	16	98	103	114	
012016	108	15	86	159	15	99	103	114	
022016	109	14	92	156	12	100	103	112	
1st Half FY 2016	**107**	**14**	**87**	**159**	**13**	**98**	**103**	**111**	**12**

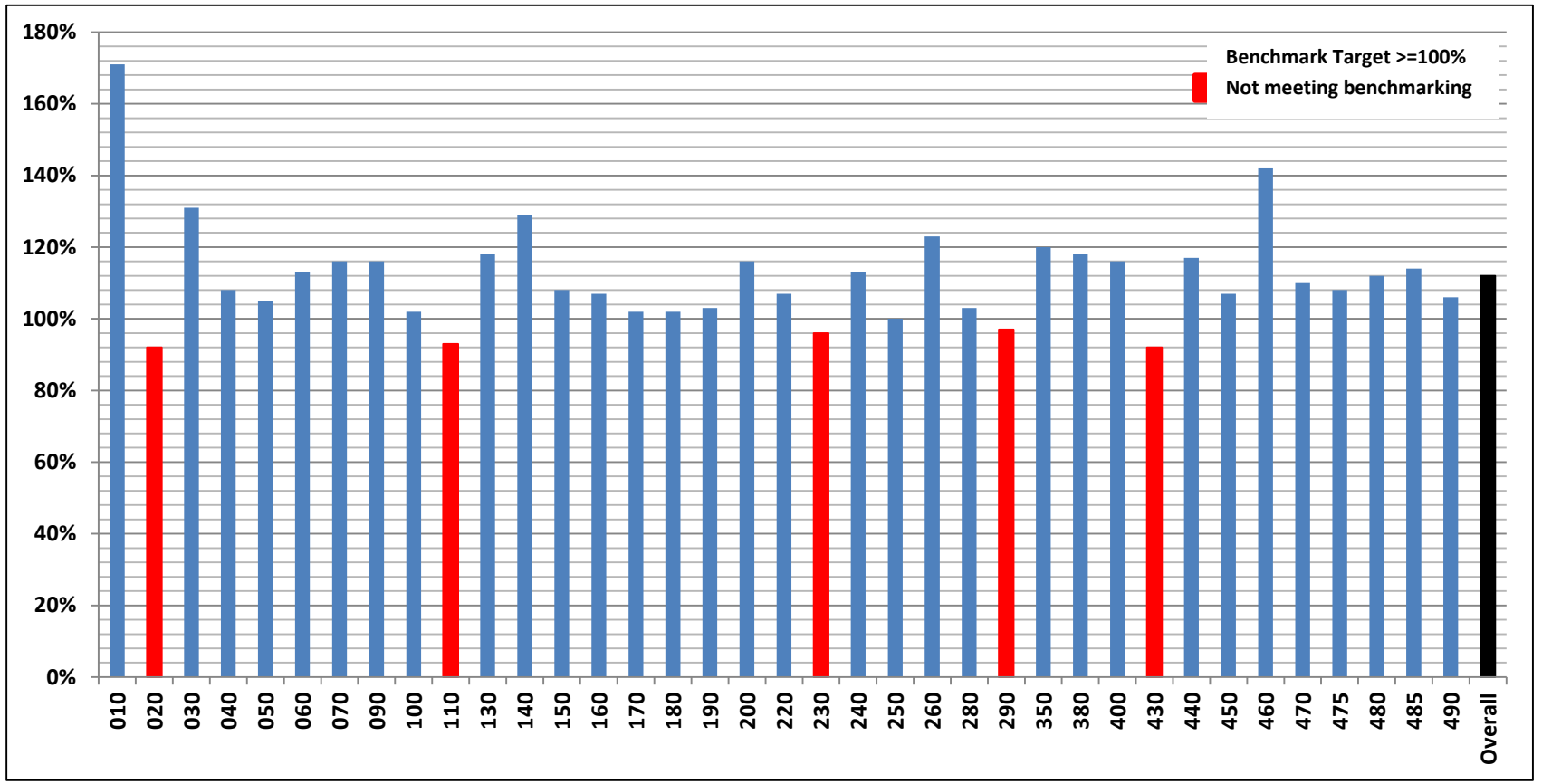
***IQT=Interquartile range**

Variation between LMHAs

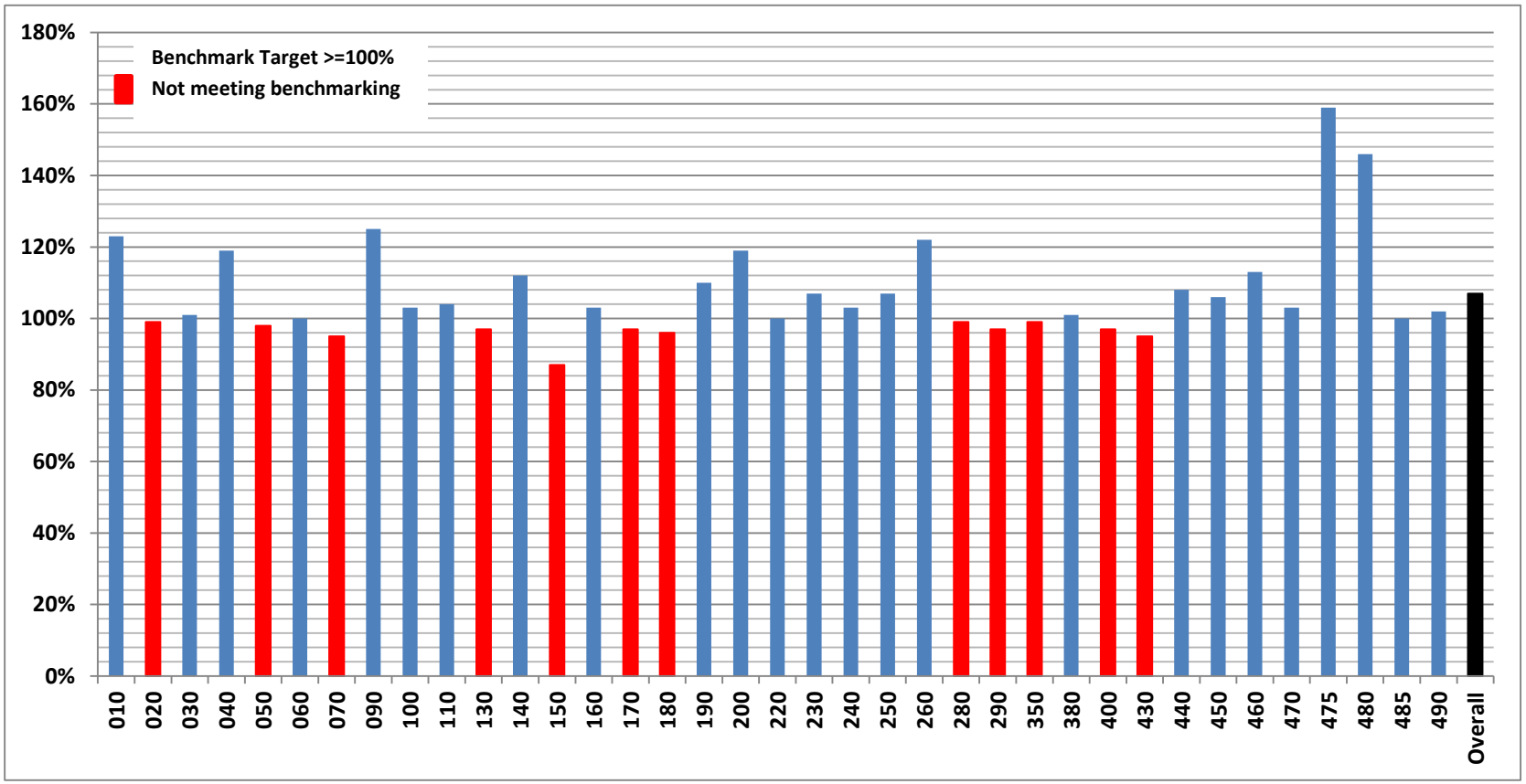
MH1 Service Target Adult Performance Level between LMHAs for 1st Half FY 2015



MH1 Service Target Adult Performance Level between LMHAs for 2nd Half FY 2015



MH1 Service Target Adult Performance Level between LMHAs for 1st Half FY 2016



MH2: Service Target Child

The performance level for MH2 represents the percent of children and youth in a FLOC compared to LMHA target.

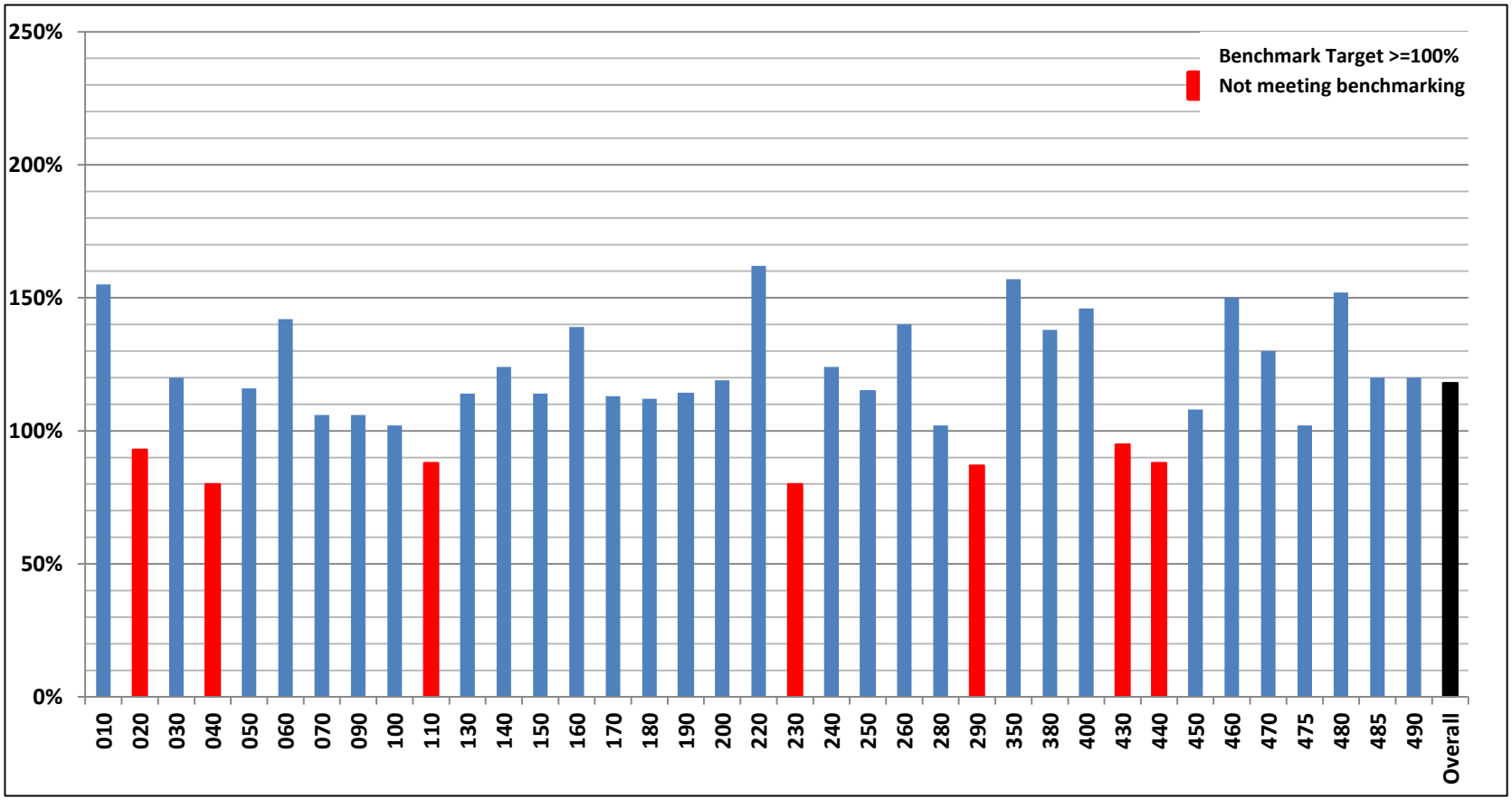
Variation across LMHAs

Performance level (%) for the overall MH2 (n=37)									
	Mean	**SD**	**Min**	**Max**	**IQT***	**25th**	**50th**	**75th**	**# LMHAs not meeting benchmarking**
QT115	**114**	**21**	**78**	**156**	**30**	**100**	**114**	**130**	
092014	111	21	74	156	27	96	112	123	
102014	115	21	79	157	31	100	113	131	
112014	117	22	78	158	32	104	115	136	
QT215	**122**	**24**	**80**	**170**	**37**	**104**	**118**	**141**	
122014	119	23	80	167	37	104	114	141	
012015	121	24	80	172	35	103	117	139	
022015	125	26	79	176	37	105	120	142	
1st Half FY 2015	**118**	**22**	**80**	**162**	**36**	**102**	**115**	**139**	**7**
QT315	**132**	**31**	**77**	**211**	**42**	**109**	**129**	**151**	
032015	129	28	78	192	39	108	127	148	
042015	132	31	78	215	43	109	129	153	
052015	133	32	75	225	44	110	127	154	
QT415	**127**	**31**	**69**	**220**	**36**	**106**	**118**	**142**	
062015	131	32	74	226	43	108	122	151	
072015	126	32	67	221	37	105	119	142	
082015	123	30	67	212	30	105	114	135	
2nd Half FY 2015	**130**	**31**	**73**	**215**	**38**	**108**	**123**	**146**	**5**
QT116	**116**	**25**	**87**	**191**	**23**	**99**	**109**	**122**	
092015	113	24	78	186	25	95	106	121	
102015	117	25	85	189	23	100	108	123	
112015	120	26	93	198	28	100	114	128	
QT216	**122**	**26**	**93**	**200**	**29**	**104**	**116**	**133**	
122015	120	26	93	204	28	102	113	130	
012016	122	27	93	203	28	103	114	131	
022016	124	26	90	193	32	104	118	136	
1st Half FY 2016	**119**	**25**	**93**	**195**	**26**	**101**	**113**	**128**	**7**

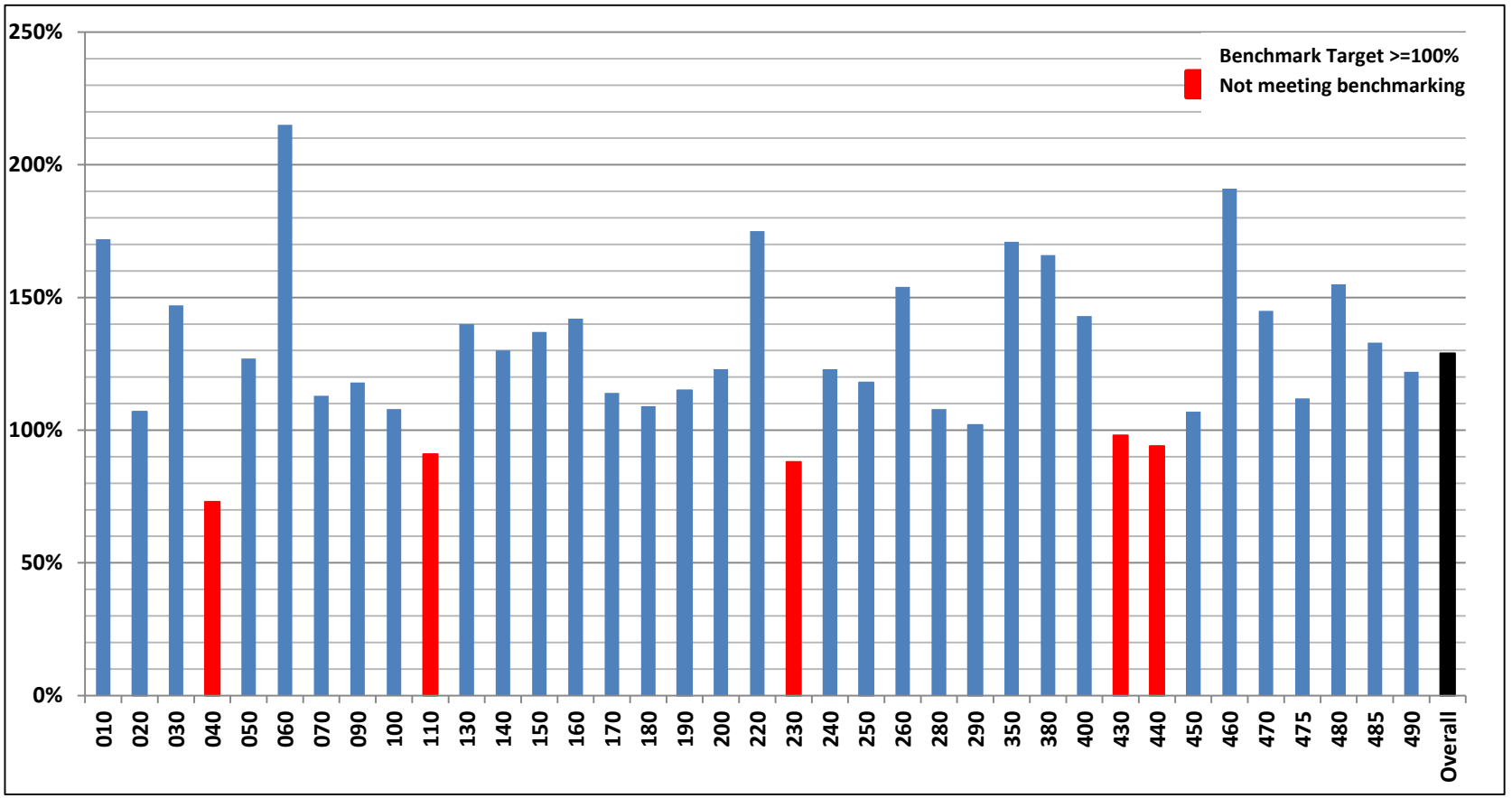
***IQT=Interquartile range**

Variation between LMHAs

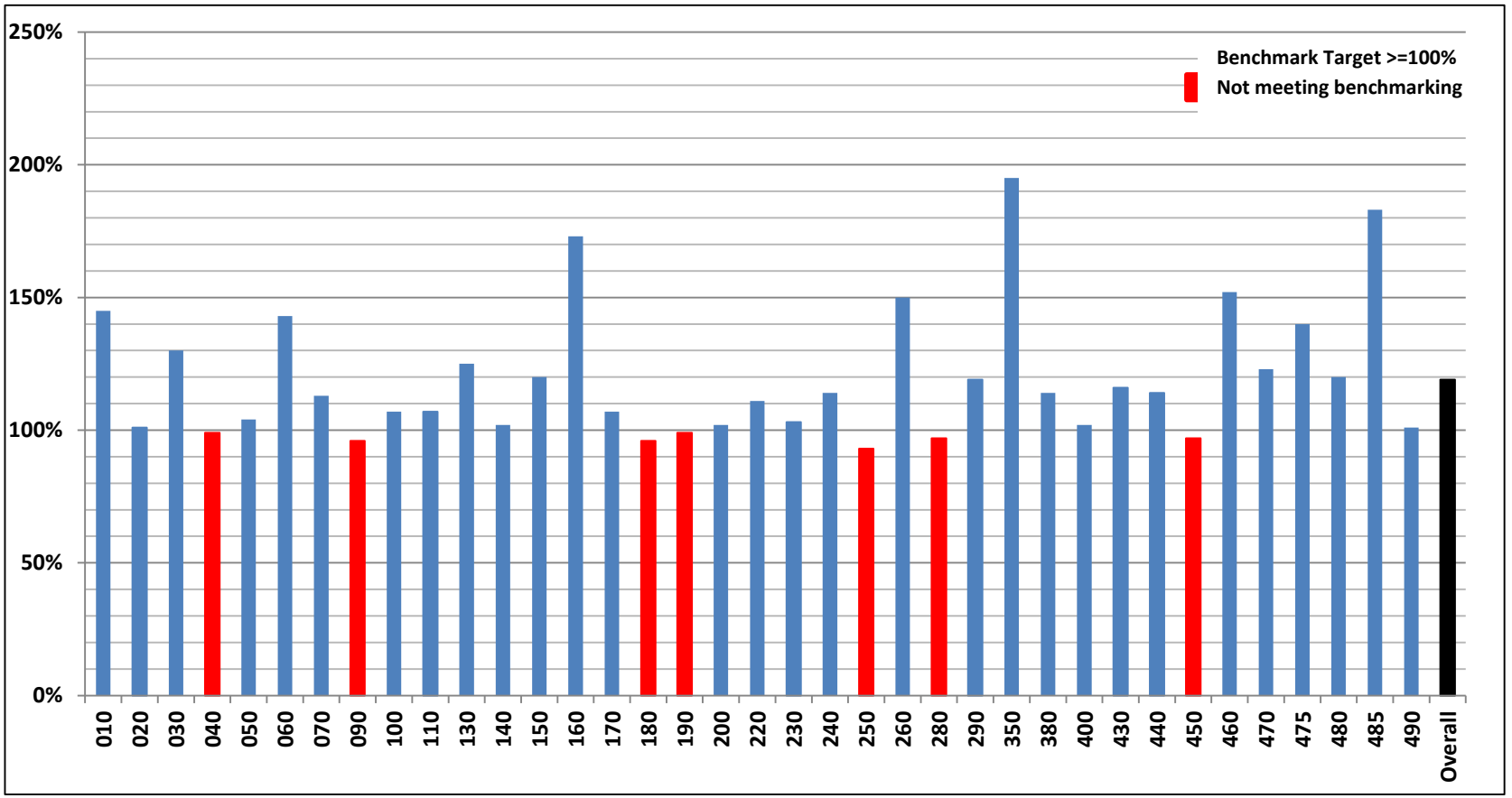
MH2 Service Target Child Performance Level between LMHAs for 1st Half FY 2015



MH2 Service Target Child Performance Level between LMHAs for 2nd Half FY 2015



MH2 Service Target Child Performance Level between LMHAs for 1st Half FY 2016



MH3: Uniform Assessment Completion Rate-Adult

The performance level for MH3 represents the percent of adults served or authorized for services during the six month period who have a completed and current uniform assessment.

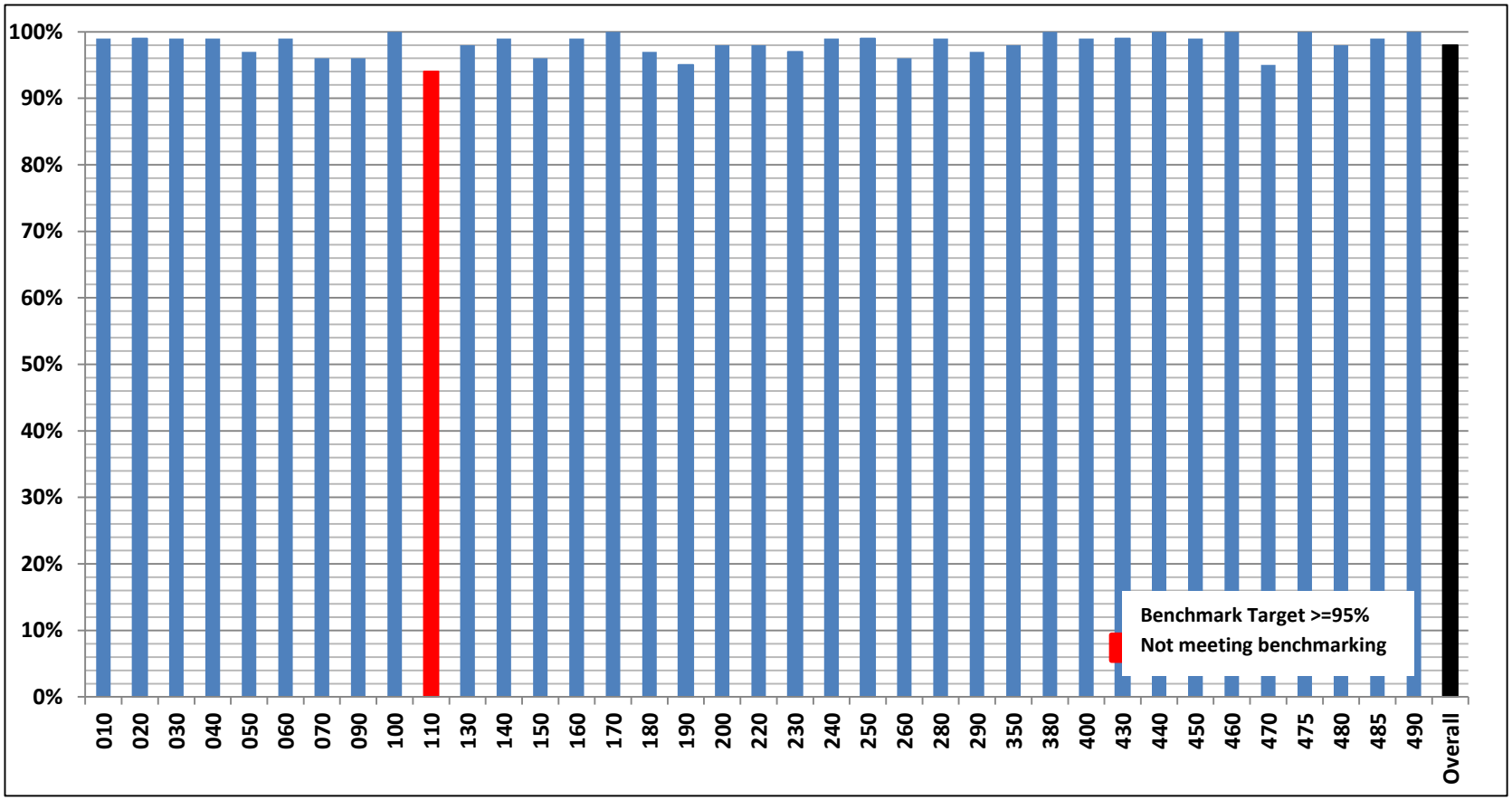
Variation across LMHAs

Performance level (%) for the overall MH3 (n=37)									
	Mean	**SD**	**Min**	**Max**	**IQT***	**25th**	**50th**	**75th**	**# LMHAs not meeting benchmarking**
QT115	**99**	**2**	**93**	**100**	**2**	**97**	**99**	**99**	
092014	99	2	90	100	2	98	99	99	
102014	99	2	94	100	2	97	99	99	
112014	99	1	94	100	2	97	99	99	
QT215	**99**	**2**	**95**	**100**	**2**	**97**	**99**	**99**	
122014	99	2	94	100	2	97	99	99	
012015	99	2	94	100	2	97	99	99	
022015	99	1	95	100	2	98	99	99	
1st Half FY 2015	**99**	**1**	**94**	**100**	**2**	**97**	**99**	**99**	**1**
QT315	**99**	**1**	**95**	**100**	**2**	**98**	**99**	**99**	
032015	99	1	95	100	2	98	99	99	
042015	99	2	94	100	2	97	99	99	
052015	99	1	95	100	2	98	99	99	
QT415	**98**	**1**	**94**	**100**	**2**	**98**	**98**	**99**	
062015	99	1	95	100	2	97	99	99	
072015	98	1	94	100	1	98	99	99	
082015	98	1	94	100	2	98	98	99	
2nd Half FY 2015	**99**	**1**	**95**	**100**	**1**	**98**	**99**	**99**	**0**
QT116	**98**	**1**	**94**	**100**	**2**	**97**	**98**	**99**	
092015	98	1	94	100	2	97	98	99	
102015	98	2	94	100	2	97	98	99	
112015	98	1	95	100	2	97	98	99	
QT216	**99**	**1**	**95**	**100**	**2**	**97**	**99**	**99**	
122015	99	1	95	100	2	97	99	99	
012016	99	1	94	100	2	97	99	99	
022016	99	1	95	100	2	98	99	99	
1st Half FY 2016	**98**	**1**	**95**	**100**	**2**	**97**	**98**	**99**	**0**

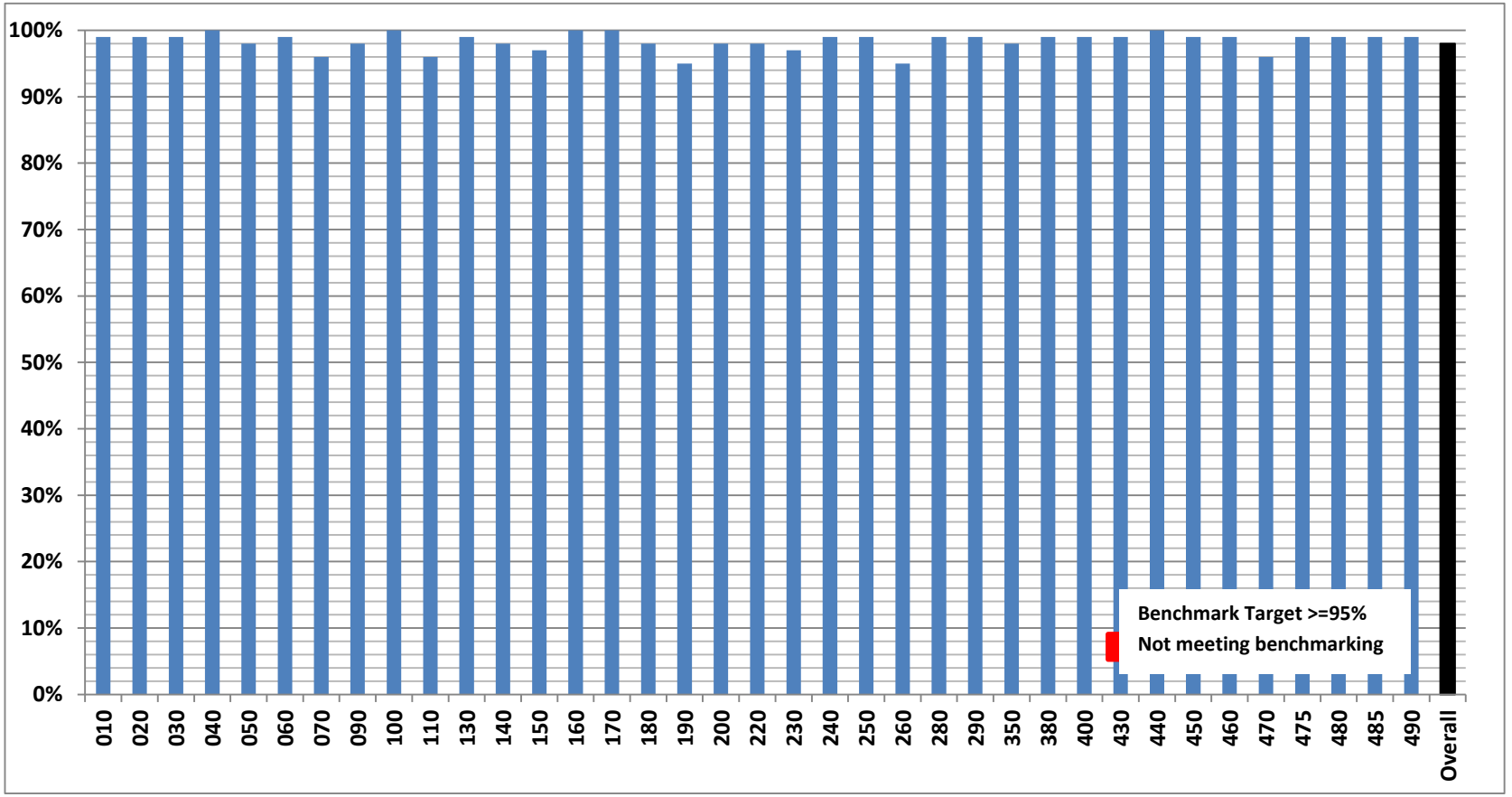
***IQT=Interquartile range**

Variation between LMHAs

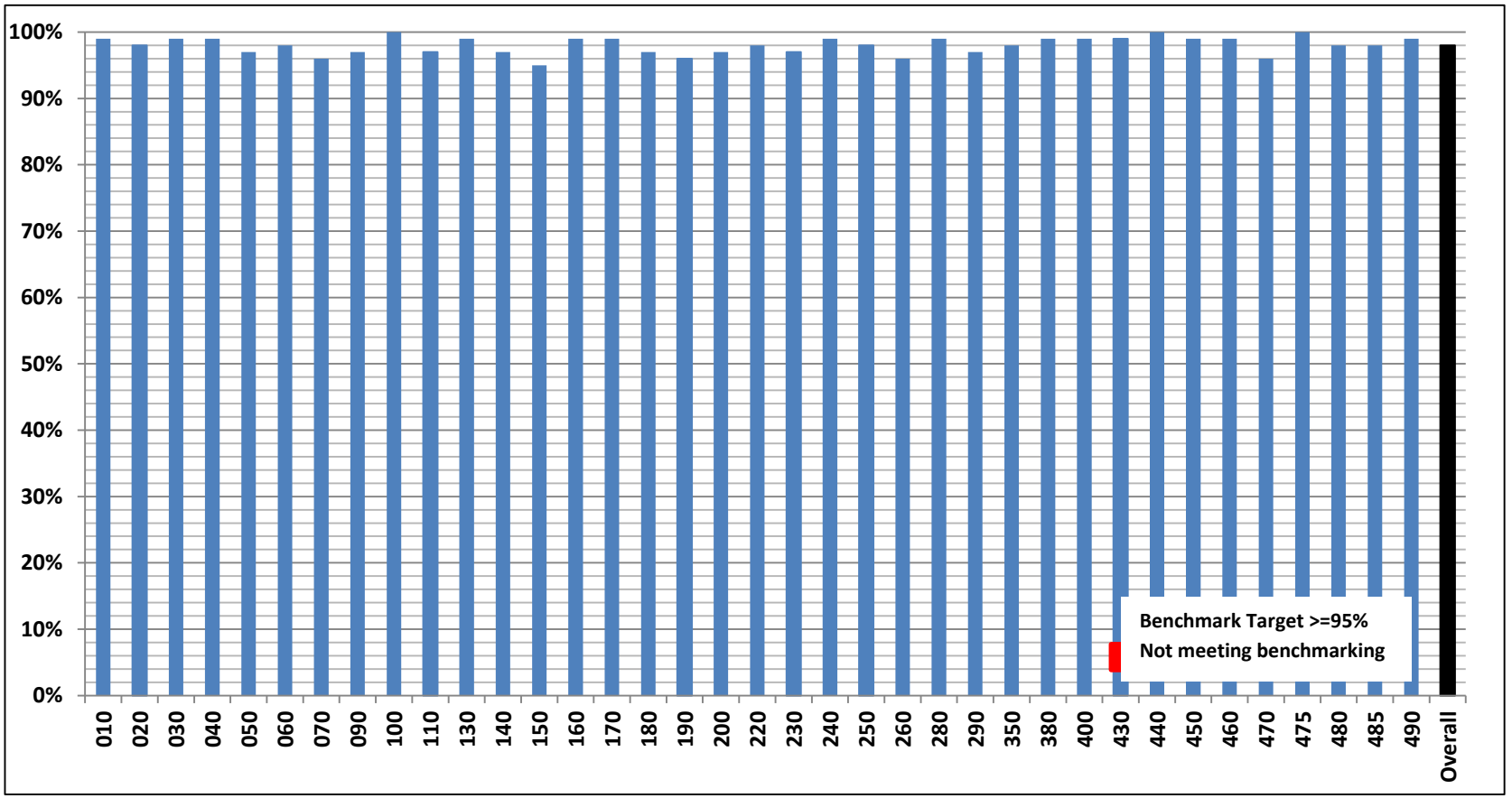
MH3 Uniform Assessment Completion-Adult Performance Level between LMHAs for 1st Half FY 2015



MH3 Uniform Assessment Completion-Adult Performance Level between LMHAs for 2nd Half FY 2015



MH3 Uniform Assessment Completion-Adult Performance Level between LMHAs for 1st Half FY 2016



MH4: Uniform Assessment Completion Rate-Child

The performance level for MH4 represents the percent of children and youth served or authorized for services during the six month period who have a completed and current uniform assessment.

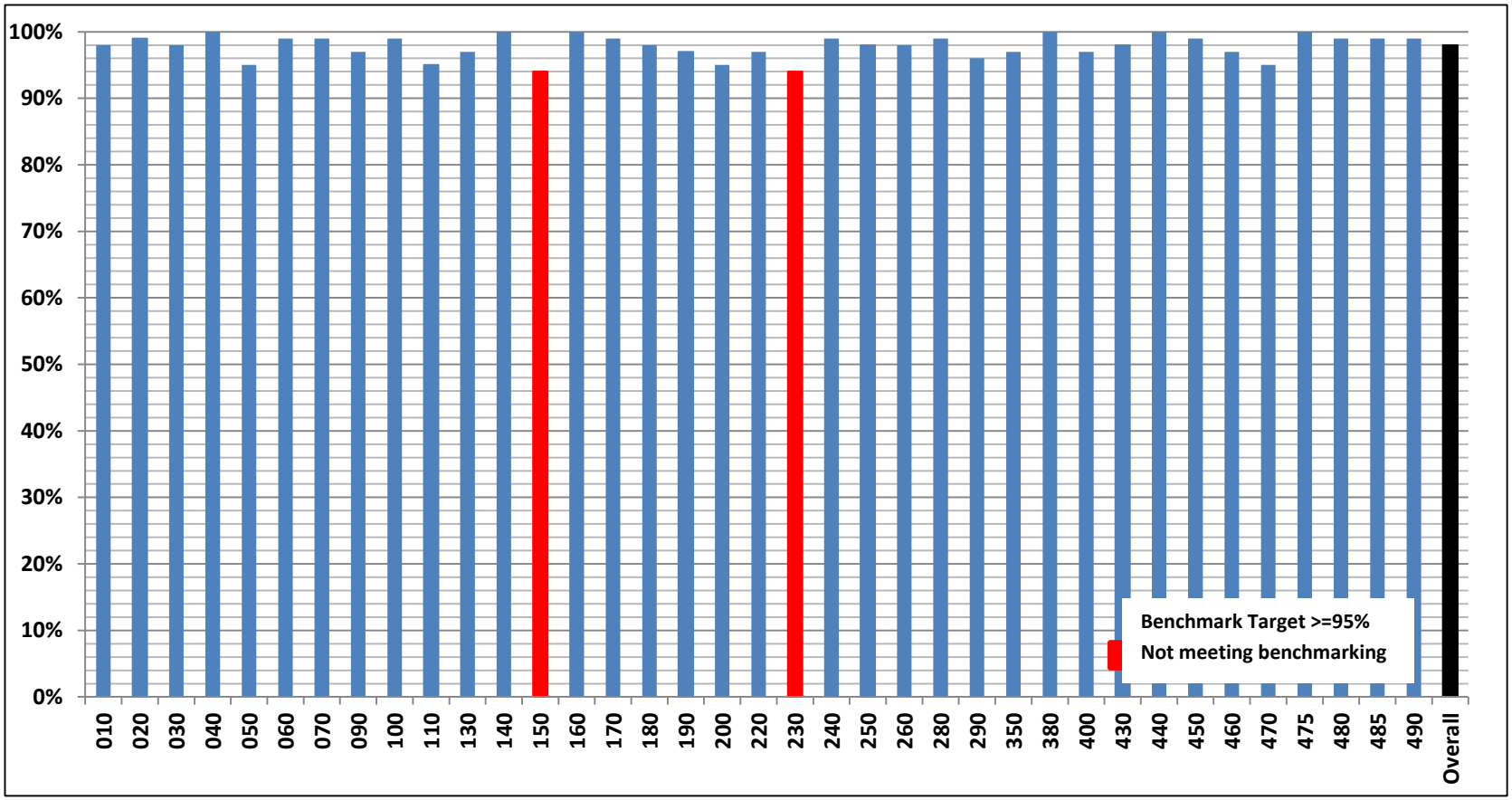
Variation across LMHAs

Performance level (%) for the overall MH4 (n=37)									
	Mean	**SD**	**Min**	**Max**	**IQT***	**25th**	**50th**	**75th**	**# LMHAs not meeting benchmarking**
QT115	**98**	**2**	**93**	**100**	**3**	**96**	**98**	**99**	
092014	98	3	90	100	3	96	98	99	
102014	98	2	94	100	3	96	98	99	
112014	99	3	90	100	3	97	99	100	
QT215	**99**	**2**	**93**	**100**	**3**	**97**	**99**	**100**	
122014	99	2	93	100	3	97	99	100	
012015	99	2	94	100	3	97	99	100	
022015	99	2	91	100	2	97	99	99	
1st Half FY 2015	**98**	**2**	**94**	**100**	**3**	**97**	**98**	**99**	**2**
QT315	**99**	**1**	**95**	**100**	**2**	**97**	**99**	**99**	
032015	99	2	93	100	2	97	99	100	
042015	99	2	95	100	2	97	99	100	
052015	99	2	94	100	2	97	99	99	
QT415	**99**	**1**	**96**	**100**	**2**	**97**	**99**	**99**	
062015	99	1	95	100	2	97	99	100	
072015	99	1	95	100	2	97	99	99	
082015	99	2	93	100	2	97	99	99	
2nd Half FY 2015	**99**	**1**	**96**	**100**	**2**	**97**	**99**	**99**	**0**
QT116	**98**	**2**	**91**	**100**	**2**	**97**	**99**	**99**	
092015	98	2	88	100	3	96	98	99	
102015	99	2	94	100	2	97	99	99	
112015	99	2	91	100	2	97	99	99	
QT216	**98**	**2**	**92**	**100**	**2**	**9**	**99**		
122015	99	2	90	100	2	98	99	99	
012016	99	2	91	100	2	97	99	99	
022016	98	2	93	100	2	97	98	99	
1st Half FY 2016	**98**	**2**	**92**	**100**	**2**	**97**	**98**	**99**	**1**

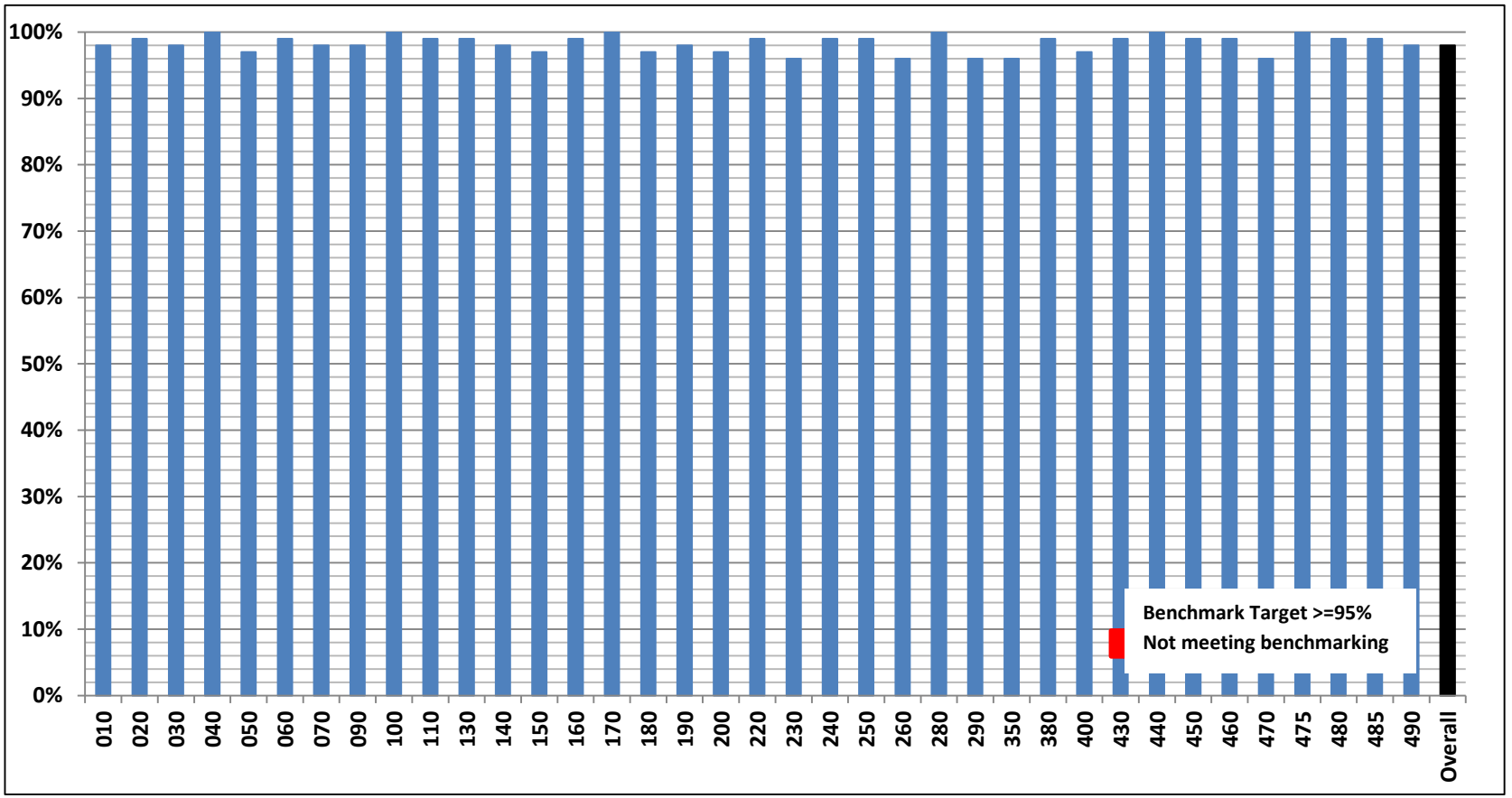
***IQT=Interquartile range**

Variation between LMHAs

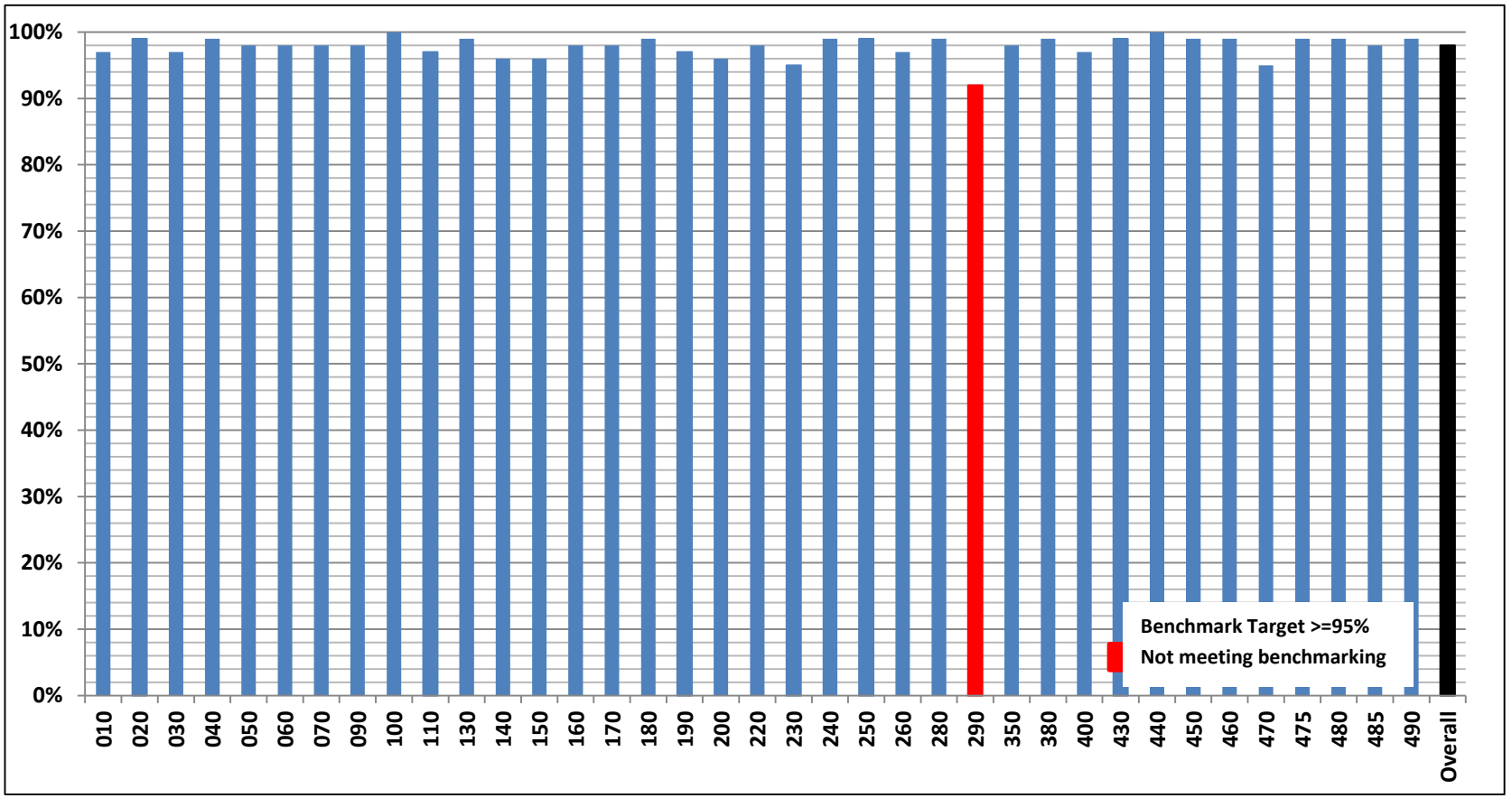
MH4 Uniform Assessment Completion-Child Performance Level between LMHAs for 1st Half FY 2015



MH4 Uniform Assessment Completion-Child Performance Level between LMHAs for 2nd Half FY 2015



MH4 Uniform Assessment Completion-Child Performance Level between LMHAs for 1st Half FY 2016



MH5: Adult Counseling

The performance level for MH5 represents the average percent of all adults authorized into LOC-2 during the fiscal year.

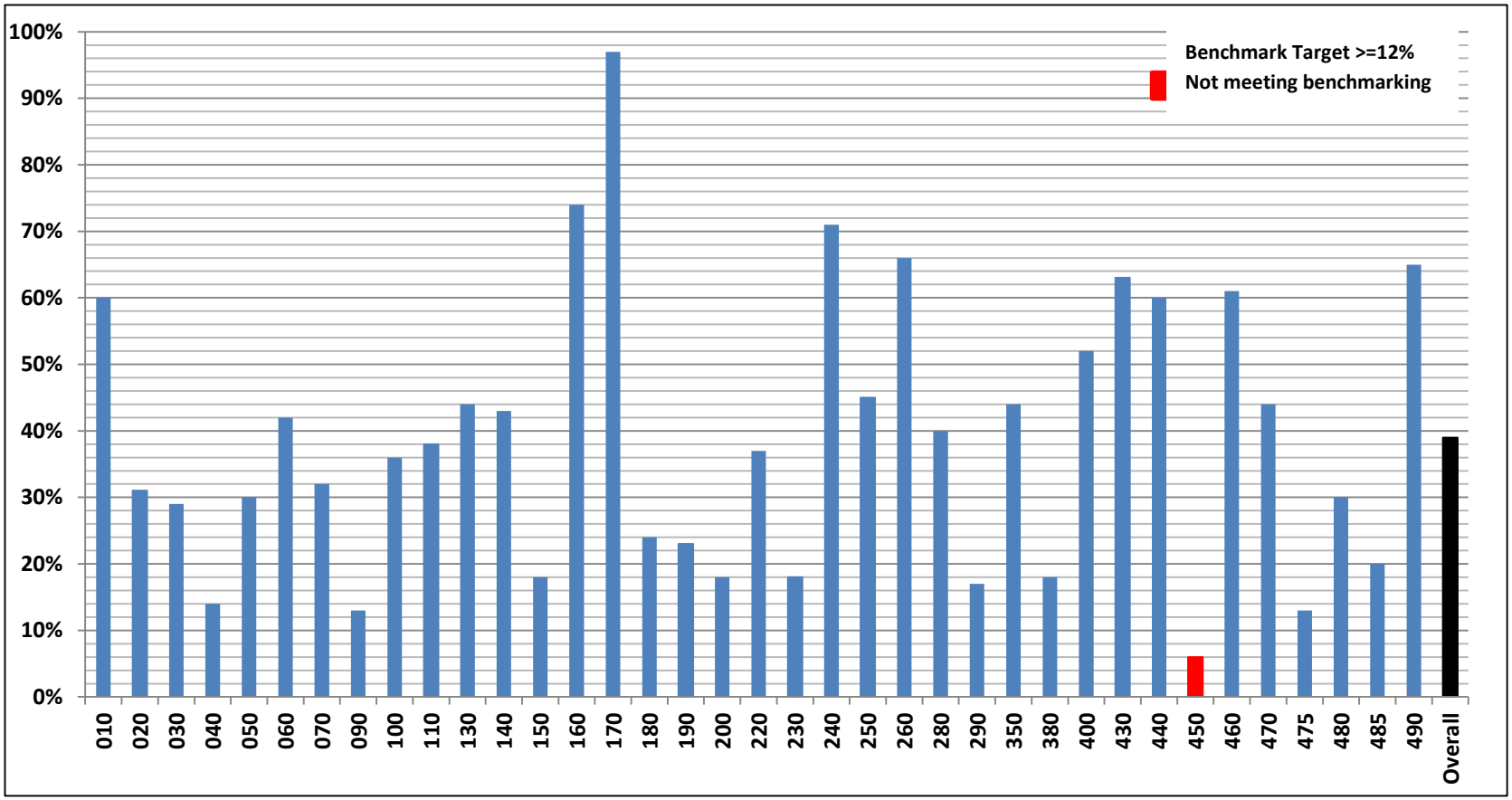
Variation across LMHAs

Performance level (%) for the overall MH5 (n=37)									
	Mean	**SD**	**Min**	**Max**	**IQT***	**25th**	**50th**	**75th**	**# LMHAs not meeting benchmarking**
QT115	**38**	**21**	**4**	**96**	**34**	**20**	**34**	**54**	
092014	36	21	3	95	31	20	34	51	
102014	38	21	6	98	32	21	35	53	
112014	39	22	5	96	34	21	37	56	
QT215	**40**	**21**	**6**	**97**	**35**	**21**	**39**	**56**	
122014	39	22	6	98	39	17	40	56	
012015	40	20	7	95	33	23	39	56	
022015	39	21	7	98	36	19	38	56	
1st Half FY 2015	**39**	**21**	**6**	**97**	**37**	**19**	**37**	**56**	**1**
QT315	**38**	**20**	**4**	**100**	**30**	**22**	**36**	**52**	
032015	38	21	6	100	36	19	37	55	
042015	38	21	5	100	31	21	36	51	
052015	38	21	2	100	27	25	33	52	
QT415	**38**	**22**	**4**	**98**	**35**	**20**	**34**	**55**	
062015	38	21	1	93	33	20	32	54	
072015	38	22	0	100	34	21	32	55	
082015	40	23	6	100	36	19	37	55	
2nd Half FY 2015	**38**	**21**	**4**	**99**	**30**	**23**	**36**	**53**	**1**
QT116	**40**	**23**	**5**	**98**	**35**	**20**	**36**	**55**	
092015	40	23	8	100	37	19	34	56	
102015	39	24	4	97	34	20	36	54	
112015	39	23	3	97	35	19	38	54	
QT216	**39**	**24**	**1**	**98**	**39**	**18**	**38**	**56**	
122015	39	24	1	97	36	18	37	54	
012016	39	25	0	97	38	18	38	56	
022016	39	25	0	100	40	19	38	59	
1st Half FY 2016	**39**	**24**	**3**	**98**	**36**	**19**	**38**	**55**	**3**

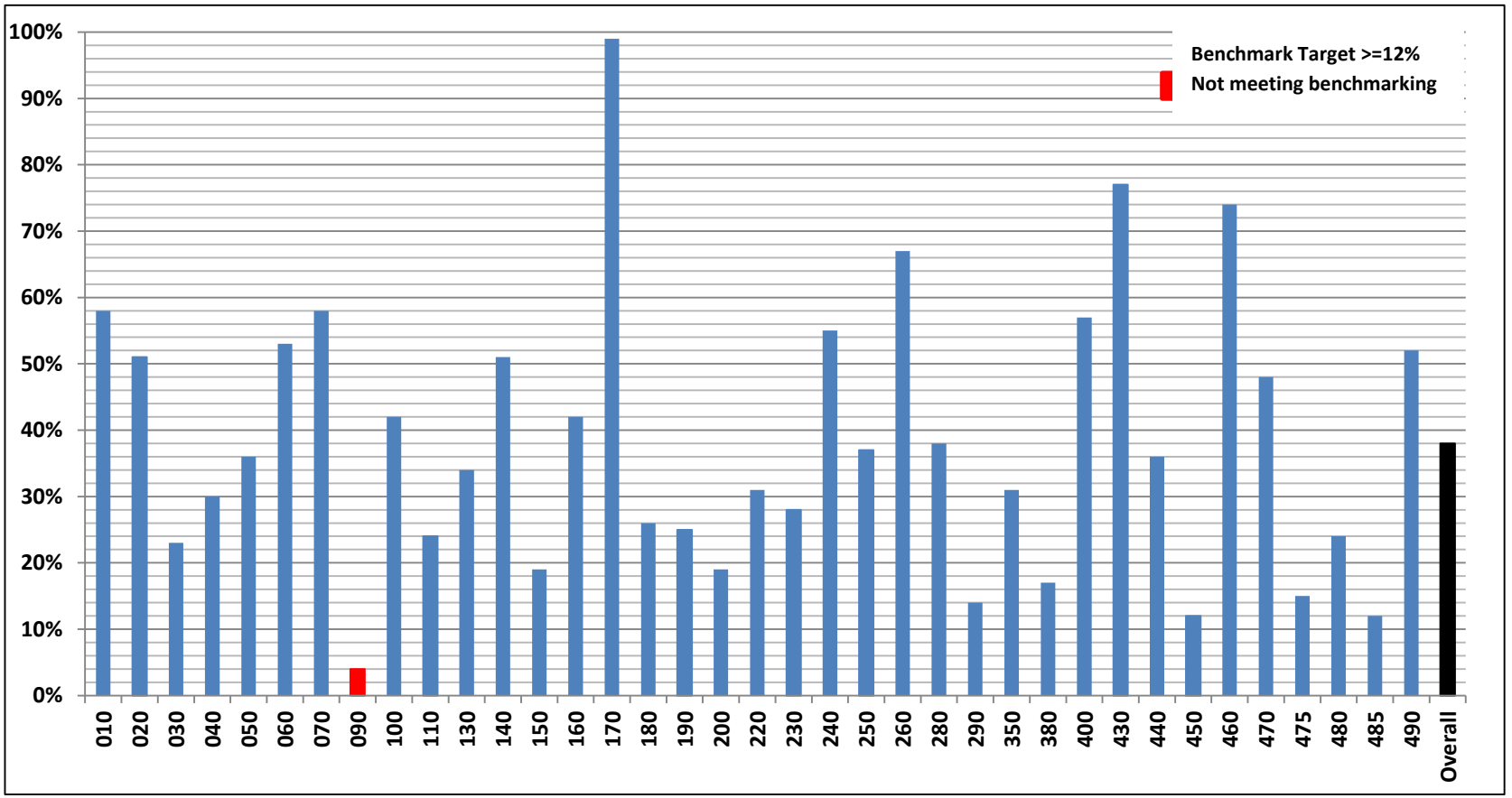
***IQT=Interquartile range**

Variation between LMHAs

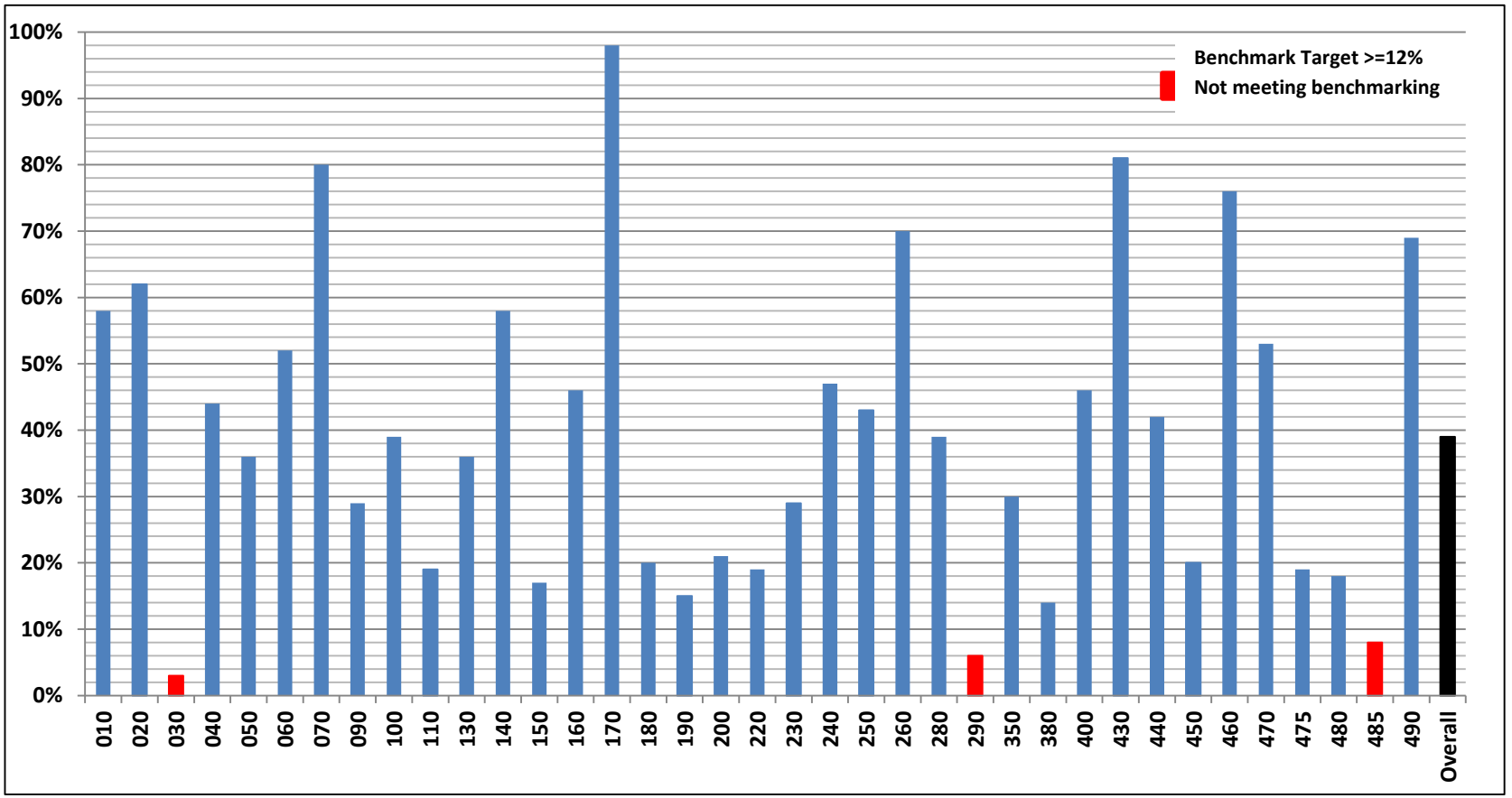
MH5 Adult Counseling Performance Level between LMHAs for 1st Half FY 2015



MH5 Adult Counseling Performance Level between LMHAs for 2nd Half FY 2015



MH5 Adult Counseling Performance Level between LMHAs for 1st Half FY 2016



MH6: Assertive Community Treatment

The performance level for MH6 represents the average percent for all adults recommended for LOC-4 and authorized into LOC-3 or LOC-4 during the fiscal year.

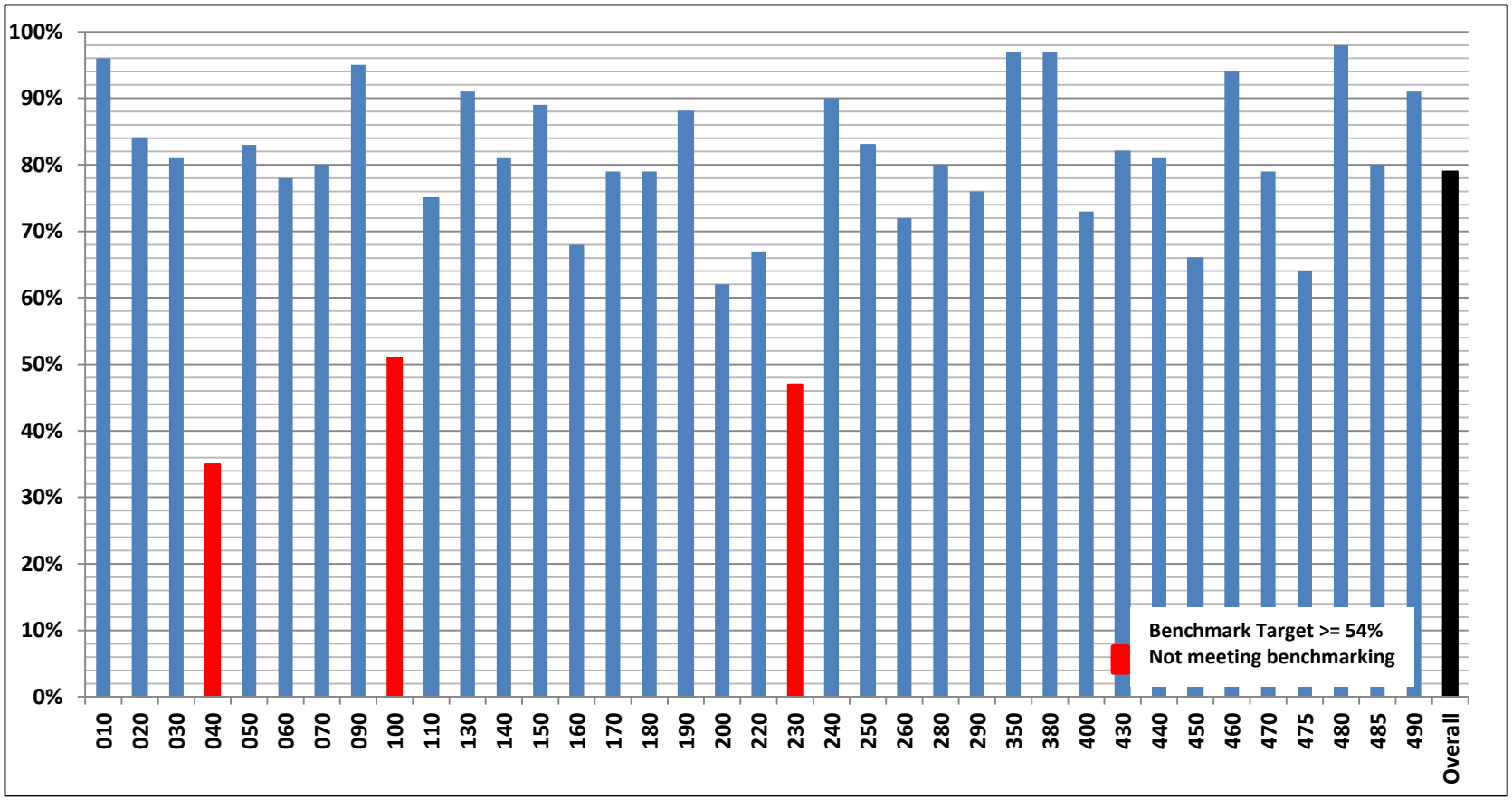
Variation across LMHAs

Performance level (%) for the overall MH6 (n=37)									
	Mean	**SD**	**Min**	**Max**	**IQT***	**25th**	**50th**	**75th**	**# LMHAs not meeting benchmarking**
QT115	**78**	**15**	**33**	**98**	**21**	**68**	**82**	**89**	
092014	77	16	30	98	22	65	82	89	
102014	78	15	38	100	21	70	81	91	
112014	79	15	30	98	20	71	81	91	
QT215	**79**	**14**	**38**	**98**	**17**	**74**	**81**	**91**	
122014	80	14	37	98	19	73	80	92	
012015	79	15	38	98	16	75	81	91	
022015	79	14	39	98	19	72	82	91	
1st Half FY 2015	**79**	**14**	**35**	**98**	**17**	**72**	**80**	**90**	**3**
QT315	**78**	**13**	**40**	**97**	**18**	**69**	**81**	**87**	
032015	78	14	38	98	19	70	79	89	
042015	79	13	45	97	20	68	81	88	
052015	78	15	33	96	18	71	82	89	
QT415	**79**	**12**	**40**	**95**	**16**	**72**	**82**	**88**	
062015	78	15	33	96	18	70	82	88	
072015	78	13	36	96	16	72	81	88	
082015	80	11	47	97	13	76	81	88	
2nd Half FY 2015	**78**	**13**	**40**	**95**	**15**	**72**	**82**	**87**	**3**
QT116	**80**	**11**	**46**	**95**	**9**	**76**	**81**	**86**	
092015	80	11	46	95	9	76	82	85	
102015	79	12	42	95	10	75	80	85	
112015	80	11	48	97	12	76	80	88	
QT216	**80**	**11**	**42**	**98**	**11**	**76**	**79**	**86**	
122015	81	11	42	97	13	76	82	88	
012016	80	11	41	97	10	75	81	85	
022016	79	12	42	99	14	72	79	86	
1st Half FY 2016	**80**	**11**	**45**	**97**	**9**	**76**	**80**	**85**	**2**

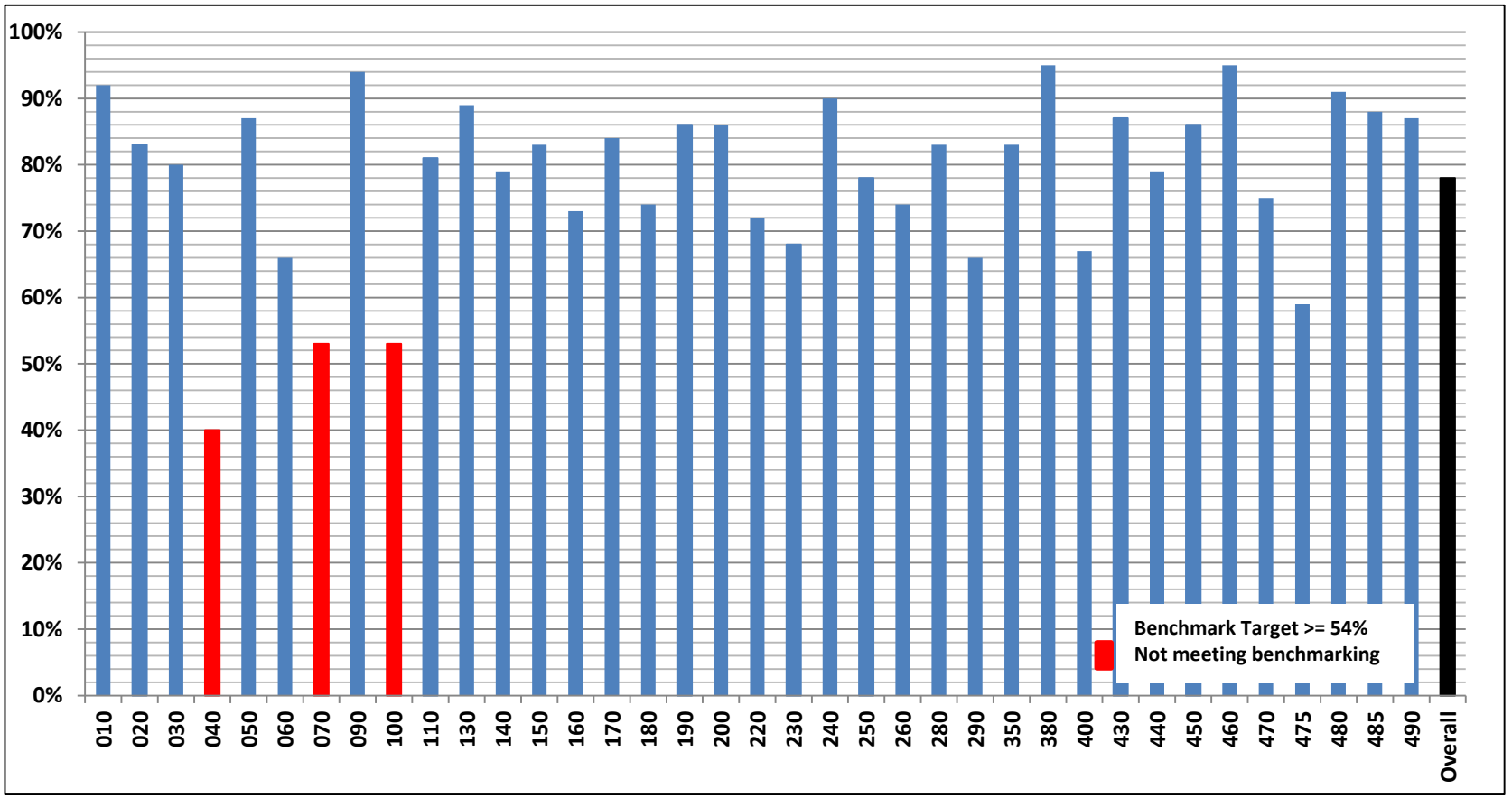
***IQT=Interquartile range**

Variation between LMHAs

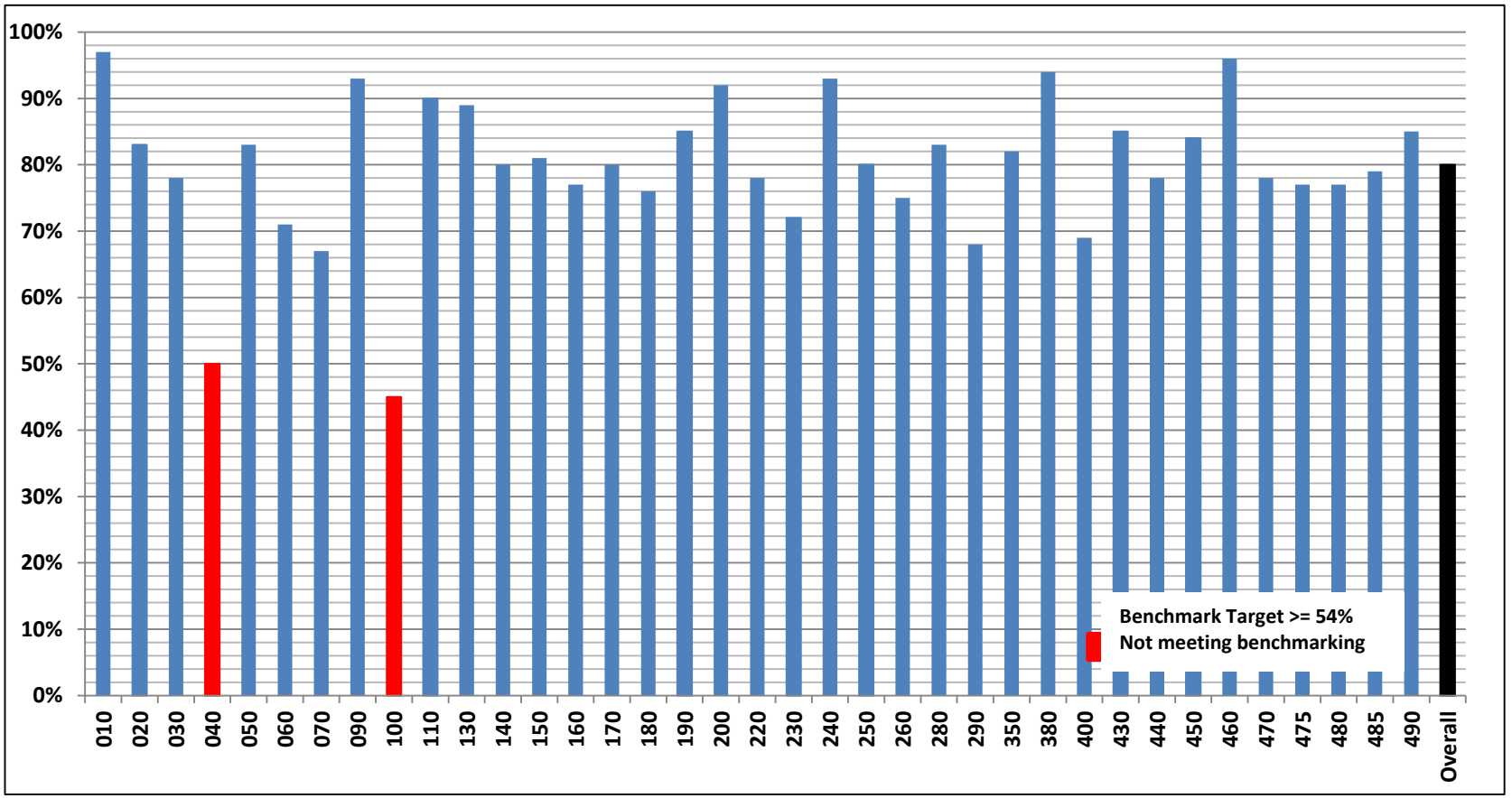
MH6 Assertive Community Treatment Performance Level between LMHAs for 1st Half FY 2015



MH6 Assertive Community Treatment Performance Level between LMHAs for 2nd Half FY 2015



MH6 Assertive Community Treatment Performance Level between LMHAs for 2nd Half FY 2016



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MH7: Access to Crisis Response Services

The performance level for MH7 represents the percent of all hotline calls that result in face to face encounter.

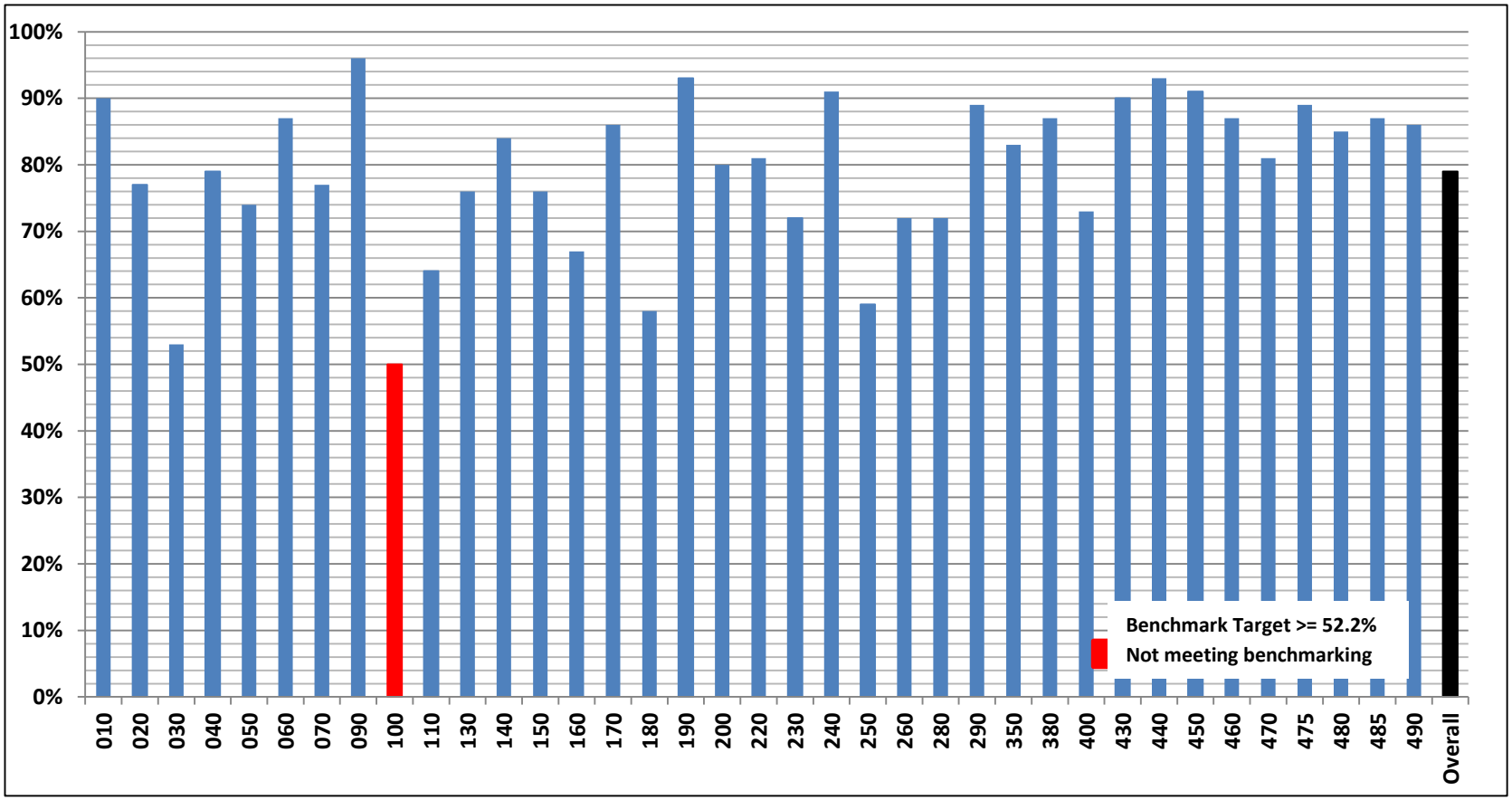
Variation across LMHAs

Performance level (%) for the overall MH7 (n=37)									
	Mean	**SD**	**Min**	**Max**	**IQT***	**25th**	**50th**	**75th**	**# LMHAs not meeting benchmarking**
QT115	**78**	**12**	**49**	**98**	**18**	**70**	**81**	**88**	
092014	77	14	49	95	23	66	82	89	
102014	79	13	48	99	21	69	82	89	
112014	80	11	49	97	17	72	79	89	
QT215	**80**	**12**	**47**	**95**	**15**	**76**	**83**	**90**	
122014	80	13	49	98	19	71	83	90	
012015	82	12	47	100	15	77	84	91	
022015	80	14	43	100	18	74	78	92	
1st Half FY 2015	**79**	**12**	**50**	**96**	**16**	**72**	**80**	**89**	**1**
QT315	**81**	**11**	**55**	**97**	**17**	**73**	**82**	**90**	
032015	79	14	45	100	22	70	79	92	
042015	82	11	46	97	13	77	85	90	
052015	82	11	56	100	17	73	83	90	
QT415	**81**	**11**	**61**	**96**	**20**	**71**	**82**	**91**	
062015	81	13	58	100	20	73	84	92	
072015	81	13	44	100	18	75	81	92	
082015	82	11	58	97	19	74	85	92	
2nd Half FY 2015	**81**	**10**	**60**	**96**	**19**	**72**	**84**	**91**	**0**
QT116	**81**	**11**	**58**	**96**	**20**	**70**	**81**	**90**	
092015	83	11	60	100	21	72	87	93	
102015	81	12	57	97	20	71	81	92	
112015	79	12	44	95	16	73	79	89	
QT216	**80**	**13**	**50**	**97**	**22**	**70**	**84**	**92**	
122015	80	15	39	100	26	68	82	93	
012016	80	13	49	96	17	73	81	90	
022016	82	14	46	100	21	71	86	92	
1st Half FY 2016	**81**	**11**	**55**	**97**	**20**	**72**	**81**	**92**	**0**

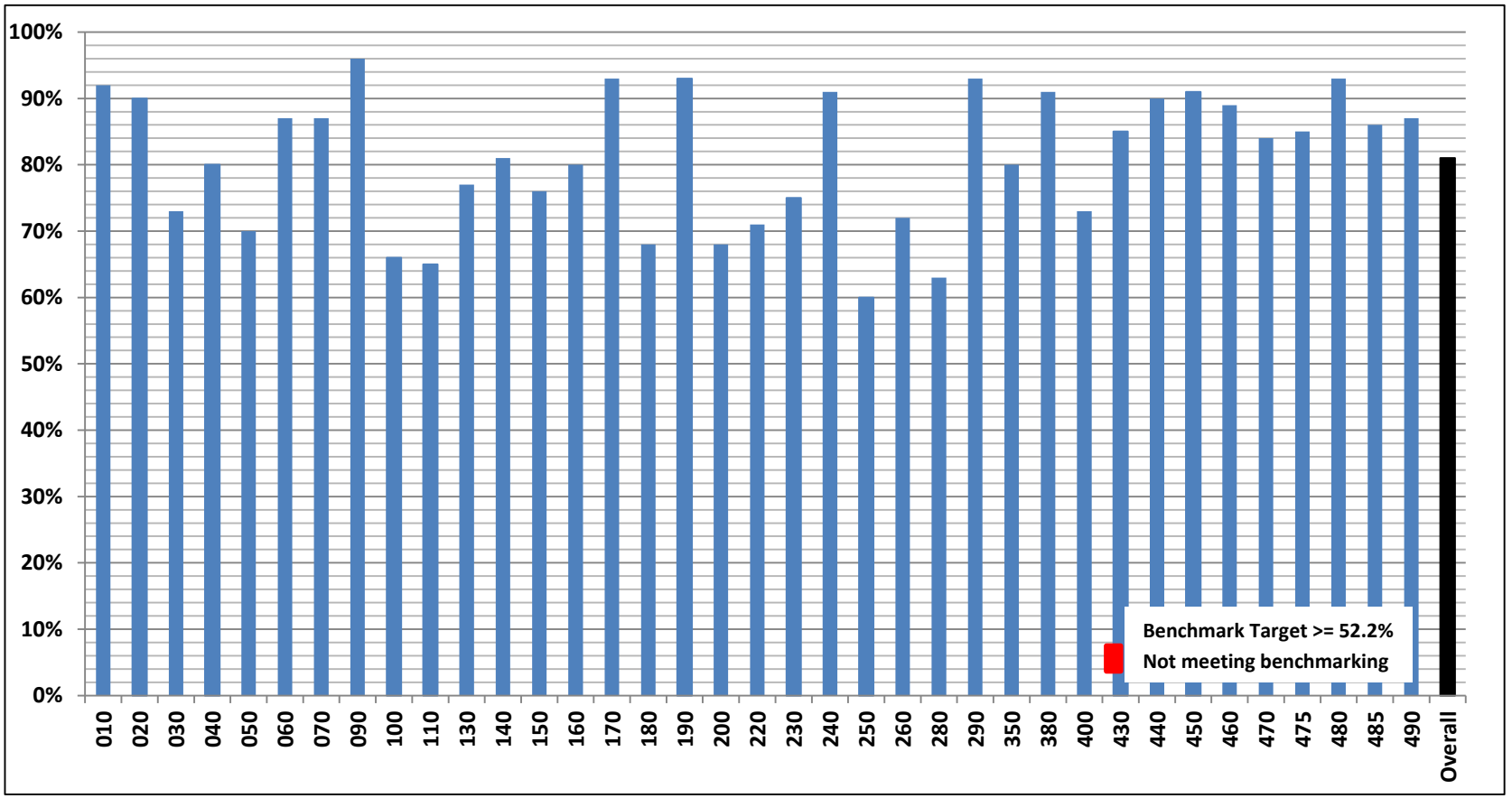
***IQT=Interquartile range**

Variation between LMHAs

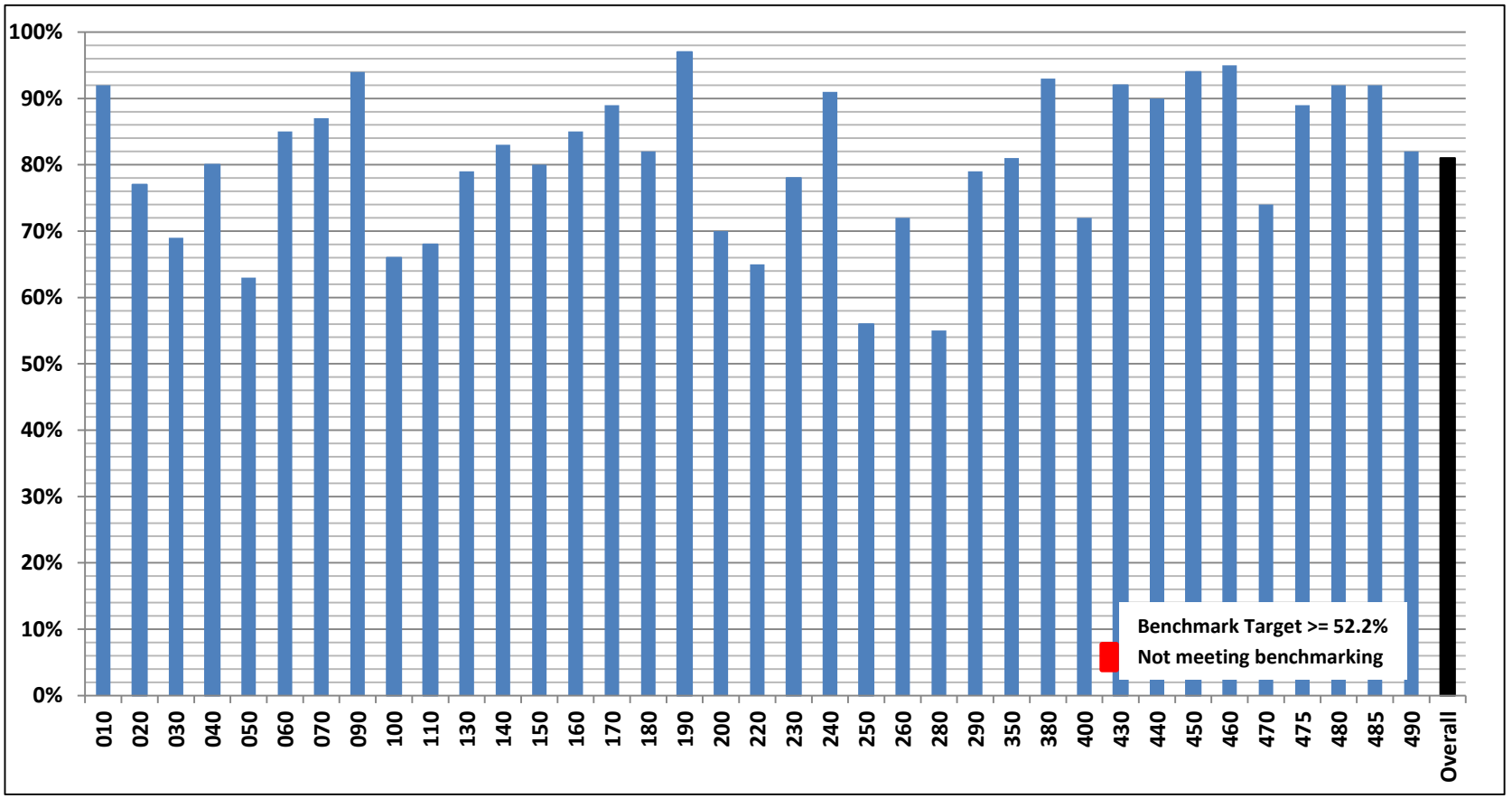
MH7 Access to Crisis Response Services Performance Level between LMHAs for 1st Half FY 2015



MH7 Access to Crisis Response Services Performance Level between LMHAs for 2nd Half FY 2015



MH7 Access to Crisis Response Services Performance Level between LMHAs for 1st Half FY 2016



MH8: Family Partner Supports

The performance level for MH8 represents the percent of full client months for children and youths authorized to receive LOC-2, 3, or YC in which at least 1 minute of family support partner support is reported.

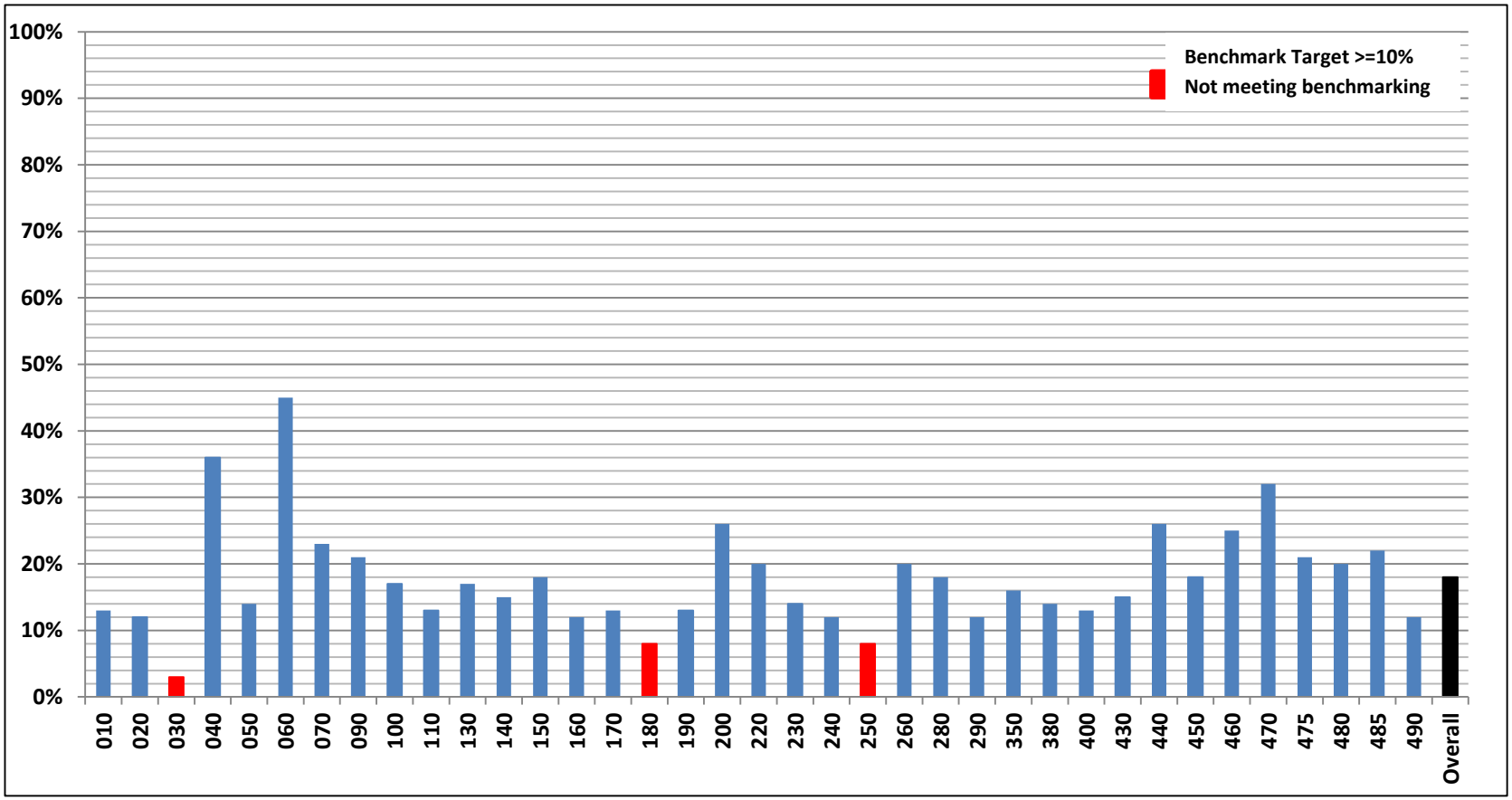
Variation across LMHAs

Performance level (%) for the overall MH8 (n=37)									
	Mean	**SD**	**Min**	**Max**	**IQT***	**25th**	**50th**	**75th**	**# LMHAs not meeting benchmarking**
QT115	**17**	**8**	**2**	**48**	**9**	**12**	**15**	**20**	
092014	16	9	1	46	8	11	16	20	
102014	19	10	2	50	12	13	17	25	
112014	17	9	2	50	7	12	16	29	
QT215	**18**	**8**	**3**	**42**	**11**	**12**	**16**	**23**	
122014	18	9	1	42	11	12	17	23	
012015	19	9	0	47	9	13	17	22	
022015	18	9	0	42	10	12	17	22	
1st Half FY 2015	**18**	**8**	**3**	**45**	**8**	**13**	**16**	**21**	**3**
QT315	**18**	**9**	**0**	**43**	**8**	**13**	**15**	**22**	
032015	18	9	0	44	12	12	17	24	
042015	18	10	0	43	9	13	16	22	
052015	17	10	0	47	9	11	15	20	
QT415	**19**	**10**	**0**	**42**	**14**	**12**	**17**	**26**	
062015	19	10	0	42	16	12	16	27	
072015	18	10	0	41	13	12	16	26	
082015	19	11	0	44	14	12	17	26	
2nd Half FY 2015	**18**	**9**	**0**	**42**	**11**	**13**	**16**	**24**	**4**
QT116	**17**	**9**	**0**	**42**	**7**	**13**	**16**	**19**	
092015	18	10	0	46	10	12	17	22	
102015	18	9	0	38	8	13	16	21	
112015	17	8	0	42	8	13	15	21	
QT216	**16**	**8**	**0**	**37**	**10**				
122015	17	10	0	45	12	11	14	23	
012016	16	8	0	35	11	11	15	22	
022016	16	9	0	38	10	11	15	22	
1st Half FY 2016	**17**	**8**	**0**	**39**	**10**	**12**	**15**	**22**	**2**

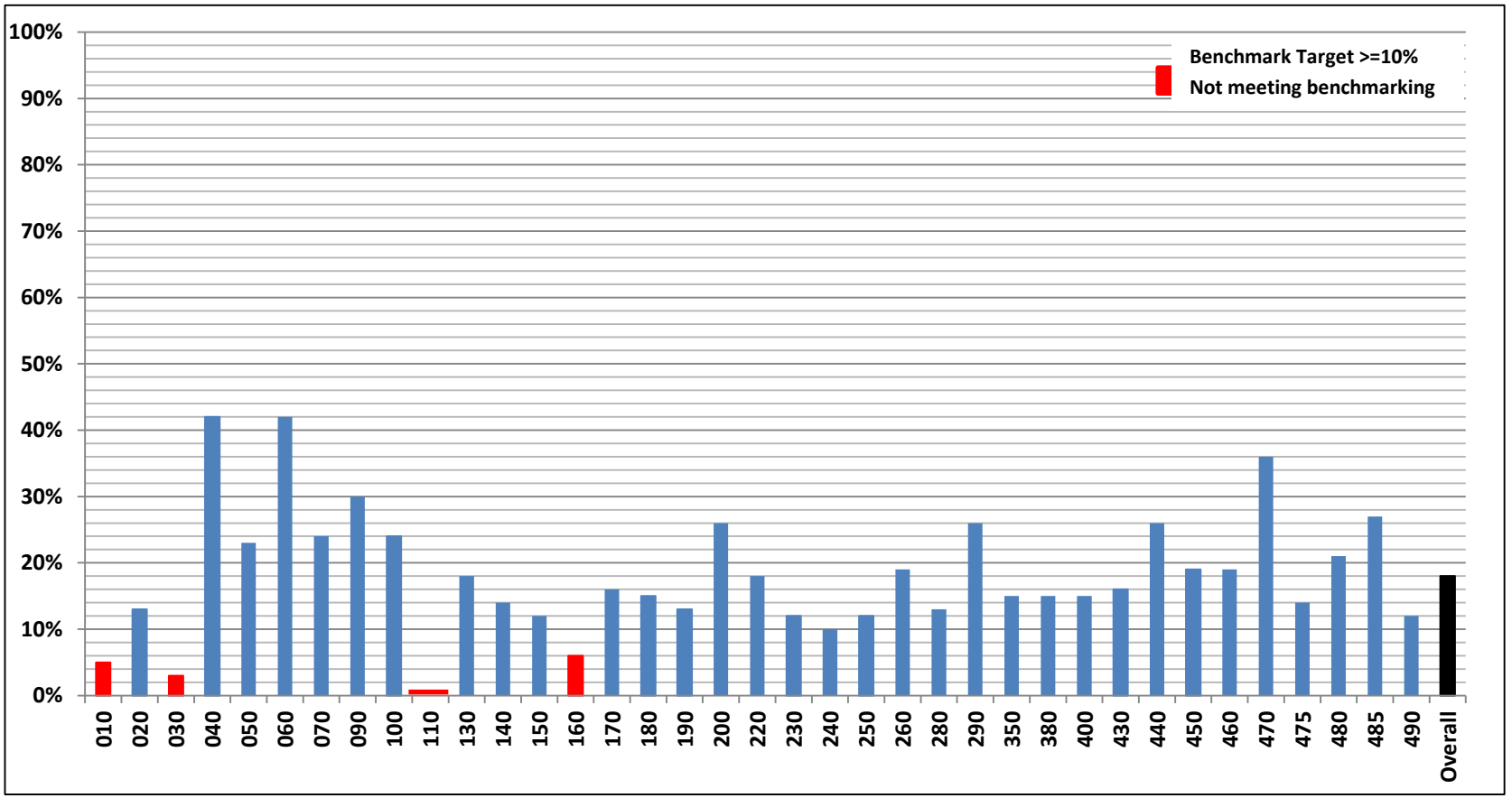
***IQT=Interquartile range**

Variation between LMHAs

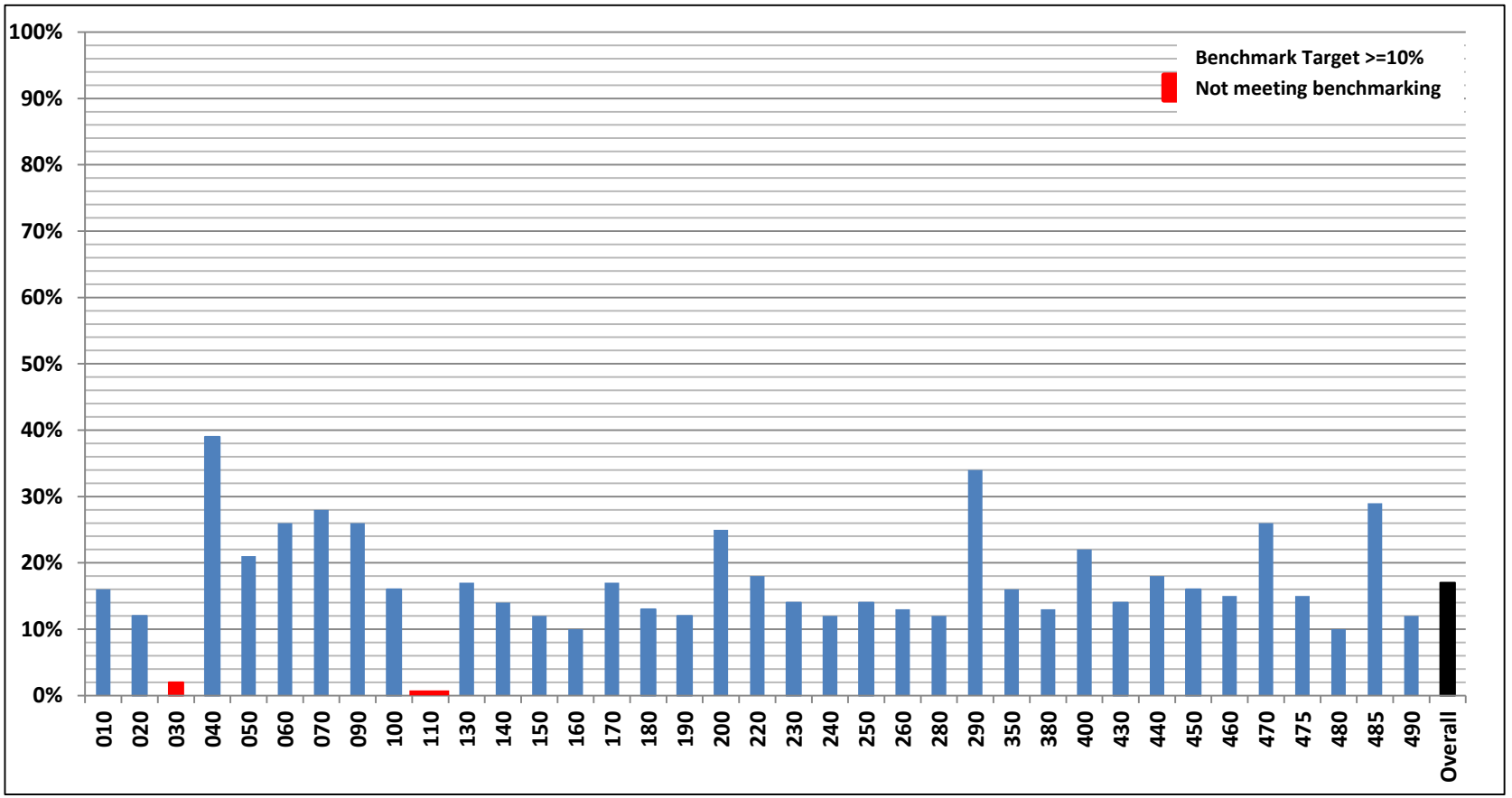
MH8 Family Partner Supports Performance Level between LMHAs for 1st Half FY 2015



MH8 Family Partner Supports Performance Level between LMHAs for 2nd Half FY 2015



MH8 Family Partner Supports Performance Level bet ween LMHAs for 1st Half FY 2016



MH9: Community Linkage

The performance level for MH9 represents the percent of LOC-A=0 that is followed by a mental health community LOC-A=1M and 1S through 5 and/or a contact at a DSHS-funded substance abuse treatment facility, or an Outreach, Screening, Assessment and Referral (OSAR) provider within 14 days of closure from Level of Care 0.

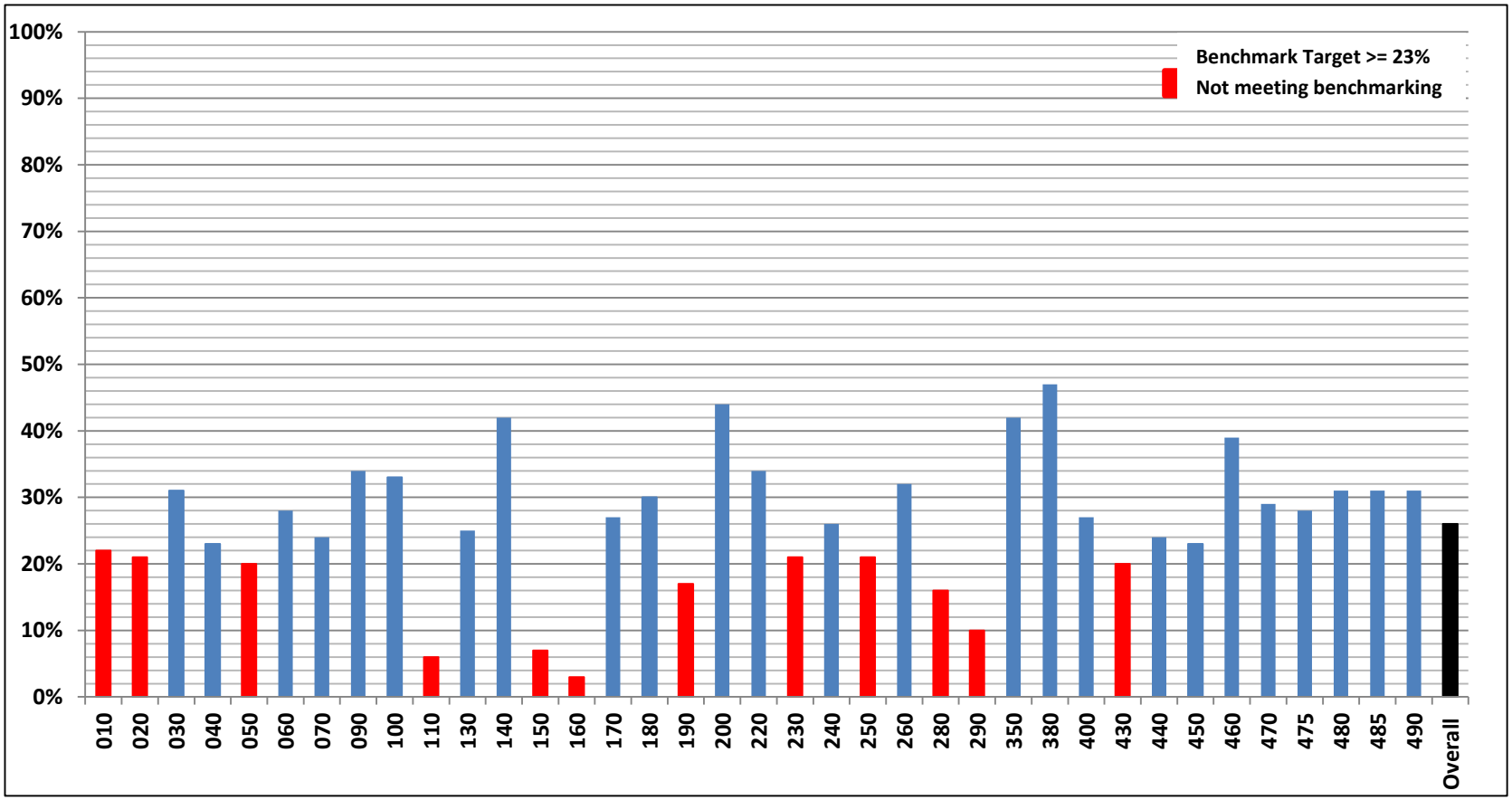
Variation across LMHAs

Performance level (%) for the overall MH9 (n=37)									
	Mean	**SD**	**Min**	**Max**	**IQT***	**25th**	**50th**	**75th**	**# LMHAs not meeting benchmarking**
QT115	**26**	**10**	**0**	**48**	**12**	**21**	**28**	**32**	
092014	28	13	0	61	15	20	27	35	
102014	28	15	0	79	15	19	26	34	
112014	23	12	0	44	19	13	25	32	
QT215	**26**	**11**	**4**	**52**	**13**	**19**	**27**	**33**	
122014	23	13	2	56	19	13	22	32	
012015	28	14	1	59	20	19	27	39	
022015	28	13	7	57	19	18	28	37	
1st Half FY 2015	**26**	**10**	**3**	**47**	**11**	**21**	**27**	**32**	**12**
QT315	**27**	**12**	**5**	**63**	**13**	**21**	**27**	**34**	
032015	28	15	0	67	23	15	29	38	
042015	27	15	0	58	19	16	26	35	
052015	27	15	6	73	15	18	25	34	
QT415	**24**	**10**	**9**	**53**	**13**	**16**	**23**	**30**	
062015	21	14	3	65	16	12	19	27	
072015	25	13	0	56	15	16	25	31	
082015	27	14	3	55	26	15	24	41	
2nd Half FY 2015	**26**	**10**	**7**	**58**	**13**	**19**	**24**	**33**	**16**
QT116	**26**	**11**	**5**	**53**	**16**	**19**	**25**	**35**	
092015	26	15	3	59	17	17	24	34	
102015	29	16	4	65	22	16	26	38	
112015	24	14	0	71	16	23	25	32	
QT216	**25**	**10**	**4**	**45**	**12**	**20**	**25**	**32**	
122015	22	10	2	44	15	14	22	28	
012016	27	14	2	57	18	19	28	36	
022016	27	13	5	50	21	18	27	39	
1st Half FY 2016	**26**	**10**	**4**	**47**	**11**	**20**	**25**	**31**	**11**

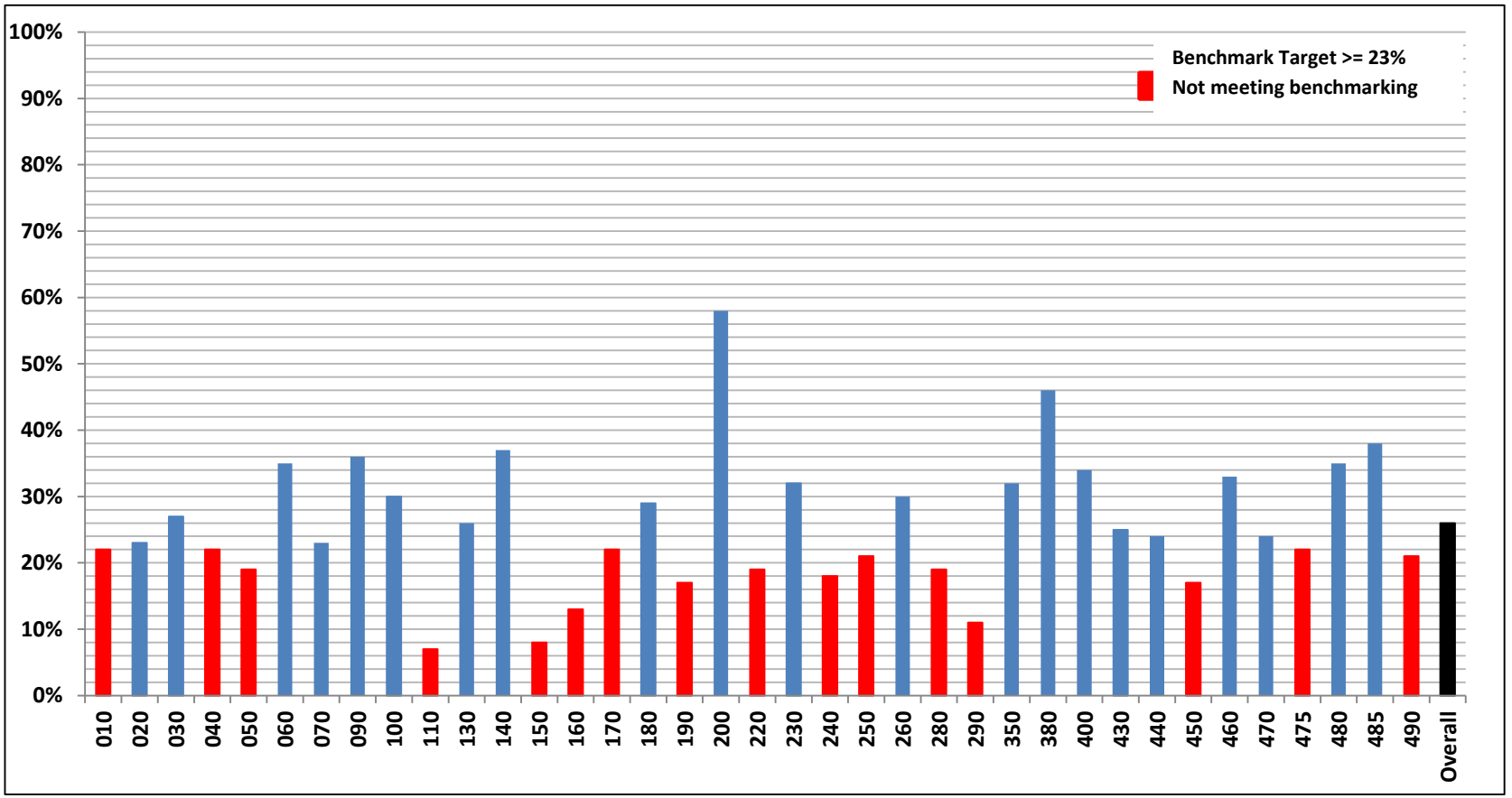
***IQT=Interquartile range**

Variation between LMHAs

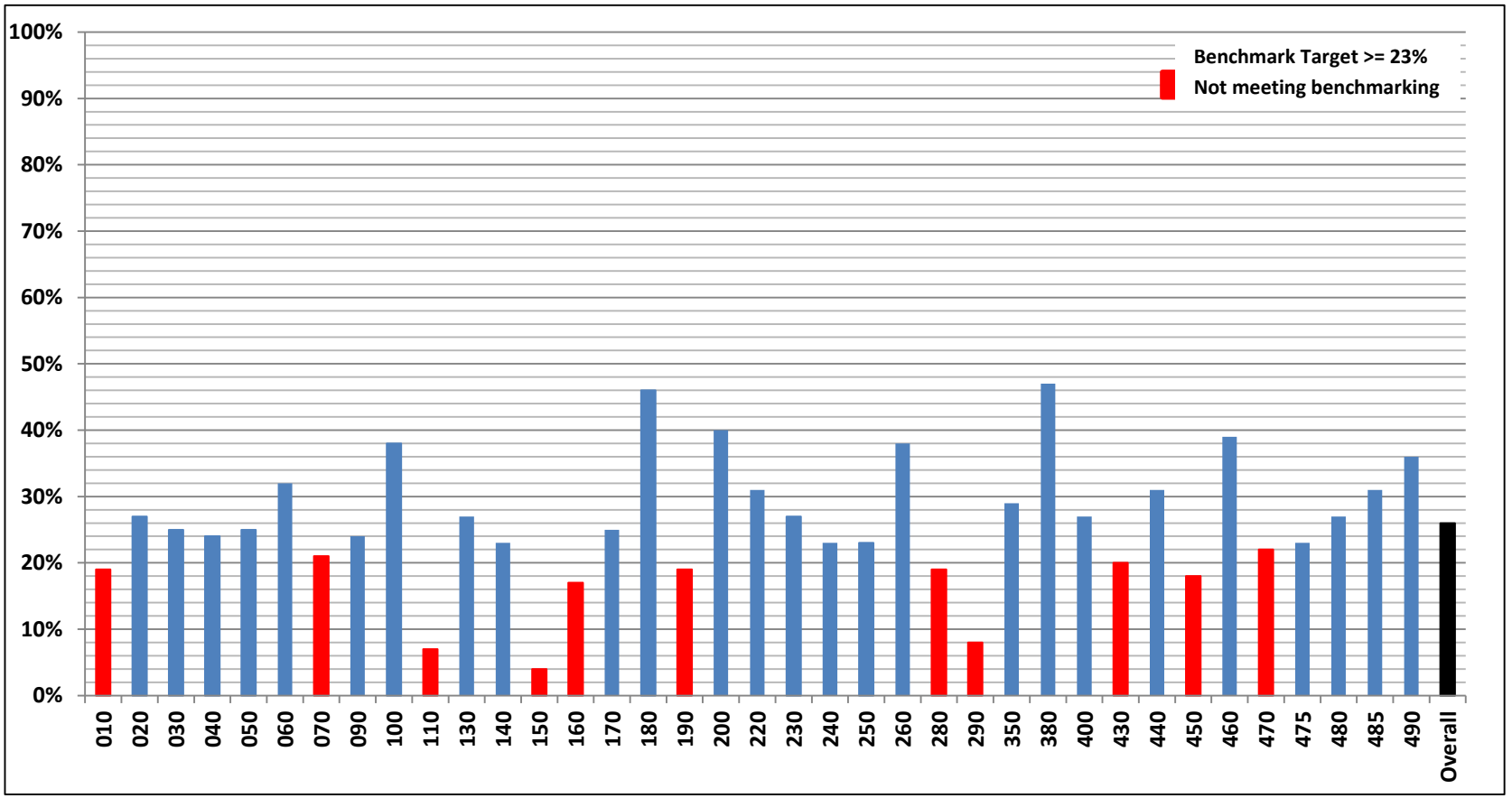
MH9 Community Linkage Performance Level between LMHAs for 1st Half FY 2015



MH9 Community Linkage Performance Level between LMHAs for 2nd Half FY 2015



MH9 Community Linkage Performance Level between LMHAs for 1st Half FY 2016



MH10: Crisis Follow-Up Within 30 Days

The performance level for MH10 represents the percent of persons with a mental health community LOC-A= 5 who receive a crisis follow-up service encounter within 30 days. For this performance measure, the performance level is presented for the half fiscal years only. Due to missing data, variation across local mental health authorities by month was not advisable.

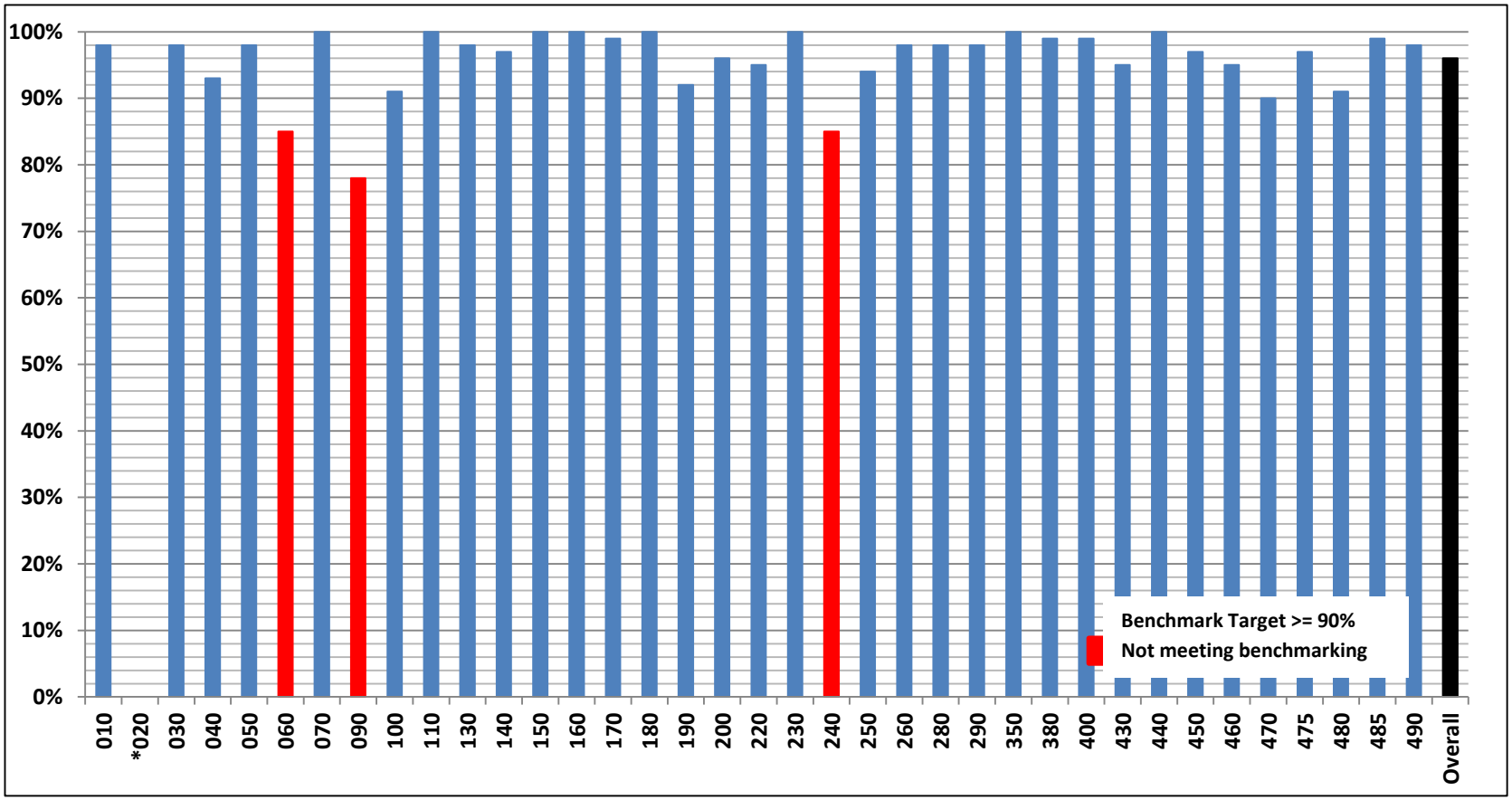
Variation across LMHAs

Performance level (%) for the overall PM10 (n=37)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	96	5	78	100	5	94	98	99	3
2nd Half FY 2015	97	3	89	100	3	96	97	100	2
1st Half FY 2016	93	17	0	100	5	94	97	100	4

***IQT=Interquartile range**

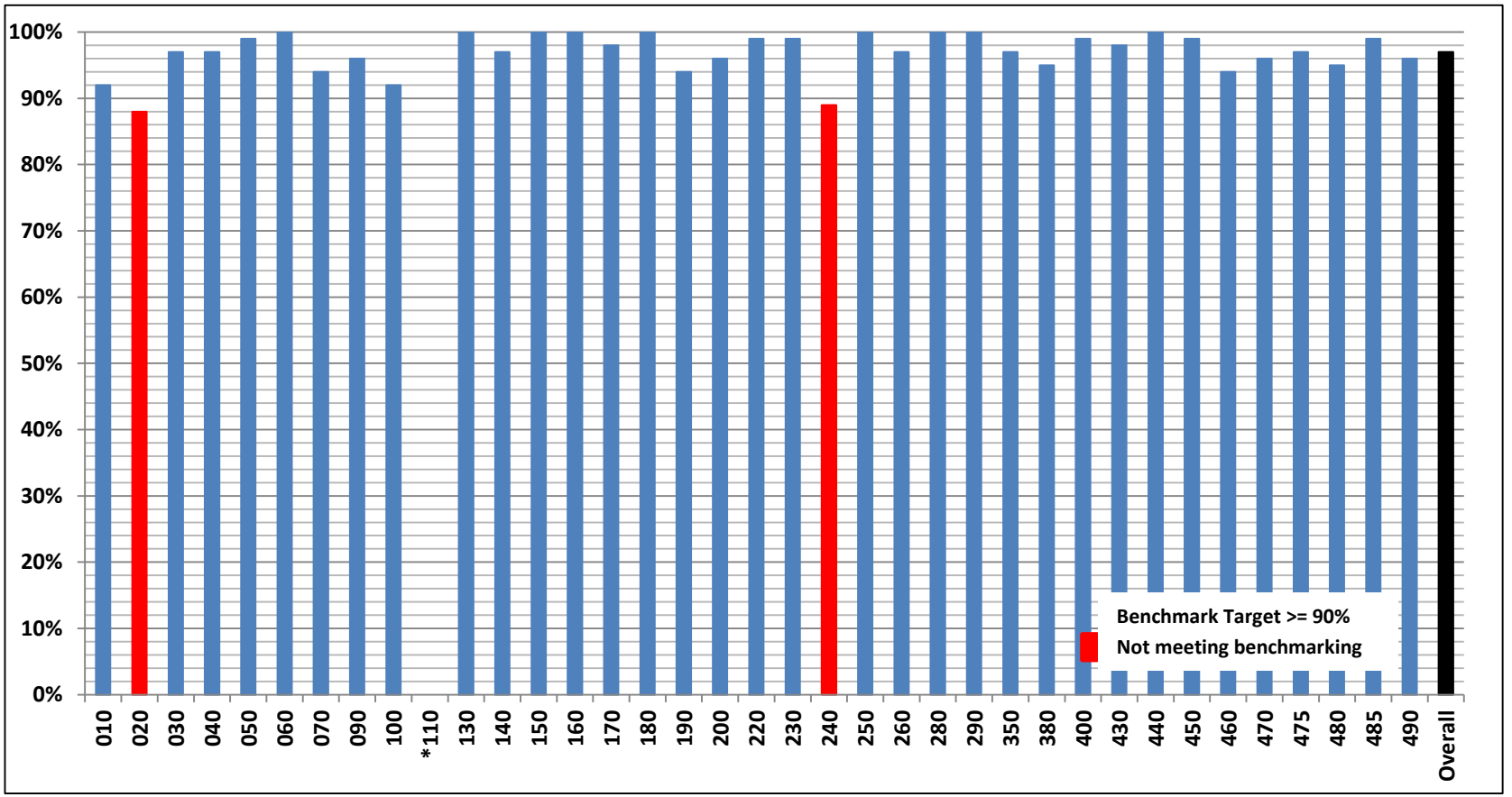
Variation between LMHAs

MH10 Crisis Follow-Up Within 30 Days Performance Level between LMHAs for 1st Half FY 2015



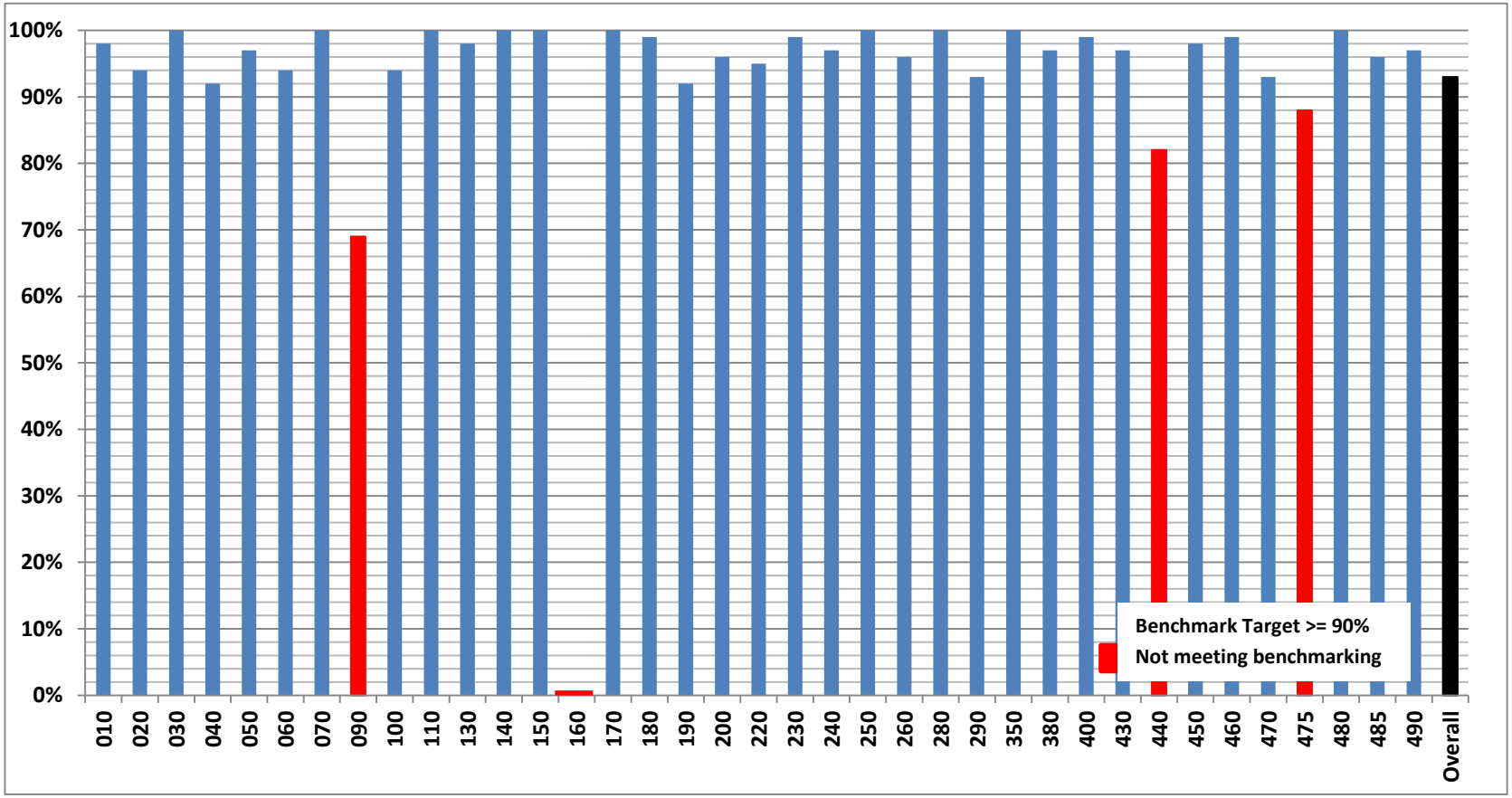
* Data was not available.

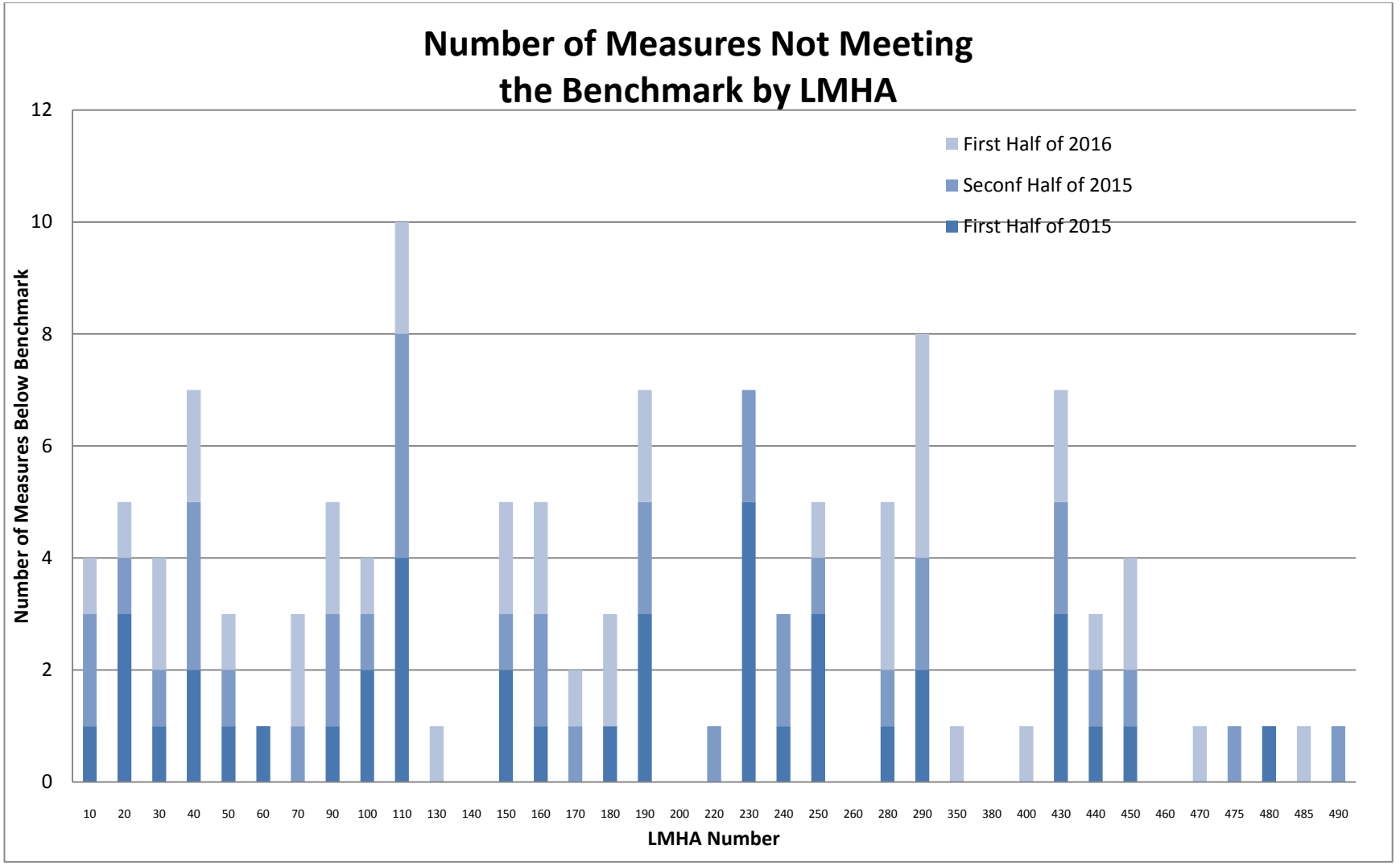
MH10 Crisis Follow-Up Within 30 Days Performance Level between LMHAs for 2nd Half FY 2015

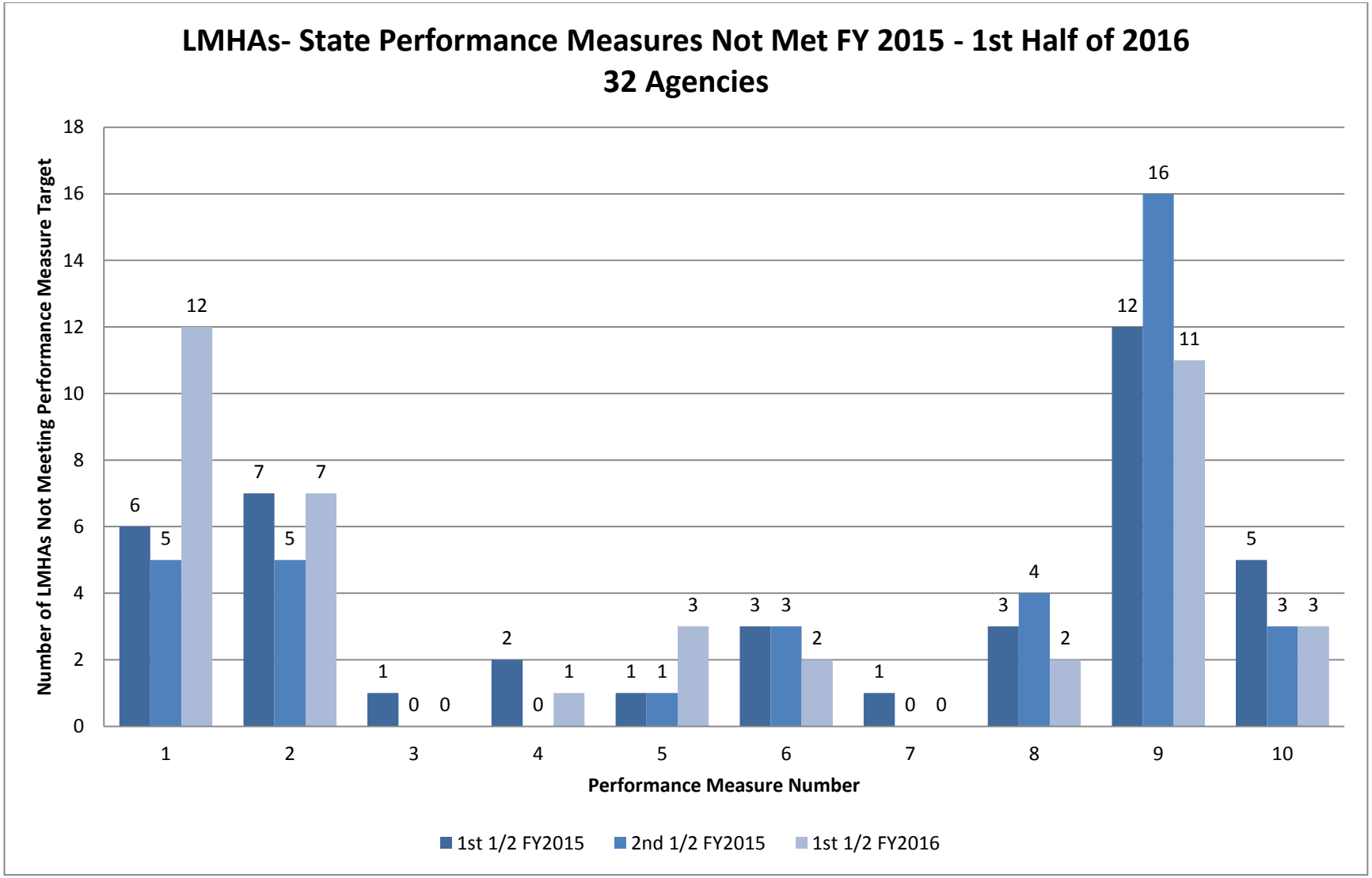


* Data was not available.

MH10 Crisis Follow-Up Within 30 Days Performance Level between LMHAs for 1st Half FY 2016




Number of Measures Not Meeting the Benchmark by LMHA
First Half of 2016
Seconf Half of 2015
First Half of 2015
Number of Measures Below Benchmark
0
2
4
6
8
10
12
10 20 30 40 50 60 70 90 100 110 130 140 150 160 170 180 190 200 220 230 240 250 260 280 290 350 380 400 430 440 450 460 470 475 480 485 490
LMHA Number


LMHAs- State Performance Measures Not Met FY 2015 - 1st Half of 2016
32 Agencies
Number of LMHAs Not Meeting Performance Measure Target
Performance Measure Number
1st 1/2 FY2015
2nd 1/2 FY2015
1st 1/2 FY2016
0
2
4
6
8
10
12
14
16
18
1 2 3 4 5 6 7 8 9 10
6 5 12
7 5 7
1 0 0
2 0 1
1 1 3
3 3 2
1 0 0
3 4 2
12 16 11
5 3 3

C. Results – *NOMS Measures* (*Federal*)

NOM1: Employment

The performance level for NOM1 represents the percent of adults served during the fiscal year with an Adult Uniform Assessment Community Data Section 4.B. Paid Employment Type score 1.

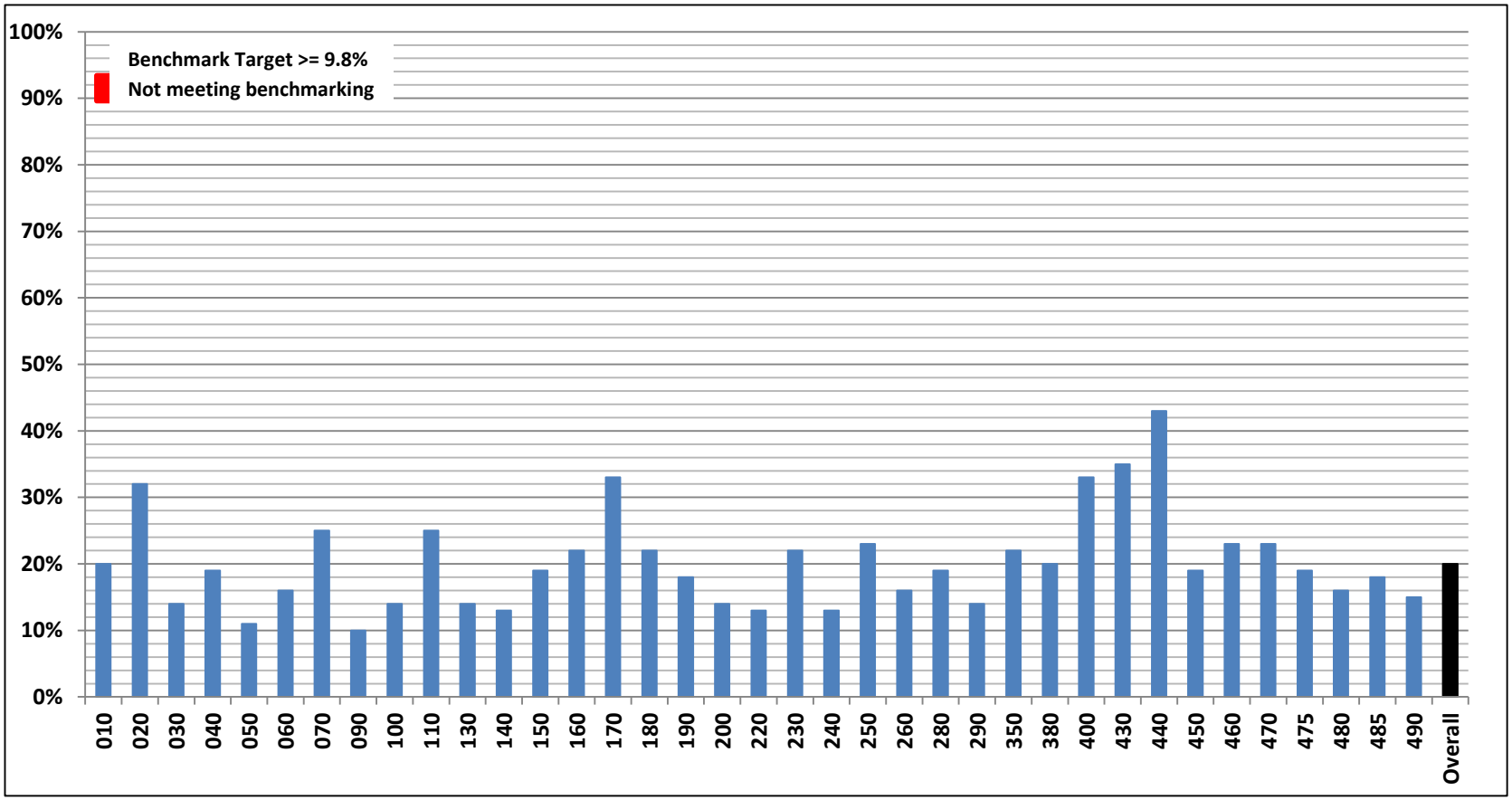
Variation across LMHAs

Performance level (%) for the overall NOM1 (n=37)									
	Mean	**SD**	**Min**	**Max**	**IQT***	**25th**	**50th**	**75th**	**# LMHAs not meeting benchmarking**
QT115	**20**	**7**	**10**	**44**	**8**	**14**	**19**	**22**	
092014	20	7	10	44	7	15	18	22	
102014	20	7	10	44	7	15	19	22	
112014	20	8	10	44	9	14	19	23	
QT215	**20**	**7**	**10**	**42**	**9**	**14**	**19**	**24**	
122014	20	8	10	44	9	15	19	23	
012015	20	7	10	42	9	14	19	23	
022015	20	7	10	42	9	15	19	24	
1st Half FY 2015	**20**	**7**	**10**	**43**	**9**	**14**	**19**	**23**	**0**
QT315	**20**	**6**	**11**	**39**	**8**	**15**	**20**	**23**	
032015	20	7	10	41	9	15	20	24	
042015	20	6	11	40	8	15	20	23	
052015	20	6	11	37	8	15	20	24	
QT415	**21**	**6**	**11**	**38**	**8**	**15**	**20**	**24**	
062015	20	6	11	37	9	15	20	24	
072015	21	6	11	38	8	16	20	24	
082015	21	6	12	38	8	16	21	24	
2nd Half FY 2015	**20**	**6**	**11**	**38**	**9**	**15**	**20**	**24**	**0**
QT116	**21**	**6**	**11**	**36**	**8**	**15**	**21**	**24**	
092015	21	6	11	36	8	16	21	24	
102015	21	6	11	36	9	15	21	24	
112015	21	6	12	36	9	16	21	25	
QT216	**21**	**6**	**11**	**36**	**10**	**16**	**21**	**25**	
122015	21	6	11	37	9	16	22	25	
012016	21	6	11	36	10	15	21	25	
022016	21	6	11	36	9	16	20	25	
1st Half FY 2016	**21**	**6**	**11**	**36**	**9**	**15**	**21**	**24**	**0**

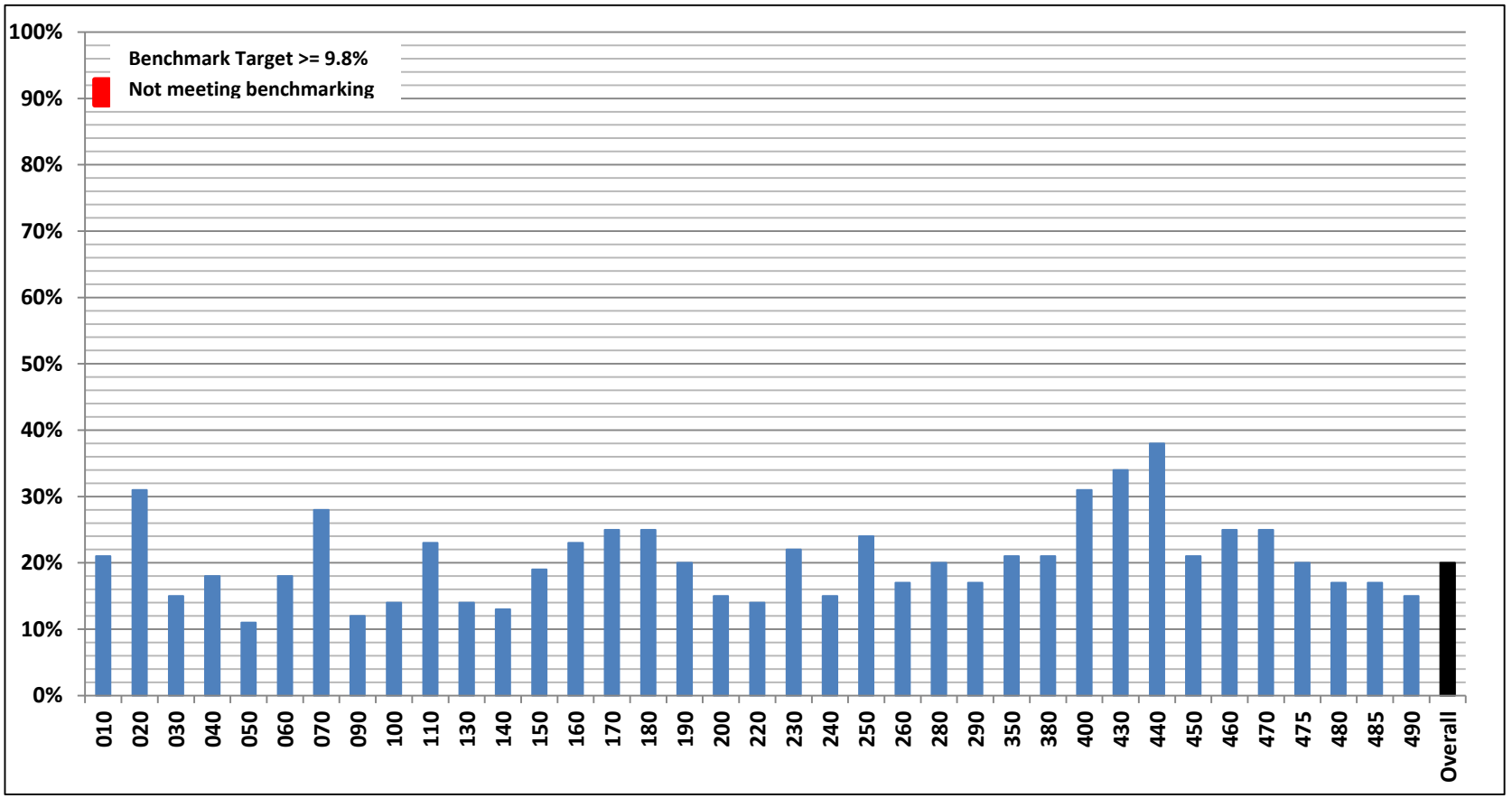
***IQT=Interquartile range**

Variation between LMHAs

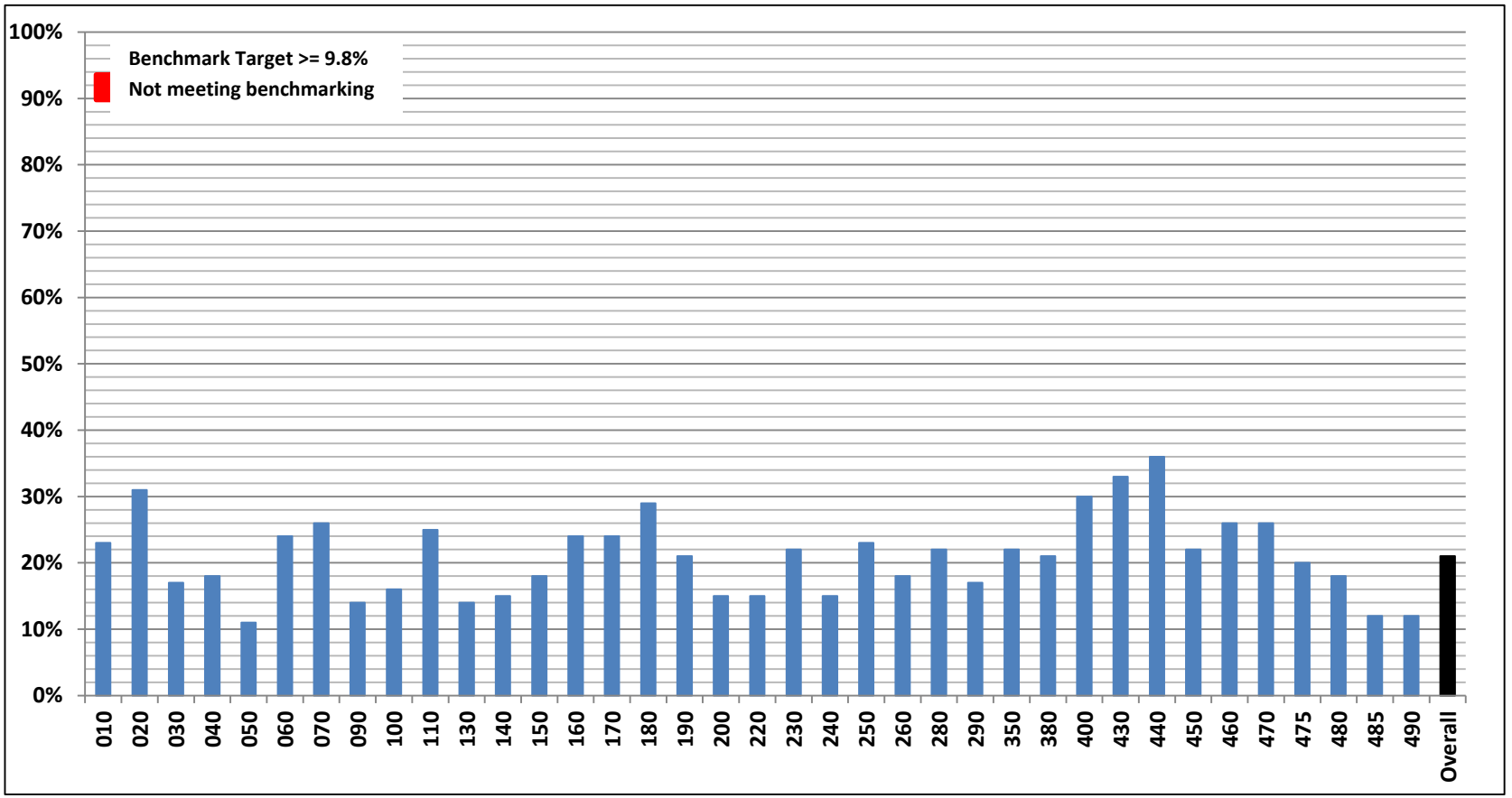
NOM1 Employment Performance Level between LMHAs for 1st Half FY 2015



NOM1 Employment Performance Level between LMHAs for 2nd Half FY 2015



NOM1 Employment Performance Level between LMHAs for 1st Half FY 2016



NOM2: Adult Improvement

The performance level for NOM2 represents the percent of adults authorized into a FLOC that show reliable improvement in at least one of the following domains as compared to the Reliable Change Index: risk behaviors, behavioral health needs, life domain functioning, strengths, substance use, and trauma.

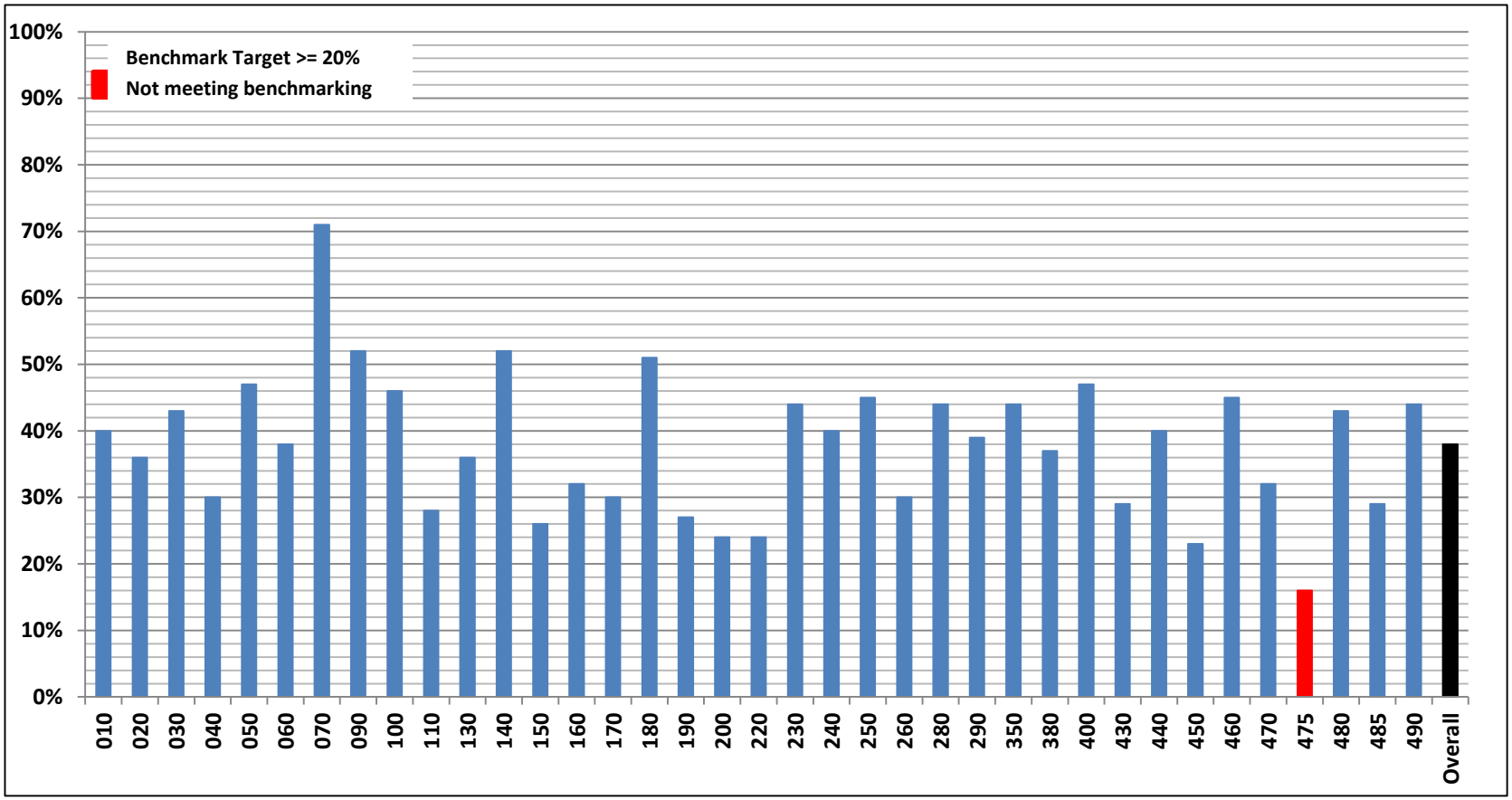
Variation across LMHAs

Performance level (%) for the overall NOM2 (n=37)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	38	11	16	71	15	30	39	45	1
2nd Half FY 2015	43	9	28	65	16	34	45	50	0
1st Half FY 2016	34	10	16	52	15	27	34	42	2

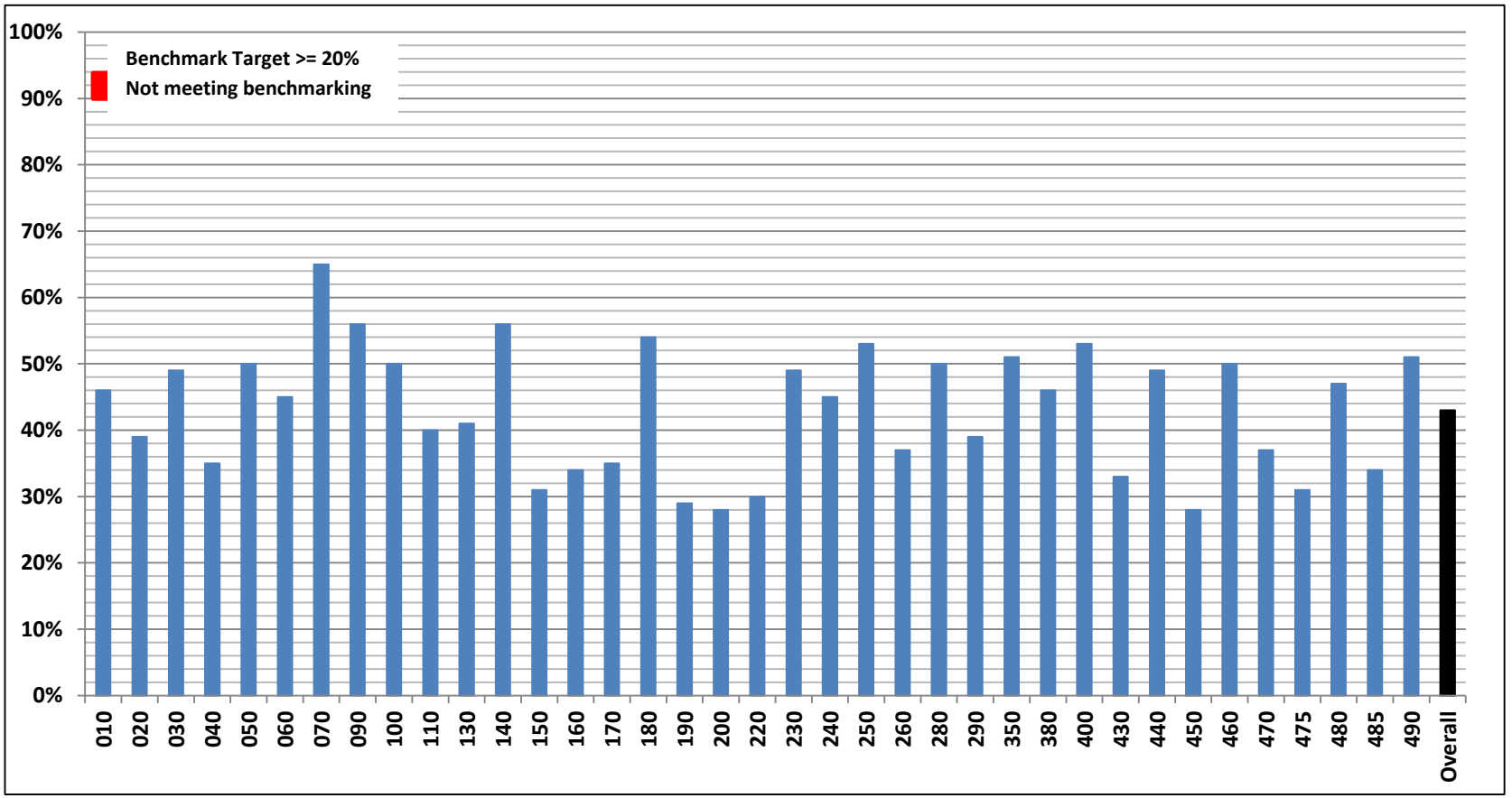
***IQT=Interquartile range**

Variation between LMHAs

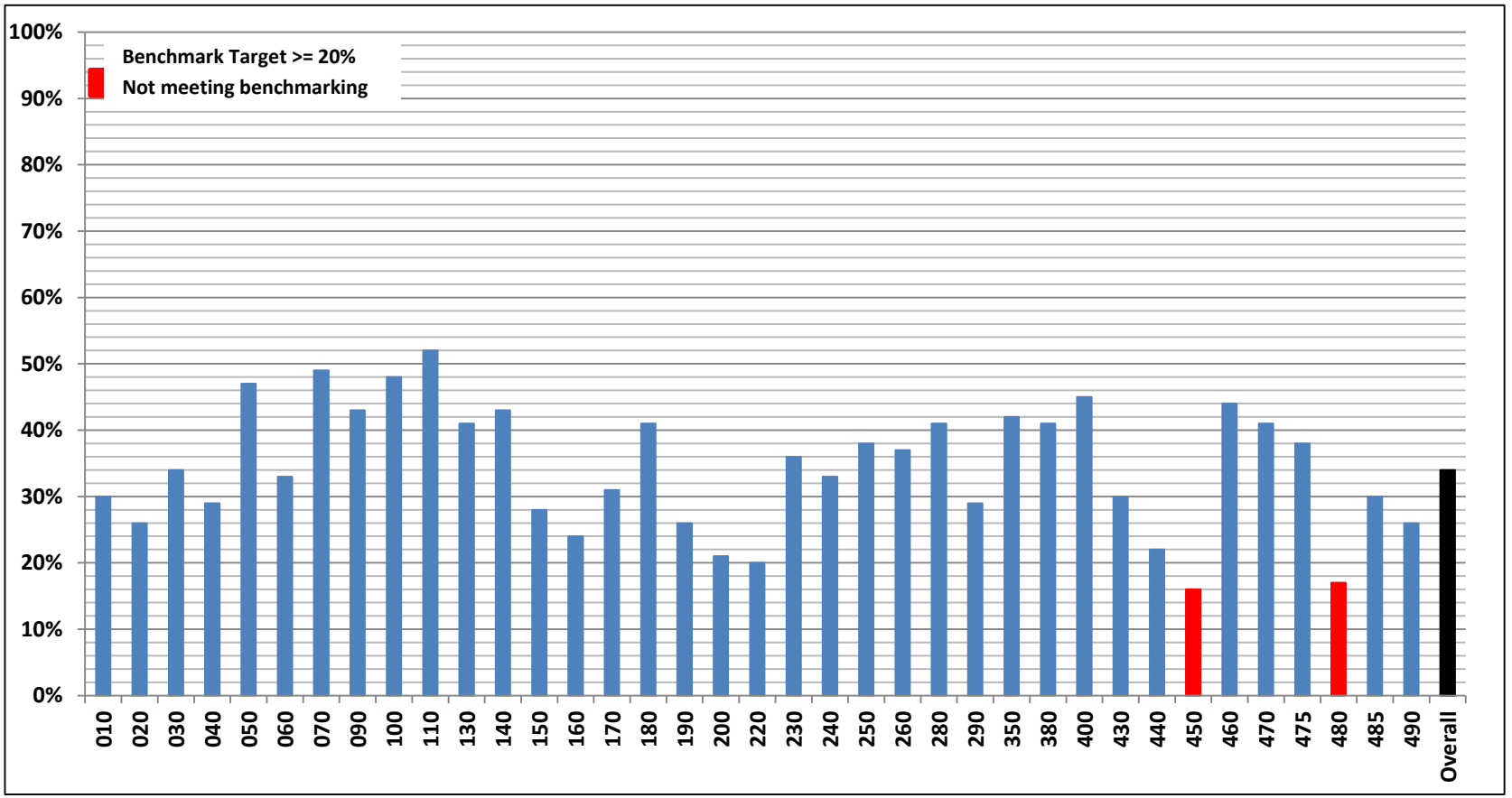
NOM2 Adult Improvement Performance Level between LMHAs for 1st Half FY 2015



NOM2 Adult Improvement Performance Level between LMHAs for 2nd Half FY 2015



NOM2 Adult Improvement Performance Level between LMHAs for 1st Half FY 2016



NOM3: Child and Youth Improvement

The performance level for NOM3 represents the percent of children and youth authorized into a FLOC that show reliable improvement in at least one of the following domains as compared to the Reliable Change Index: risk behaviors, behavioral health needs, life domain functioning, strengths, substance use, and trauma.

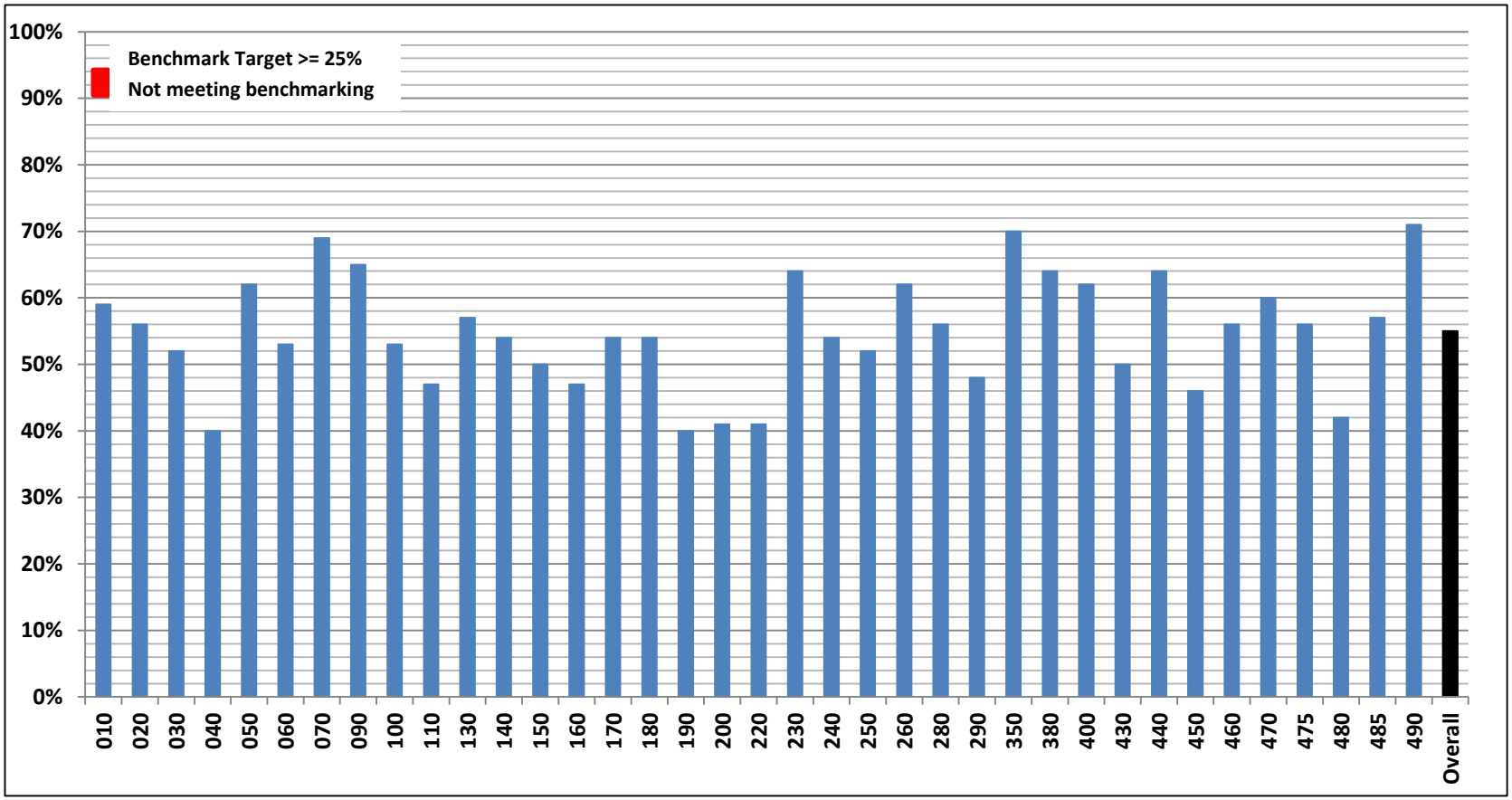
Variation across LMHAs

Performance level (%) for the overall NOM3 (n=37)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	55	8	40	71	13	49	54	62	0
2nd Half FY 2015	61	9	43	77	10	58	61	68	0
1st Half FY 2016	50	10	24	75	12	44	52	56	1

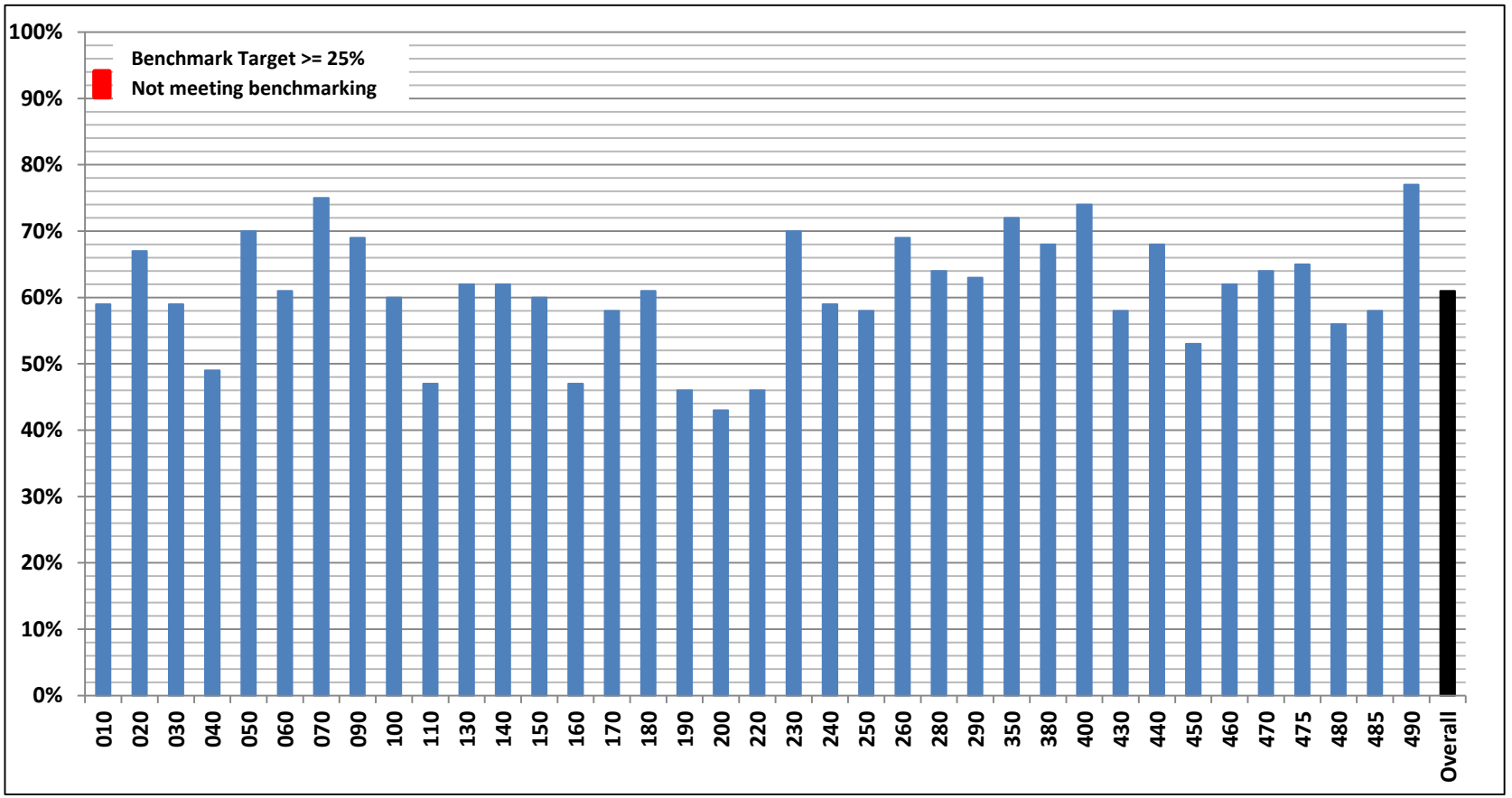
*IQT=Interquartile range

Variation between LMHAs

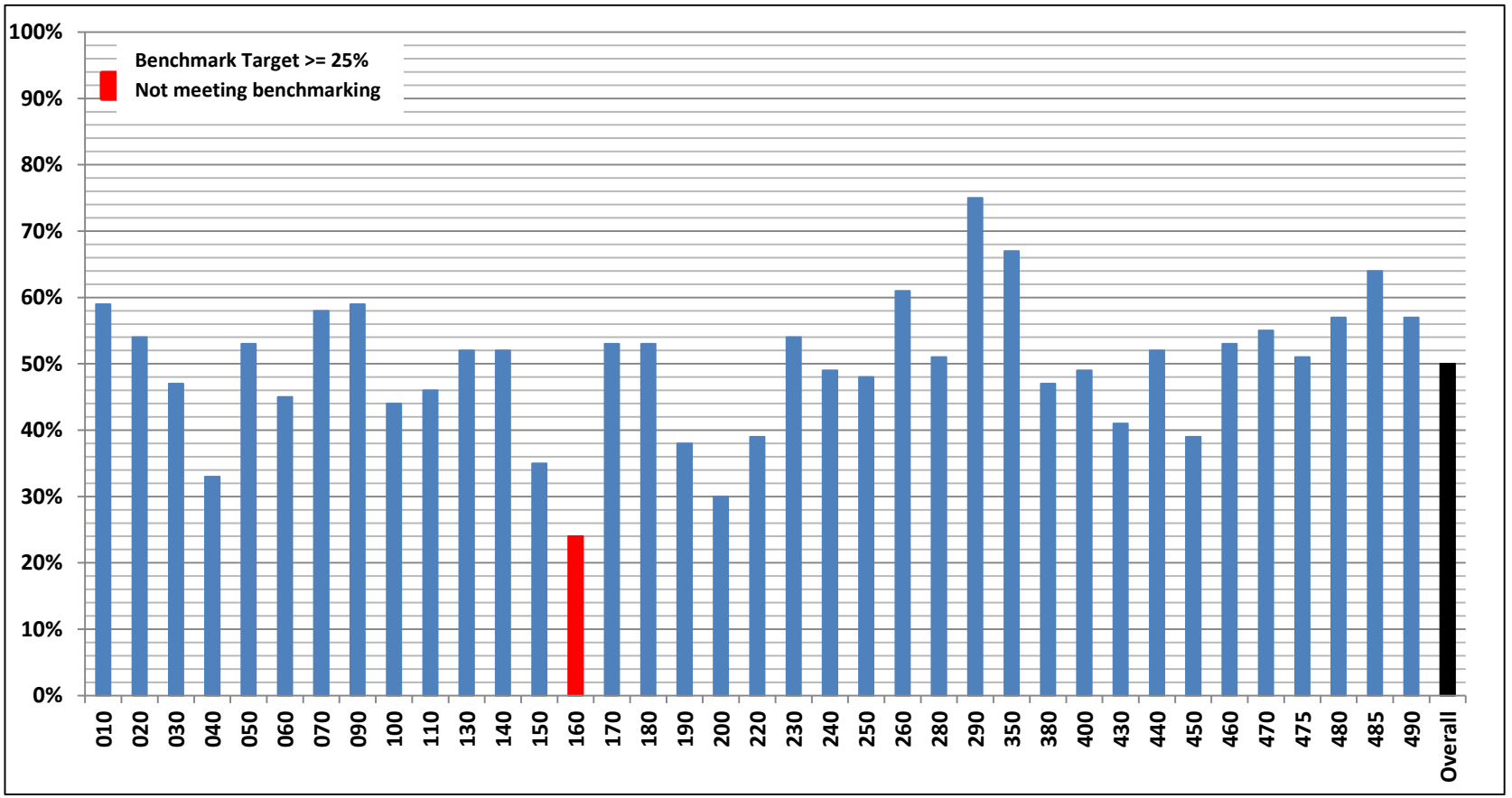
NOM3 Child and Youth Improvement Performance Level between LMHAs for 1st Half FY 2015



NOM3 Child and Youth Improvement Performance Level between LMHAs for 2nd Half FY 2015



NOM3 Child and Youth Improvement Performance Level between LMHAs for 1st Half FY 2016



NOM4: Community Tenure Adult

The performance level for NOM4 represents the percent of adults in a FLOC that avoid hospitalization in a DSHS Purchased Inpatient Bed after authorization into a FLOC.

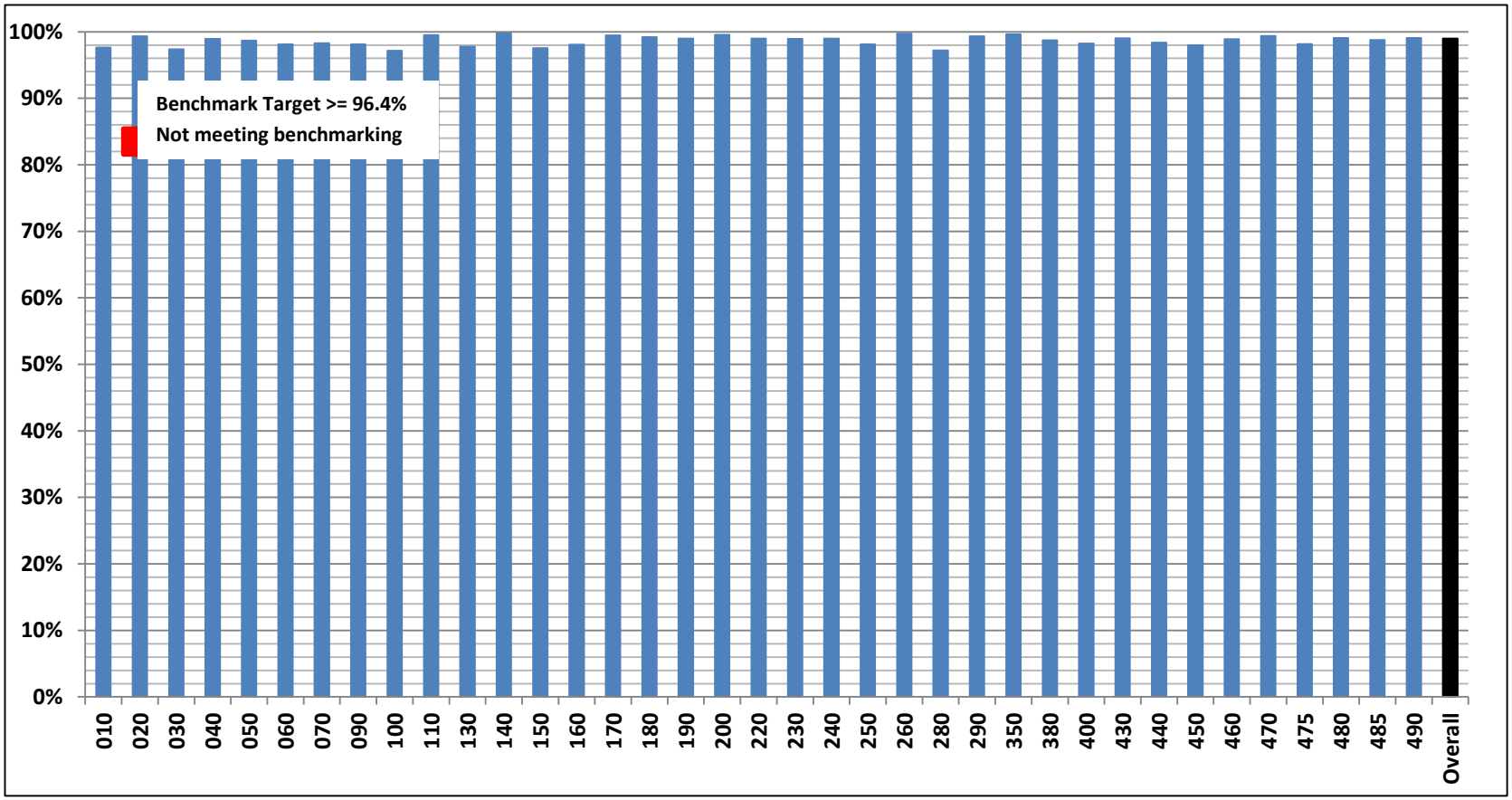
Variation across LMHAs

Performance level (%) for the overall NOM4 (n=37)									
	Mean	**SD**	**Min**	**Max**	**IQT***	**25th**	**50th**	**75th**	**# LMHAs not meeting benchmarking**
QT115	99	1	98	100	1	99	99	100	
QT215	99	1	98	100	1	99	99	100	
1st Half FY 2016	**99**	**1**	**97**	**100**	**1**	**98**	**99**	**99**	**0**
QT315	99	1	98	100	1	99	99	100	
QT415	99	1	97	100	1	99	99	100	
2nd Half FY 2015	**99**	**1**	**96**	**100**	**1**	**98**	**99**	**99**	**0**
QT116	99	1	98	100	1	99	99	100	
QT216	99	1	97	100	1	98	99	100	
1st Half FY 2016	**99**	**1**	**96**	**100**	**1**	**98**	**99**	**99**	**0**

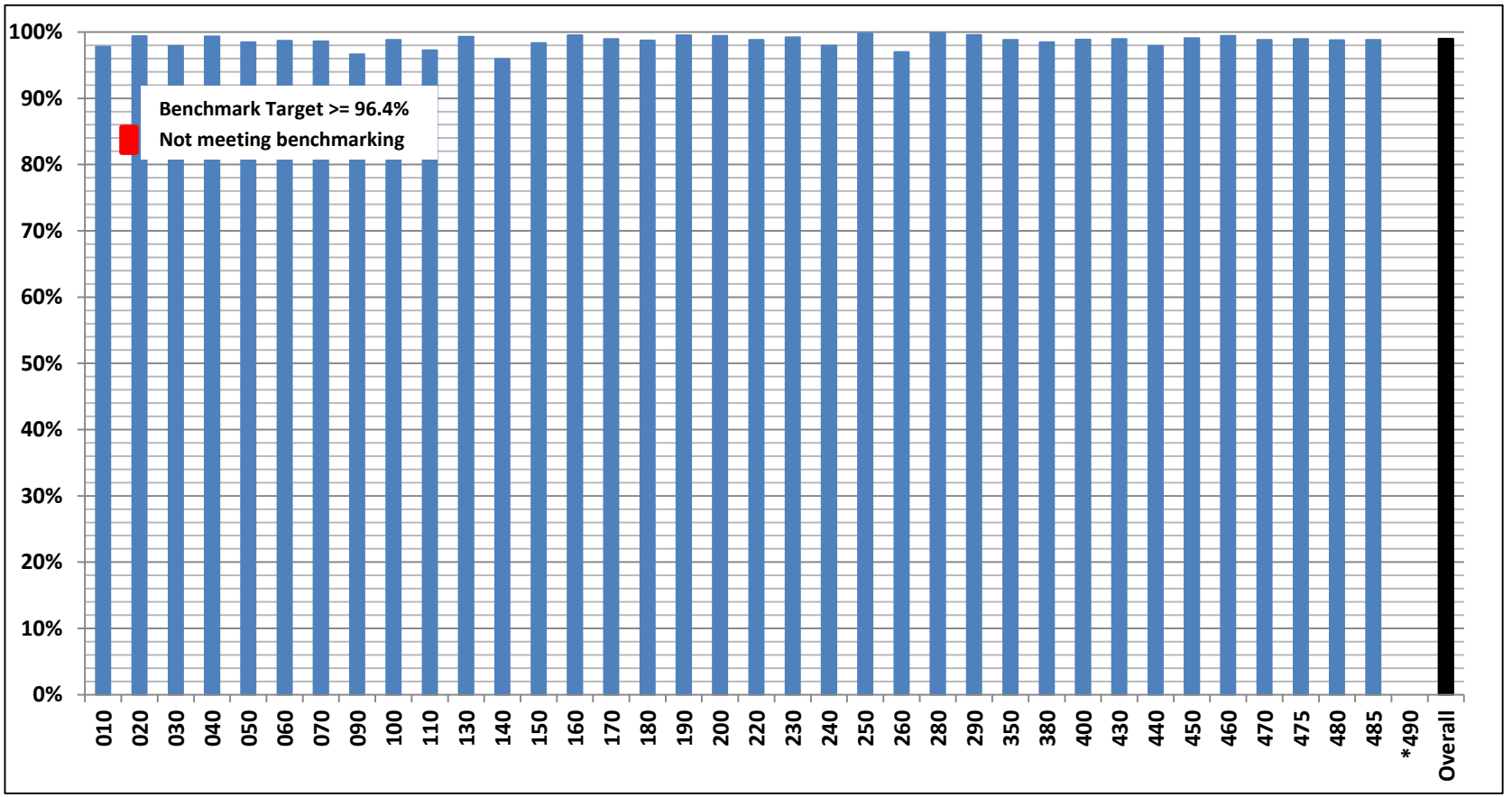
***IQT=Interquartile range**

Variation between LMHAs

NOM4 Community Tenure Adult Performance Level between LMHAs for 1st Half FY 2015

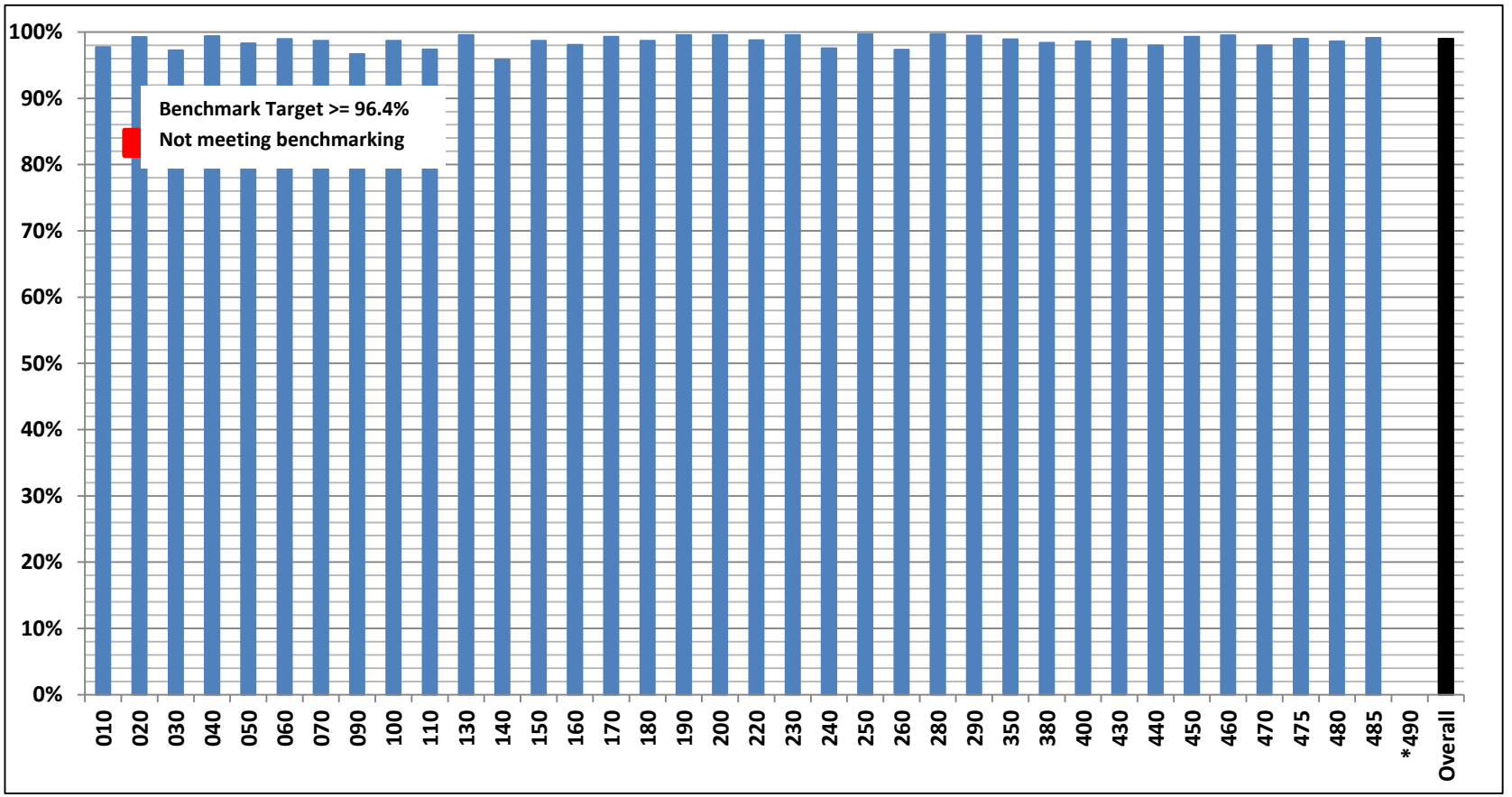


NOM4 Community Tenure Adult Performance Level between LMHAs for 2nd Half FY 2015



* Data was not available.

NOM4 Community Tenure Adult Performance Level between LMHAs for 1st Half FY 2016



* Data was not available.

NOM5: Community Tenure Child and Youth

The performance level for NOM5 represents the percent of children and youth in a FLOC avoiding psychiatric hospitalization in a DSHS Purchased Inpatient Bed after authorization into a FLOC.

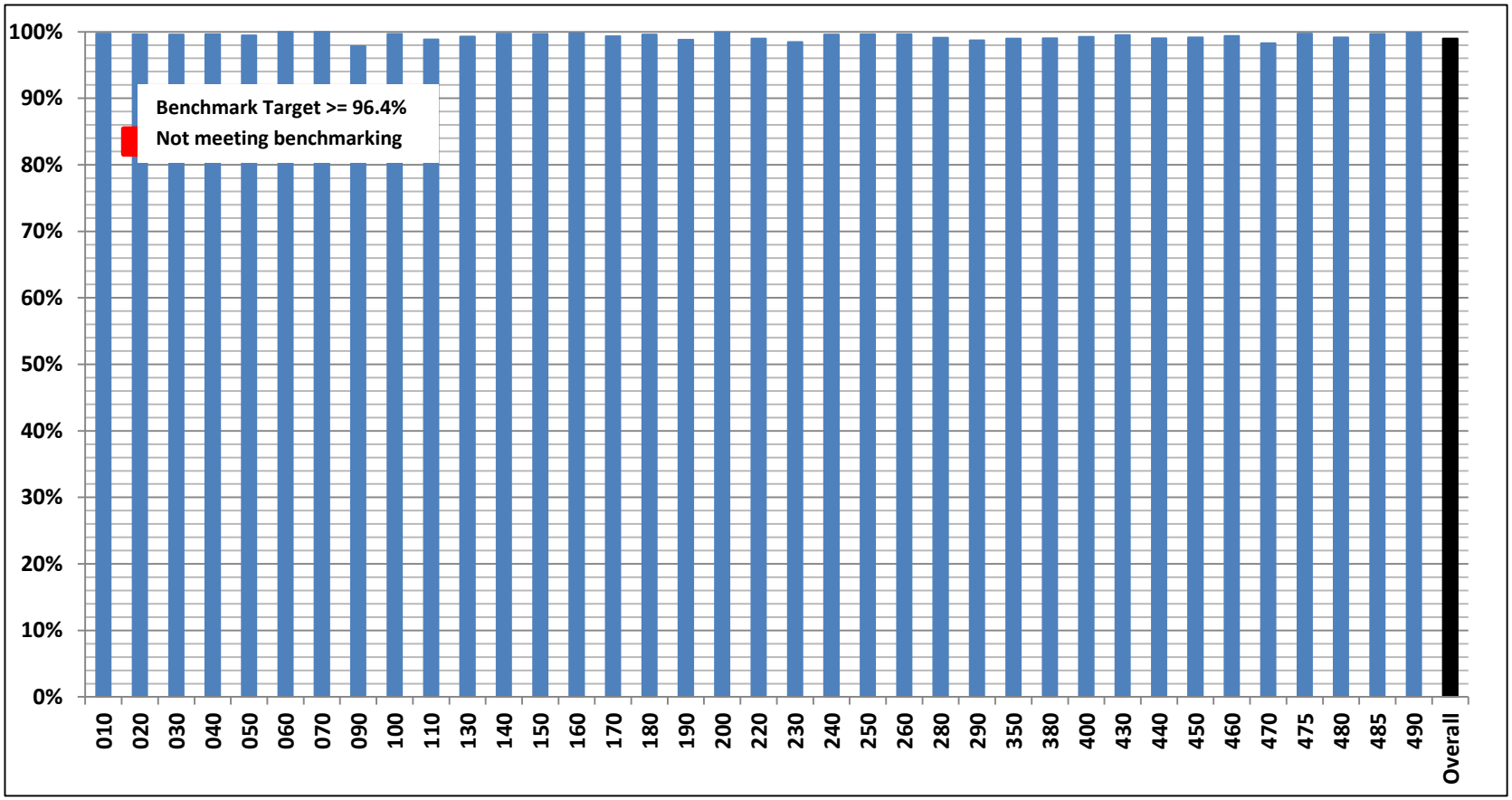
Variation across LMHAs

Performance level (%) for the overall NOM5 (n=37)									
	Mean	**SD**	**Min**	**Max**	**IQT***	**25th**	**50th**	**75th**	**# LMHAs not meeting benchmarking**
QT115	100	0.4	99	100	1	99	100	100	
QT215	100	0.4	99	100	1	99	100	100	
1st Half FY 2016	**99**	**1**	**98**	**100**	**1**	**99**	**99**	**100**	**0**
QT315	99	1	98	100	1	99	99	99	
QT415	99	1	97	100	1	99	99	100	
2nd Half FY 2015	**99**	**1**	**96**	**100**	**1**	**99**	**99**	**99**	**0**
QT116	99	1	98	100	1	99	99	100	
QT216	99	1	97	100	1	99	99	100	
1st Half FY 2016	**99**	**1**	**96**	**100**	**1**	**98**	**99**	**99**	**0**

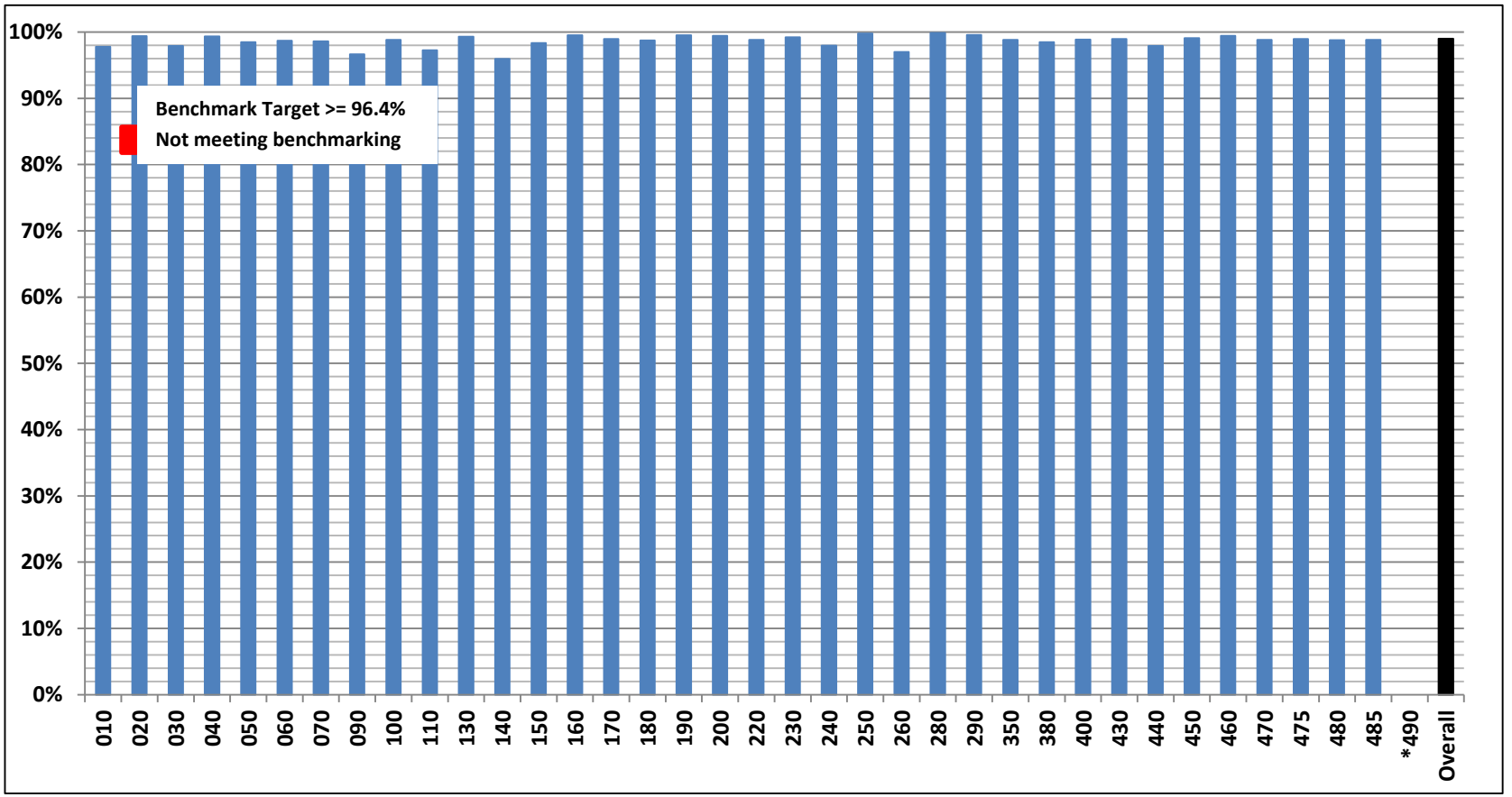
***IQT=Interquartile range**

Variation between LMHAs

NOM5 Community Tenure Child and Youth Performance Level between LMHAs for 1st Half FY 2015

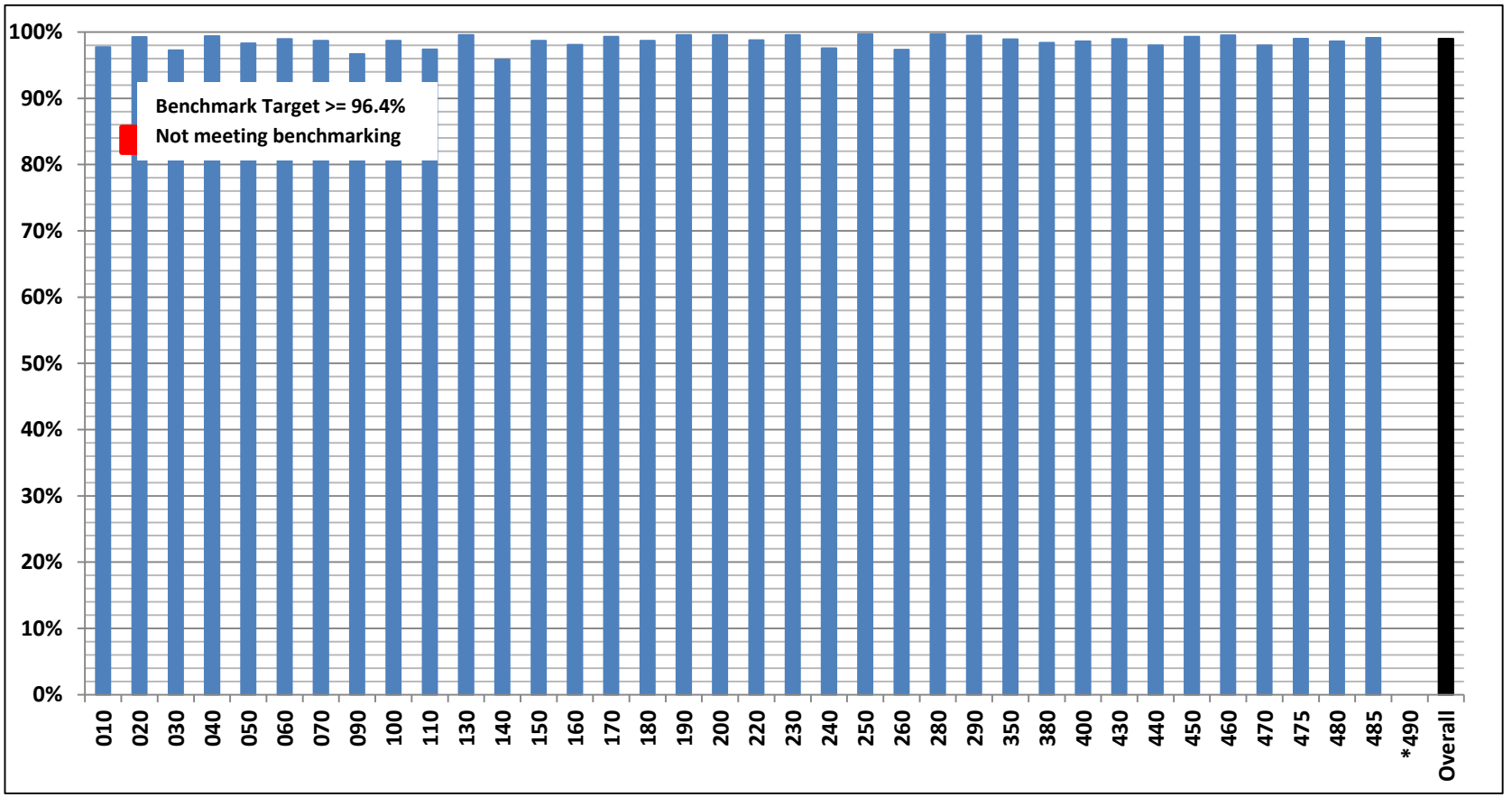


NOM5 Community Tenure Child and Youth Performance Level between LMHAs for 2nd Half FY 2015



* Data was not available.

NOM5 Community Tenure Child and Youth Performance Level between LMHAs for 1st Half FY 2016



* Data was not available.

NOM6: Effective Crisis Response

The performance level for NOM6 represents the percent of persons receiving crisis services who avoid admission to a DSHS Purchased Inpatient Bed within 30 days of the start of the crisis episode.

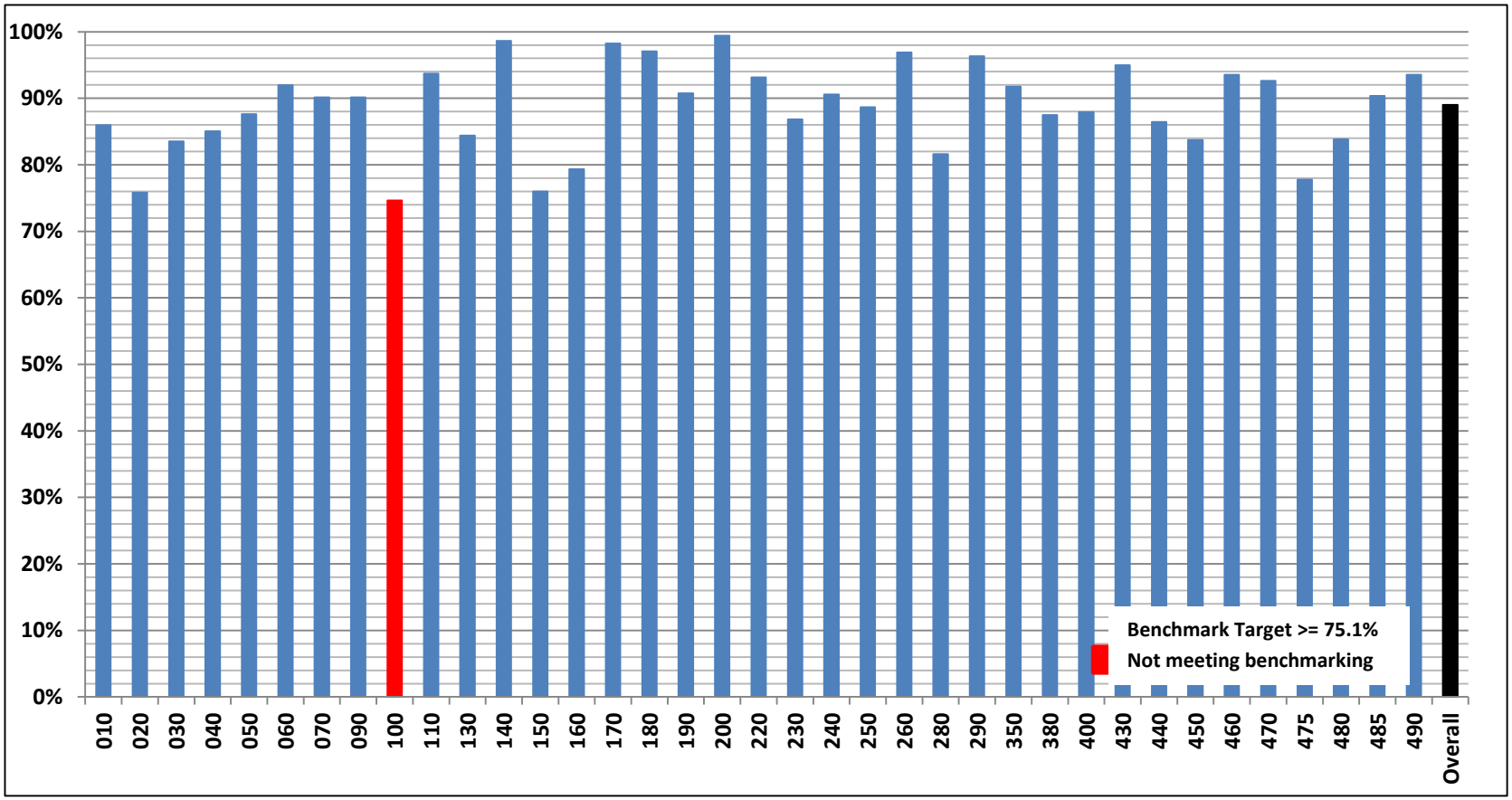
Variation across LMHAs

Performance level (%) for the overall NOM6 (n=37)									
	Mean	**SD**	**Min**	**Max**	**IQT***	**25th**	**50th**	**75th**	**# LMHAs not meeting benchmarking**
QT115	88	7	71	100	9	84	89	93	
QT215	89	7	77	99	11	84	90	94	
1st Half FY 2016	**89**	**7**	**75**	**99**	**9**	**84**	**90**	**94**	**1**
QT315	89	6	77	99	8	85	88	94	
QT415	90	6	75	99	8	86	91	94	
2nd Half FY 2015	**90**	**6**	**76**	**99**	**8**	**86**	**89**	**94**	**0**
QT116	89	6	76	99	10	85	89	95	
QT216	88	7	70	99	10	84	89	94	
1st Half FY 2016	**89**	**6**	**73**	**99**	**10**	**85**	**89**	**95**	**1**

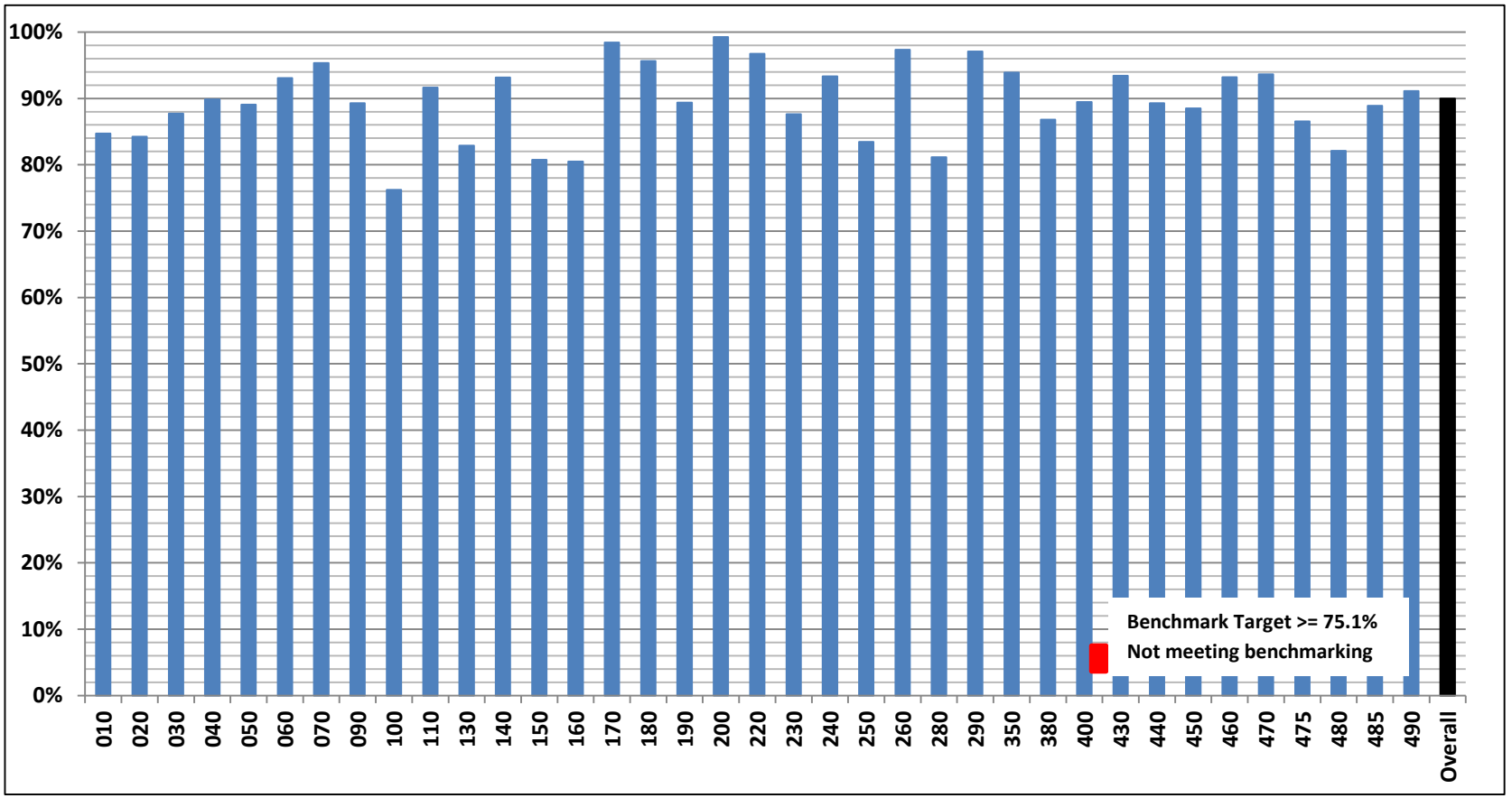
***IQT=Interquartile range**

Variation between LMHAs

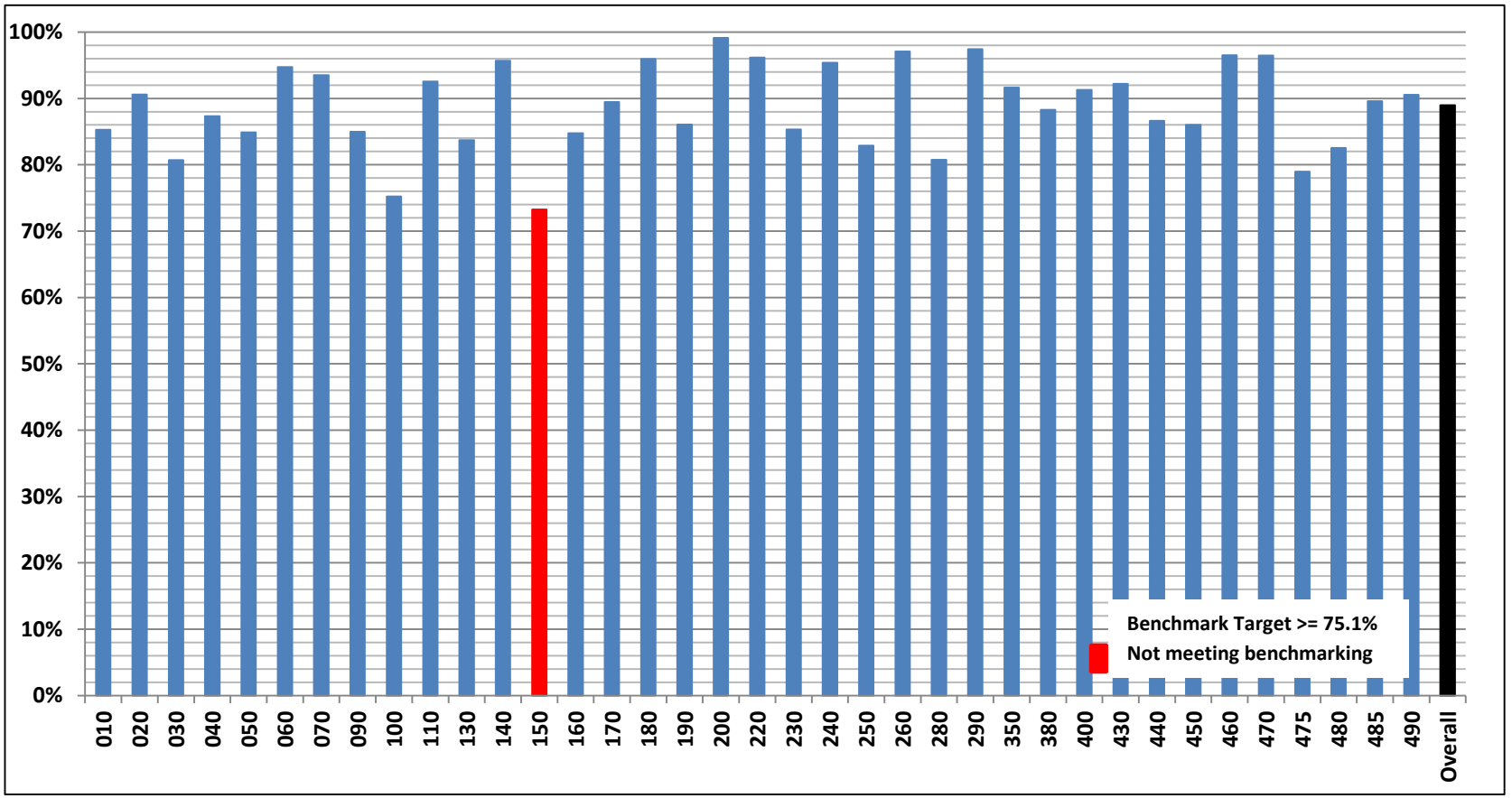
NOM6 Effective Crisis Response Performance Level between LMHAs for 1st Half FY 2015



NOM6 Effective Crisis Response Performance Level between LMHAs for 2nd Half FY 2015



NOM6 Effective Crisis Response Performance Level between LMHAs for 1st Half FY 2016



NOM7: Adult Monthly Service Provision

The performance level for NOM7 represents the percent of individuals authorized in a FLOC receiving at least one mental health hourly services per month.

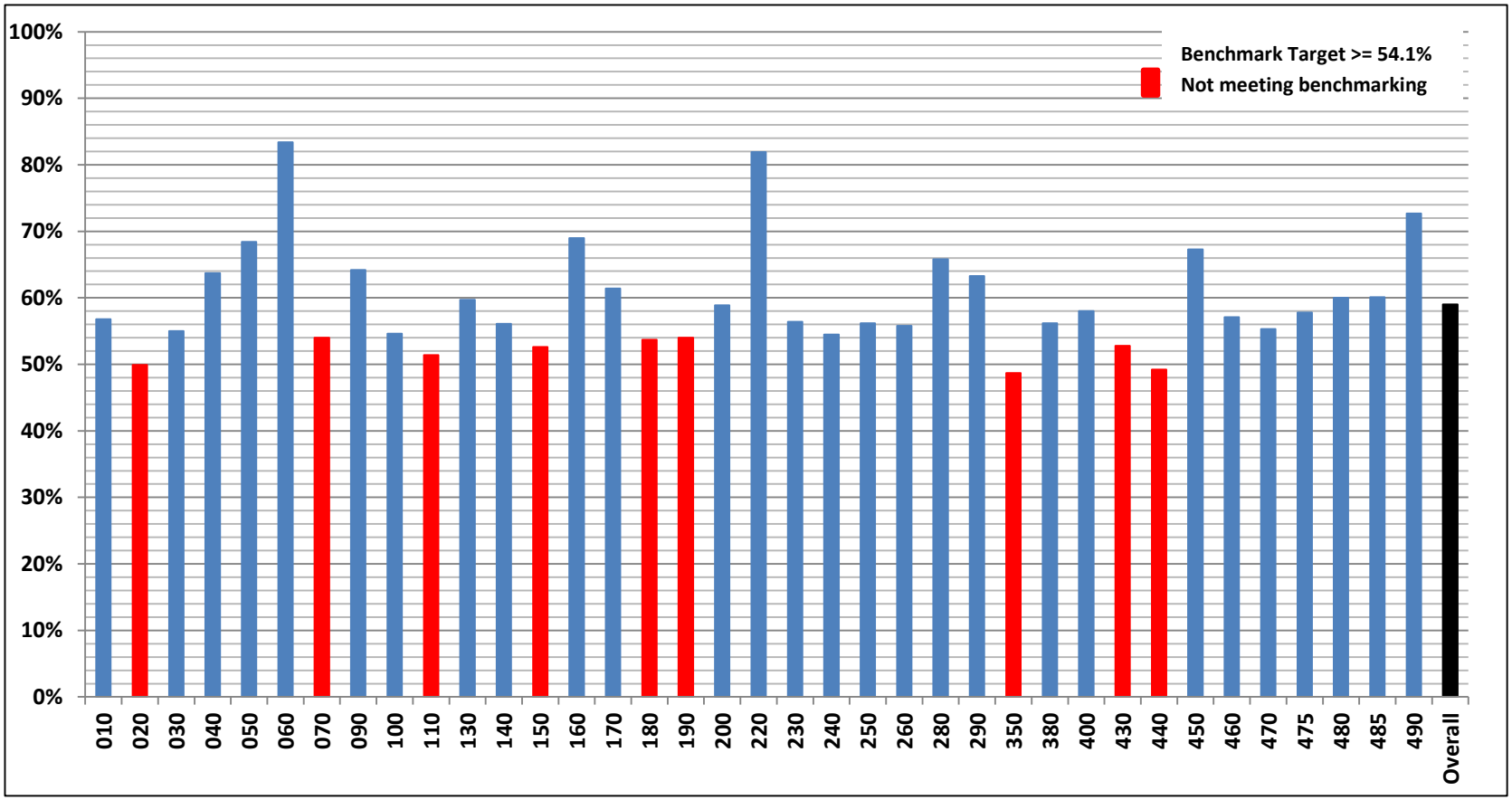
Variation across LMHAs

Performance level (%) for the overall NOM7 (n=37)									
	Mean	**SD**	**Min**	**Max**	**IQT***	**25th**	**50th**	**75th**	**# LMHAs not meeting benchmarking**
QT115	**59**	**8**	**46**	**84**	**9**	**54**	**58**	**62**	
092014	61	8	48	86	10	55	60	65	
102014	62	8	48	83	9	57	61	66	
112014	55	9	41	84	11	49	55	60	
QT215	**59**	**8**	**49**	**83**	**9**	**54**	**58**	**63**	
122014	59	9	46	83	10	53	57	63	
012015	61	8	48	86	10	55	58	66	
022015	59	9	47	82	10	53	57	63	
1st Half FY 2015	**59**	**8**	**49**	**83**	**9**	**54**	**57**	**64**	**9**
QT315	**75**	**9**	**56**	**96**	**14**	**68**	**74**	**82**	
032015	76	8	58	96	13	70	76	83	
042015	75	89	56	97	13	68	74	82	
052015	73	11	51	96	15	65	73	80	
QT415	**75**	**9**	**59**	**98**	**12**	**68**	**74**	**81**	
062015	75	9	54	97	14	68	76	81	
072015	75	9	54	97	13	68	76	81	
082015	74	9	52	98	11	69	74	80	
2nd Half FY 2015	**75**	**9**	**59**	**97**	**13**	**68**	**73**	**81**	**0**
QT116	**74**	**8**	**59**	**96**	**10**	**68**	**74**	**78**	
092015	75	8	60	95	8	70	74	78	
102015	75	8	59	97	10	69	77	79	
112015	73	8	54	96	12	66	72	78	
QT216	**75**	**7**	**55**	**96**	**8**	**71**	**75**	**79**	
122015	74	8	51	93	9	69	74	79	
012016	75	8	58	94	10	69	75	79	
022016	77	8	58	96	8	72	76	80	
1st Half FY 2016	**75**	**7**	**57**	**95**	**9**	**70**	**75**	**78**	**0**

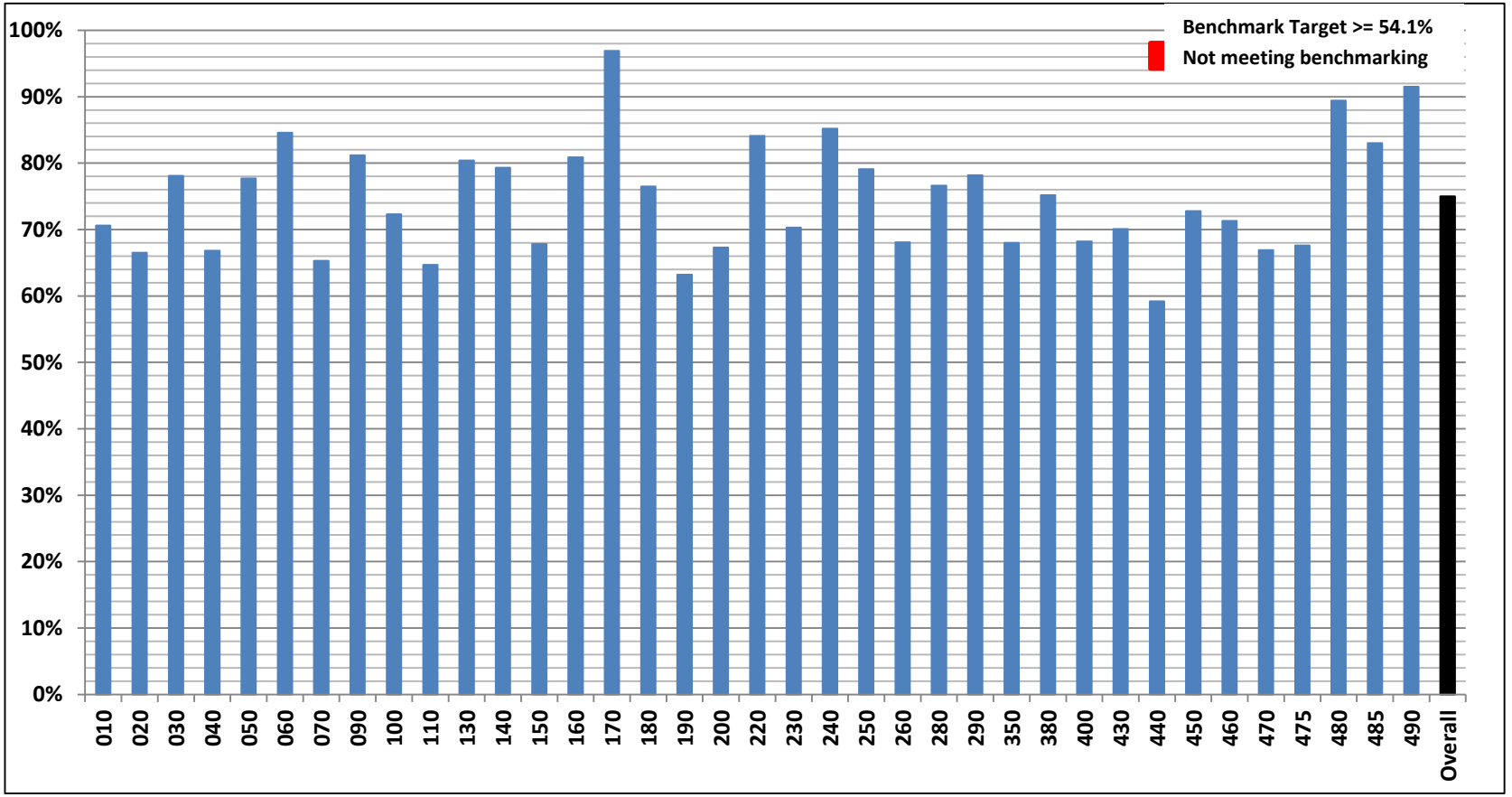
***IQT=Interquartile range**

Variation between LMHAs

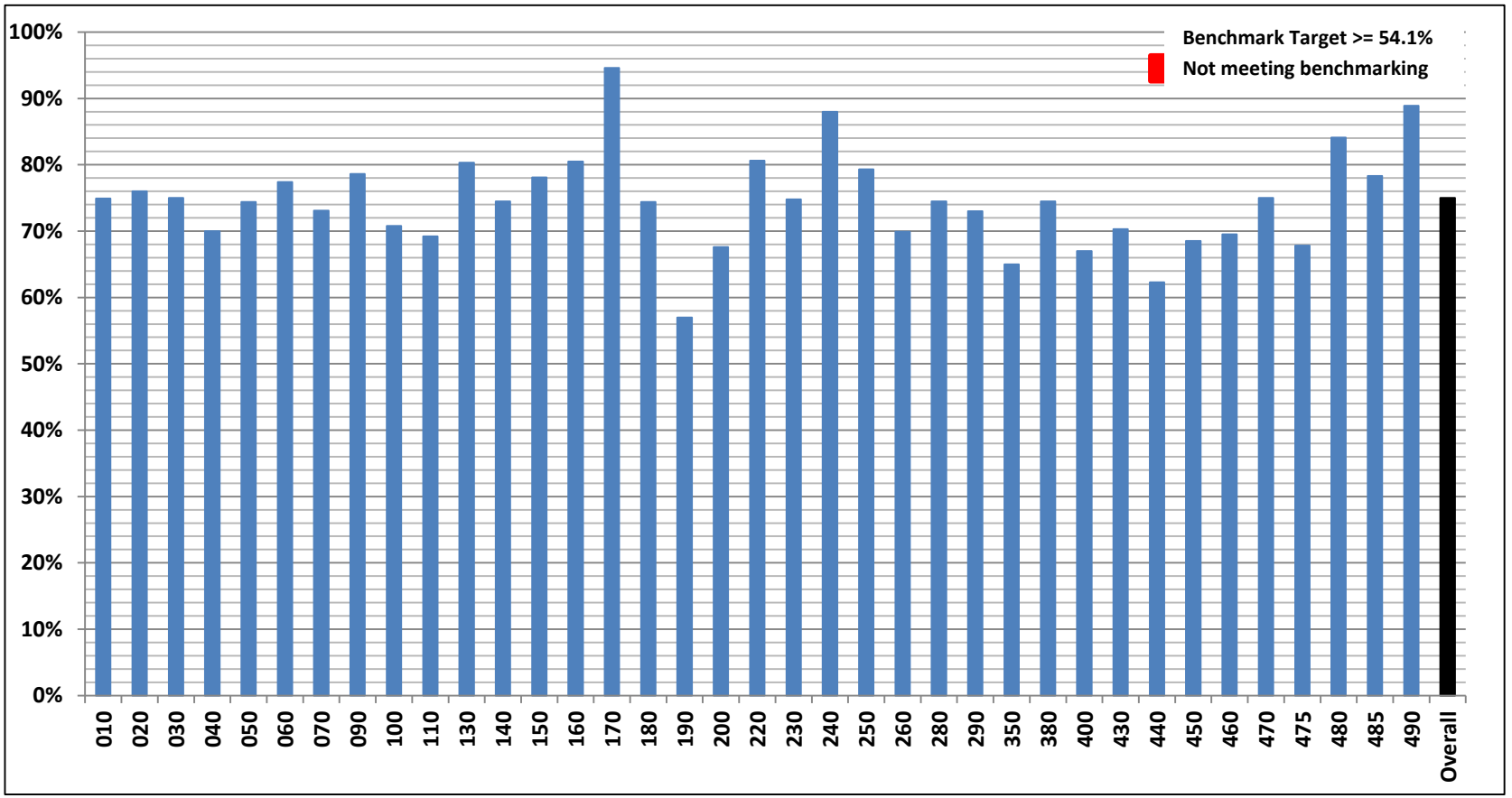
NOM7 Adult Monthly Service Provision Performance Level between LMHAs for 1st Half FY 2015



NOM7 Adult Monthly Service Provision Performance Level between LMHAs for 2nd Half FY 2015



NOM7 Adult Monthly Service Provision Performance Level between LMHAs for 1st Half FY 2016



NOM8: Children and Youth Monthly Service Provision

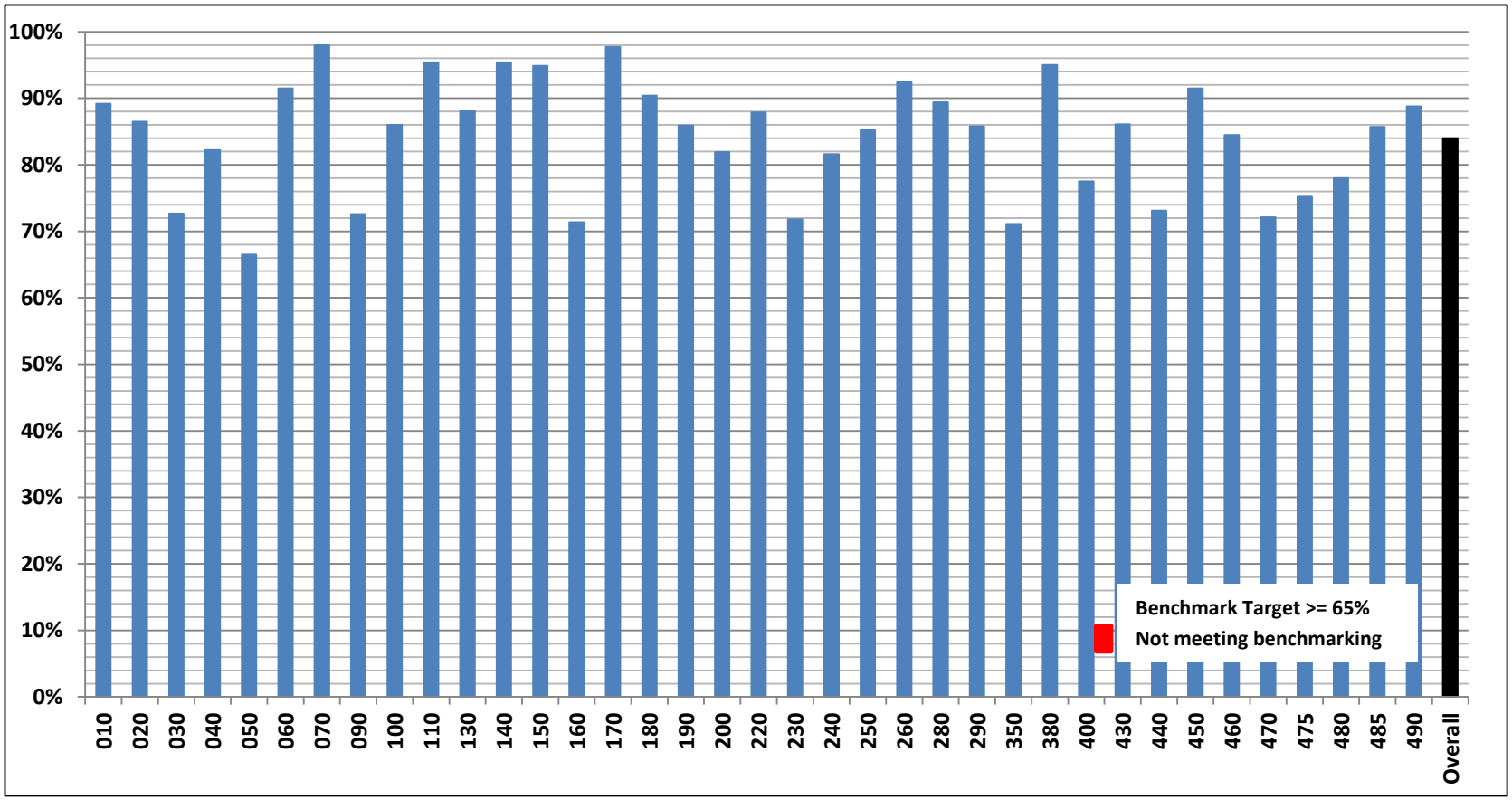
The performance level for NOM8 represents the percent of children and youth authorized in a FLOC receiving at least one mental health hourly services per month.

Performance level (%) for the overall NOM8 (n=37)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
QT115	**84**	**10**	**64**	**99**	**16**	**76**	**86**	**92**	
092014	85	10	61	99	14	78	87	92	
102014	83	10	63	100	18	77	88	94	
112014	82	10	56	99	16	73	82	89	
QT215	**84**	**8**	**68**	**98**	**14**	**78**	**86**	**91**	
122014	84	8	66	97	13	79	85	92	
012015	85	9	67	99	12	79	87	91	
022015	84	10	64	100	17	75	85	92	
1st Half FY 2015	**84**	**9**	**67**	**98**	**15**	**76**	**86**	**91**	**0**
QT315	**84**	**8**	**68**	**99**	**13**	**77**	**84**	**90**	
032015	85	9	67	100	14	78	87	91	
042015	85	8	70	100	13	78	85	91	
052015	82	9	67	99	16	74	82	91	
QT415	**76**	**8**	**62**	**96**	**12**	**73**	**78**	**84**	
062015	79	10	47	95	16	72	77	88	
072015	77	10	51	96	11	71	78	82	
082015	81	8	65	97	13	74	80	88	
2nd Half FY 2015	**81**	**8**	**65**	**98**	**11**	**76**	**80**	**87**	**0**
QT116	**74**	**8**	**59**	**96**	**10**	**68**	**74**	**78**	
092015	75	8	60	95	8	70	74	78	
102015	75	8	59	97	10	69	77	79	
112015	73	8	54	96	12	66	72	78	
QT216	**75**	**7**	**55**	**93**	**8**	**71**	**75**	**79**	
122015	74	8	51	93	9	69	74	79	
012016	75	8	58	94	10	69	75	79	
022016	77	8	58	93	8	72	77	80	
1st Half FY 2016	**75**	**7**	**57**	**95**	**9**	**70**	**74**	**78**	**2**

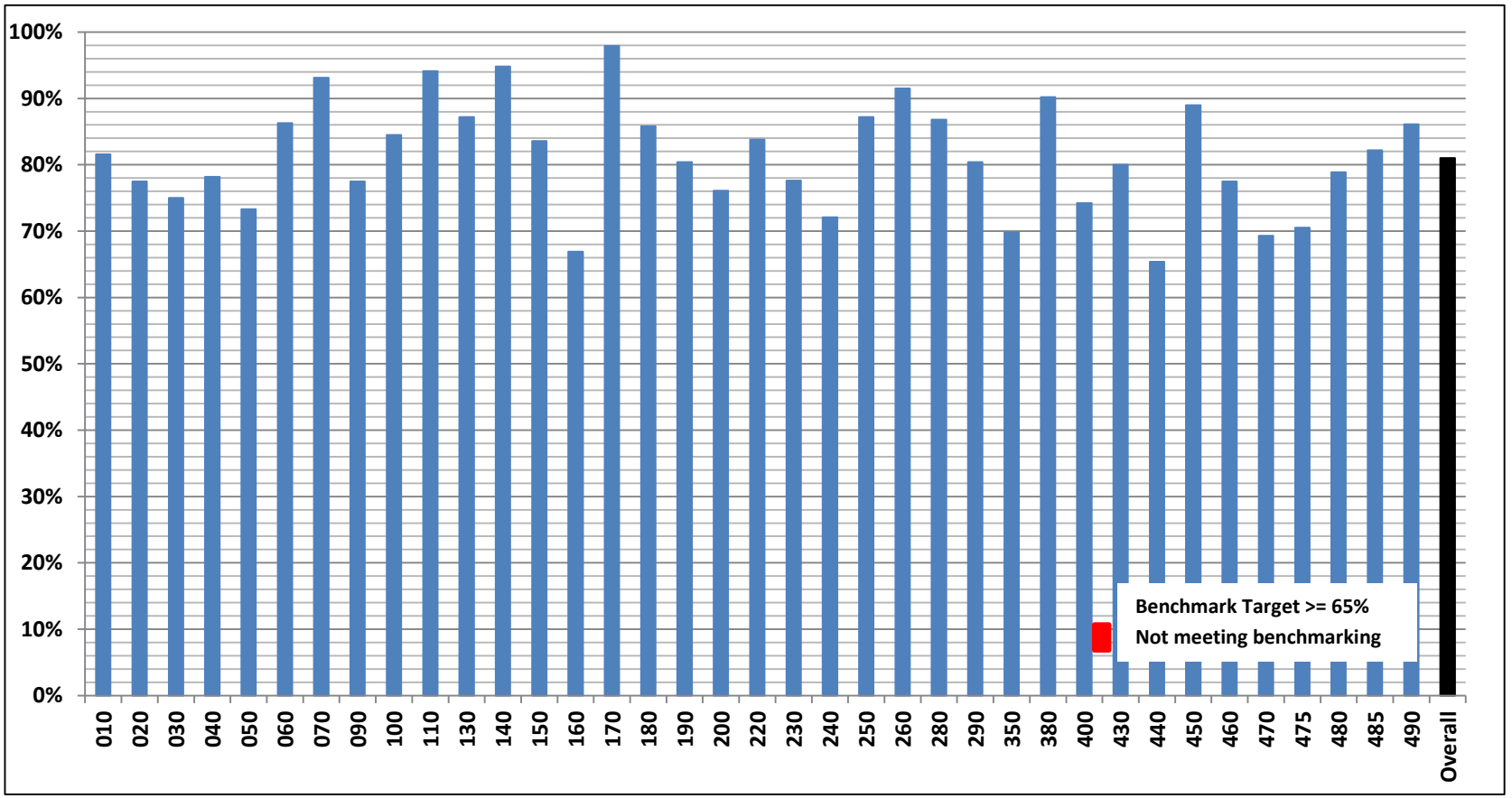
***IQT=Interquartile range**

Variation between LMHAs

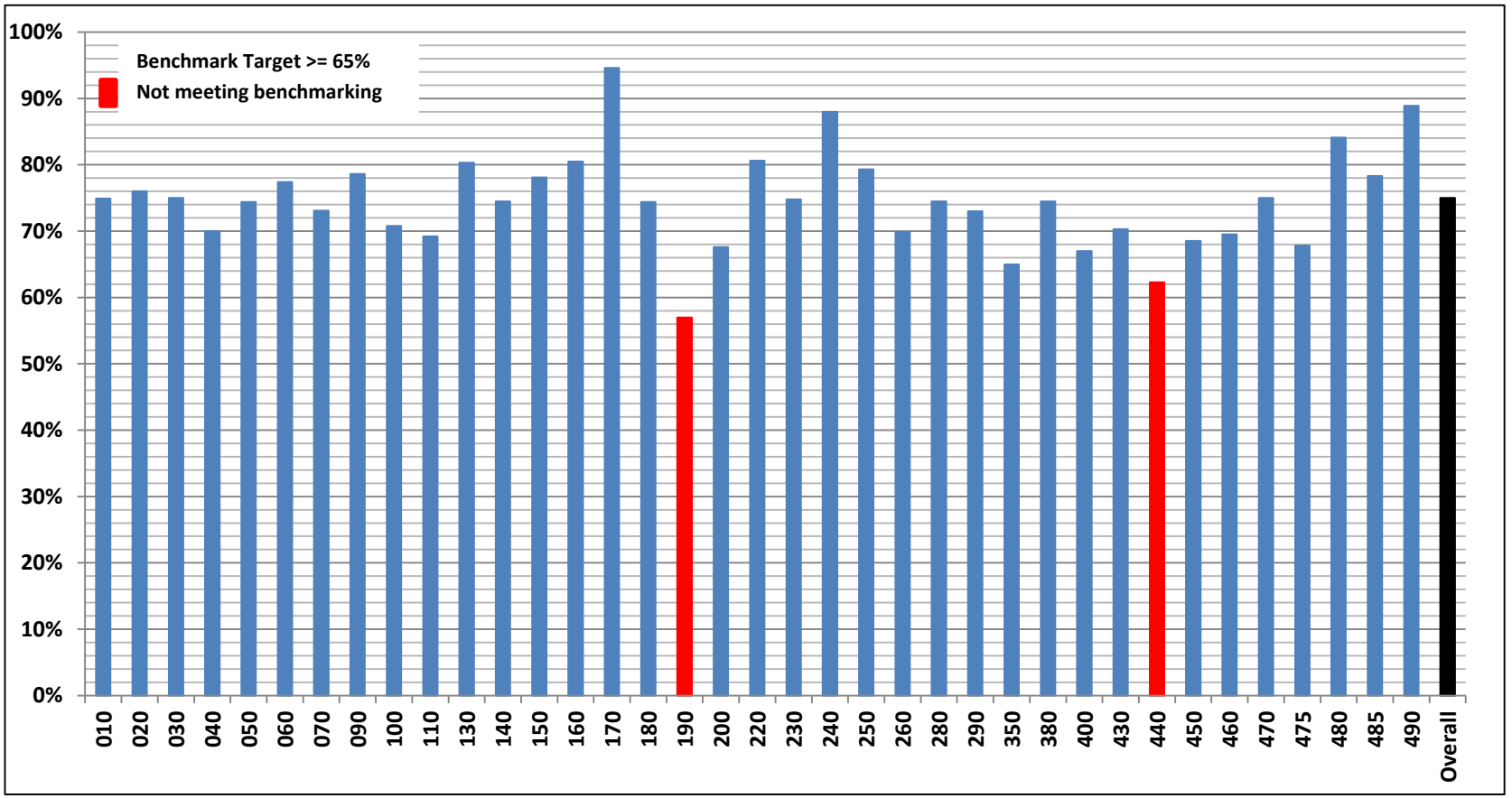
NOM8 Children and Youth Monthly Service Provision Performance Level between LMHAs for 1st Half FY 2015



NOM8 Children and Youth Monthly Service Provision Performance Level between LMHAs for 2nd Half FY 2015



NOM8 Children and Youth Monthly Service Provision Performance Level between LMHAs for 1st Half FY 2016



NOM9: Hospitalization

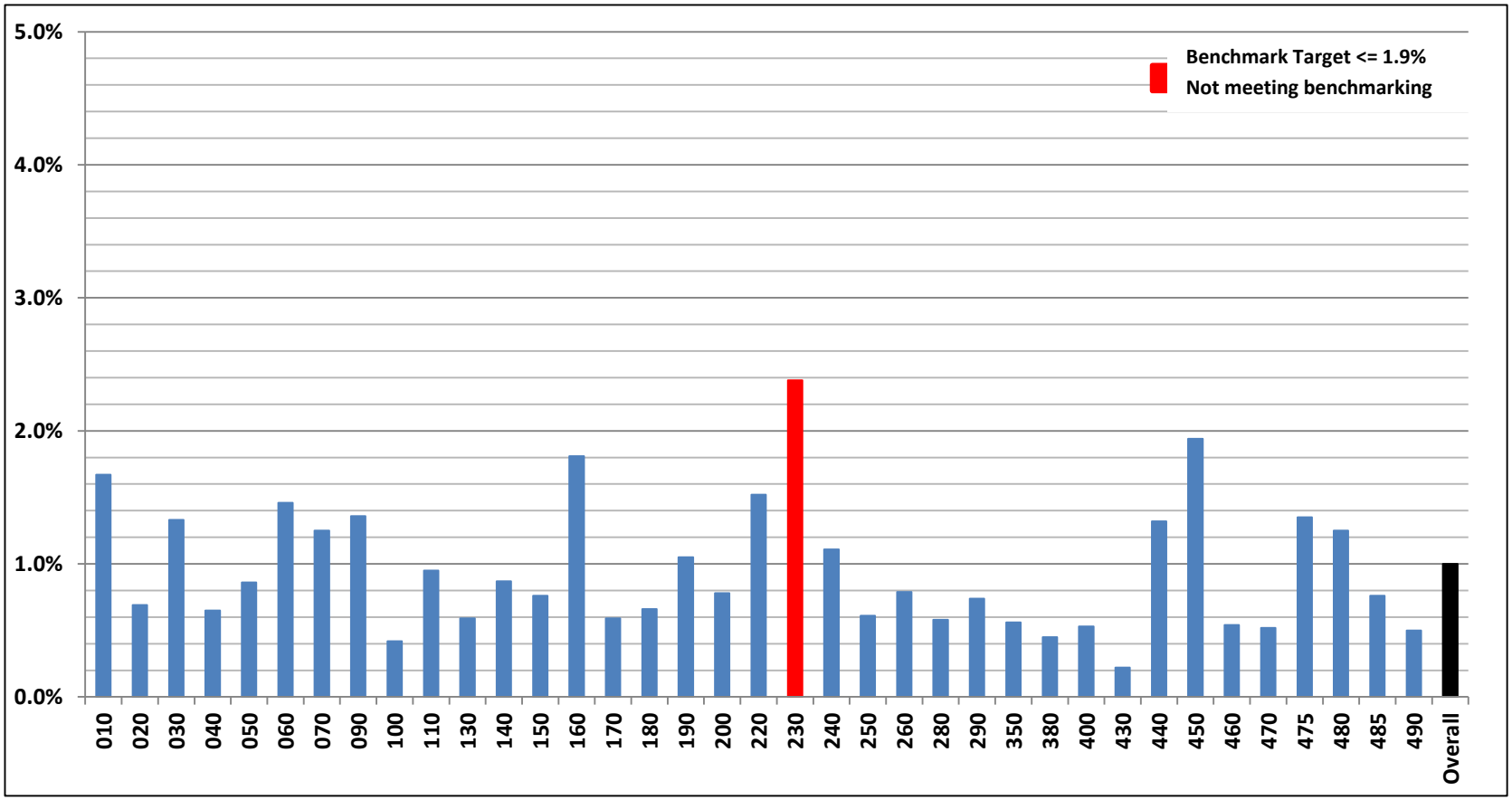
The performance level for NOM9 represents the equity-adjusted rate of DSHS Purchased Inpatient bed Days in the population.

Performance level (%) for the overall NOM9 (n=37)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
QT115	**0.5**	**0.2**	**0.1**	**1.1**	**0.4**	**0.3**	**0.4**	**0.6**	
092014	0.2	0.1	0.0	0.4	0.1	0.1	0.1	0.2	
102014	0.2	0.1	0.0	0.4	0.1	0.1	0.1	0.2	
112014	0.2	0.1	0.0	0.4	0.1	0.1	0.1	0.2	
QT215	**0.5**	**0.3**	**0.1**	**1.3**	**0.4**	**0.3**	**0.4**	**0.6**	
122014	0.2	0.1	0.0	0.4	0.1	0.1	0.1	0.2	
012015	0.2	0.1	0.0	0.5	0.1	0.1	0.1	0.2	
022015	0.2	0.1	0.0	0.4	0.1	0.1	0.1	0.2	
1st Half FY 2015	**1.0**	**0.5**	**0.2**	**2.4**	**0.7**	**0.6**	**0.8**	**1.3**	**1**
QT315	**0.5**	**0.2**	**0.1**	**1.1**	**0.4**	**0.3**	**0.4**	**06**	
032015	0.2	0.1	0.0	0.4	0.1	0.1	0.1	0.2	
042015	0.2	0.1	0.1	0.4	0.1	0.1	0.1	0.2	
052015	0.2	0.1	0.0	0.4	0.1	0.1	0.1	0.2	
QT415	**0.5**	**0.2**	**0.1**	**1.3**	**0.4**	**0.3**	**0.4**	**0.6**	
062015	0.2	0.1	0.0	0.4	0.1	0.1	0.1	0.2	
072015	0.2	0.1	0.0	0.4	0.1	0.1	0.1	0.2	
082015	0.2	0.1	0.0	0.4	0.1	0.1	0.1	0.2	
2nd Half FY 2015	**1.0**	**0.5**	**0.3**	**2.4**	**0.7**	**0.5**	**0.8**	**1.2**	**1**
QT116	**0.5**	**0.3**	**1.4**	**1.3**	**0.4**	**0.3**	**0.4**	**0.7**	
092015	0.2	0.1	0.0	0.4	0.1	0.1	0.1	0.2	
102015	0.2	0.1	0.0	0.5	0.1	0.1	0.1	0.2	
112015	0.2	0.1	0.0	0.5	0.1	0.1	0.1	0.2	
QT216	**0.5**	**0.3**	**0.1**	**1.3**	**0.4**	**0.3**	**0.1**	**0.7**	
122015	0.2	0.1	0.0	0.5	0.1	0.1	0.1	0.2	
012016	0.2	0.1	0.0	0.5	0.1	0.1	0.1	0.2	
022016	0.2	0.1	0.0	0.4	0.1	0.1	0.1	0.2	
1st Half FY 2016	**1.0**	**0.5**	**0.2**	**2.8**	**0.8**	**0.6**	**0.8**	**1.4**	**1**

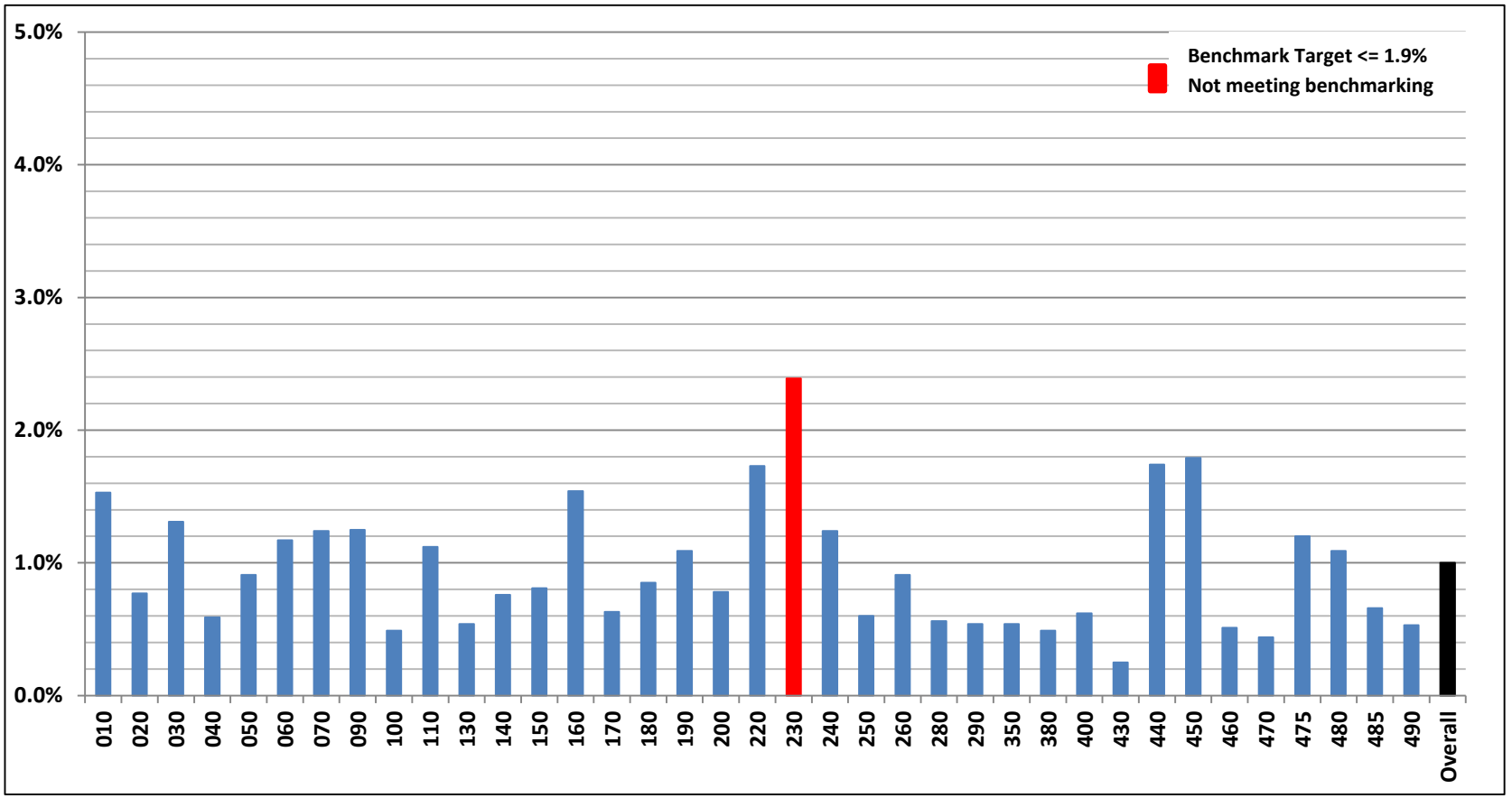
***IQT=Interquartile range**

Variation between LMHAs

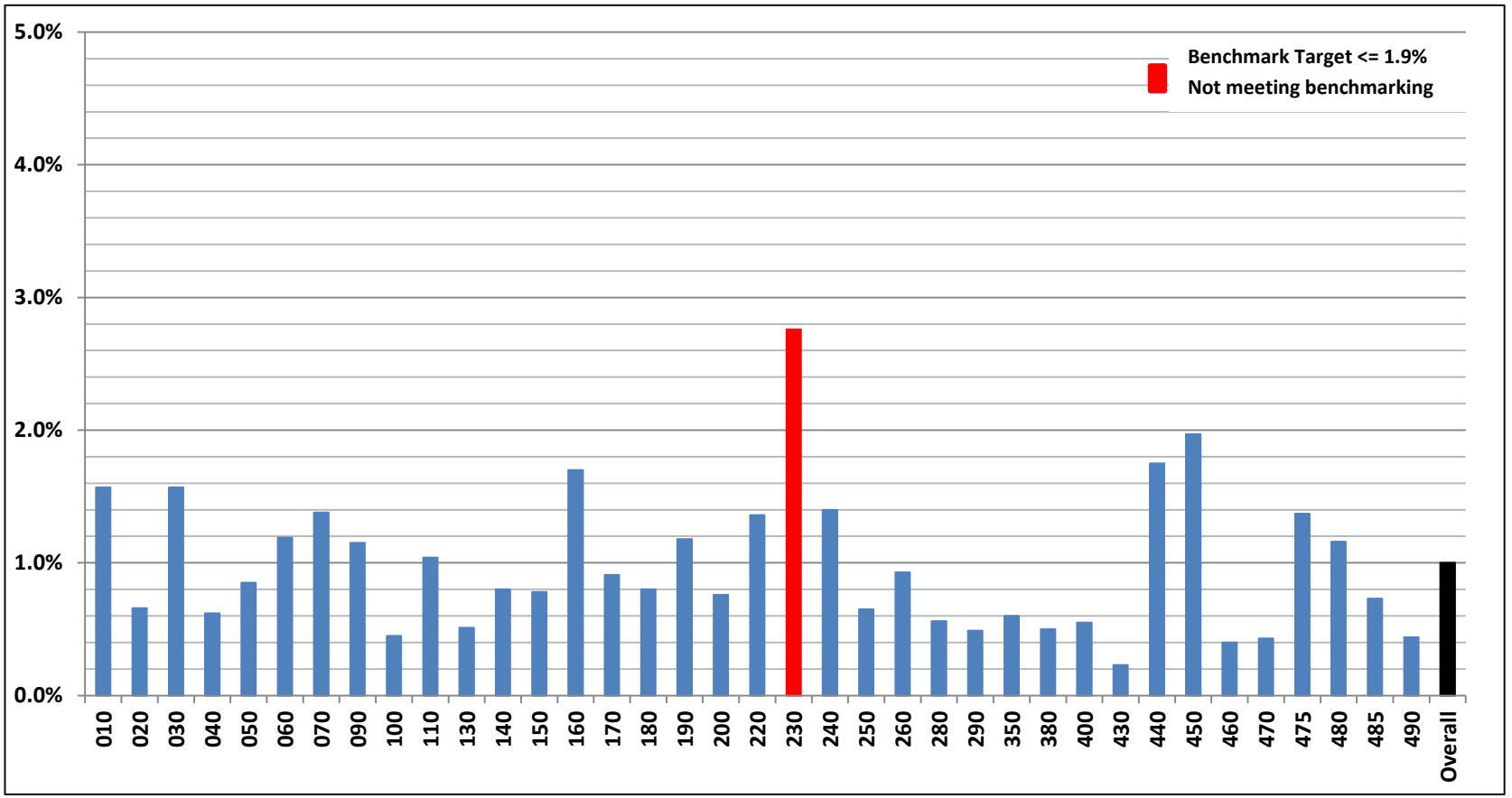
NOM9 Hospitalization Performance Level between LMHAs for 1st Half FY 2015



NOM9 Hospitalization Performance Level between LMHAs for 2nd Half FY 2015



NOM9 Hospitalization Performance Level between LMHAs for 1st Half FY 2016



NOM10: Adult Jail Diversion

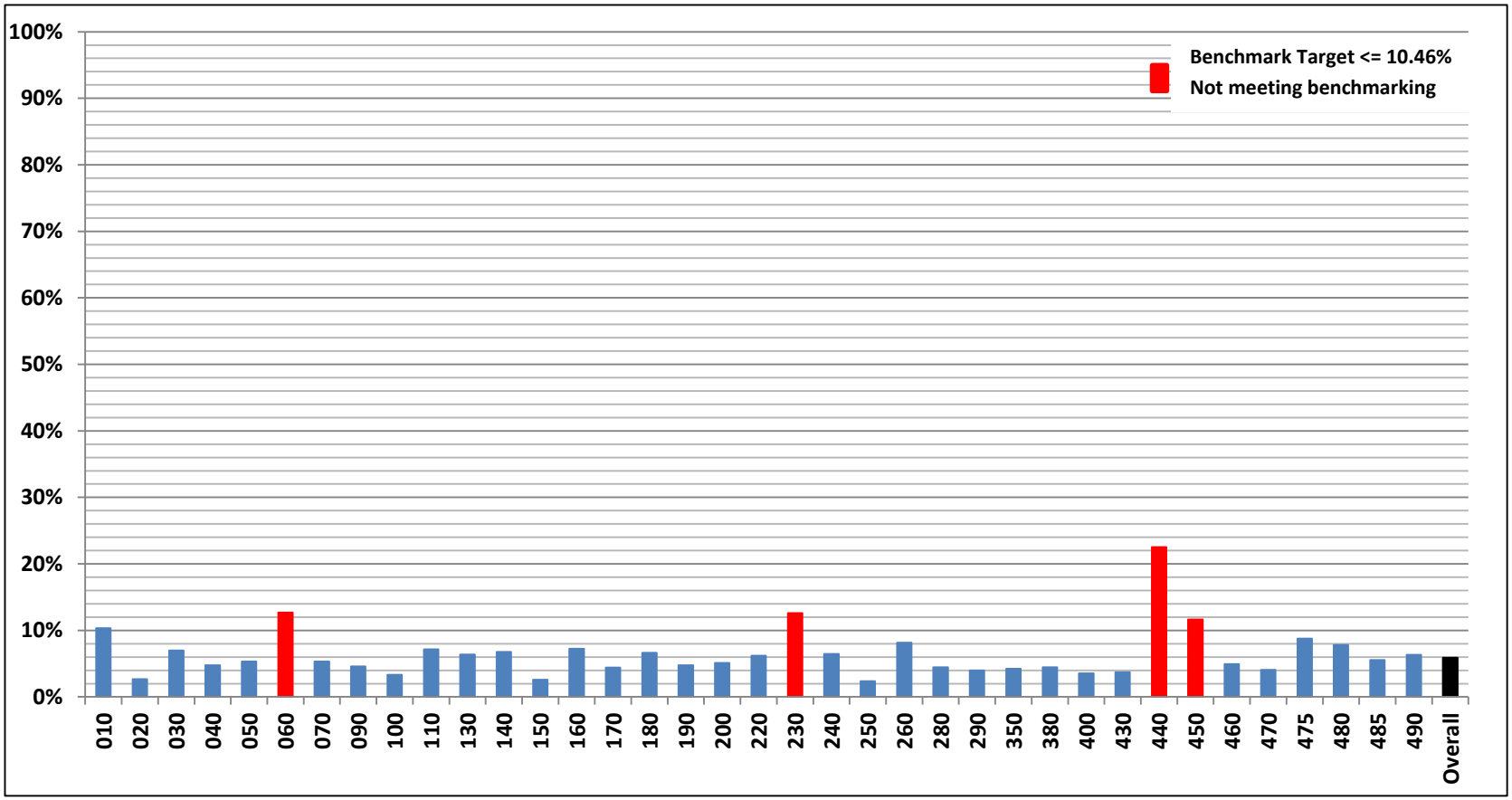
The performance level for NOM10 represents the equity-adjusted number of valid TLETS bookings in the local service area with a CARE match divided by the number of valid TLETS bookings in the local service area.

Performance level (%) for the overall PM (n=37)									
	Mean	**SD**	**Min**	**Max**	**IQT***	**25th**	**50th**	**75th**	**# LMHAs not meeting benchmarking**
QT115	**6**	**3**	**1**	**13**	**3**	**4**	**5**	**7**	
092014	6	3	1	13	3	4	5	7	
102014	6	3	1	15	3	4	5	7	
112014	6	3	1	15	3	4	5	7	
QT215	**6**	**3**	**2**	**14**	**3**	**5**	**6**	**7**	
122014	6	2	3	13	3	4	6	7	
012015	6	3	2	15	3	4	6	7	
022015	6	3	1	15	3	4	6	7	
1st Half FY 2015	**6**	**3**	**2**	**13**	**3**	**4**	**5**	**7**	**4**
QT315	**7**	**3**	**3**	**15**	**3**	**5**	**6**	**8**	
032015	7	3	3	18	4	4	6	8	
042015	7	3	3	16	3	5	6	8	
052015	7	3	2	13	4	5	7	8	
QT415	**7**	**3**	**3**	**13**	**4**	**5**	**7**	**9**	
062015	7	3	3	14	3	5	7	8	
072015	8	4	3	18	4	5	7	9	
082015	8	3	3	17	4	5	7	9	
2nd Half FY 2015	**7**	**3**	**3**	**15**	**3**	**5**	**7**	**8**	**6**
QT116	**6**	**3**	**3**	**15**	**4**	**4**	**6**	**8**	
092015	6	3	2	15	4	4	6	8	
102015	6	3	2	14	4	4	5	8	
112015	6	3	3	18	4	4	5	8	
QT216	**7**	**3**	**3**	**16**	**4**	**4**	**6**	**8**	
122015	7	4	3	21	4	5	6	8	
012016	6	3	3	15	4	4	6	8	
022016	7	3	3	16	4	4	6	9	
1st Half FY 2016	**7**	**3**	**3**	**16**	**4**	**4**	**6**	**8**	**5**

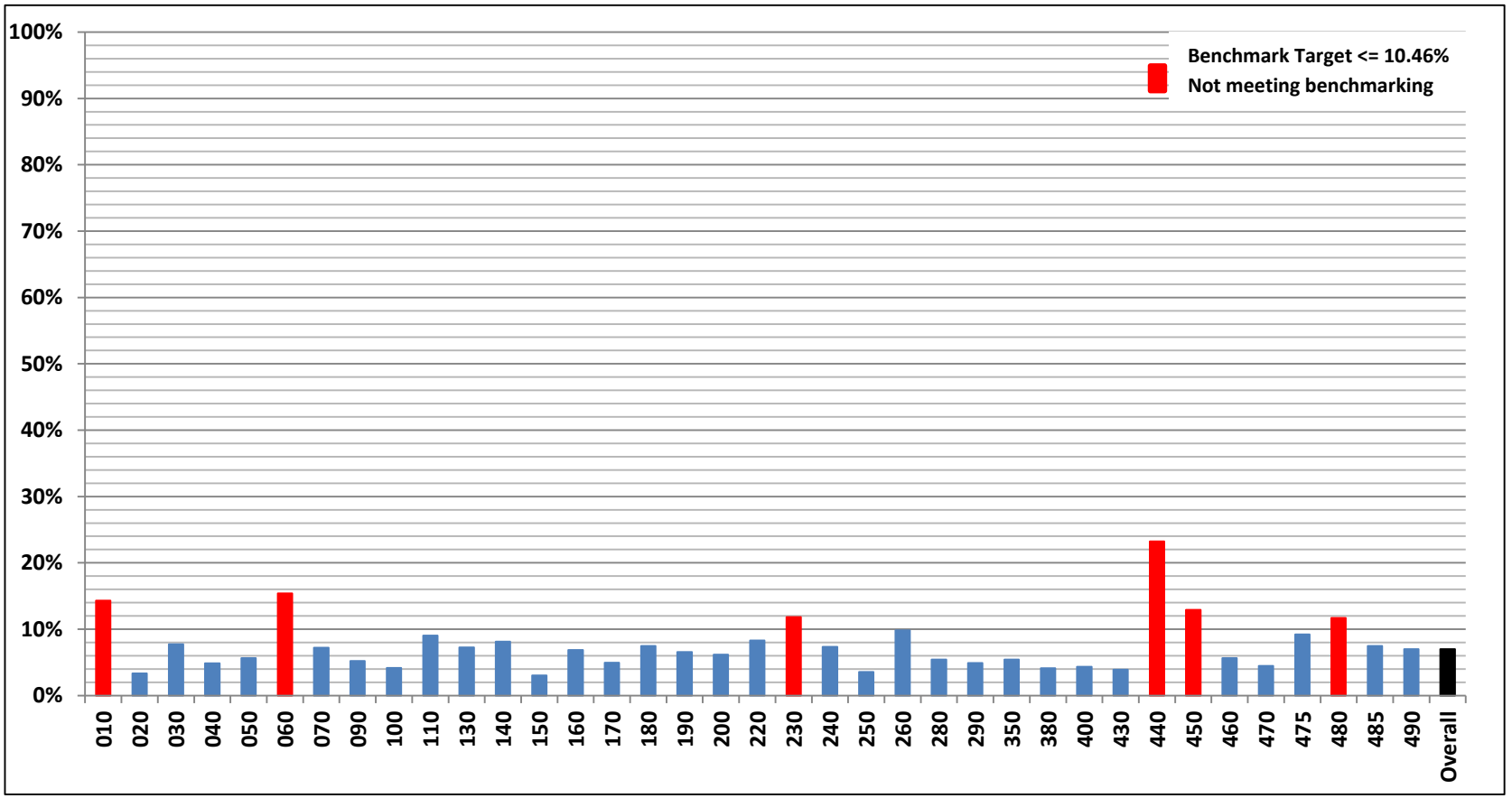
***IQT=Interquartile range**

Variation between LMHAs

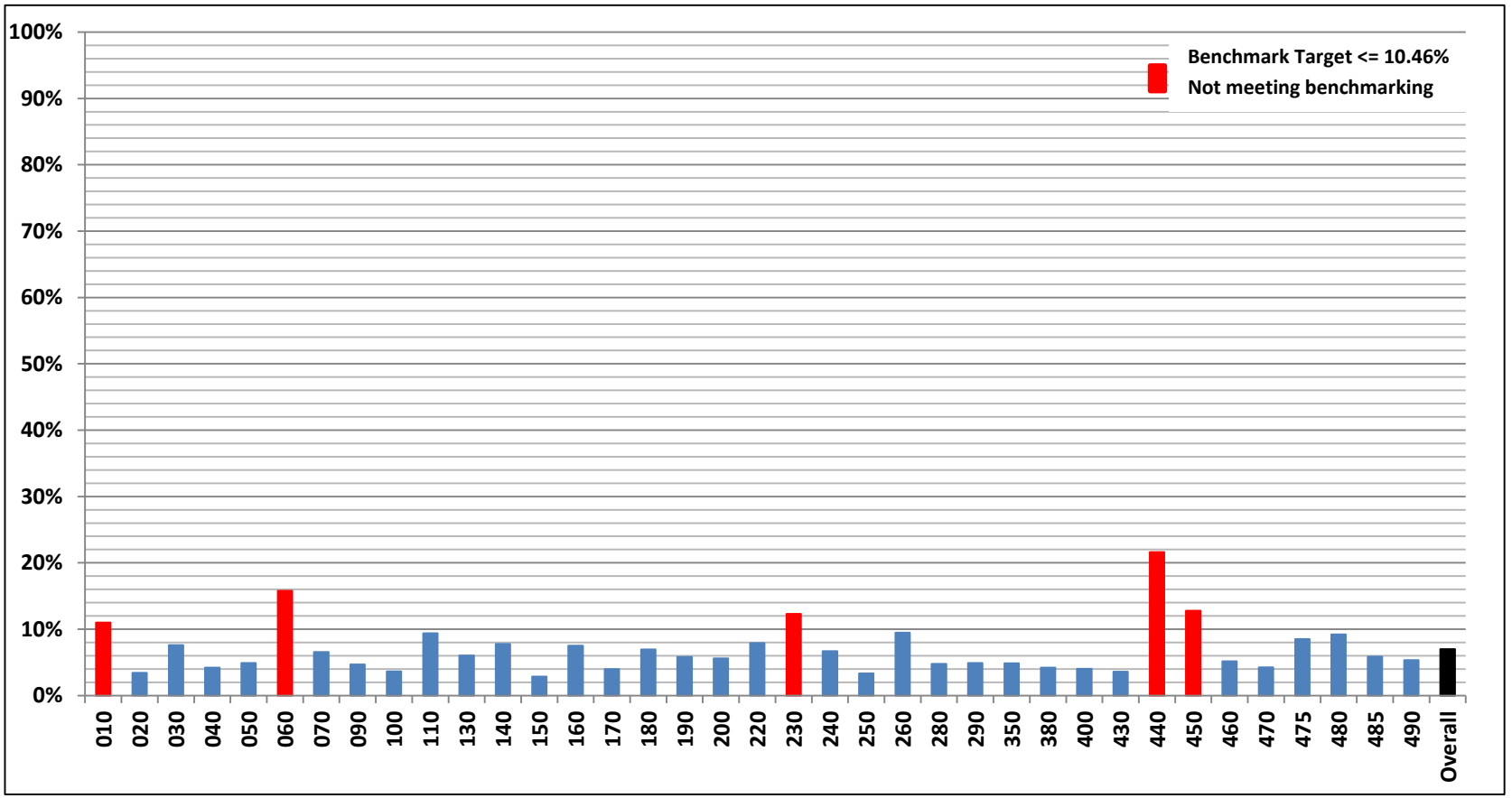
NOM10 Adult Jail Diversion Performance Level between LMHAs for 1st Half FY 2015



NOM10 Adult Jail Diversion Performance Level between LMHAs for 2nd Half FY 2015



NOM10 Adult Jail Diversion Performance Level between LMHAs for 1st Half FY 2016



NOM11: Juvenile Justice Avoidance

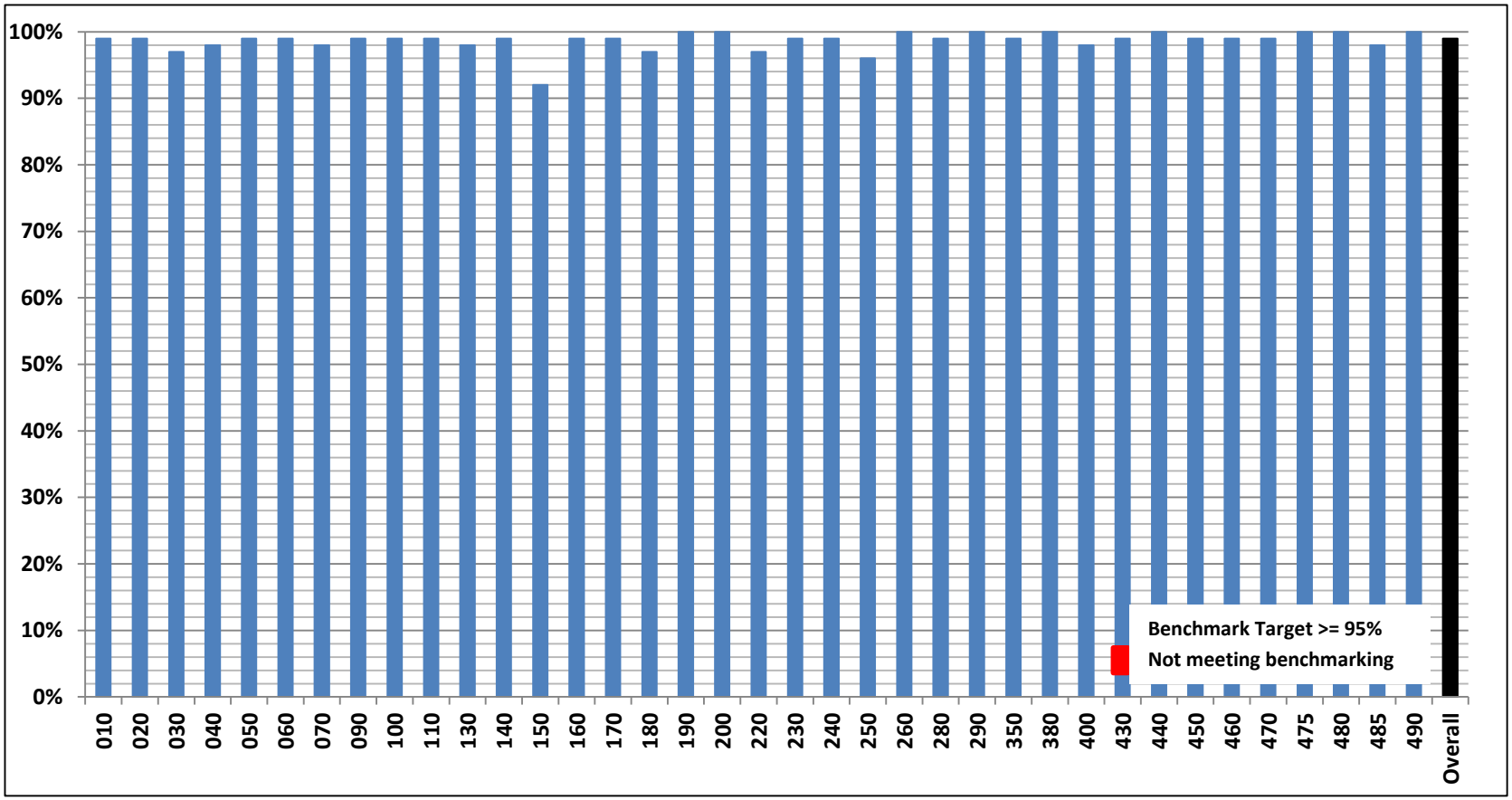
The performance level for NOM11 represents the percent of children/youth enrolled in a FLOC showing no arrests (acceptable) or a reduction of arrests (improving) from time of first assessment to time of last assessment within the measurement period (with assessments occurring at least 90 days apart).

Performance level (%) for the overall NOM11 (n=37)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	99	1	92	100	1	98	99	99	0
2nd Half FY 2015	99	1	94	100	1	98	99	99	0
1st Half FY 2016	99	1	97	100	1	99	99	100	0

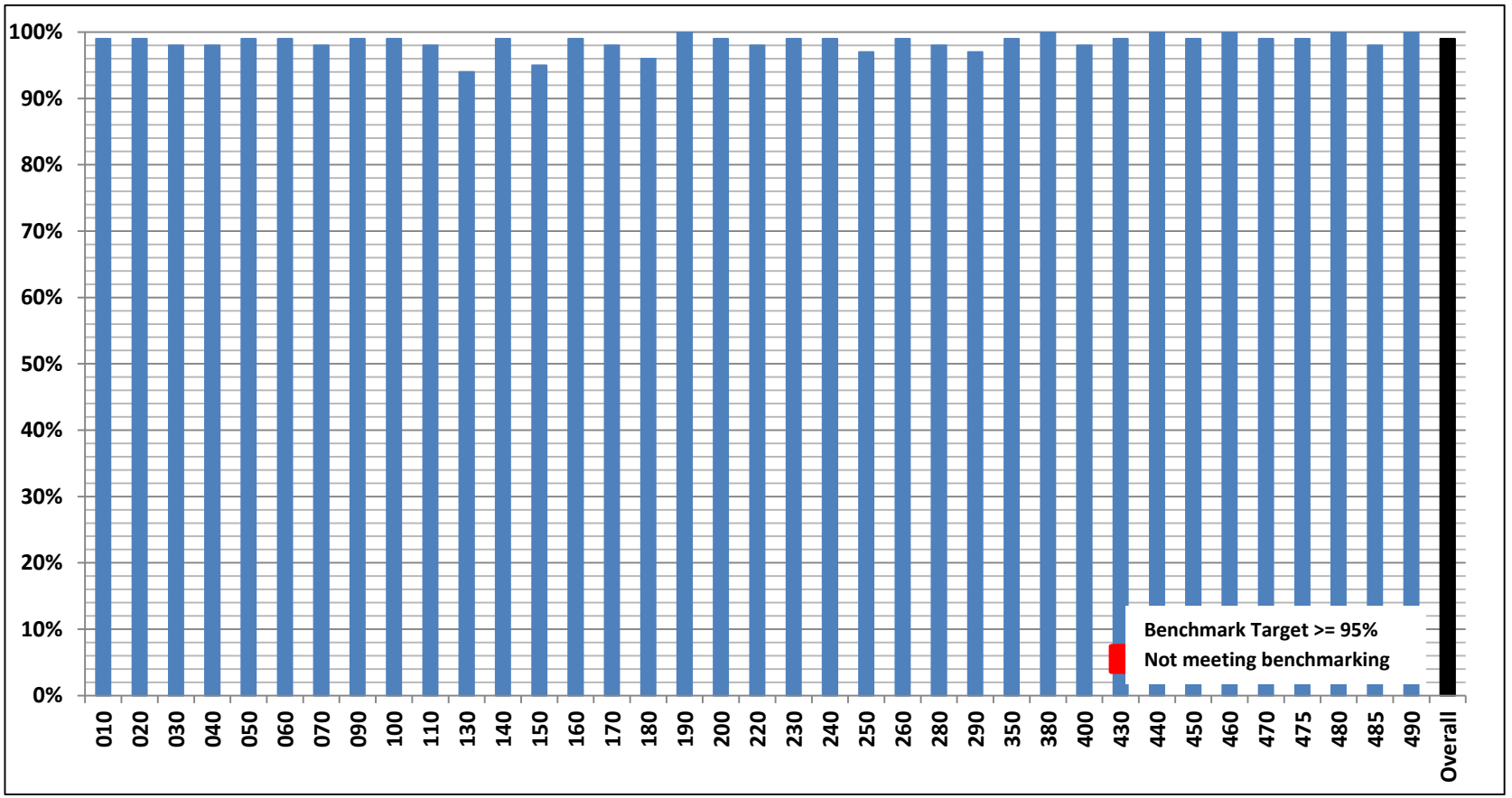
*IQT=Interquartile range

Variation between LMHAs

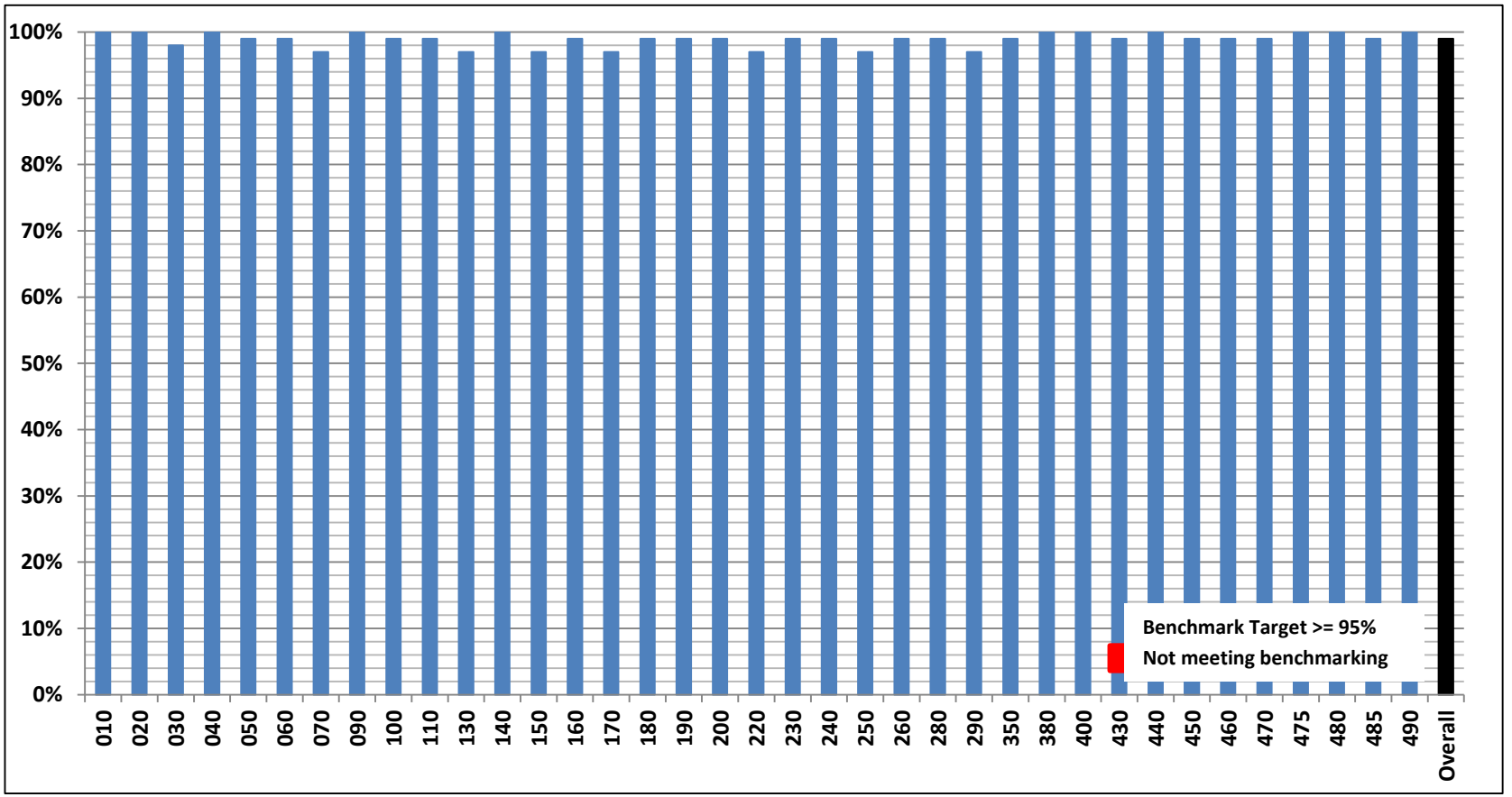
NOM11 Juvenile Justice Avoidance Performance Level between LMHAs for 1st Half FY 2015



NOM11 Juvenile Justice Avoidance Performance Level between LMHAs for 2nd Half FY 2015



NOM11 Juvenile Justice Avoidance Performance Level between LMHAs for 1st Half FY 2016



NOM12: Frequent Admissions

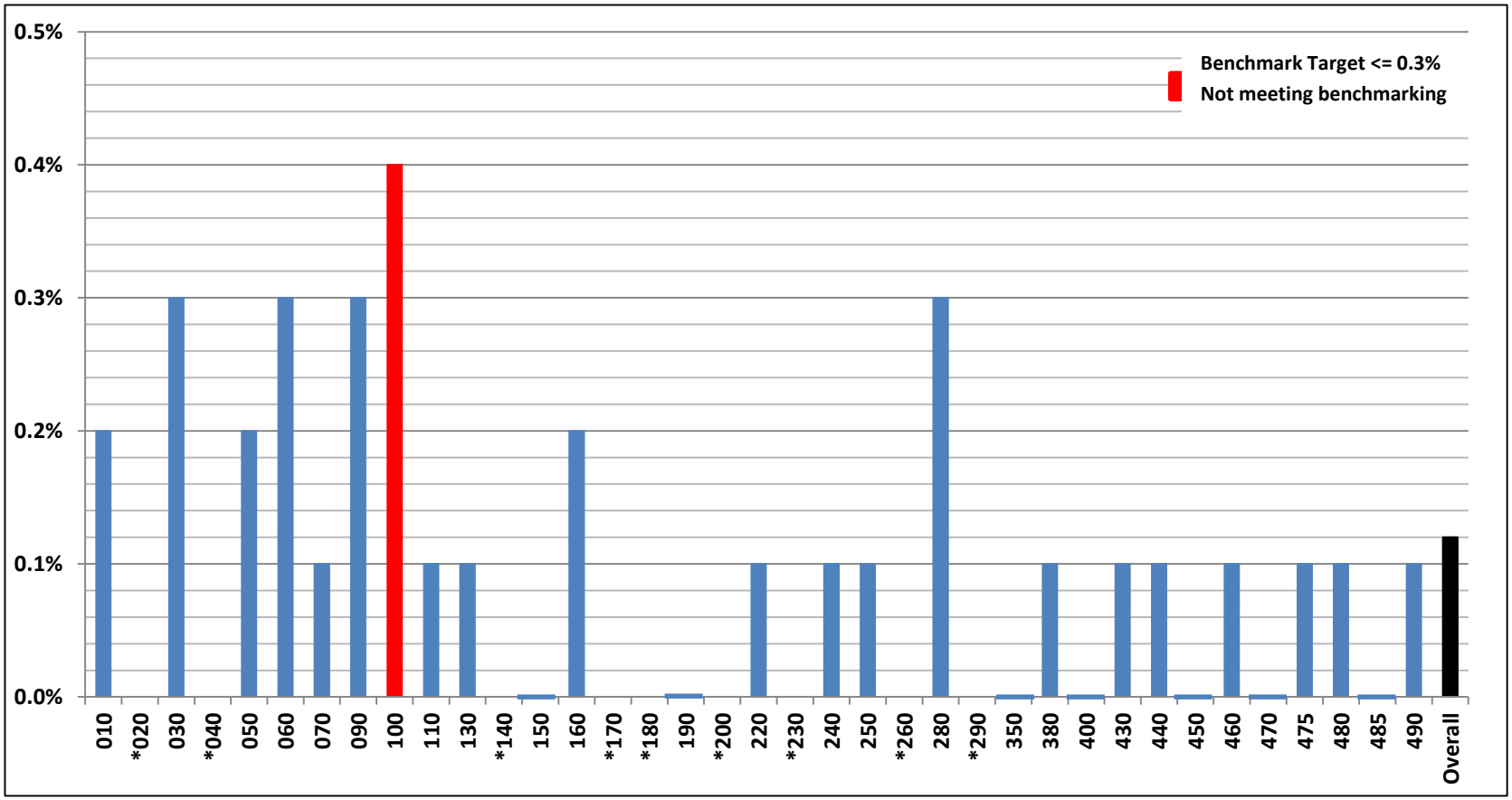
The performance level for NOM12 represents the percent of adults and children authorized in a FLOC who are admitted 3 or more times within 180 days to a DSHS operated or contracted inpatient psychiatric bed. Due to missing data, variation across local mental health authorities by month was not advisable.

Performance level (%) for the overall NOM12 (n=37)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	0.12	0.10	0.00	0.40	0.10	0.05	0.10	0.18	1
2nd Half FY 2015	0.12	0.11	0.00	0.40	0.10	0.04	0.10	0.16	1
1st Half FY 2016	0.11	0.13	0.10	0.00	0.50	0.02	0.06	0.14	2

***IQT=Interquartile range**

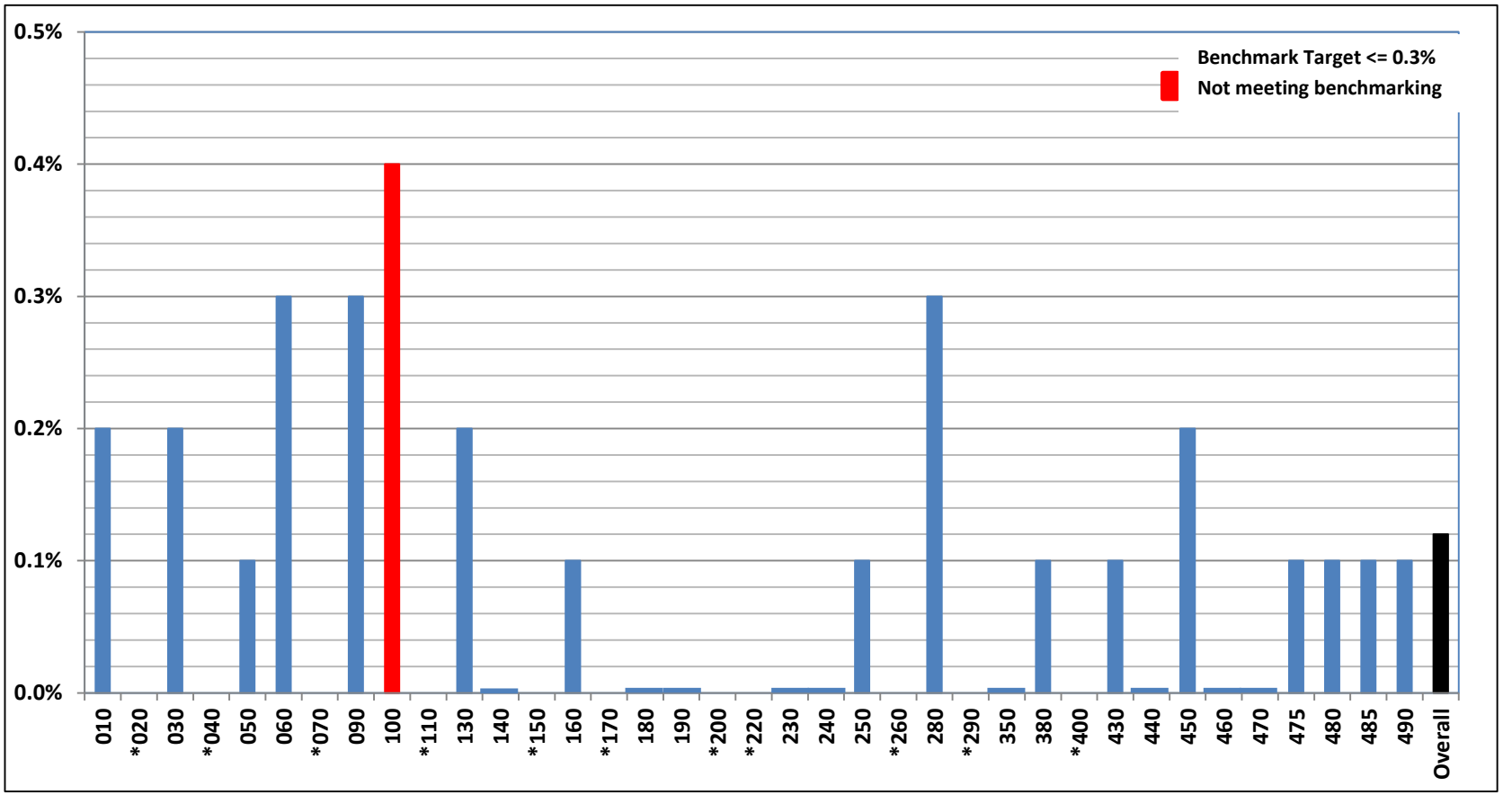
Variation between LMHAs

NOM12 Frequent Admissions Performance Level between LMHAs for 1st Half FY 2015



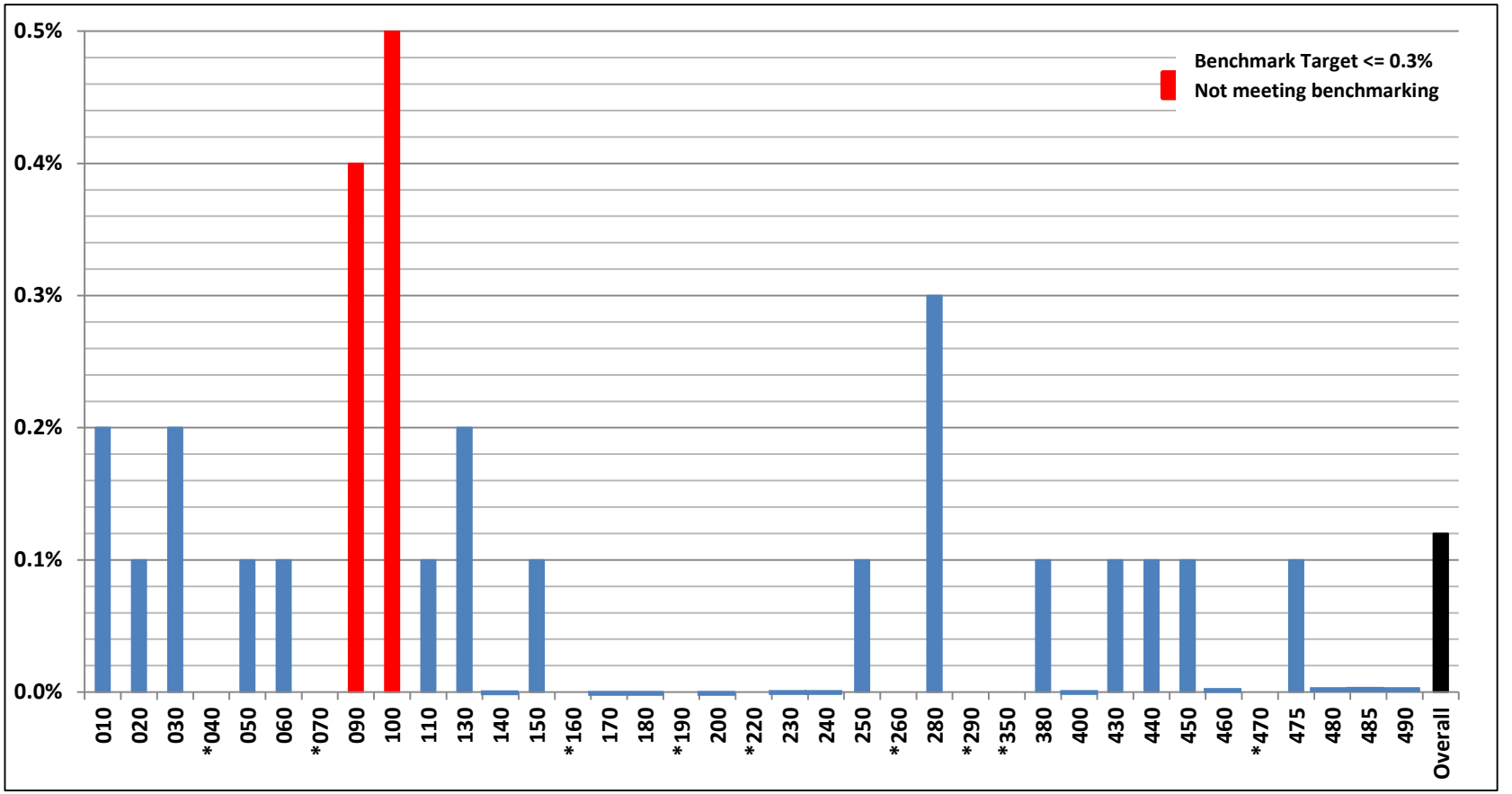
*Data was not available.

NOM12 Frequent Admissions Performance Level between LMHAs for 2nd Half FY 2015

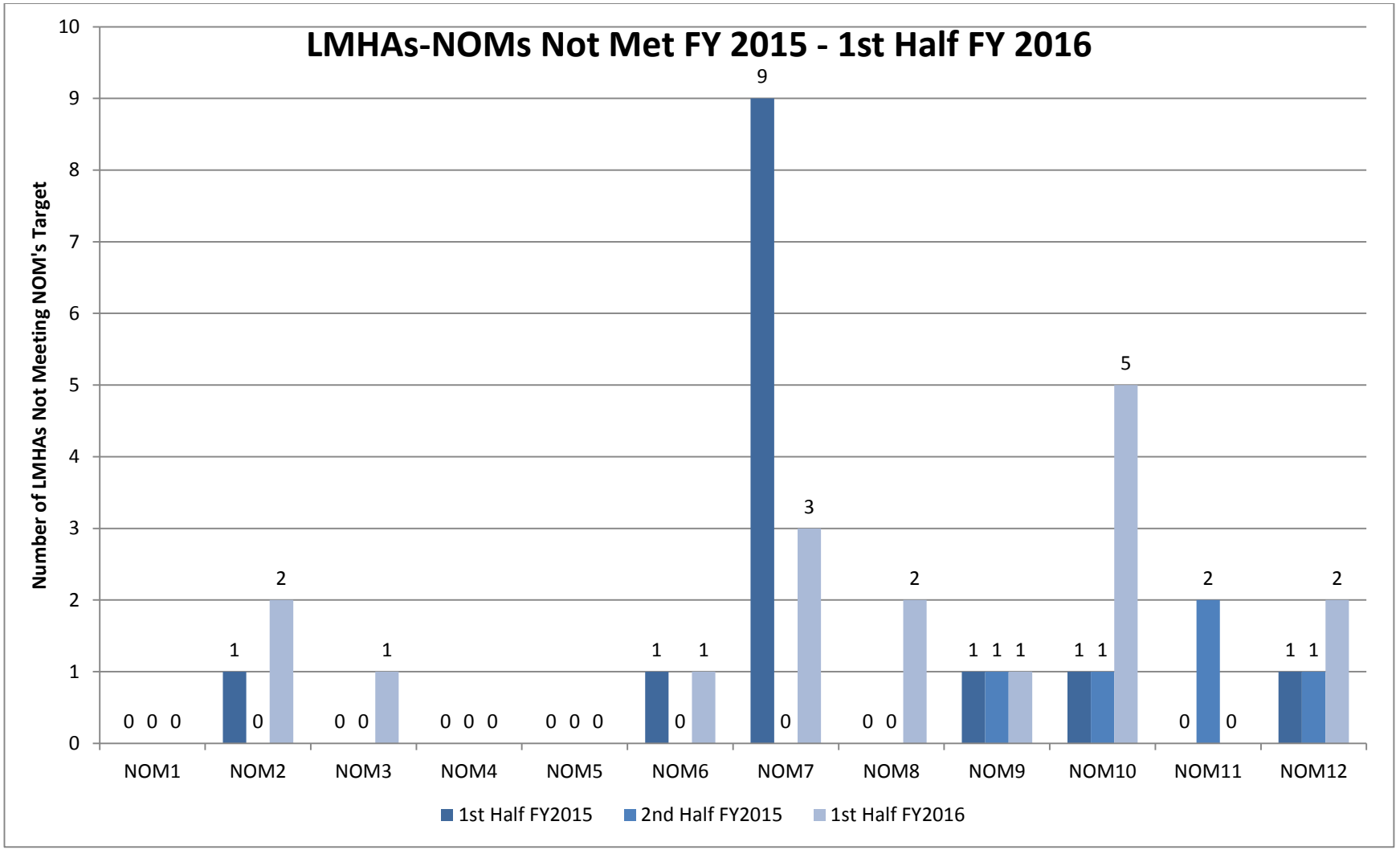


* Data was not available.

NOM12 Frequent Admissions Performance Level between LMHAs for 1st Half FY 2016



*Data was not available.


LMHAs-NOMs Not Met FY 2015 - 1st Half FY 2016
Number of LMHAs Not Meeting NOM's Target
10
9
8
7
6
5
4
3
2
1
0
0 0 0
1
0
2
0 0
1
0 0 0
0 0 0
1
0
1
9
0
3
0 0
2
1 1 1
1 1
5
0
2
0
1 1
2
NOM1
NOM2
NOM3
NOM4
NOM5
NOM6
NOM7
NOM8
NOM9
NOM10
NOM11
NOM12
1st Half FY2015
2nd Half FY2015
1st Half FY2016

Section II. Substance Use Providers

A. Performance measures

The tables below present the performance measures included for analysis for the substance use providers. Two types of performance measures were analyzed: (1) performance measures related to contracts, and (2) related to treatment.

List of substance use performance measures – *Contract Measures*		
Code	Measure Name (Target)	Measure Description
SA1	Adult clients not arrested during the reporting month (=90%)	Percent of DSHS-funded adult clients who ended a (specific service type) during the fiscal year to date and were not arrested during a specific reporting month.
SA2	Youth clients not arrested during the reporting month (=90%)	Percent of DSHS-funded youth clients who ended a (specific service type) during the fiscal year to date and were not arrested during a specific reporting month.
SA3	Adult clients reporting abstinence during the reporting month (=95%)	Percent of DSHS-funded adult clients that were listed as abstinent from all substances for the past 30 days on the substance abuse portion of the service end or discharge assessment.
SA4	Youth clients reporting abstinence during the reporting month (=95%)	Percent of DSHS-funded youth clients that were listed as abstinent from all substances for the past 30 days on the substance abuse portion of the service end or discharge assessment.
SA5	Adult clients reporting employ/ed during the reporting month (=60%)	Percent of DSHS-funded adult clients with a client's employment status as employed "full time", "part time", or "not in the labor force" on the service end or discharge assessment.
SA6	Youth clients reporting employ/ed during the reporting month (=60%)	Percent of DSHS-funded youth clients with a client's employment status as employed "full time", "part time", or "not in the labor force" on the service end or discharge assessment.
SA7	Adult clients reporting stable housing during the reporting month (=55%)	Percent of DSHS-funded adult clients who ended a (specific service type) during the fiscal year to date and were not listed with a current living situation as "homeless" or "shelter".
SA8	Youth clients reporting stable housing during the reporting month (=60%)	Percent of DSHS-funded youth clients who ended a (specific service type) during the fiscal year to date and were not listed with a current living situation as "homeless" or "shelter".

SA9	All adult clients receiving reproductive health visit (prenatal visit, postpartum visit, interconception Visit) (=64%)	Number of adults whose cases were closed during the reporting month that received all reproductive health visits as recommended by the American Congress of Obstetricians and Gynecologists for the period of time the client was receiving PPI services.
SA10	All adult clients whose children received all recommended well-child visits during the time the client's case was open (=98%)	Number of adults whose cases were closed during the reporting month, whose children received all well-child visits as recommended by the American Academy of Pediatrics for the period of time the client was receiving PPI services.
SA11	All youth clients receiving reproductive health visit (prenatal visit, postpartum visit, interconception Visit) (=40%)	Number of youth whose cases were closed during the reporting month that received all reproductive health visits as recommended by the American Congress of Obstetricians and Gynecologists for the period of time the client was receiving PPI services.
SA12	All youth clients whose children received all recommended well-child visits during the time the client's case was open (=95%)	Number of youth whose cases were closed during the reporting month, whose children received all well-child visits as recommended by the American Academy of Pediatrics for the period of time the client was receiving PPI services.
SA13	All pregnant adults delivering at full-term (=89%)	Number of adults with a PPI open case prior to 28 weeks gestation and through the delivery, who delivered at full-term (37 weeks gestation or later) during the reporting period.
SA14	All pregnant adult delivering healthy baby weight (=89%)	Number of adults with a PPI open case prior to 28 weeks gestation and through the delivery, who delivered a healthy weight baby (5 pounds, 8 ounces or more) during the reporting period.
SA15	All pregnant adults reporting abstinence from date of open case to delivery (=95%)	Number of adults giving birth during reporting month (regardless of when the case was opened) who maintained abstinence from alcohol, tobacco, and other non-prescribed drugs from the time the case was opened in CMBHS to at least the time of delivery.
SA16	All pregnant youth delivering at full-term (=87%)	Number of youth with a PPI open case prior to 28 weeks gestation and through the delivery, who delivered at full-term (37 weeks gestation or later) during the reporting period.
SA17	All pregnant youth delivering healthy baby weight (=87%)	Number of youth with a PPI open case prior to 28 weeks gestation and through the delivery, who delivered a healthy weight baby (5

		pounds, 8 ounces or more) during the reporting period.
SA18	All pregnant youth reporting abstinence from date of open case to delivery (=95%)	Number of youth giving birth during reporting month (regardless of when the case was opened) who maintained abstinence from alcohol, tobacco, and other non-prescribed drugs from the time the case was opened in CMBHS to at least the time of delivery.
List of substance use performance measures – *Treatment Measures*		
Code	Measure Name	Measure Description
SA19	Client engagement	Percent of DSHS-funded clients who ended a co-occurring psychiatric and substance use disorders (COPSD) service during the fiscal year to date.
SA20	Involved in ongoing treatment	Percent of clients who admitted to, or started in, another level of service or be listed as attending a support group in the substance abuse section of the service end or discharge assessment.
SA21	Not arrested	Percent of DSHS-funded clients who ended a (specific service type) during the fiscal year to date and were not arrested during a specific reporting month.
SA22	Abstinence	Percent of DSHS-funded clients that were listed as abstinent from all substances for the past 30 days on the substance abuse portion of the service end or discharge assessment.
SA23	Employment	Percent of DSHS-funded clients with a client's employment status as employed "full time", "part time", or "not in the labor force" on the service end or discharge assessment.
SA24	School attendance	Percentage of DSHS-funded clients who ended a (specific service type) during the fiscal year to date and on the service end or discharge assessment, the answer to "Is the client enrolled in school?" was "yes".
SA25	Stable housing	Percent of DSHS-funded clients who ended a (specific service type) during the fiscal year to date and were not listed with a current living situation as "homeless" or "shelter".

SA26	Mental health treatment at discharge	Percent of DSHS-funded clients who ended a COPSD service during the fiscal year to date and who have activity associated with mental health services during the episode at same or different provider or a referral with a referral type of “Mental Health Treatment (Inpatient)” or “Mental Health Treatment (Outpatient)”.
SA27	Residential detoxification with referral after initial episode	DSHS-funded clients who ended a residential detoxification service for the fiscal year to date after initial episode.
SA28	Residential detoxification with referral after multiple episodes	DSHS-funded clients who ended a residential detoxification service for the fiscal year to date after multiple episodes.
SA29	Substance abuse treatment at discharge	Percent of DSHS-funded clients who ended a COPSD service during the fiscal year to date.
SA30	Treatment completion	Percent of DSHS-funded clients who ended a (specific service type) service during the fiscal year to date where the service end reason was not “non-compliant with service”, “discharged without completing service”, “client left service against professional advice” or blank due to an administrate discharge.
SA31	Ambulatory detoxification with concurrent outpatient admission	DSHS-funded clients who ended an ambulatory detoxification service during the fiscal year to date, and who also had an overlapping service begin for an outpatient service, either at the same or another provider.
SA32	Detoxification completion	Percent of DSHS-funded clients who ended a detoxification service during the fiscal year to date where the service end reason is not “non-compliant with service”, “discharged without completing service”, “client left service against professional advice” or blank due to an administrative discharge.
SA33	Number of motivational sessions per client with multiple residential detoxification episodes	Average number of administrative notes with a note type of "motivational interviewing" for DSHS-funded clients who ended a residential detoxification service during the fiscal year to date.
SA34	Community support referrals	Average number of referrals with referral follow-up on DSHS funded clients who ended a (specific service type) during the fiscal year to date.

B. Substance use providers

The tables below present the list of substance use providers included for analysis. The first table contains the substance use providers related to contract measures (n=20), and the following table presents the substance use providers related to treatment (n=68).

List of substance use providers – *Contract Measures*	
Code	**Name of the provider**
1	Abilene Regional Coada, Inc.
2	Aliviane Inc.
3	Alpha Home Inc.
4	Behavioral Health Alliance Of Texas Inc.
5	Behavioral Health Solutions Of South Texas
6	Brazos Valley Council On Alcohol & Substance Abuse
7	Cenikor Foundation
8	Central Texas Council Alcoholism & Drug Abuse
9	Coastal Bend Wellness Foundation Inc.
10	Council On Alcohol And Drug Abuse Coastal Bend
11	Houston Council On Alcoholism And Drug Abuse, Inc.
12	Lifesteps Council On Alcohol And Drugs
13	Longview Wellness Center Inc.
14	Lubbock Regional Mhmr Center
15	Nexus Recovery Center, Inc.
16	Permian Basin Regional Council On Alcohol And Drug Abuse
17	Santa Maria Hostel, Inc.
18	Serving Children And Adults In Need Inc.
19	Tarrant County Hospital District
20	University Of Texas At Arlington

List of substance use providers – Treatment Measures	
Code	**Name of the provider**
1001	1 Stop Recovery, Inc.
1002	Alcohol And Drug Abuse Cncl. For The Concho Valley
1003	Aliviane No-Ad, Inc.
1004	Alpha Home, Inc.
1005	Amarillo Council On Alcoholism And Drug Abuse
1006	Association For The Advancement Of Mexican-Americans, Inc.
1007	Austin Recovery, Inc.
1008	Austin-Travis County Mental Health And Mental Retardation Center
1009	Azleway, Inc.
1010	Behavioral Health Alliance Of Texas
1011	Bluebonnet Trails Community Mhmr Center
1012	Brazoria County Alcoholic Recovery Center, Inc.
1013	Brazos Valley Council On Alcohol/Substance Abuse
1014	Career And Recovery Resources, Inc.
1015	Cenikor Foundation
1016	Center For Health Care Services, The
1017	Center For Success And Independence
1018	Central Plains Center
1019	Central Texas Mhmr Center Dba The Center For Life Resources
1020	Charlies Place Recovery Center
1021	Cheyenne Center Inc.
1022	Choices Adolescent Treatment Center, Inc.
1023	Christian Farms-Treehouse Inc.
1024	Clean Investments, Inc. Counseling Center
1025	Council On Alcohol And Drug Abuse - Coastal Bend, The
1026	Dapa Family Recovery Programs
1027	Deborah Judith, Inc. Dba Elite Counseling

1028	Developmental Counseling Center, Inc. Dba Dcci
1029	Fort Bend Regional Council On Substance Abuse, Inc.
1030	Gulf Coast Center, The
1031	Hays Caldwell Council On Alcohol / Drug Abuse
1032	Helen Farabee Centers
1033	Hill Country Community Mhmr
1034	Hill Country Council On Alcohol And Drug Abuse
1035	Homeward Bound, Inc.
1036	Lakes Regional Mhmr Center Dba Lakes Behavioral Health
1037	Lena Pope Home, Inc.
1038	Longview Wellness Center, Inc.(Dba) Wellness Pointe
1039	Managed Care Center For Addictive/Other Disorders, Inc.
1040	Mental Health Mental Retardation Of Tarrant County
1041	Mid-Texas Council On Alcohol And Drug Abuse, Inc.
1042	Montrose Counseling Center, Inc.
1043	Nexus Recovery Center, Inc.
1044	North Texas Addiction Counseling And Education, Inc.
1045	Pecan Valley Mhmr
1046	Permian Basin Community Centers For Mhmr
1047	Phoenix Associates Counseling Services, Inc.
1049	Phoenix Houses Of Texas, Inc.
1049	Plainview Serenity Center, Inc.
1050	Rccc, Inc.
1051	Riverside General Hospital
1052	Sabine Valley Regional Mhmr Center Dba Community Healthcore
1053	San Antonio Lifetime Recovery, Inc Dba Lifetime Recovery
1054	Santa Maria Hostel, Inc.- Adm
1055	Serenity Foundation Of Texas
1056	Serving Children And Adults In Need, Inc.
1057	South East Texas Regional Planning Commission

1058	South Texas Rural Health Services, Inc.
1059	South Texas Substance Abuse Recovery Services, Inc.
1060	Special Health Resources For Texas, Inc.
1061	Star Council On Substance Abuse
1062	Teddy Buerger Center, A Department Of Guadalupe Regional Medical Center
1063	The Bes Group Inc.
1064	Tri-County Services
1065	The Turning Point, Inc.
1066	Unlimited Visions Aftercare, Inc.
1067	Volunteers Of America Texas, Inc.
1068	Ysleta Del Sur Pueblo

C. Results – Contract Measures

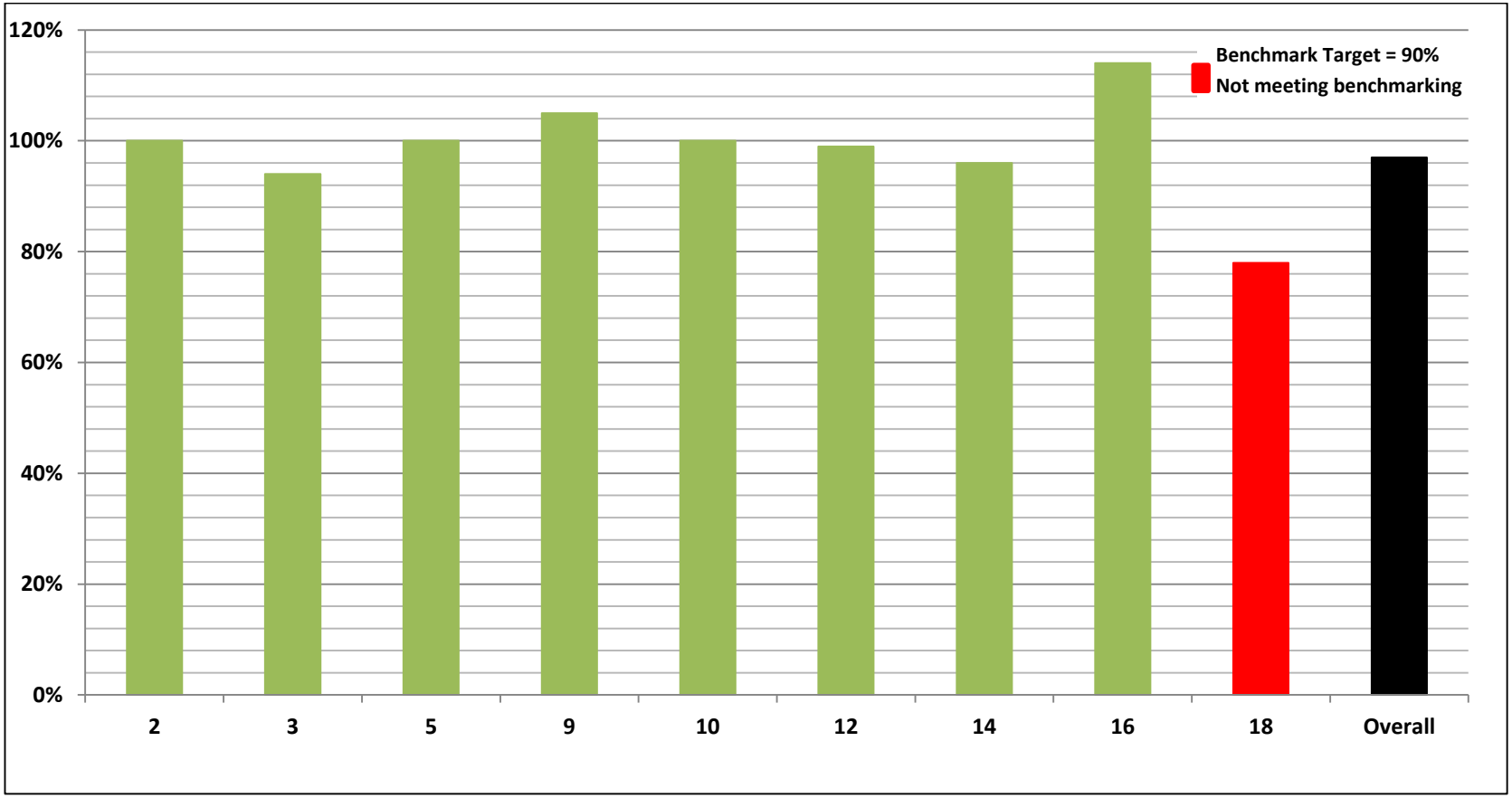
SA1: Adult Clients Not Arrested during the Reporting Month

The performance level for SA1 represents the percent of DSHS-funded adult clients who ended a specific service type during the fiscal year to date and were not arrested during a specific reporting month.

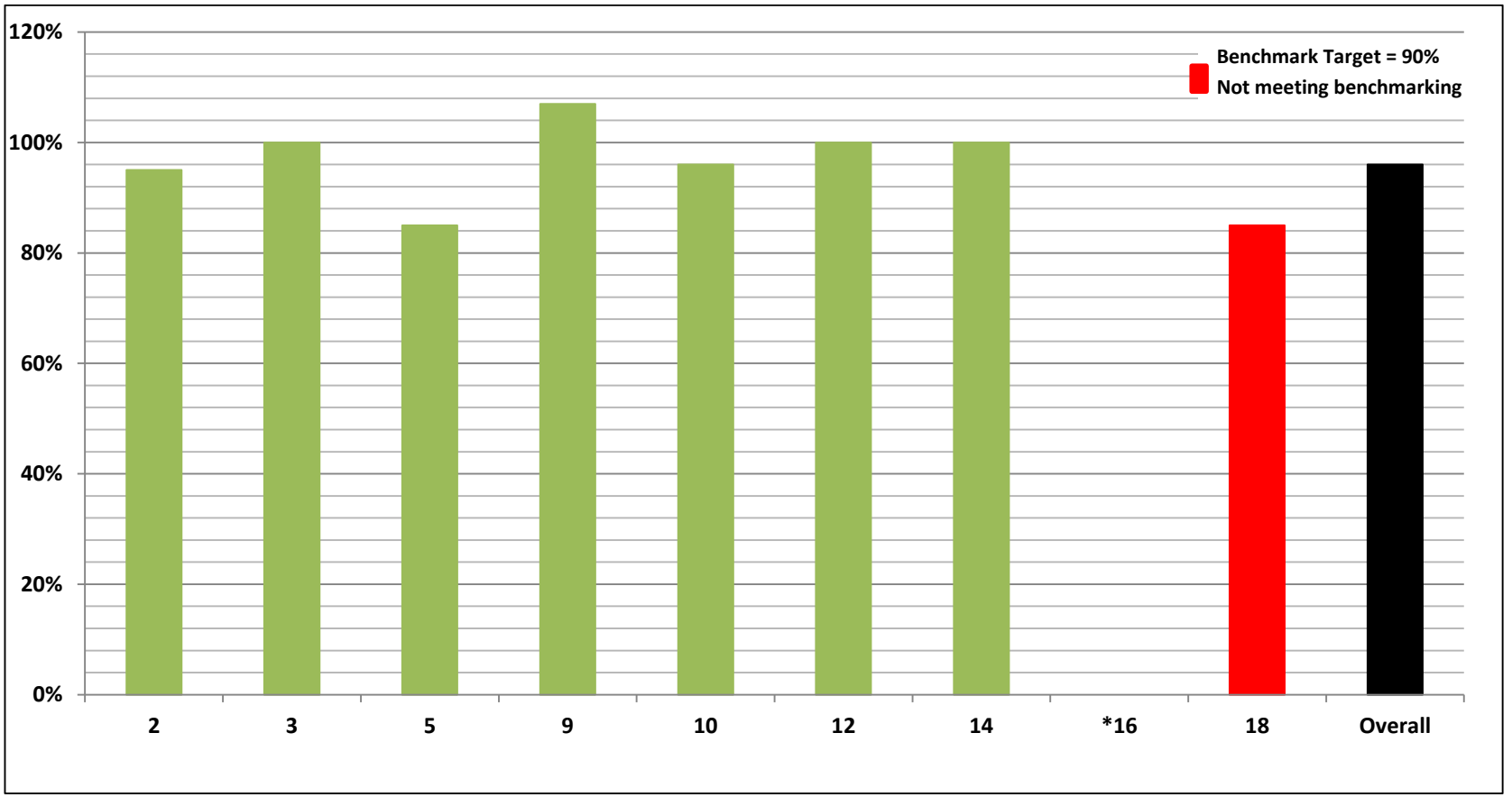
Performance level (%) for the overall SA1 (n=9)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	97	8	78	105	6	94	100	100	1
2nd Half FY 2015	96	8	85	107	12	88	98	100	1
*IQT=Interquartile range									

Variation between substance use providers

SA1 Adult Clients Not Arrested during the Reporting Month for 1st Half FY 2015



SA1 Adult Clients Not Arrested during the Reporting Month for 2nd Half FY 2015



* Data was not available.

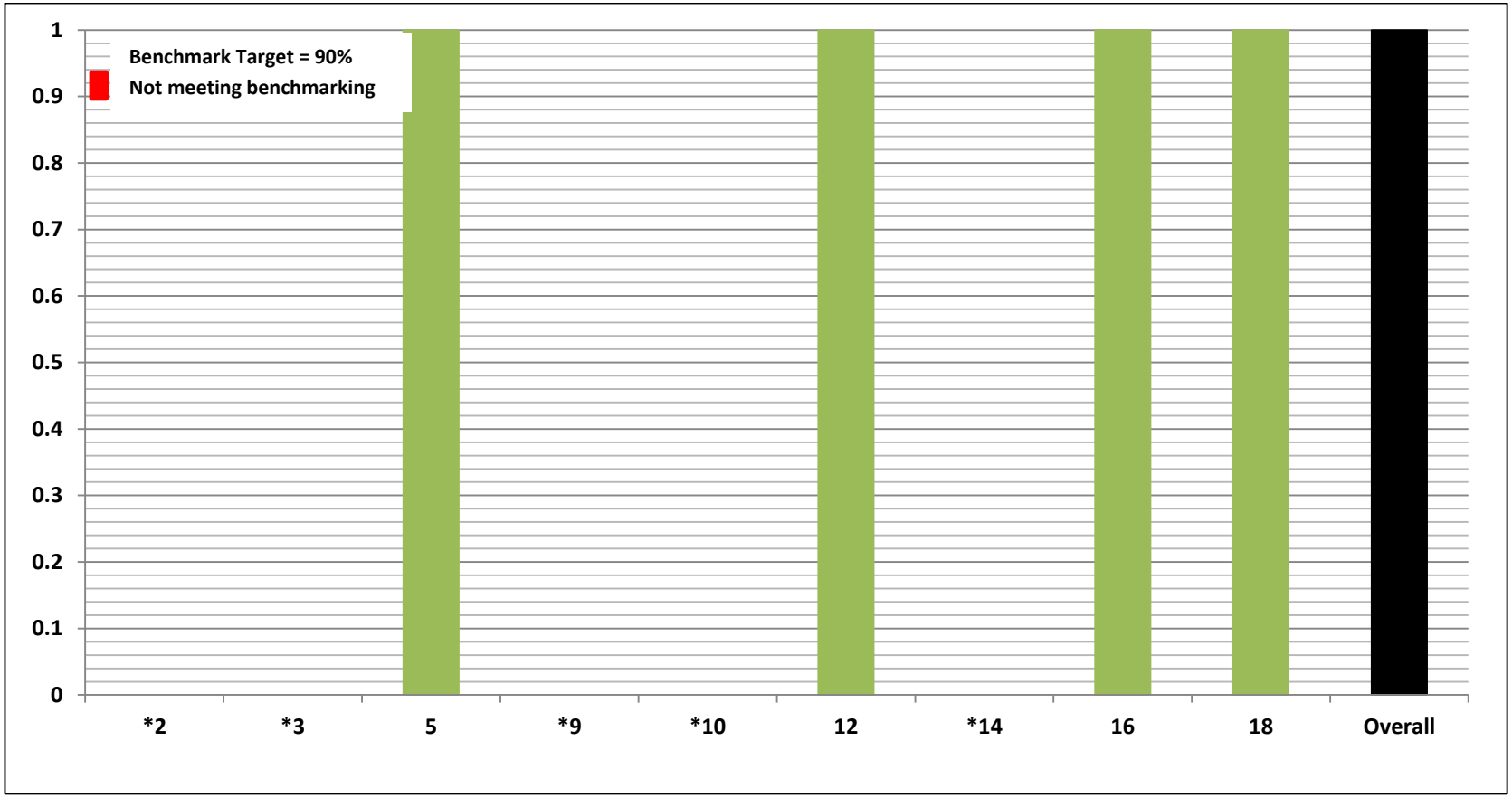
SA2: Youth Clients Not Arrested during the Reporting Month

The performance level for SA2 represents the percent of DSHS-funded youth clients who ended a specific service type during the fiscal year to date and were not arrested during a specific reporting month.

No variation across organizations was found, therefore, the table is not presented.

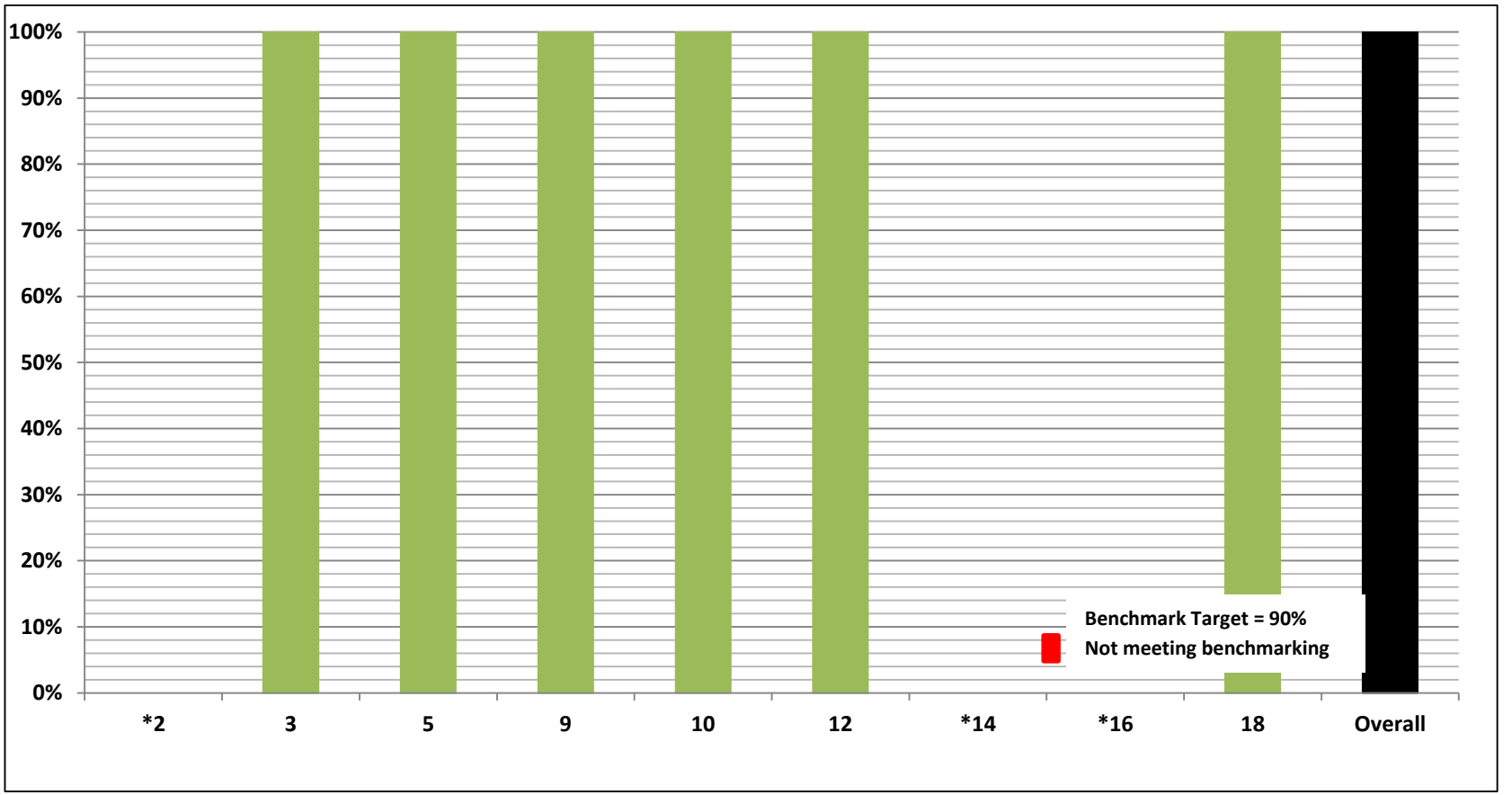
Variation between substance use providers

SA2 Youth Clients Not Arrested during the Reporting Month for 1st Half FY 2015



*Data was not available.

SA2 Youth Clients Not Arrested during the Reporting Month for 2nd Half FY 2015



*Data was not available.

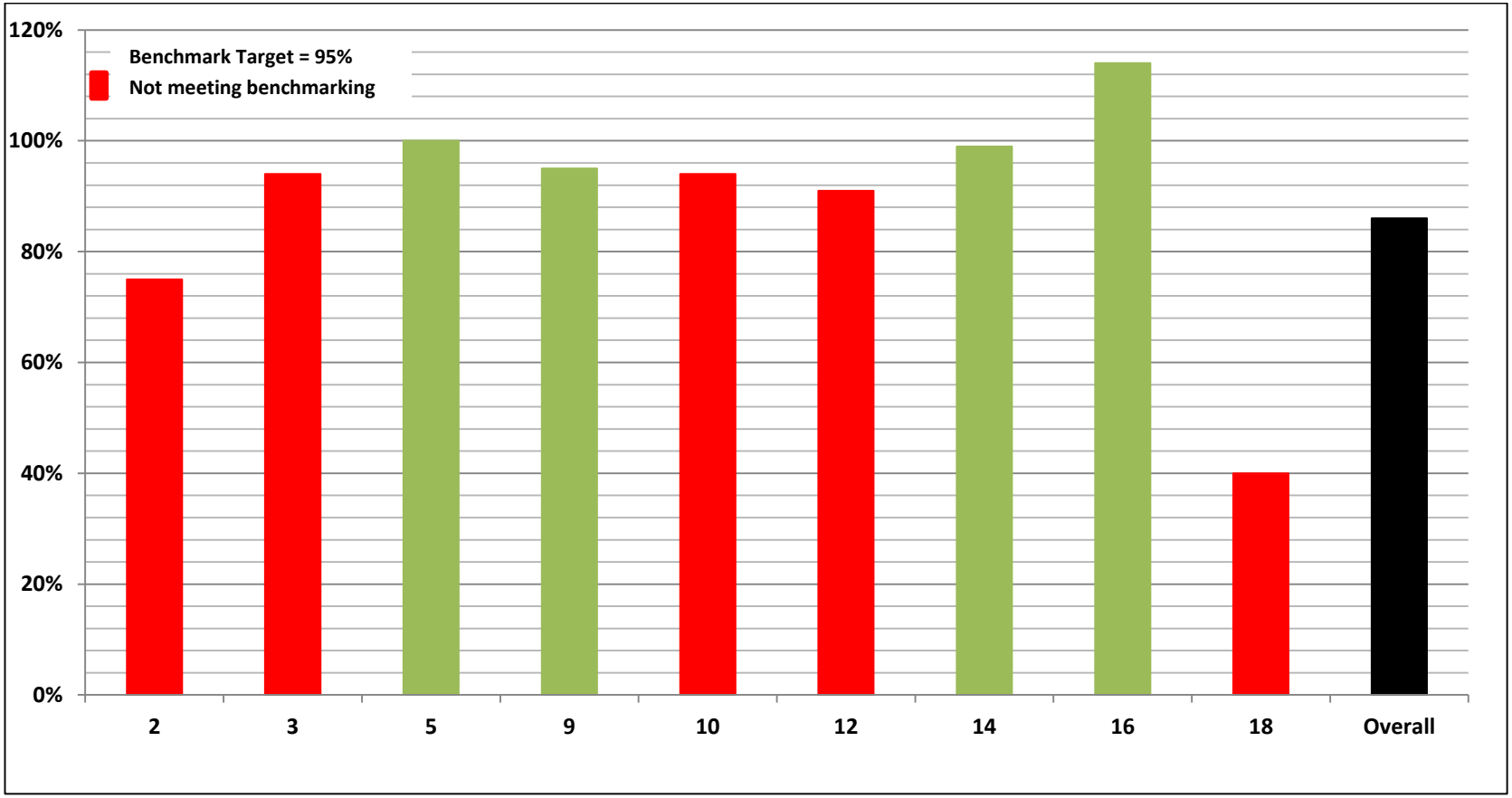
SA3: Adult Clients Reporting Abstinence during the Reporting Month

The performance level for SA3 represents the percent of DSHS-funded adult clients that were listed as abstinent from all substance for the past 30 days on the substance abuse portion of the services end or discharge assessment.

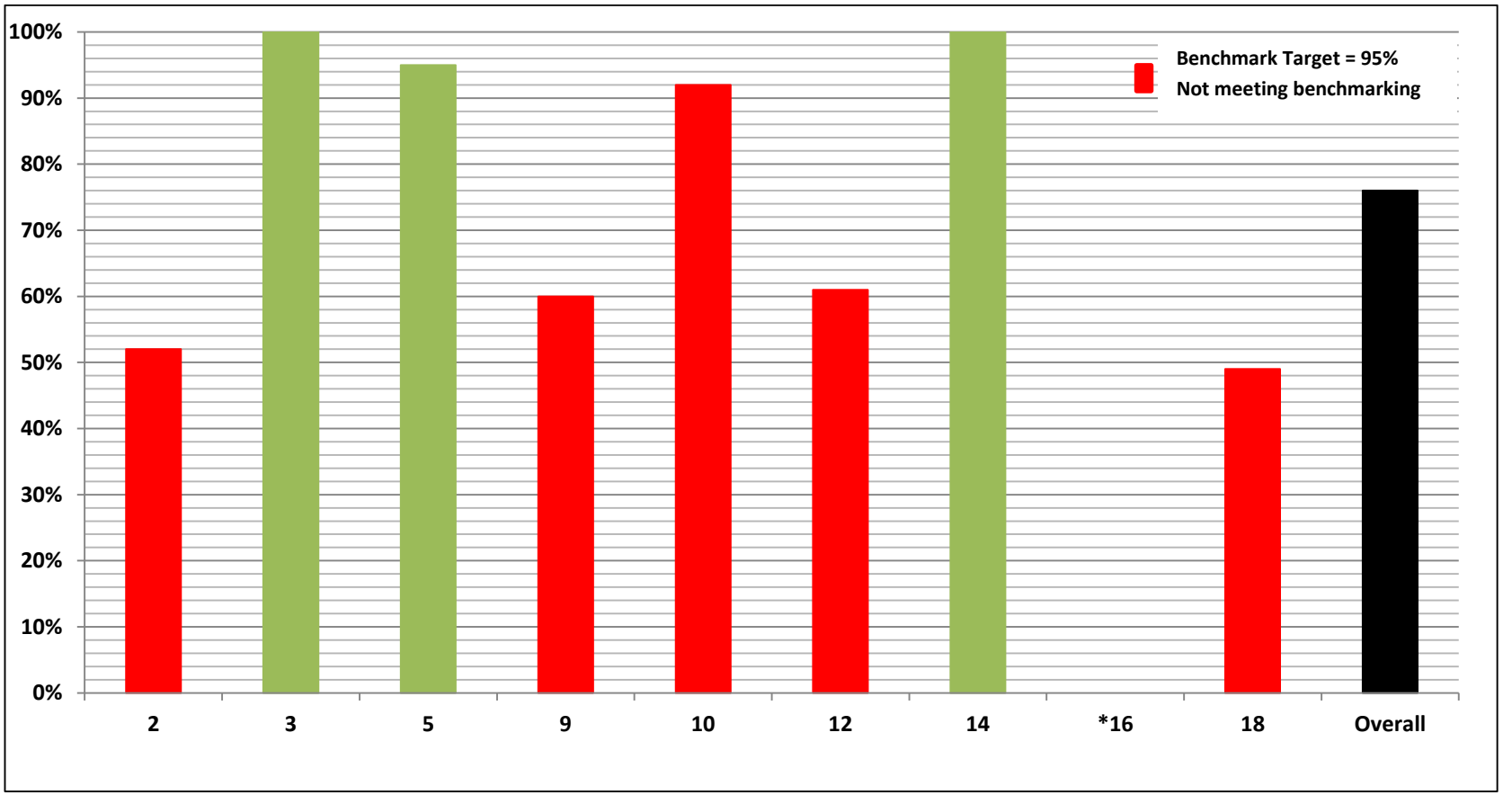
Performance level (%) for the overall SA3 (n=9)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	86	20	40	100	19	79	94	98	5
2nd Half FY 2015	76	22	49	100	45	83	94	97	5
*IQT=Interquartile range									

Variation between substance use providers

SA3 Adult Clients Reporting Abstinence during the Reporting Month for 1st Half FY 2015



SA3 Adult Clients Reporting Abstinence during the Reporting Month for 2nd Half FY 2015



*Data was not available.

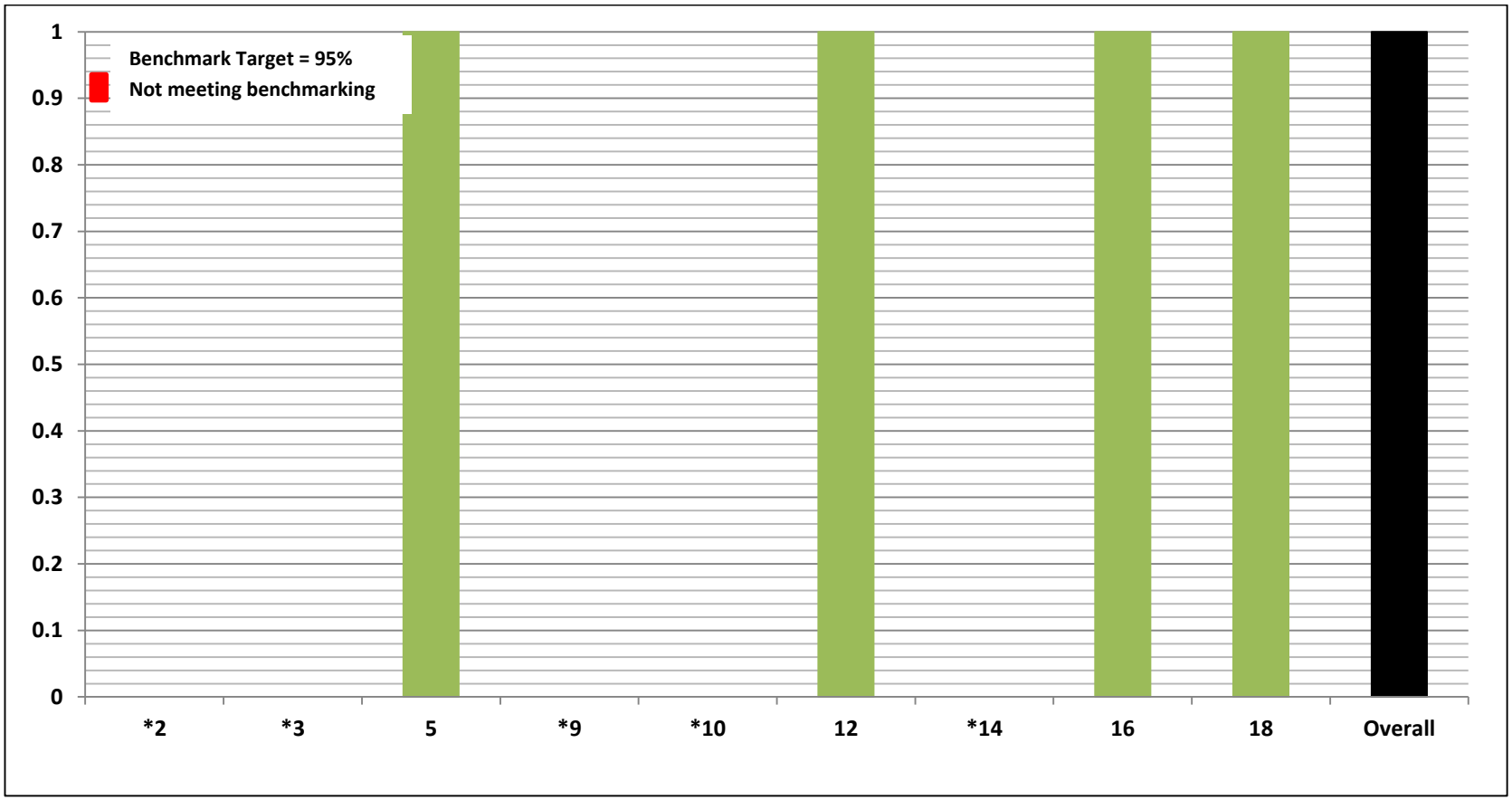
SA4: Youth Clients Reporting Abstinence during the Reporting Month

The performance level for SA4 represents the percent of DSHS-funded youth that were listed as abstinent from all substance for the past 30 days on the substance abuse portion of the services end or discharge assessment.

No variation across organizations was found, therefore, the table is not presented.

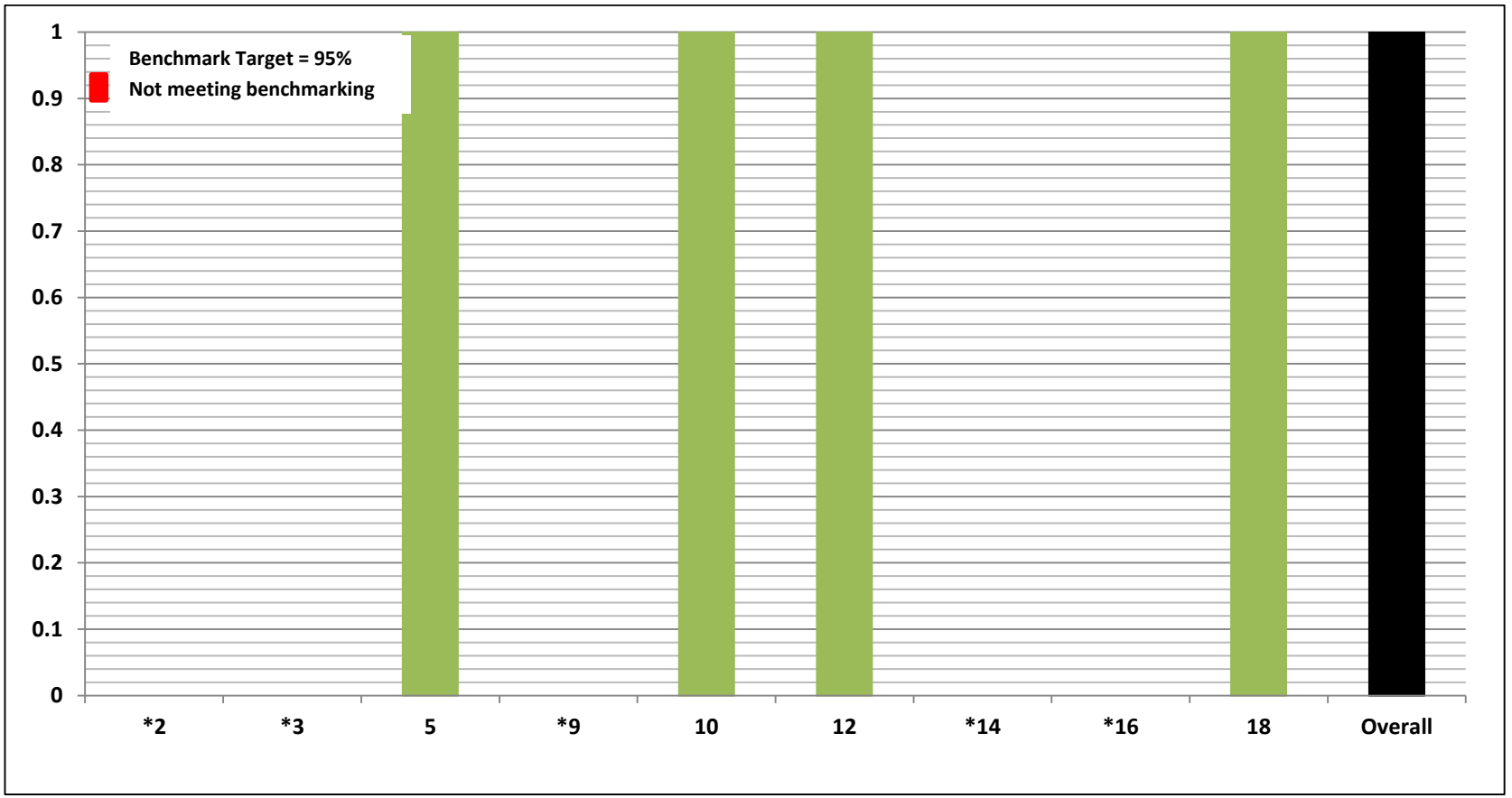
Variation between substance use providers

SA4 Youth Clients Reporting Abstinence during the Reporting Month for 1st Half FY 2015



*Data was not available.

SA4 Youth Clients Reporting Abstinence during the Reporting Month for 2nd Half FY 2015



*Data was not available.

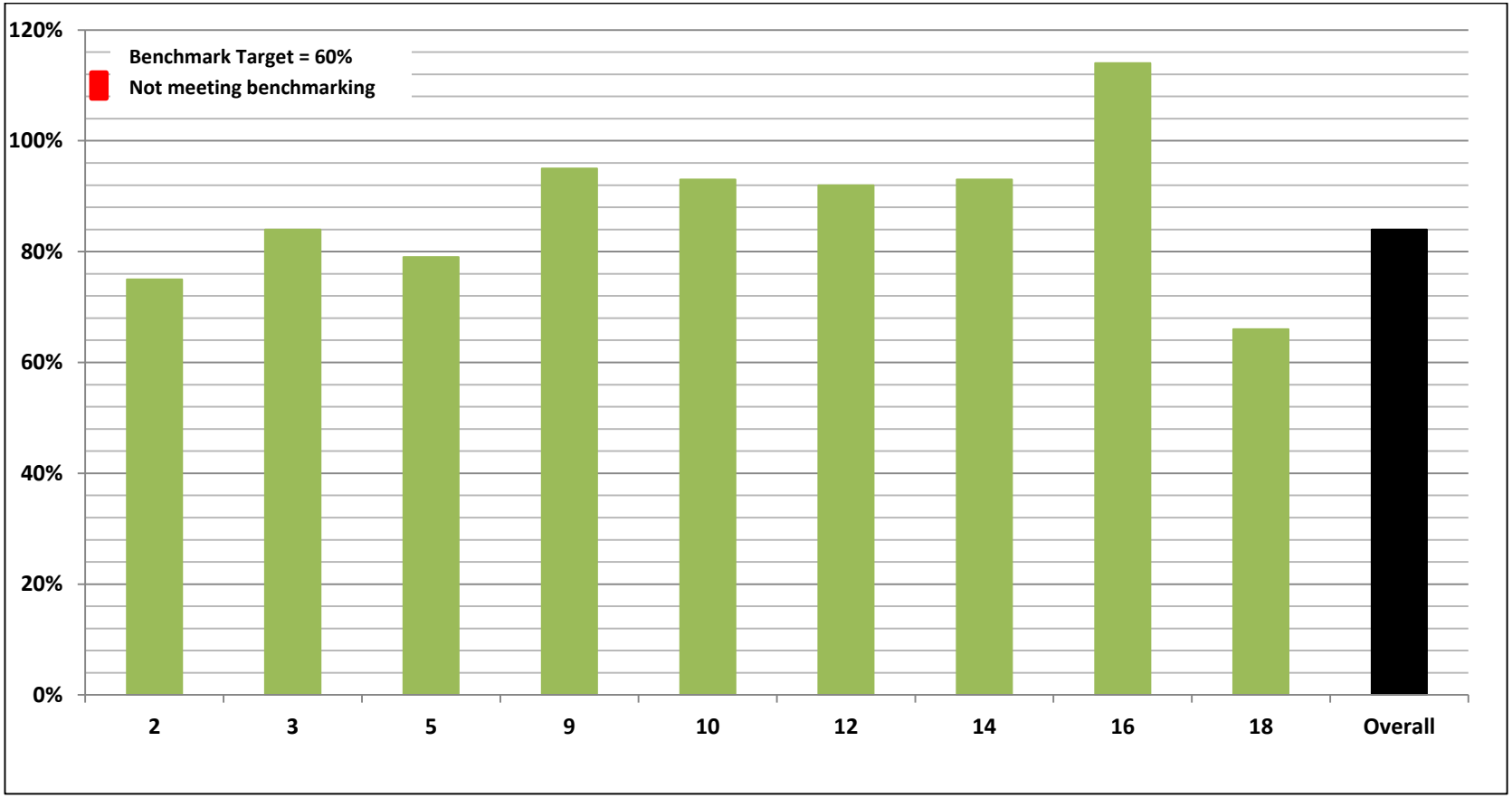
SA5: Adult Clients Reporting Active Employ/ed during the Reporting Month

The performance level for SA5 represents the percent of DSHS-funded adult with a client's employment status as employed "full time", "part time", or "not in labor force" on the service end or discharge assessment.

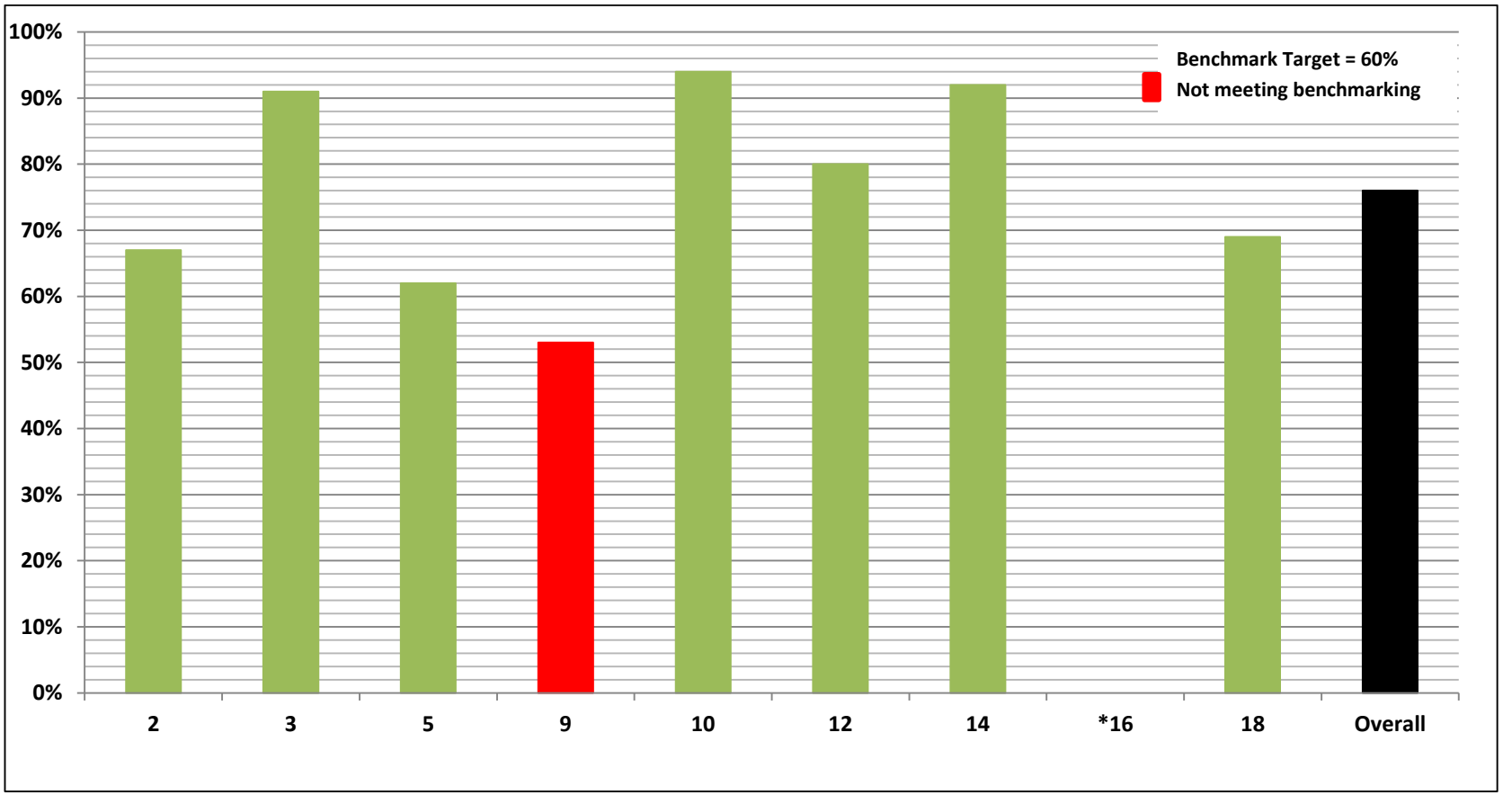
Performance level (%) for the overall SA5 (n=9)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	85	11	66	95	17	76	88	93	0
2nd Half FY 2015	80	15	53	94	28	77	88	93	1
*IQT=Interquartile range									

Variation between substance use providers

SA5 Adult Clients Reporting Active Employ/ed during the Reporting Month for 1st Half FY 2015



SA5 Adult Clients Reporting Active Employ/ed during the Reporting Month for 2nd Half FY 2015



*Data was not available.

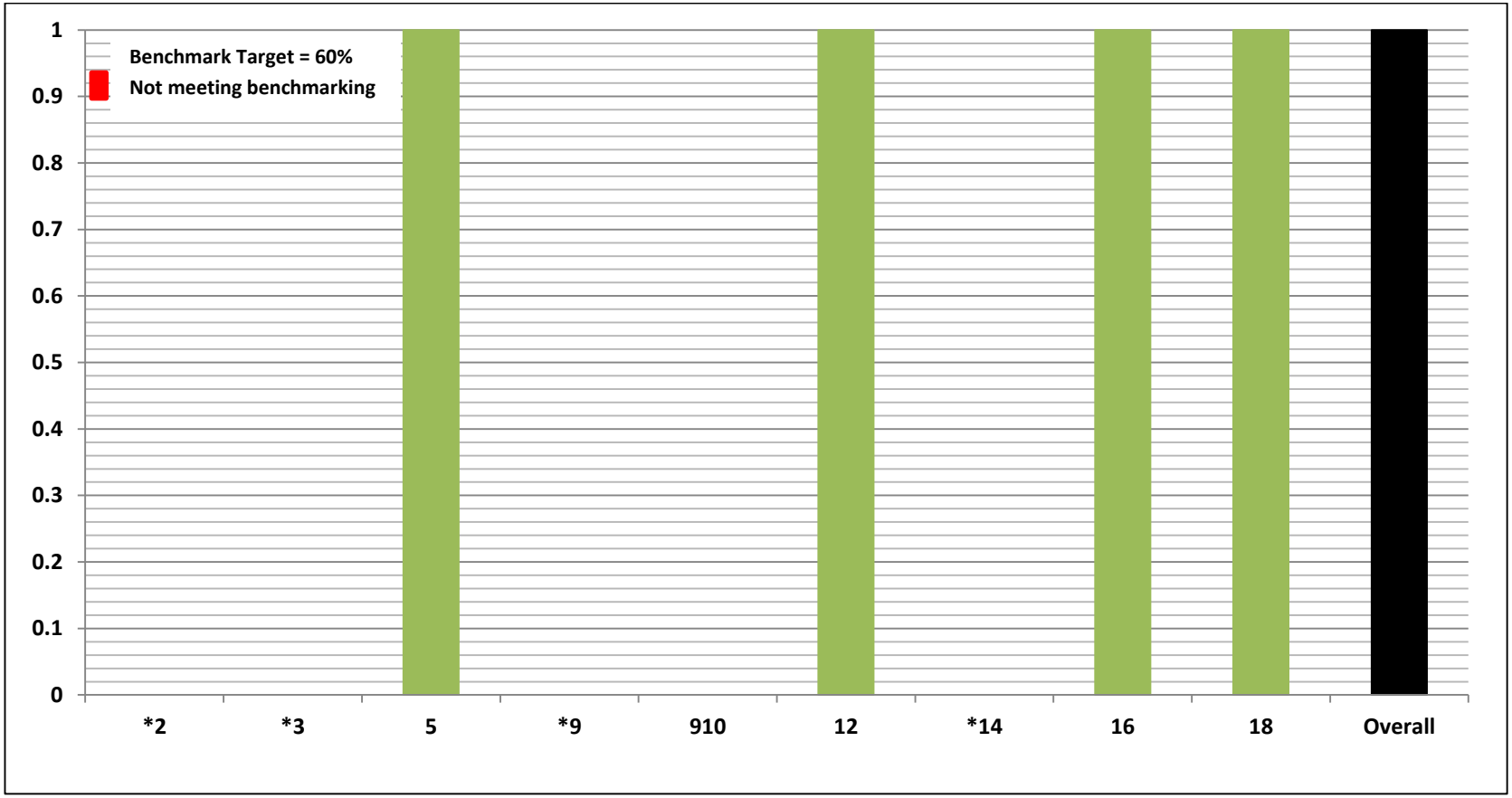
SA6: Youth Clients Reporting Active Employ/ed during the Reporting Month

The performance level for SA6 represents the percent of DSHS-funded youth clients with a client's employment status as employed "full time", "part time", or "not in labor force" on the service end or discharge assessment.

No variation across organizations was found, therefore, the table is not presented.

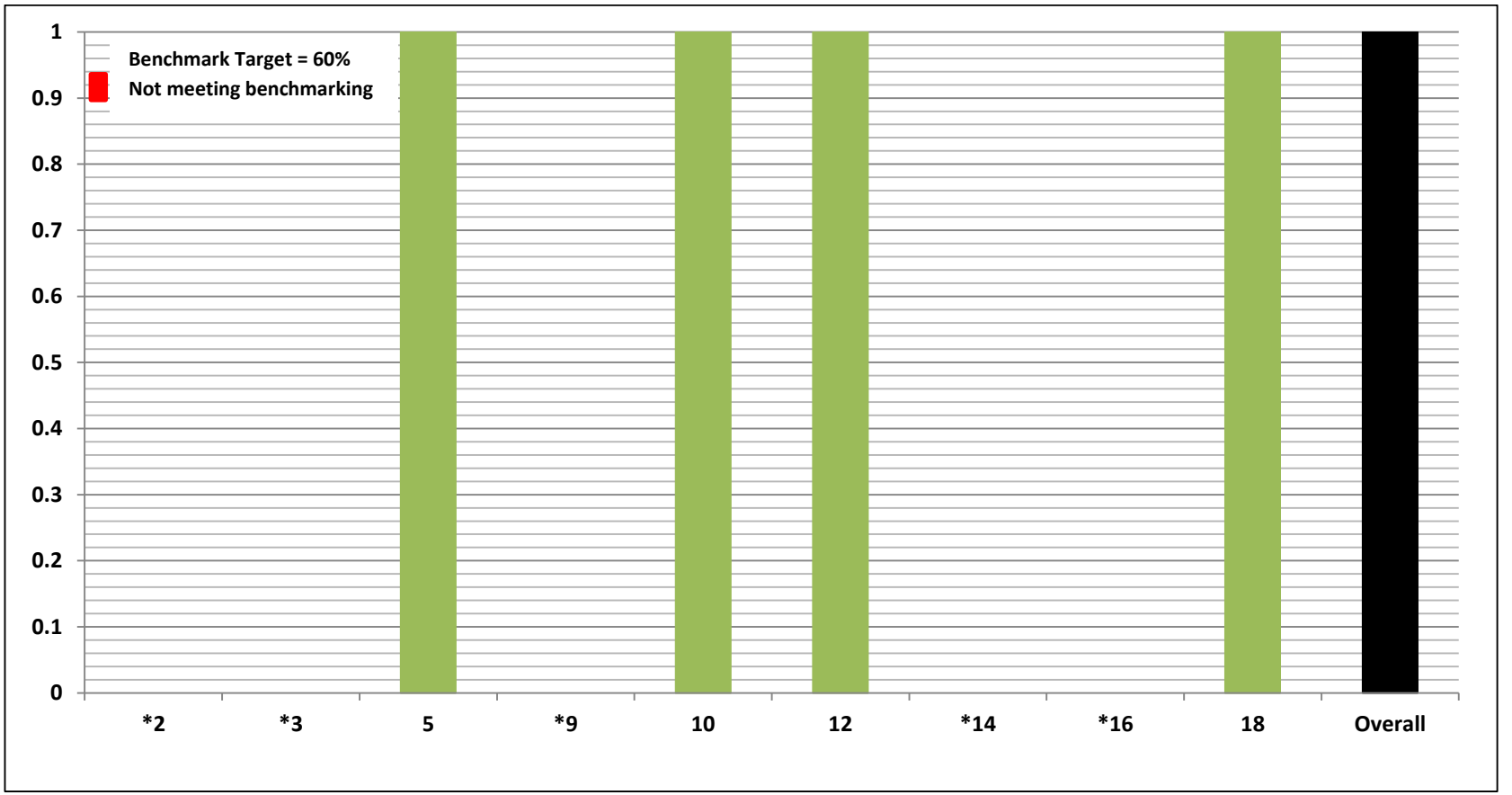
Variation between substance use providers

SA6 Youth Clients Reporting Active Employ/ed during the Reporting Month for 1st Half FY 2015



*Data was not available.

SA6 Youth Clients Reporting Active Employ/ed during the Reporting Month for 2nd Half FY 2015



*Data was not available.

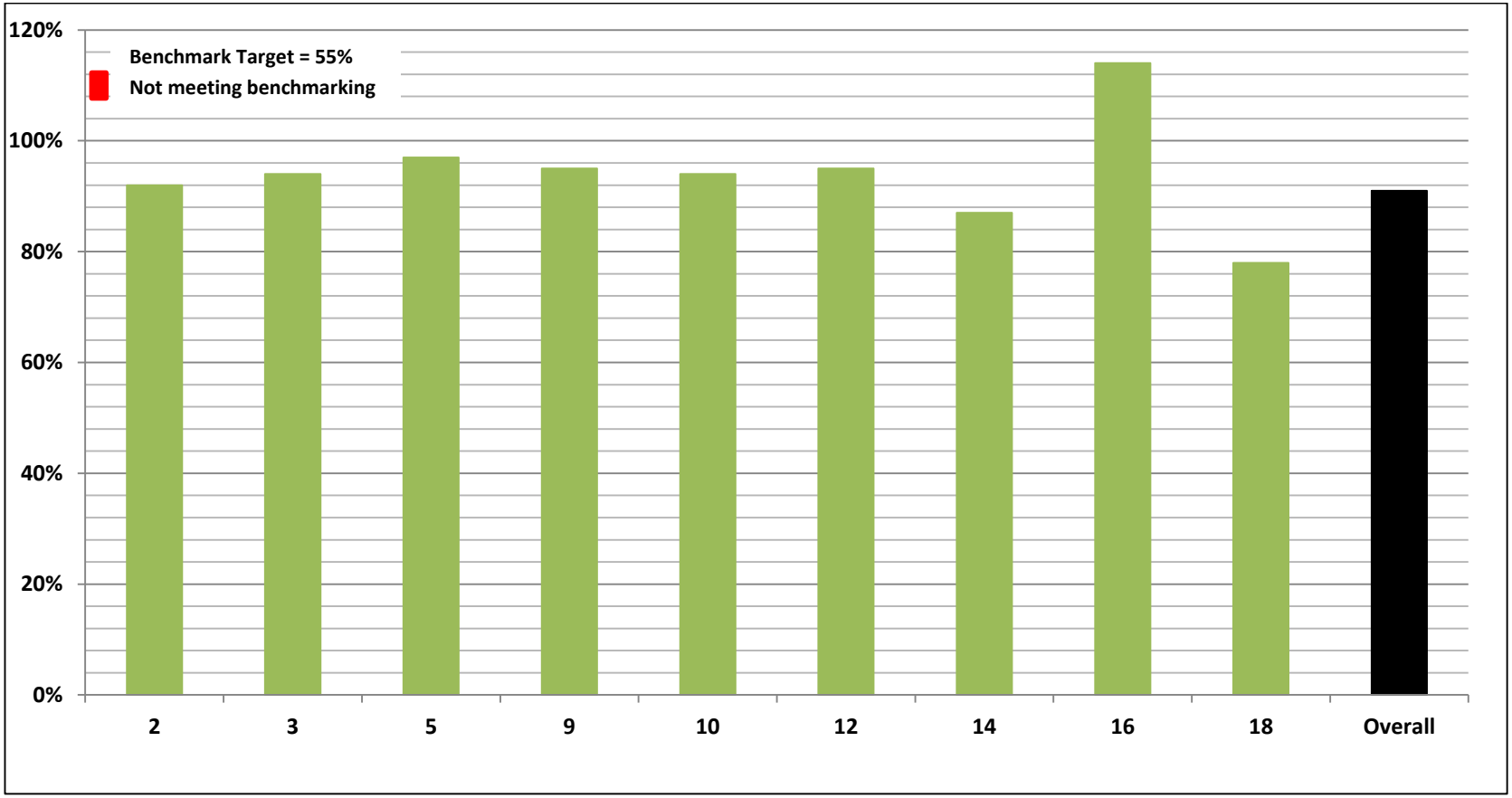
SA7: Adult Clients Reporting Stable Housing during the Reporting Month

Percent of DSHS-funded adult clients who ended a (specific service type) during the fiscal year to date and were not listed with a current living situation as "homeless" or "shelter".

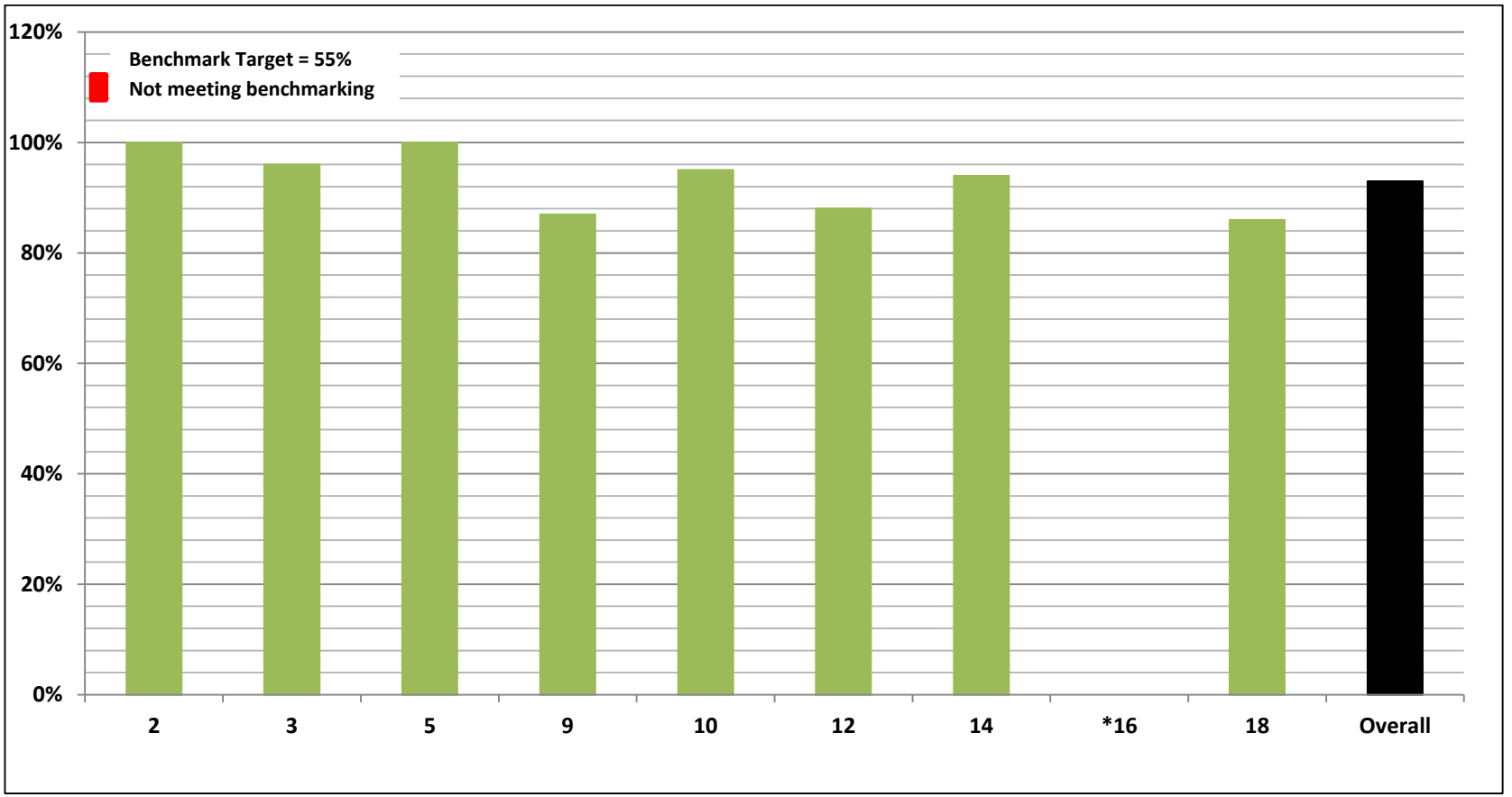
Performance level (%) for the overall SA7 (n=9)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	92	6	78	97	7	88	94	95	0
2nd Half FY 2015	93	6	86	100	12	87	95	99	0
*IQT=Interquartile range									

Variation between substance use providers

SA7 Adult Clients Reporting Stable Housing during the Reporting Month for 1st Half FY 2015



SA7 Adult Clients Reporting Stable Housing during the Reporting Month for 2nd Half FY 2015



*Data was not available.

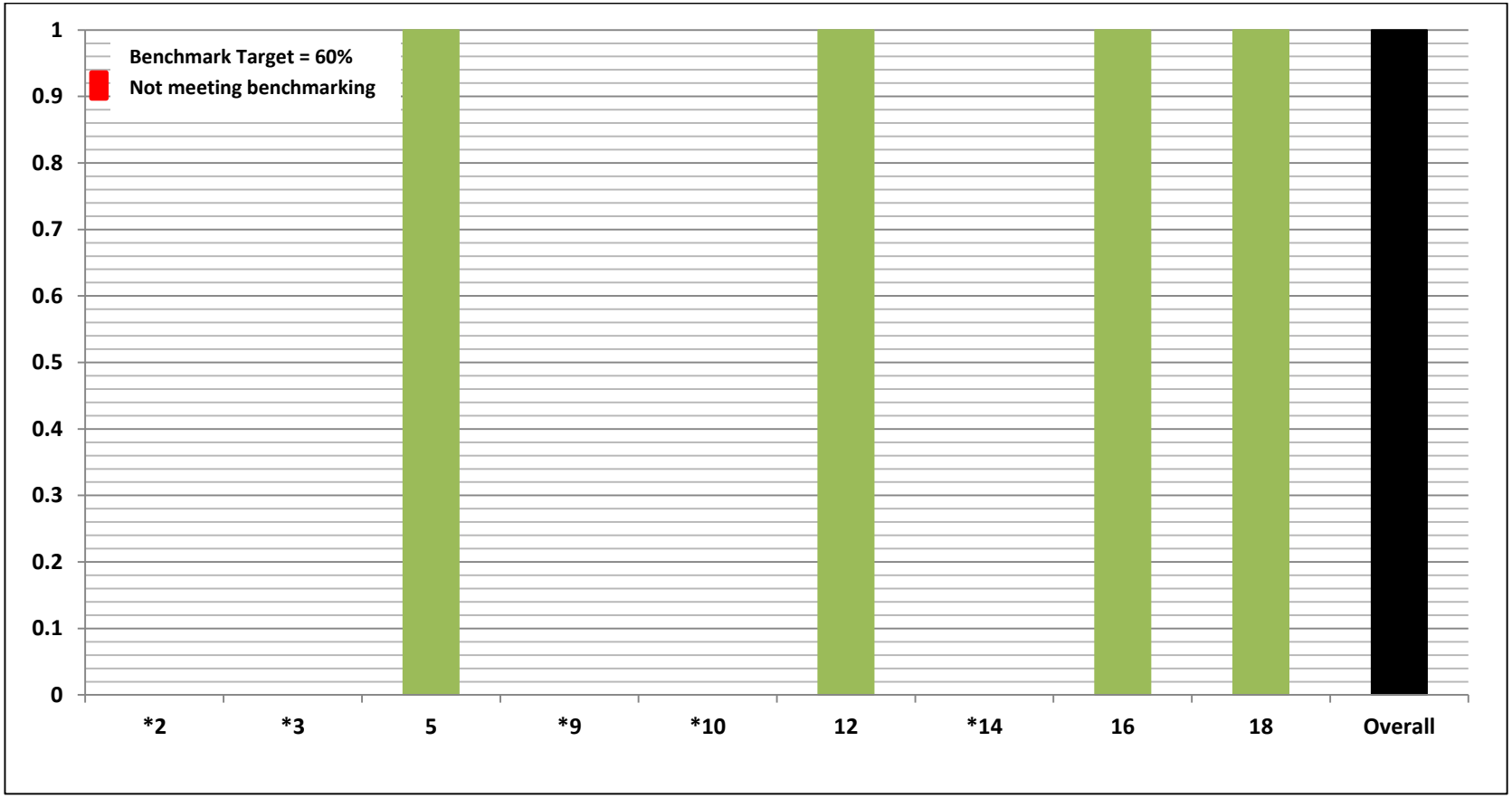
SA8: Youth Clients Reporting Stable Housing during the Reporting Month

The performance level for SA8 represents the percent of DSHS-funded youth clients who ended a specific service type during the fiscal year to date and were not listed with a current living situation as "homeless" or "shelter".

No variation across organizations was found, therefore, the table is not presented.

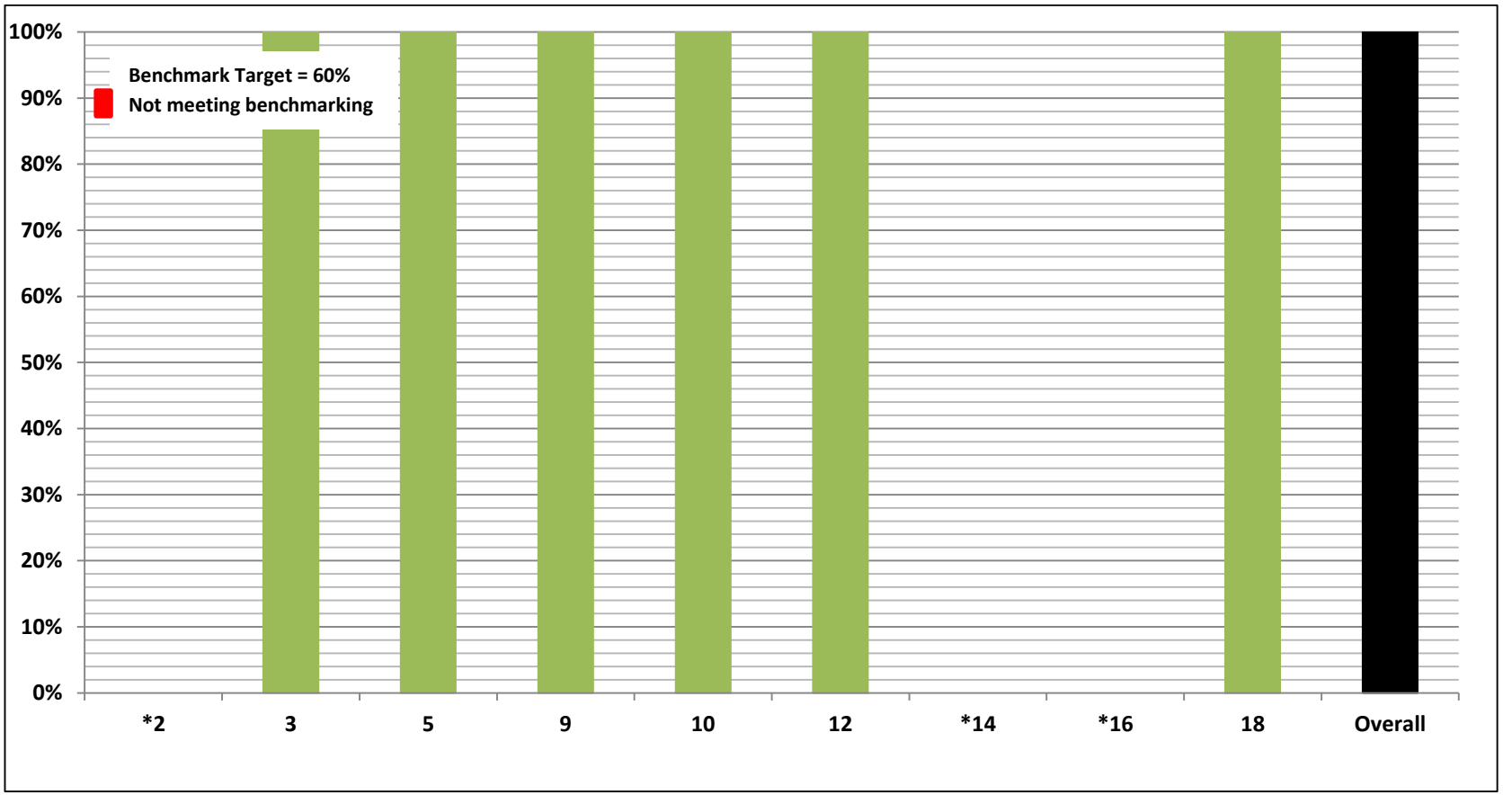
Variation between substance use providers

SA8 Youth Clients Reporting Stable Housing during the Reporting Month for 1st Half FY 2015



*Data was not available.

SA8 Youth Clients Reporting Stable Housing during the Reporting Month for 2nd Half FY 2015



*Data was not available.

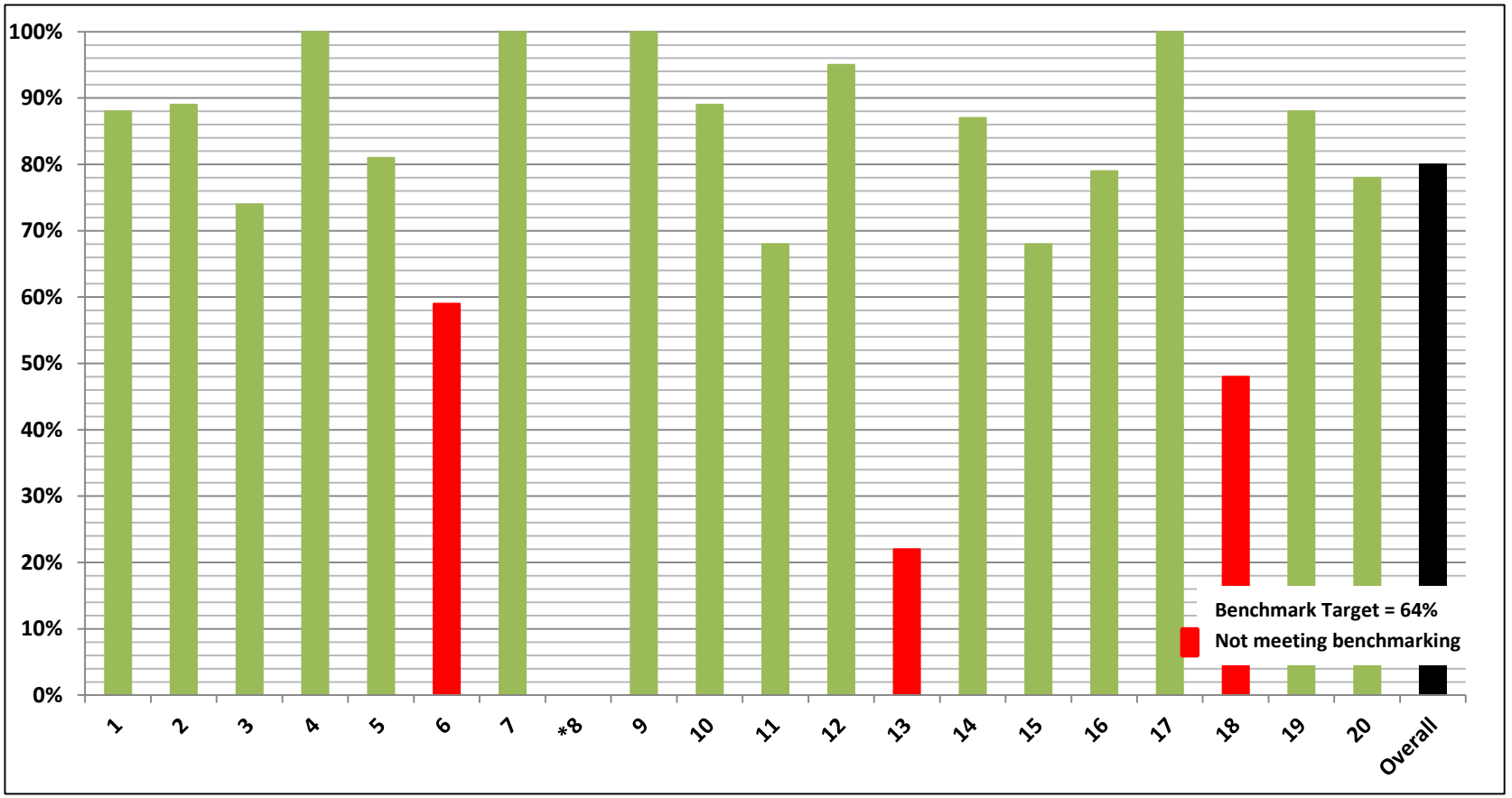
SA9: All Adult Clients Receiving Reproductive Health Visit (prenatal visit, postpartum visit, interconception visit)

The performance level for SA9 represents the number of adults whose cases were closed during the reporting month that received all reproductive health visits as recommended by the American Congress of Obstetricians and Gynecologist for the period of time the client was receiving PPI services.

Performance level (%) for the overall SA9 (n=20)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	80	21	22	100	28	68	88	97	3
2nd Half FY 2015	81	22	30	100	23	75	86	98	5
*IQT=Interquartile range									

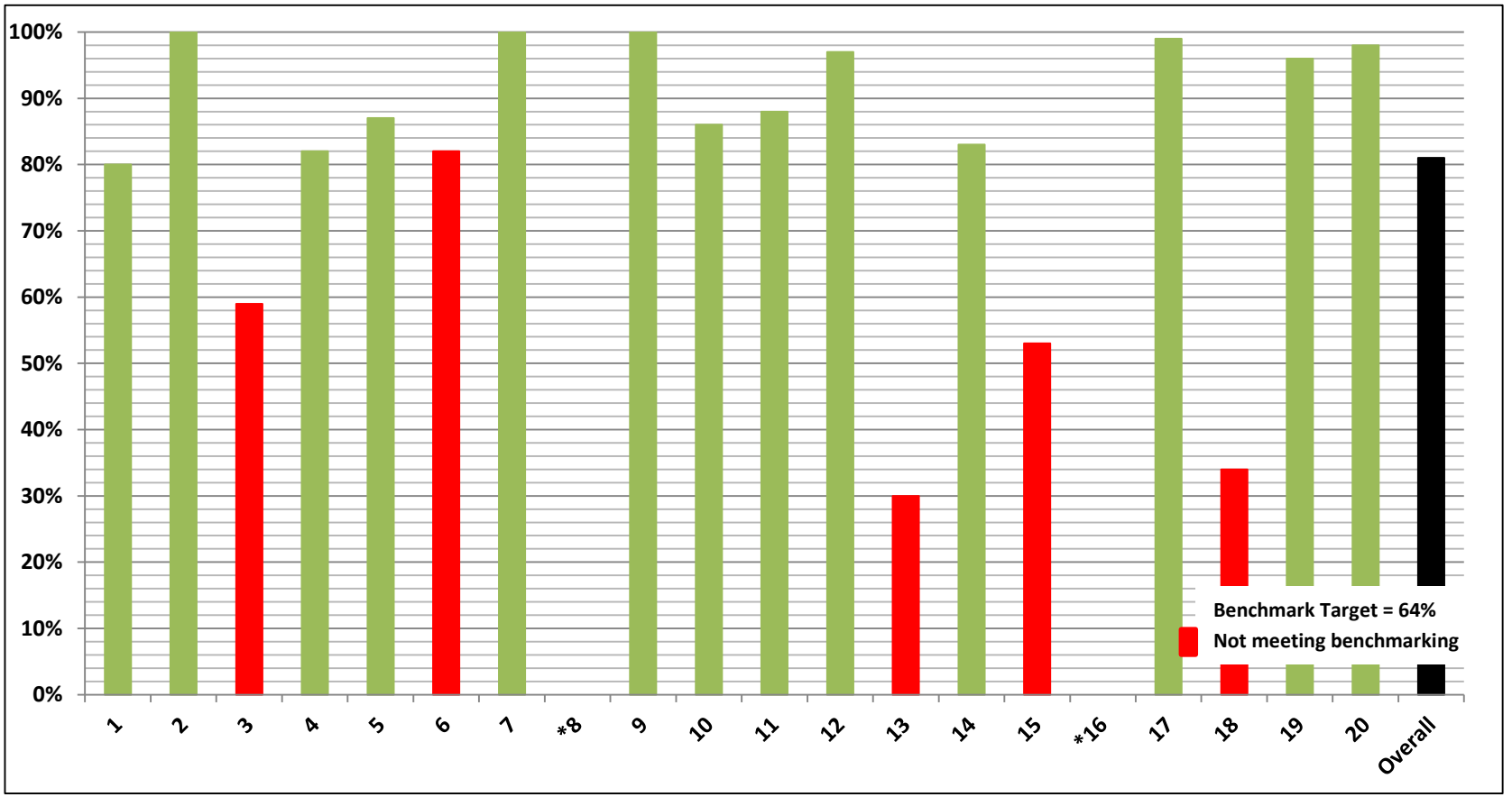
Variation between substance use providers

SA9 All Adult Clients Receiving Reproductive Health Visit for 1st Half FY 2015



*Data was not available.

SA9 All Adult Clients Receiving Reproductive Health Visit for 2nd Half FY 2015



*Data was not available.

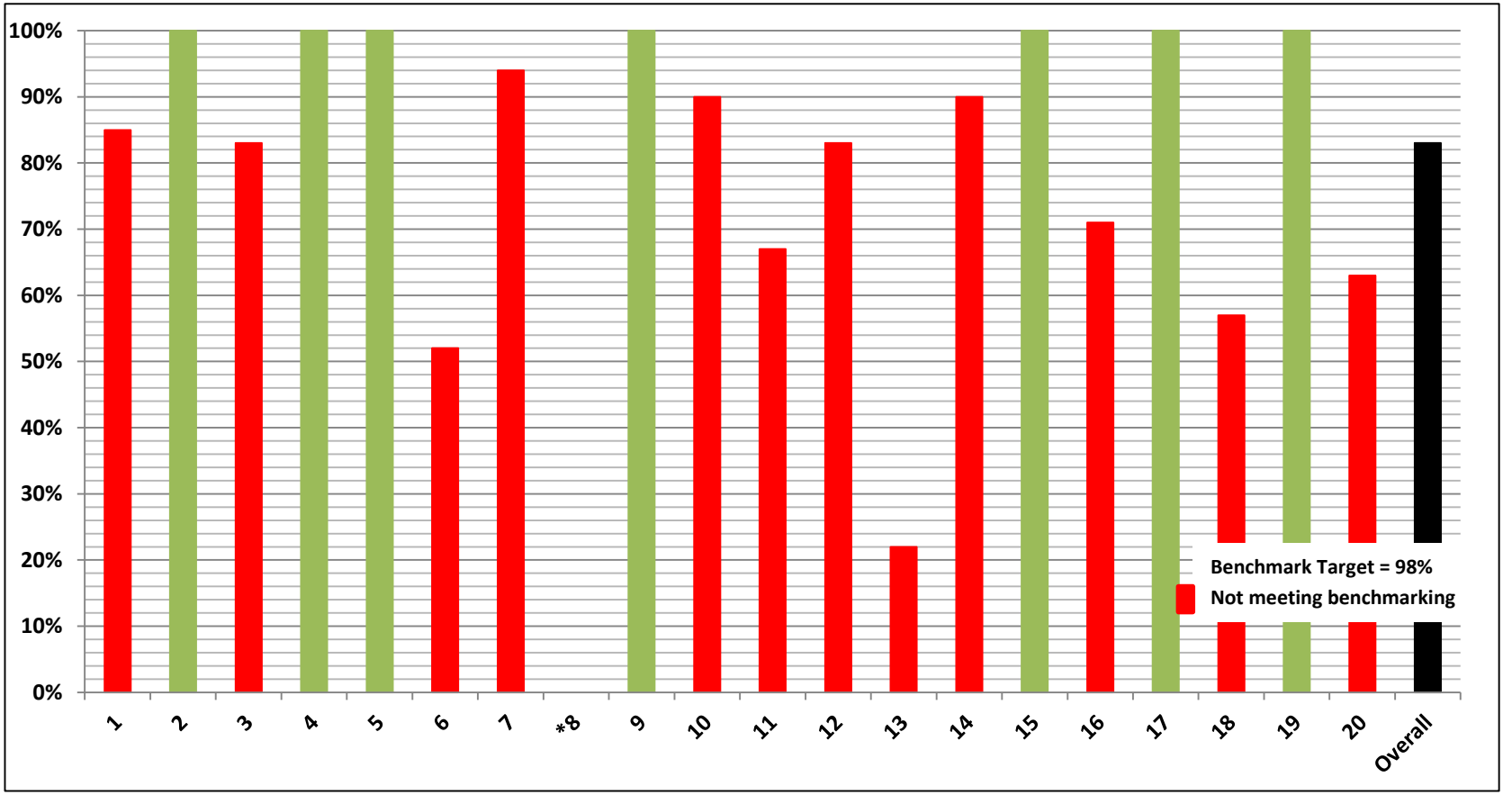
SA10: All Adult Clients Whose Children Received All Recommended Well-child Visits During the Time the Client's Case Was Open

The performance level for SA10 represents the number of adults whose cases were closed during the reporting month, whose children received all well-child visits as recommended by the American Academy of Pediatrics for the period of time the client was receiving PPI services.

Performance level (%) for the overall SA19 (n=20)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	83	22	22	100	34	66	90	100	12
2nd Half FY 2015	82	25	21	100	80	69	93	100	10
*IQT=Interquartile range									

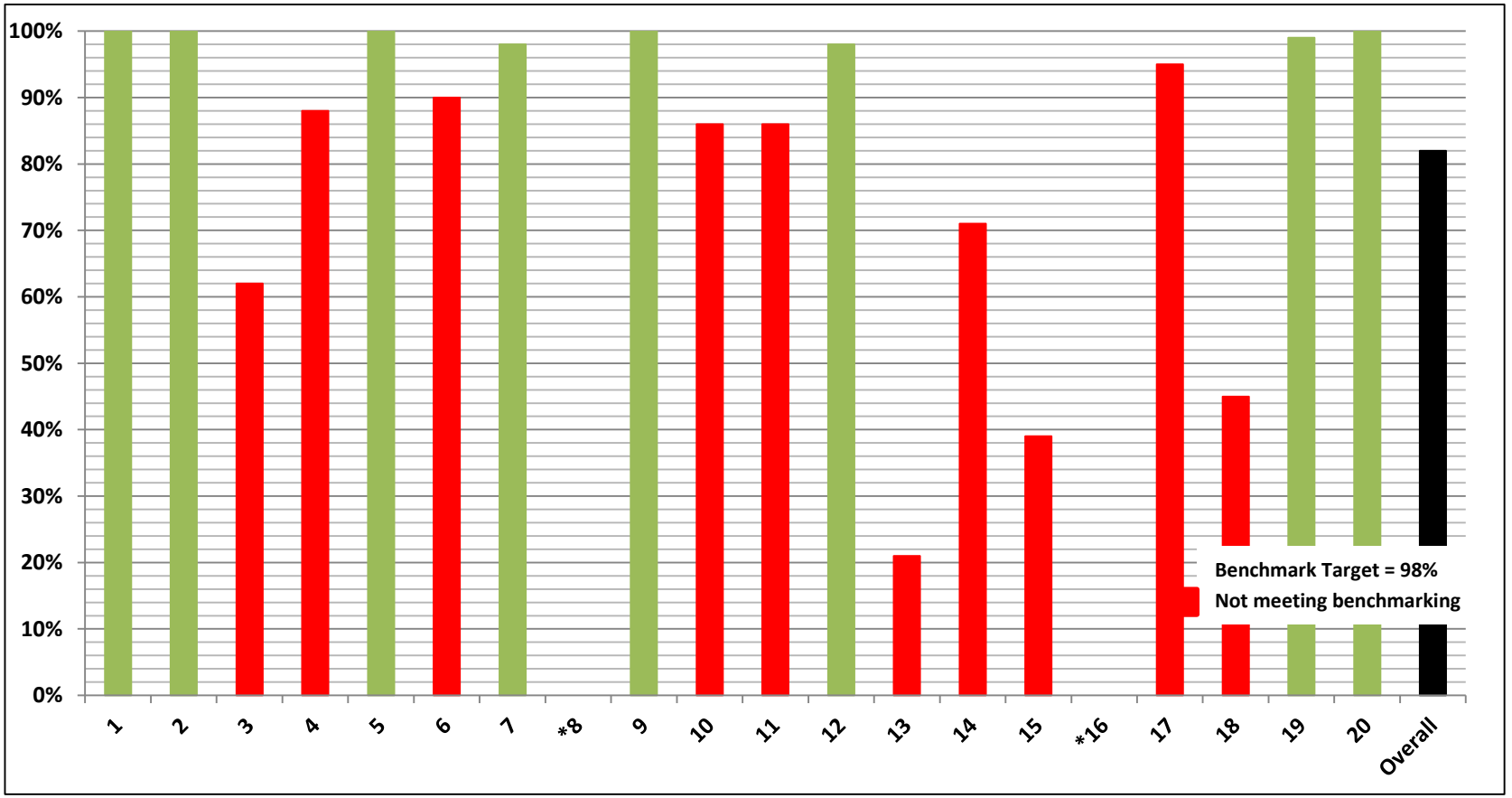
Variation between substance use providers

SA10 All Adult Clients Whose Children Received All Recommended Well-child Visits During the Time the Client's Case Was Open for 1st Half FY 2015



*Data was not available.

SA10 All Adult Clients Whose Children Received All Recommended Well-child Visits During the Time the Client's Case Was Open for 2nd Half FY 2015



*Data was not available.

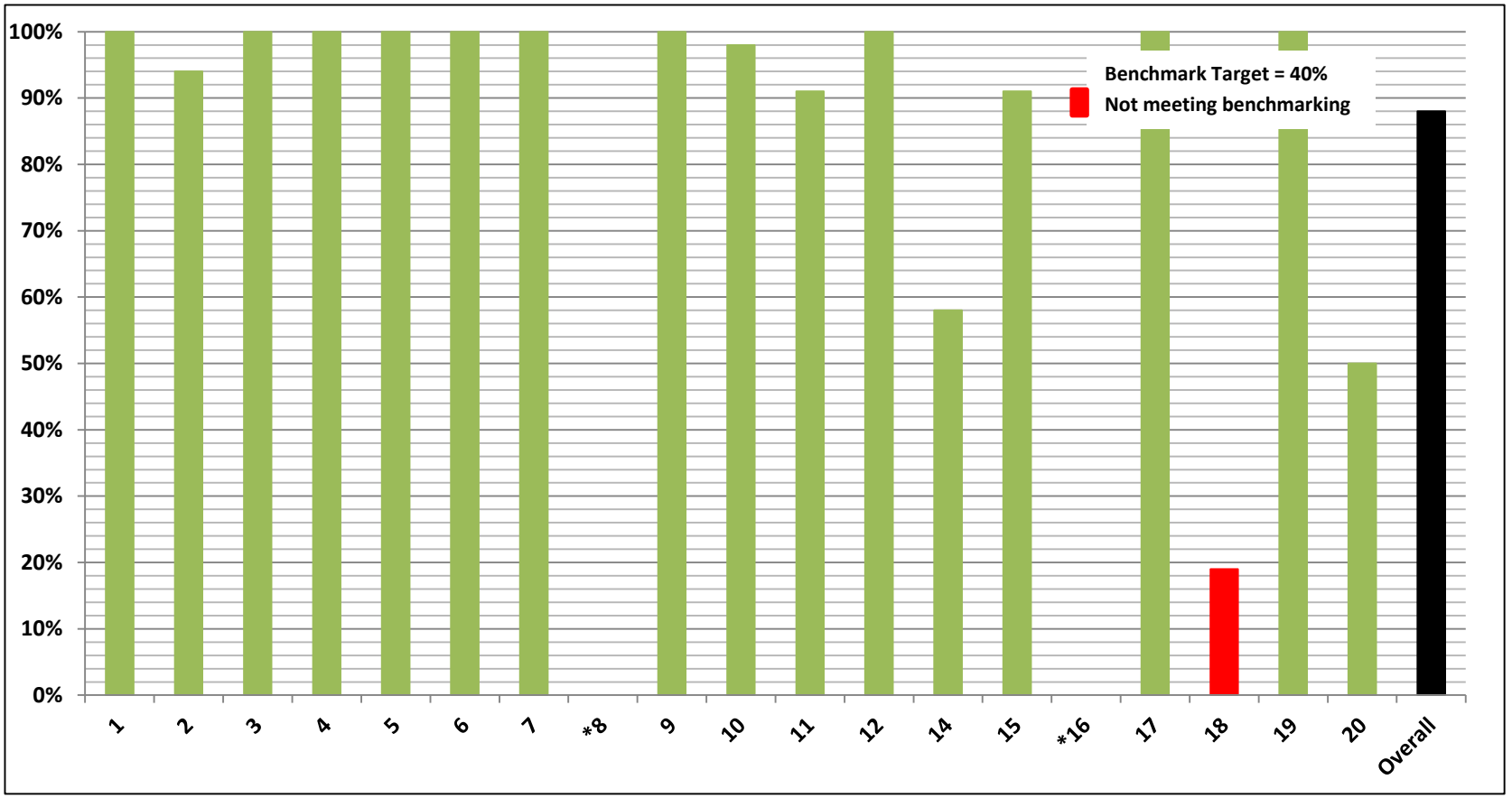
SA11: All Youth Clients Receiving Reproductive Health Visit (prenatal visit, postpartum visit, interconception visit)

The performance level for SA11 represents the number of youth whose cases were closed during the reporting month that received all reproductive health visits as recommended by the American Congress of Obstetricians and Gynecologist for the period of time the client was receiving PPI services.

Performance level (%) for the overall SA19 (n=19)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	88	23	19	100	9	91	100	100	1
2nd Half FY 2015	78	26	0	100	23	75	82	98	1
*IQT=Interquartile range									

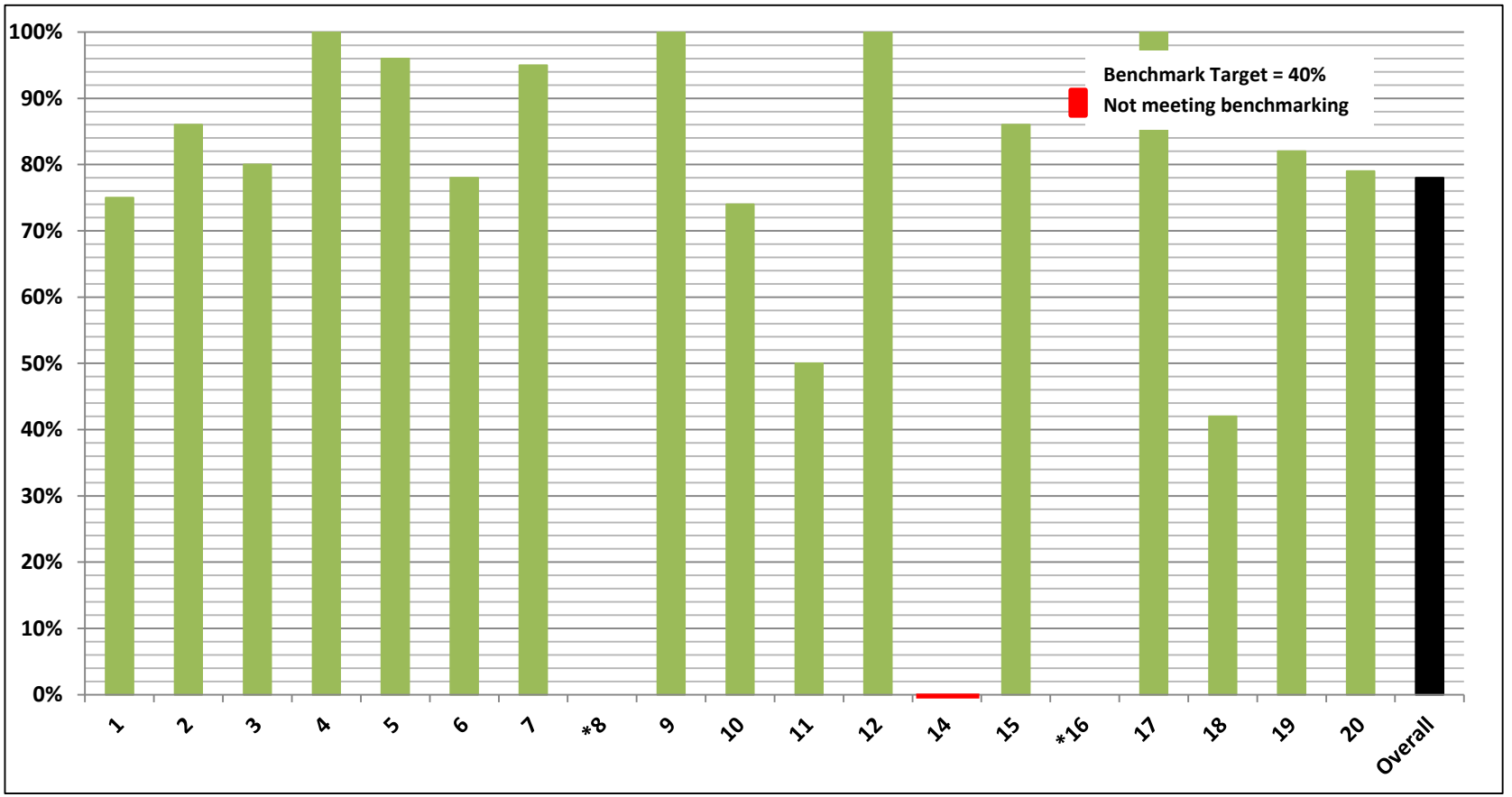
Variation between substance use providers

SA11 All Youth Clients Receiving Reproductive Health Visit for 1st Half FY 2015



*Data was not available.

SA11 All Youth Clients Receiving Reproductive Health Visit for 2nd Half FY 2015



*Data was not available.

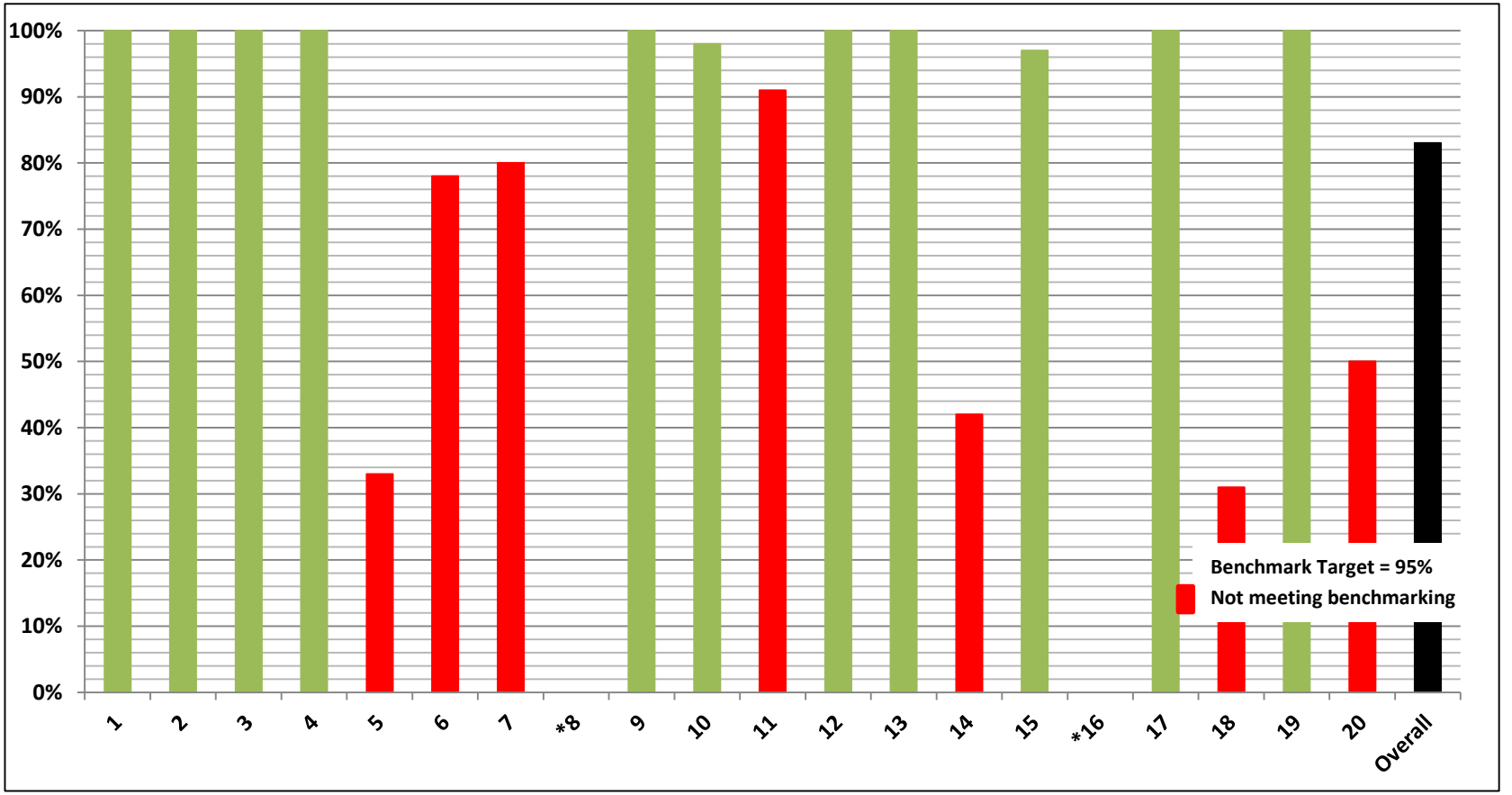
SA12: All Youth Clients Whose Children Received All Recommended Well-child Visits During the Time the Client's Case Was Open

The performance level for SA12 represents the number of adults whose cases were closed during the reporting month, whose children received all well-child visits as recommended by the American Academy of Pediatrics for the period of time the client was receiving PPI services.

Performance level (%) for the overall SA12 (n=20)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	83	26	31	100	29	71	99	100	7
2nd Half FY 2015	76	20	42	100	41	55	79	97	13
*IQT=Interquartile range									

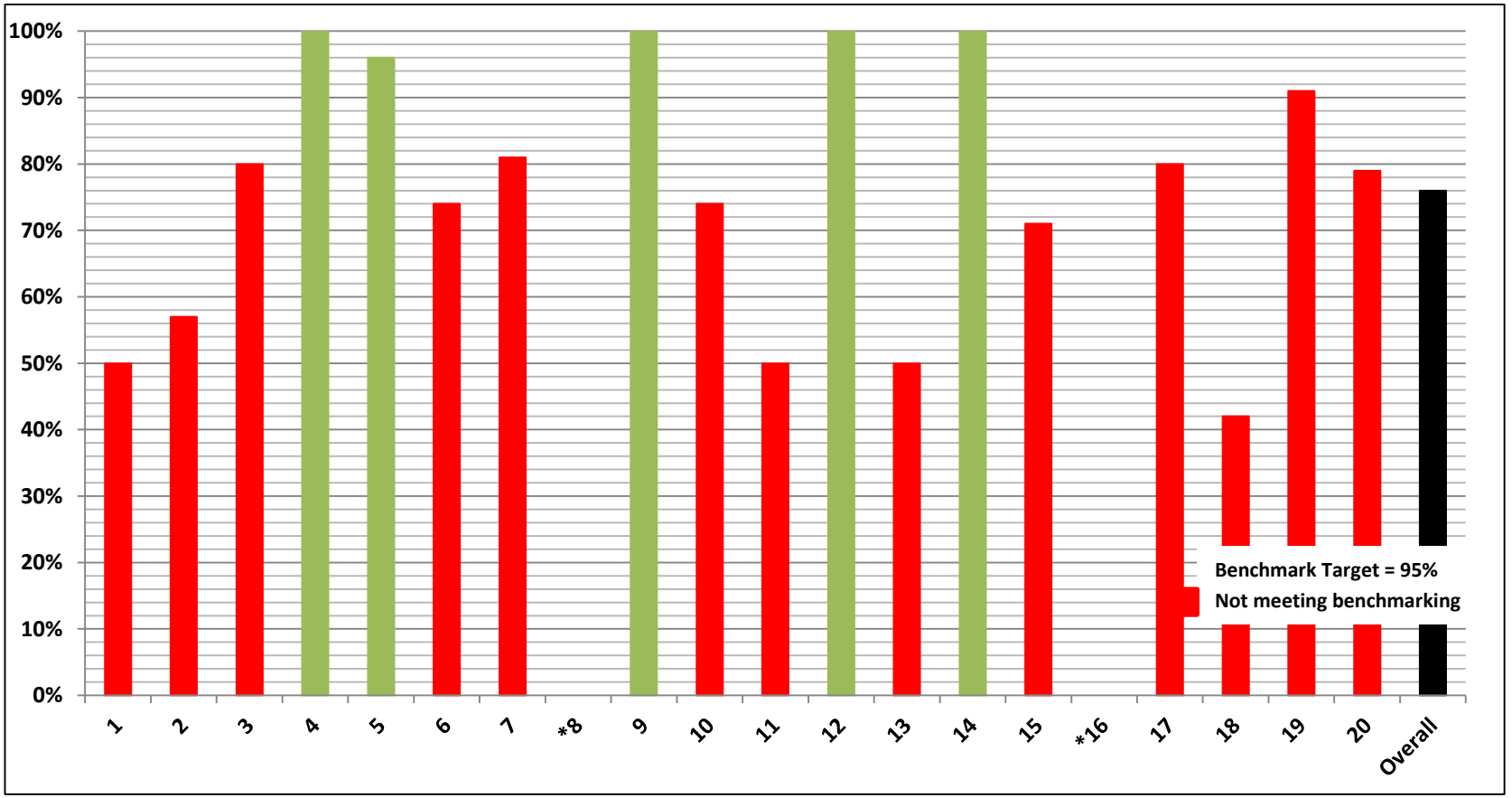
Variation between substance use providers

SA12 All Youth Clients Whose Children Received All Recommended Well-child Visits During the Time the Client's Case Was Open for 1st Half FY 2015



*Data was not available.

SA12 All Youth Clients Whose Children Received All Recommended Well-child Visits During the Time the Client's Case Was Open for 2nd Half FY 2015



*Data was not available.

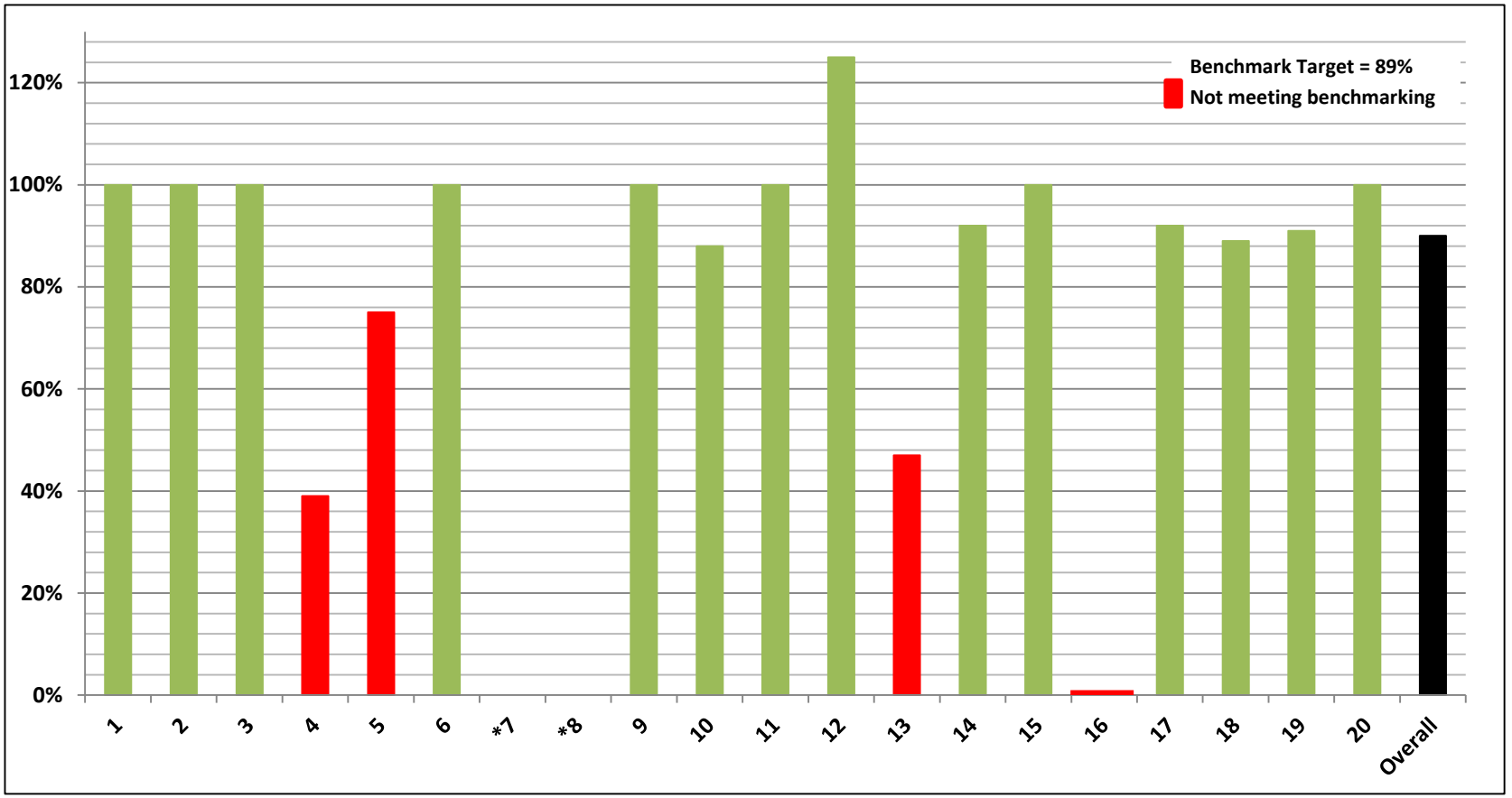
SA13: All Pregnant Adults Delivering at Full-Term

The performance level for SA13 represents the number of adults with a PPI open case prior to 28 weeks gestation and through the delivery, who delivered at full term (37 weeks gestation or later) during the reporting period.

Performance level (%) for the overall SA13 (n=20)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	90	21	39	125	11	89	100	100	4
2nd Half FY 2015	74	35	0	105	44	56	88	100	10
*IQT=Interquartile range									

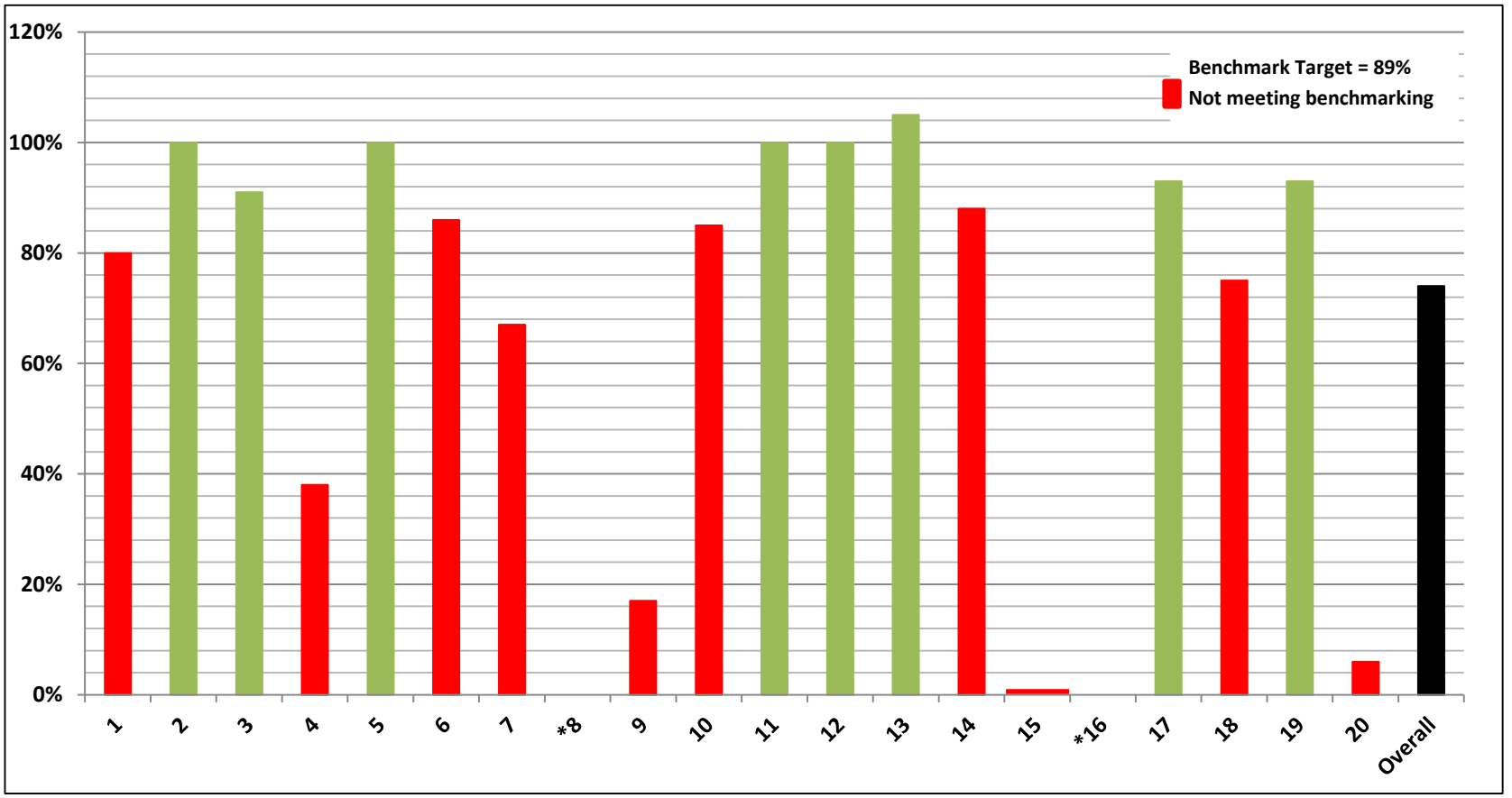
Variation between substance use providers

SA13 All Pregnant Adults Delivering at Full-Term for 1st Half FY 2015



*Data was not available.

SA13 All Pregnant Adults Delivering at Full-Term for 2nd Half FY 2015



*Data was not available.

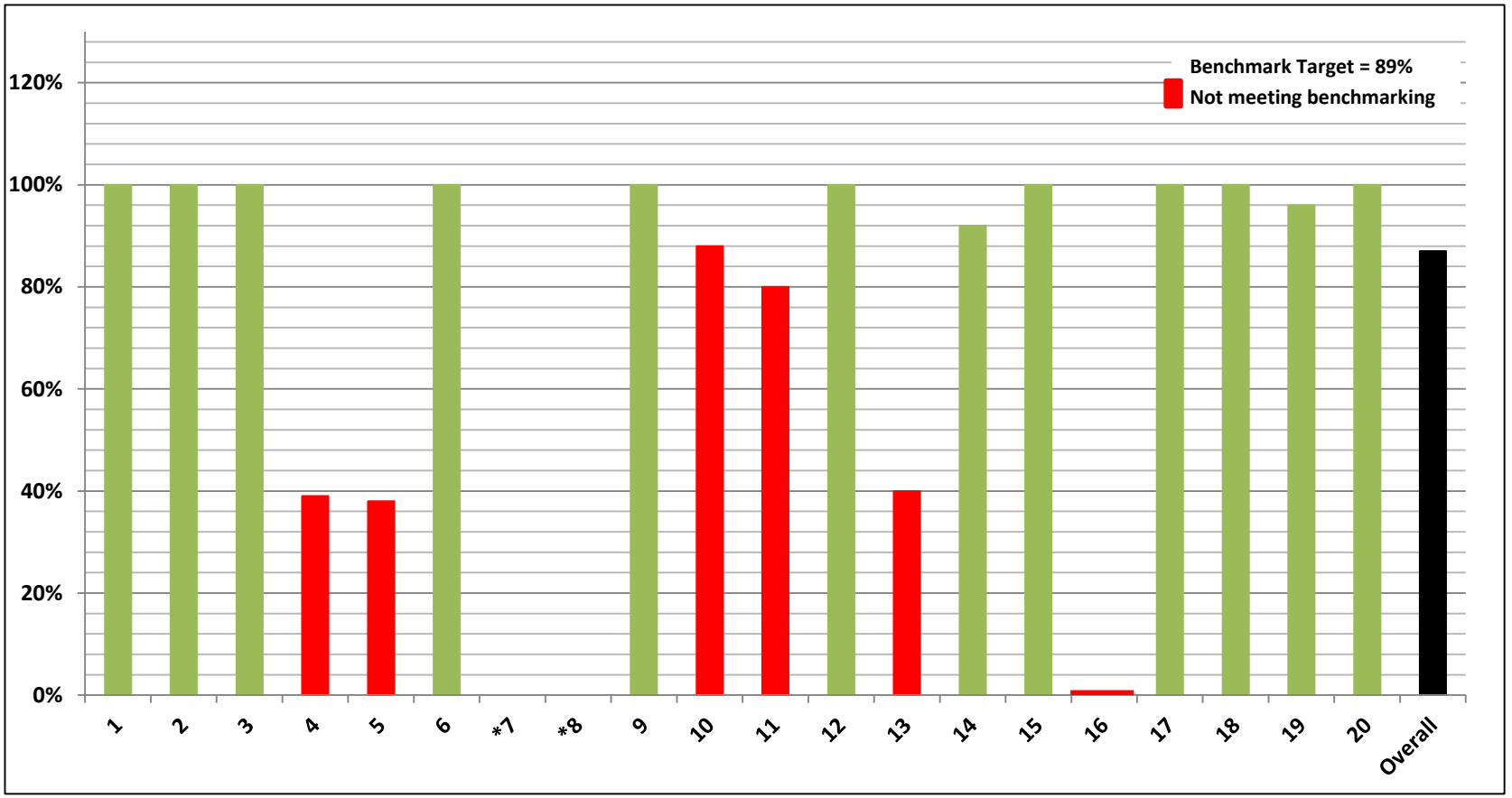
SA14: All Pregnant Adults Delivering Healthy Baby Weight

The performance level for SA14 represents the number of adults with a PPI open case prior to 28 weeks gestation and through the delivery, who delivered a healthy baby weight (5 pounds, 8 ounces) during the reporting period.

Performance level (%) for the overall SA14 (n=20)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	87	24	38	100	16	84	100	100	6
2nd Half FY 2015	72	37	5	105	54	89	100	100	10
*IQT=Interquartile range									

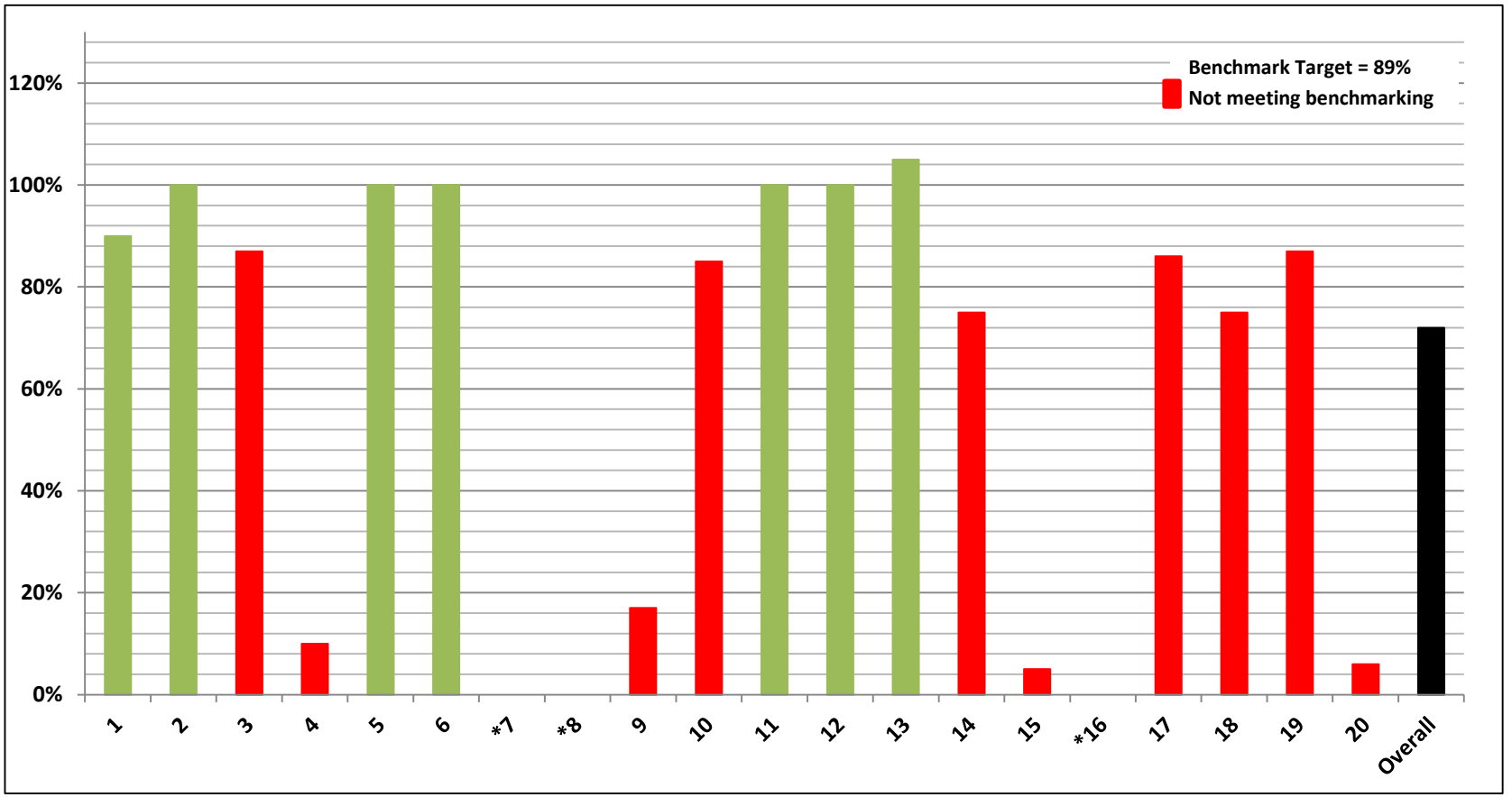
Variation between substance use providers

SA14 All Pregnant Adults Delivering Healthy Baby Weight for 1st Half FY 2015



*Data was not available.

SA14 All Pregnant Adults Delivering Healthy Baby Weight for 2nd Half FY 2015



*Data was not available.

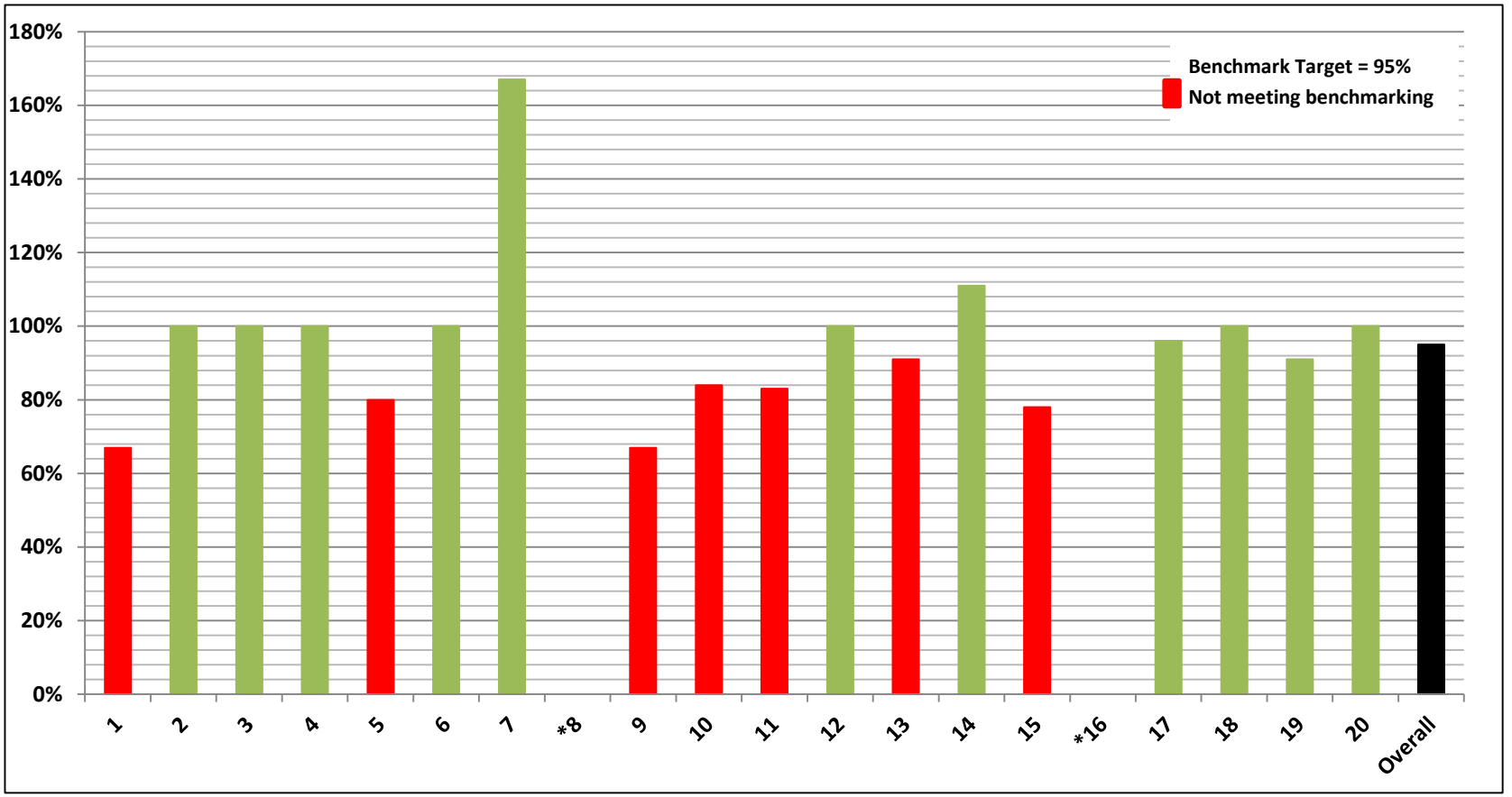
SA15: All Pregnant Adults Reporting Abstinence from Date of Open Case to Delivery

The performance level for SA15 represents the number of adults giving birth during reporting month (regardless of when the case was open) who maintained abstinence from alcohol, tobacco, and other non-prescribed drugs from the time the case was opened in CMBHS to at least the time of delivery.

Performance level (%) for the overall SA15 (n=20)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	95	22	67	168	18	83	98	100	7
2nd Half FY 2015	93	24	31	146	13	87	100	100	5
*IQT=Interquartile range									

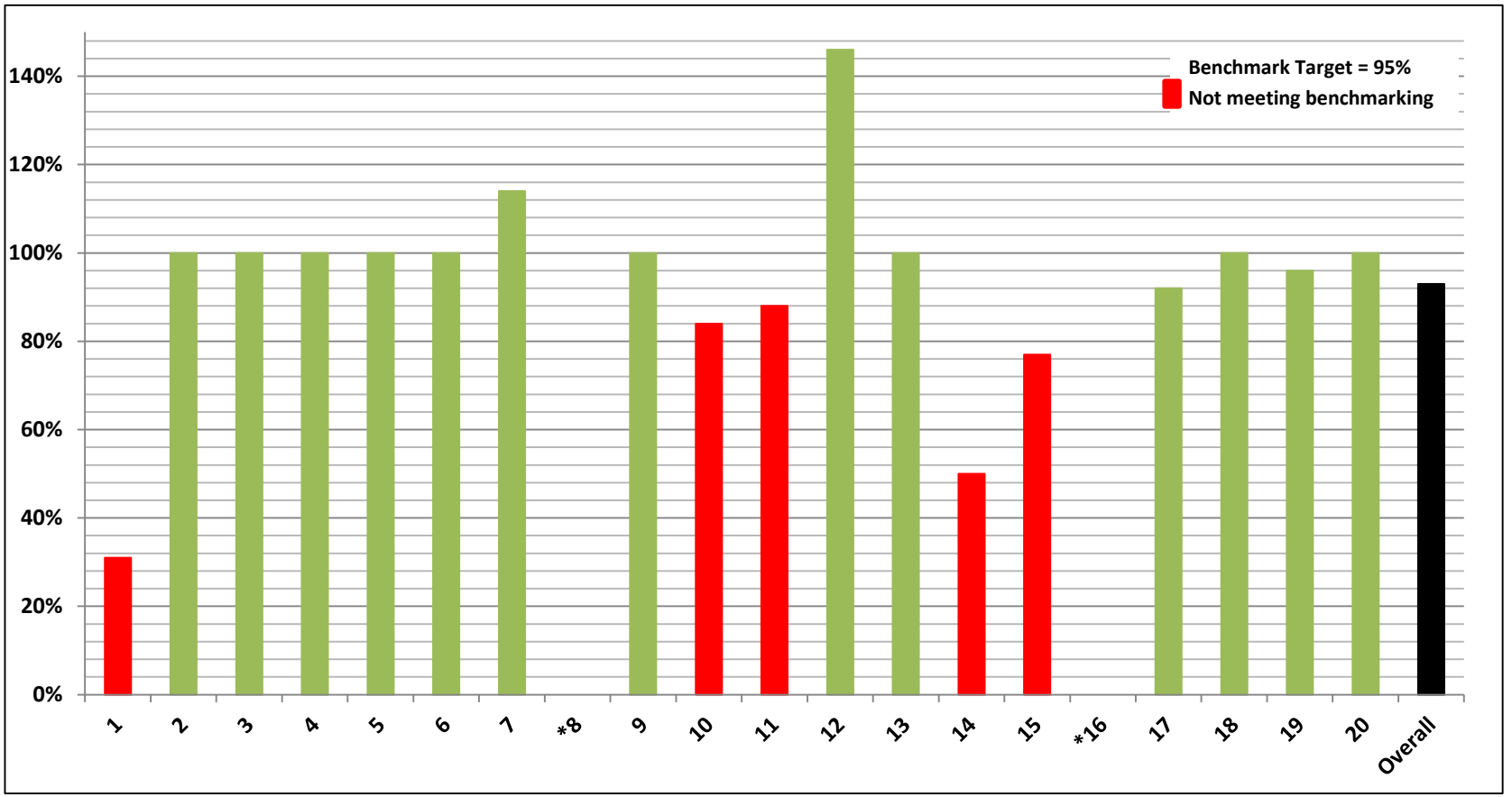
Variation between substance use providers

SA15 All Pregnant Adults Reporting Abstinence from Date of Open Case to Delivery for 1st Half FY 2015



*Data was not available.

SA15 All Pregnant Adults Reporting Abstinence from Date of Open Case to Delivery for 2nd Half FY 2015



*Data was not available.

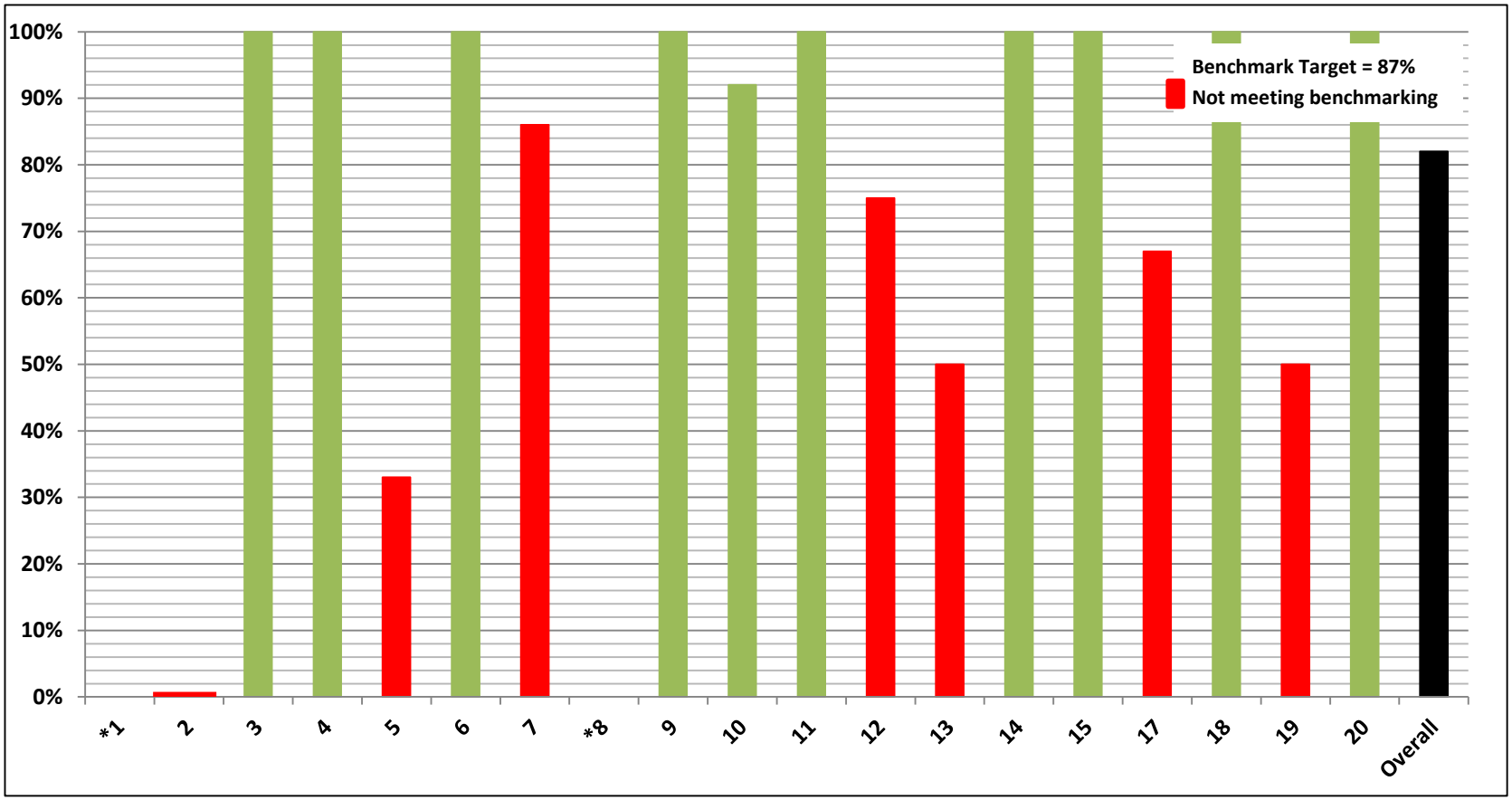
SA16: All Pregnant Youth Delivering at Full-Term

The performance level for SA16 represents the number of youth with a PPI open case prior to 28 weeks gestation and through the delivery, who delivered at full term (37 weeks gestation or later) during the reporting period.

Performance level (%) for the overall SA16 (n=19)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	82	23	33	100	38	63	96	100	7
2nd Half FY 2015	81	33	0	100	34	66	100	100	5
*IQT=Interquartile range									

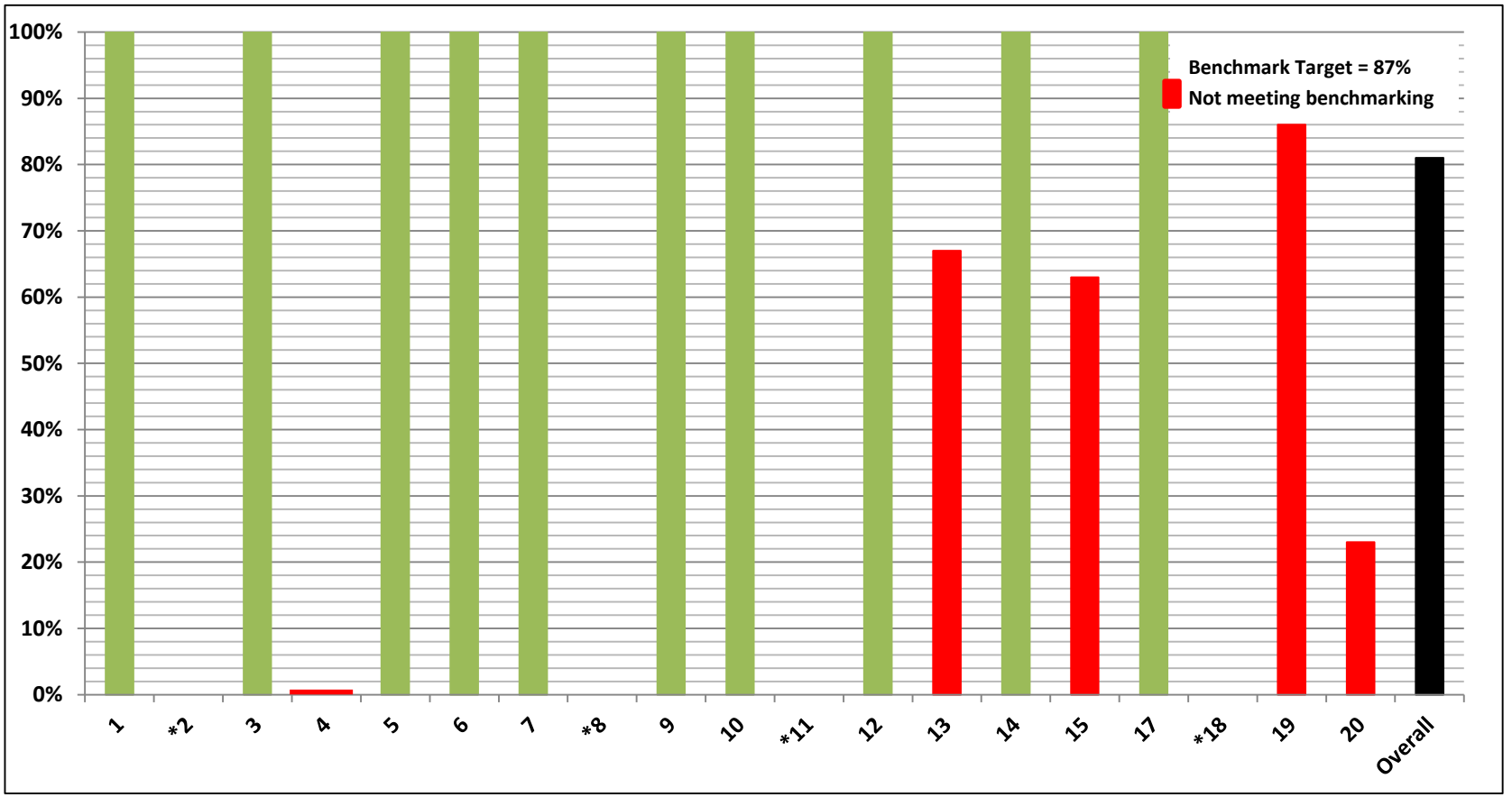
Variation between substance use organizations

SA16 All Pregnant Youth Delivering at Full-Term for 1st Half FY 2015



*Data was not available.

SA16 All Pregnant Youth Delivering at Full-Term for 2nd Half FY 2015



*Data was not available.

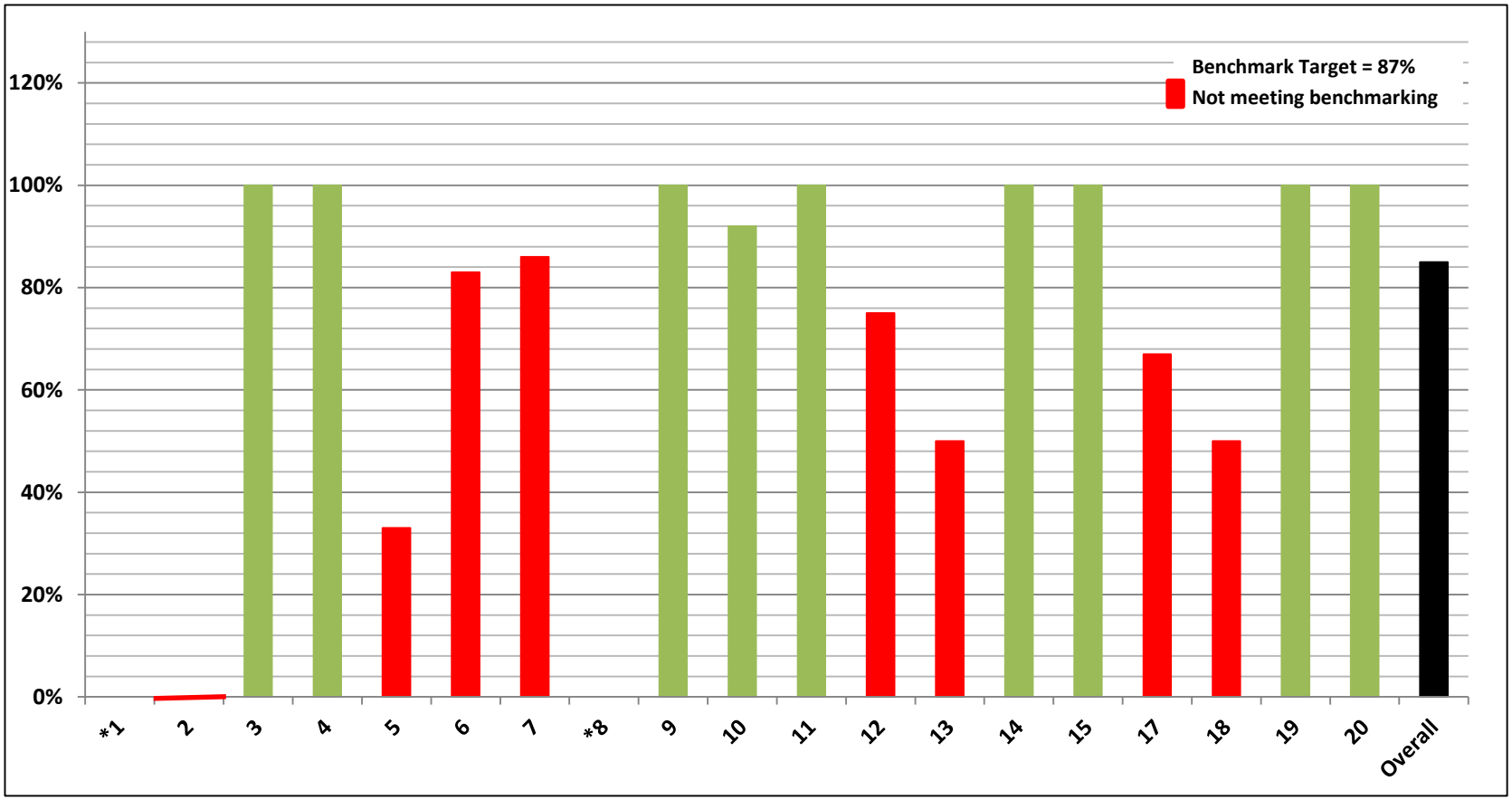
SA17: All Pregnant Youth Delivering Healthy Baby Weight

The performance level for SA14 represents the number of youth with a PPI open case prior to 28 weeks gestation and through the delivery, who delivered a healthy baby weight (5 pounds, 8 ounces) during the reporting period.

Performance level (%) for the overall SA19 (n=20)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	85	21	33	100	27	73	96	100	8
2nd Half FY 2015	82	32	0	100	19	81	97	100	4
*IQT=Interquartile range									

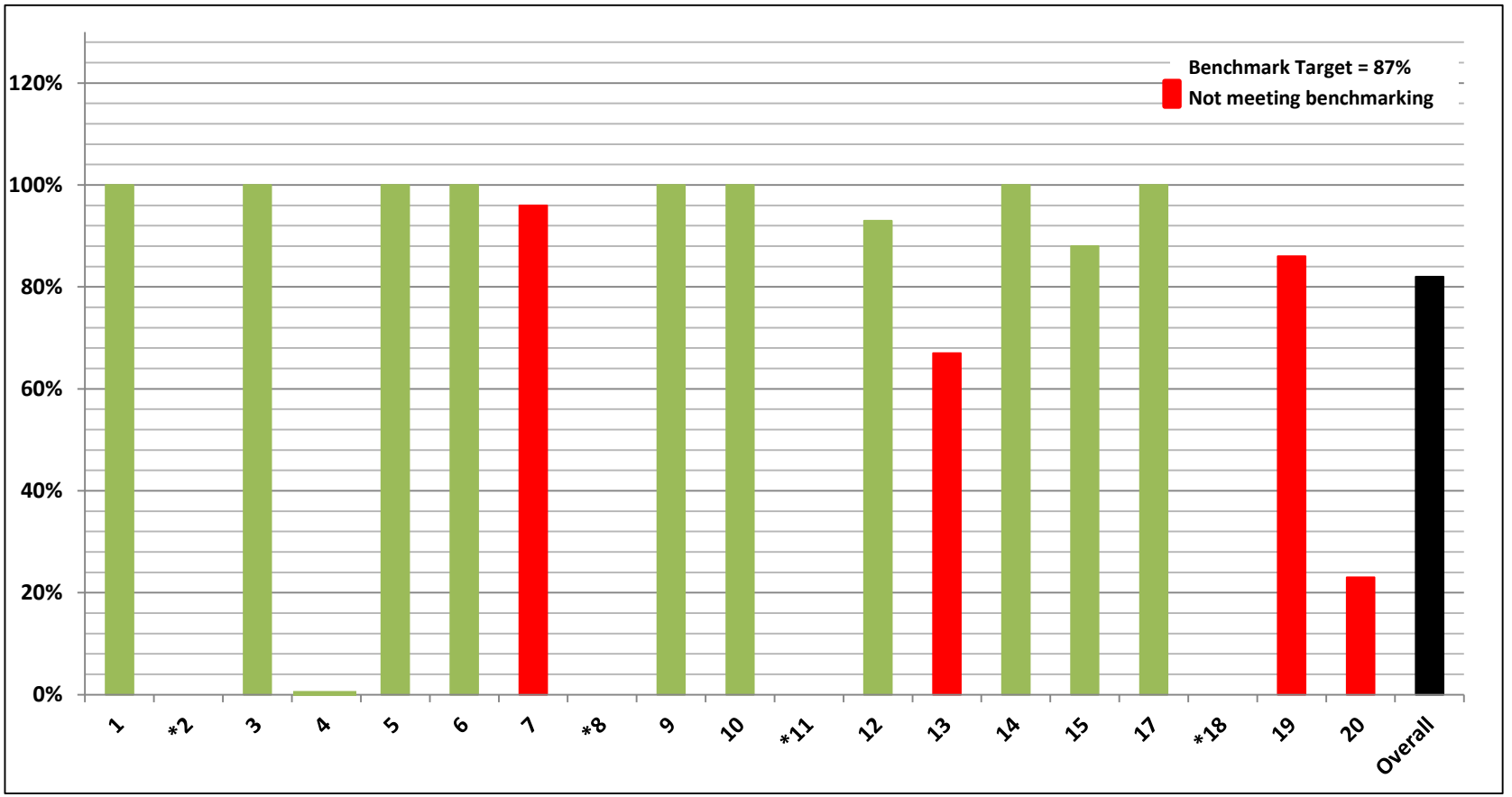
Variation between substance use providers

SA17 All Pregnant Youth Delivering Healthy Baby Weight for 1st Half FY 2015



*Data was not available.

SA17 All Pregnant Youth Delivering Healthy Baby Weight for 2nd Half FY 2015



*Data was not available.

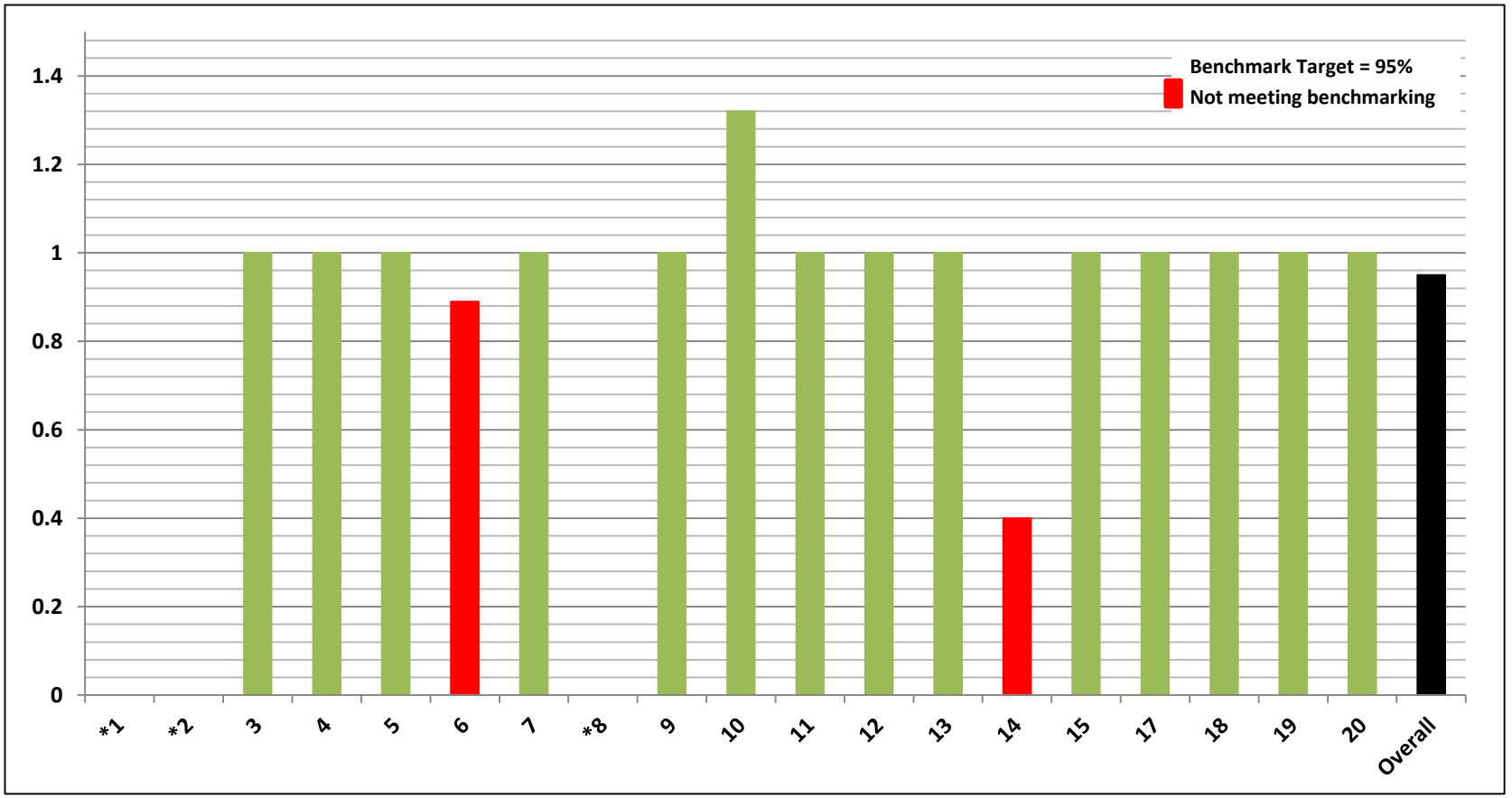
SA18: All Pregnant Youth Reporting Abstinence from Date of Open Case to Delivery

The performance level for SA15 represents the number of youth giving birth during reporting month (regardless of when the case was open) who maintained abstinence from alcohol, tobacco, and other non-prescribed drugs from the time the case was opened in CMBHS to at least the time of delivery.

Performance level (%) for the overall SA18 (n=19)									
	Mean	SD	Min	Max	IQT*	25th	50th	75th	# LMHAs not meeting benchmarking
1st Half FY 2015	97	20	40	132	0	100	100	100	2
2nd Half FY 2015	No variation								0
*IQT=Interquartile range									

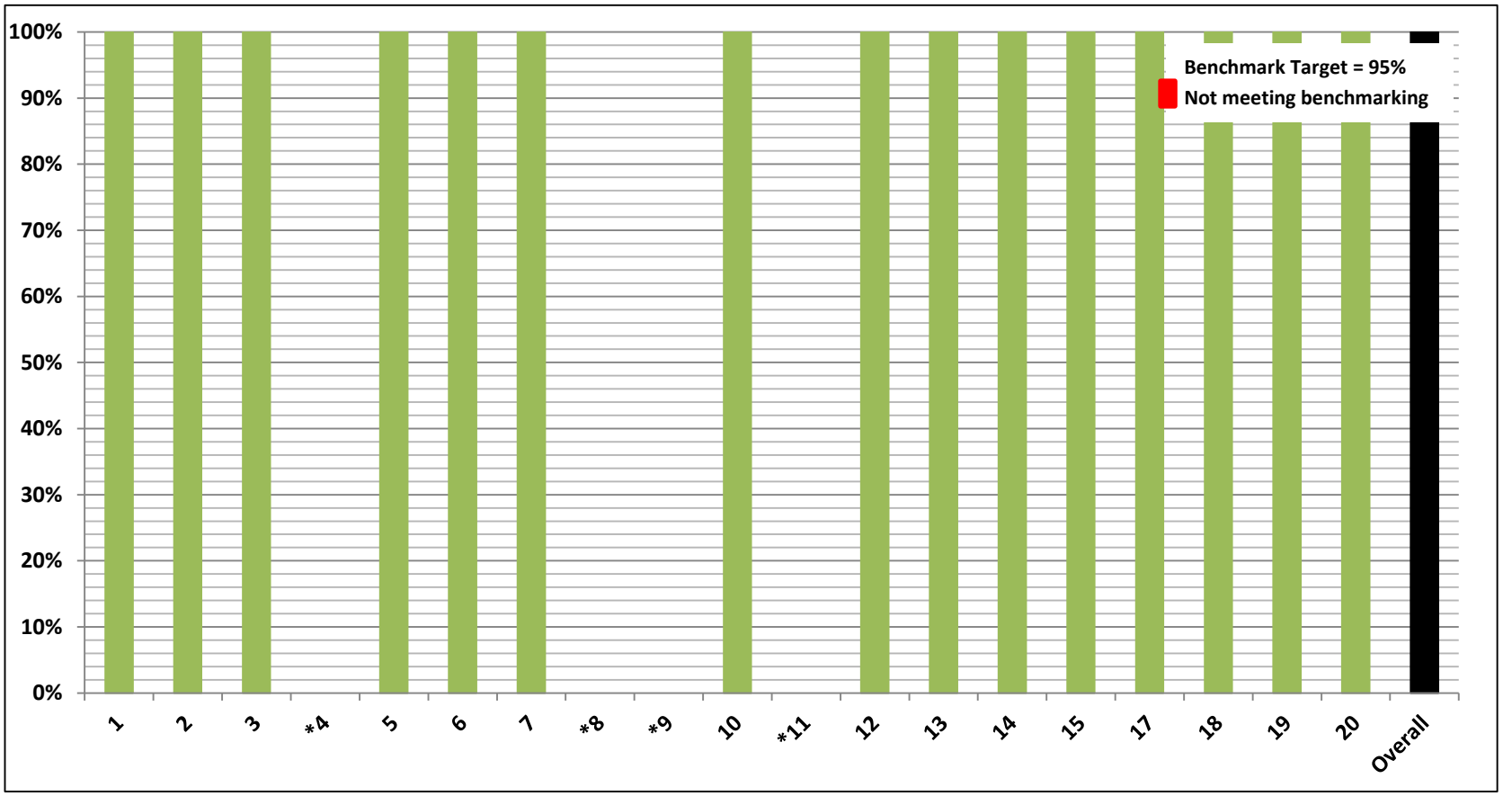
Variation between substance use providers

SA18 All Pregnant Youth Reporting Abstinence from Date of Open Case to Delivery for 1st Half FY 2015



*Data was not available.

SA18 All Pregnant Youth Reporting Abstinence from Date of Open Case to Delivery for 2nd Half FY 2015



*Data was not available.

D. Results – Treatment Measures

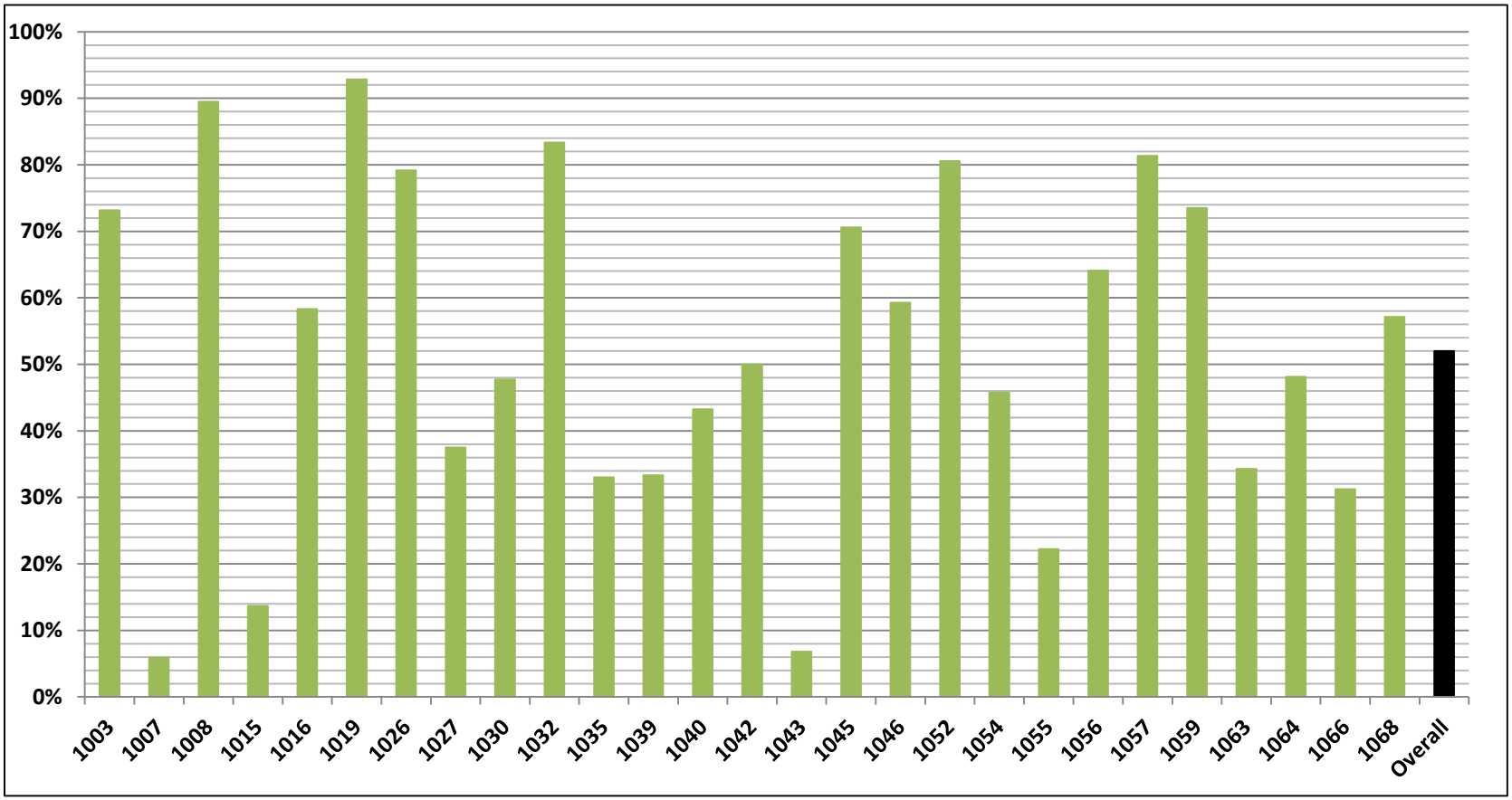
SA19: Client Engagement

The performance level for SA19 represents the percent of DSHS-funded clients who ended a co-occurring psychiatric and substance use disorders (COPSD) services during the fiscal year to date.

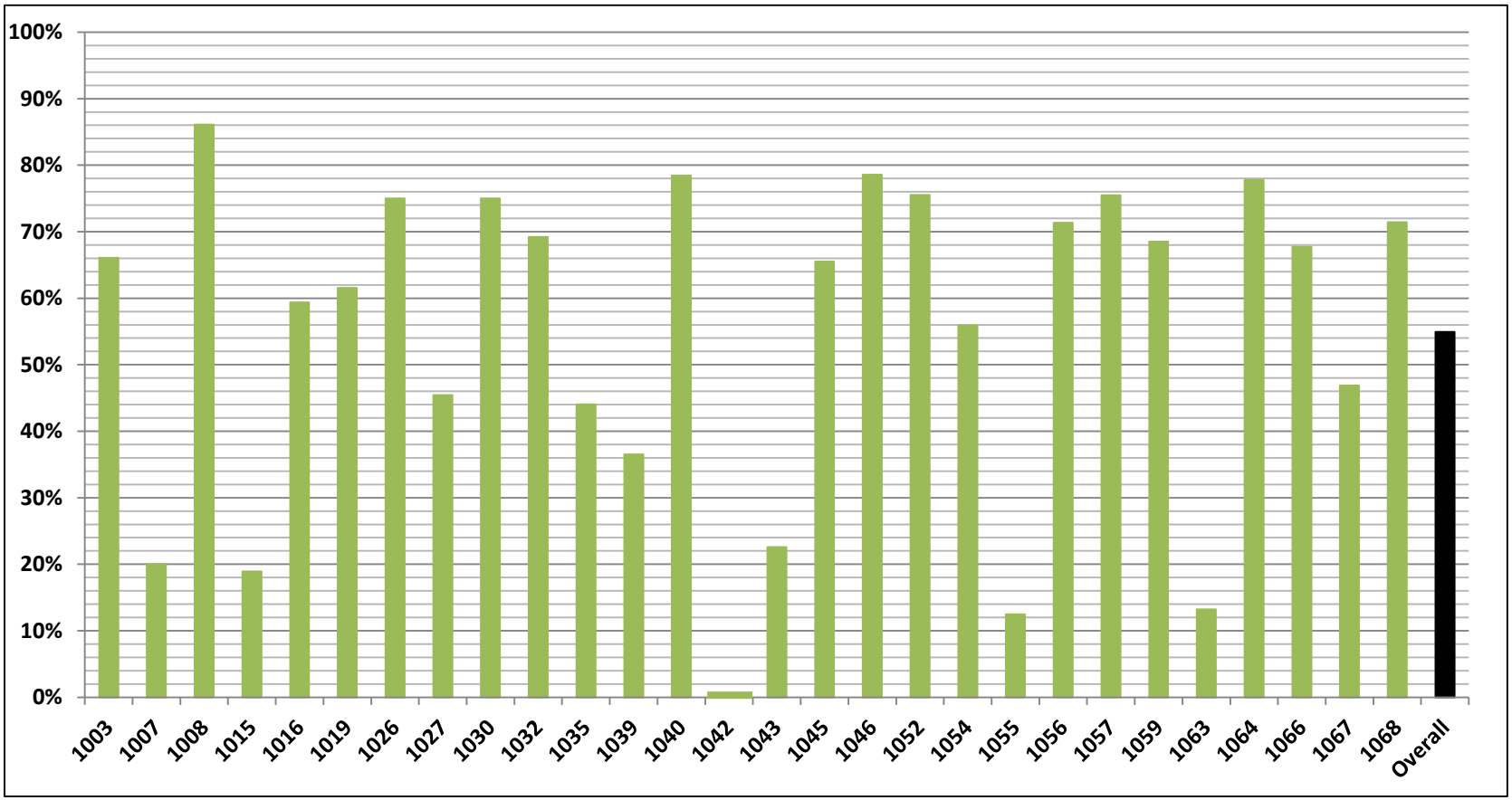
Performance level (%) for the overall SA19 (n=27; n=28)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
1st Half FY 2015	52	25	6	93	40	33	50	74
2nd Half FY 2015	55	25	0	86	38	37	66	75
*IQT=Interquartile range								

Variation between substance use providers

SA19 Client Engagement Performance Level during the Reporting Period for 1st Half FY 2015



SA19 Client Engagement Performance Level during the Reporting Period for 2nd Half FY 2015



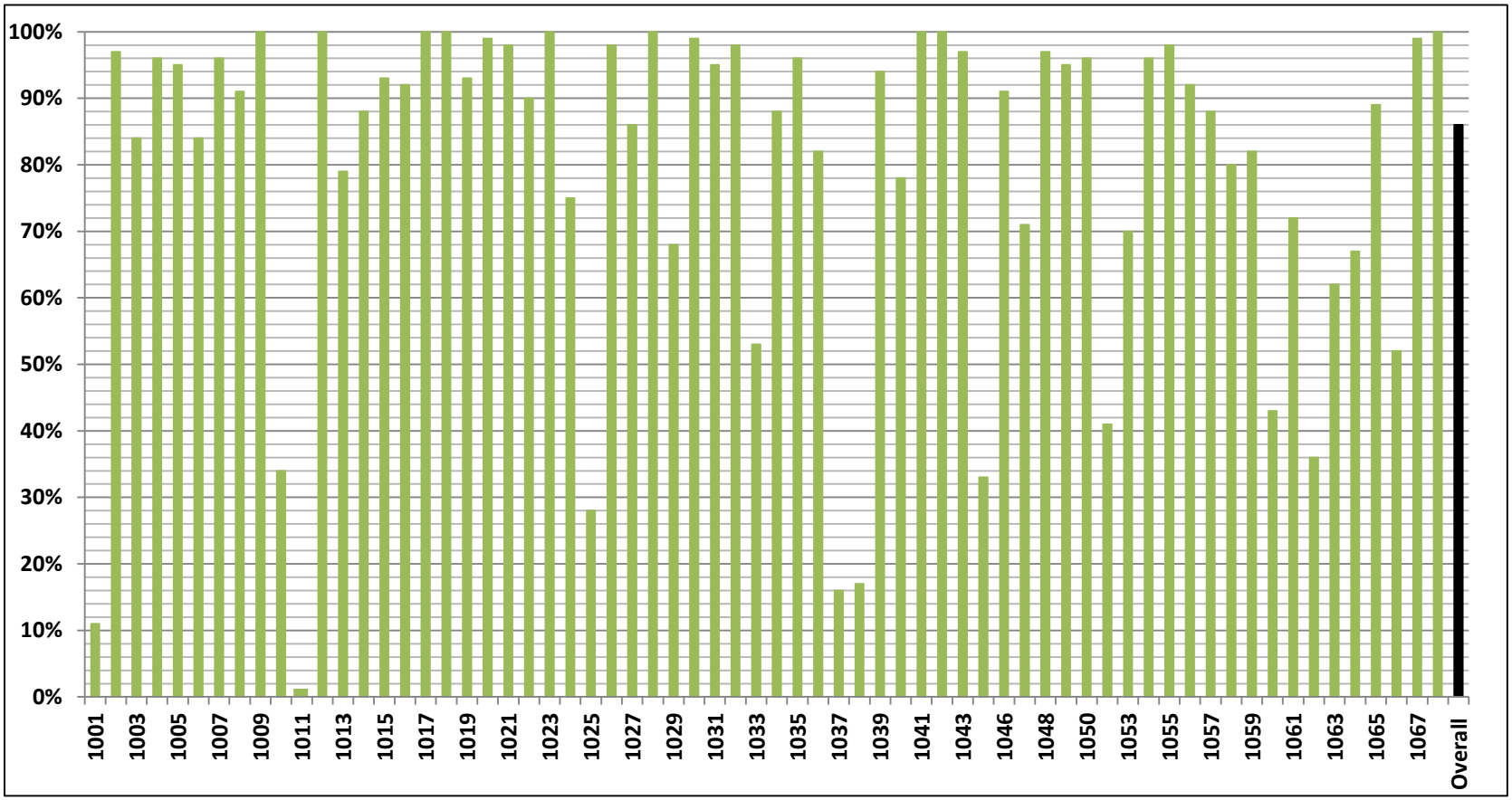
SA20: Involved in Ongoing Treatment

The performance level for SA20 is expressed as a percentage of clients who admitted to, or started in, another level of service or be listed as attending a support group in the substance abuse section of the service end or discharge assessment.

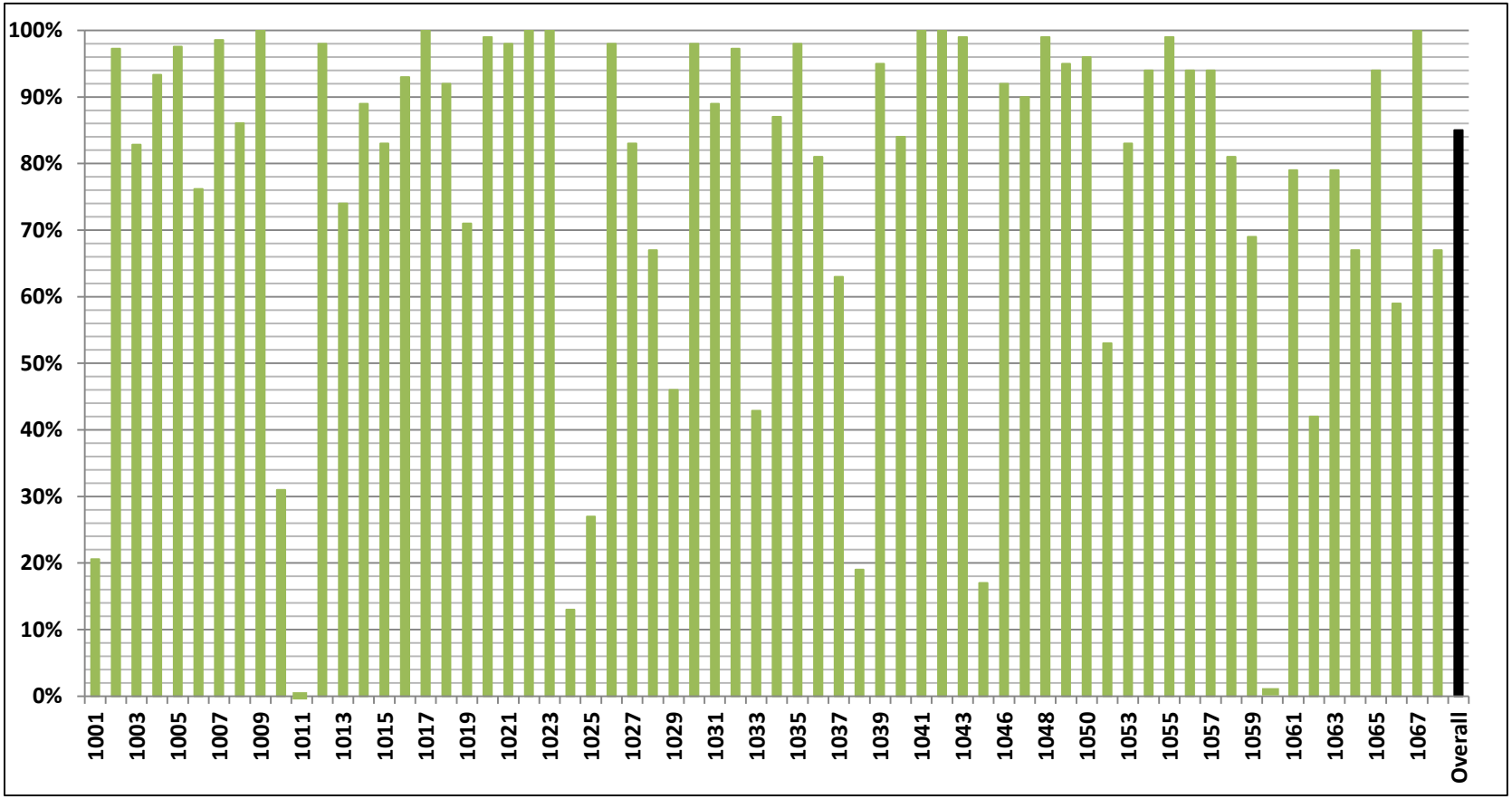
Performance level (%) for the overall SA20 (n=66)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
1st Half FY 2015	79	26	0	100	27	71	91	97
2nd Half FY 2015	77	28	0	100	30	67	89	98
*IQT=Interquartile range								

Variation between substance use providers

SA20 Involved in Ongoing Treatment Performance Level during the Reporting Period for 1st Half FY 2015



SA20 Involved in Ongoing Treatment Performance Level during the Reporting Period for 2nd Half FY 2015



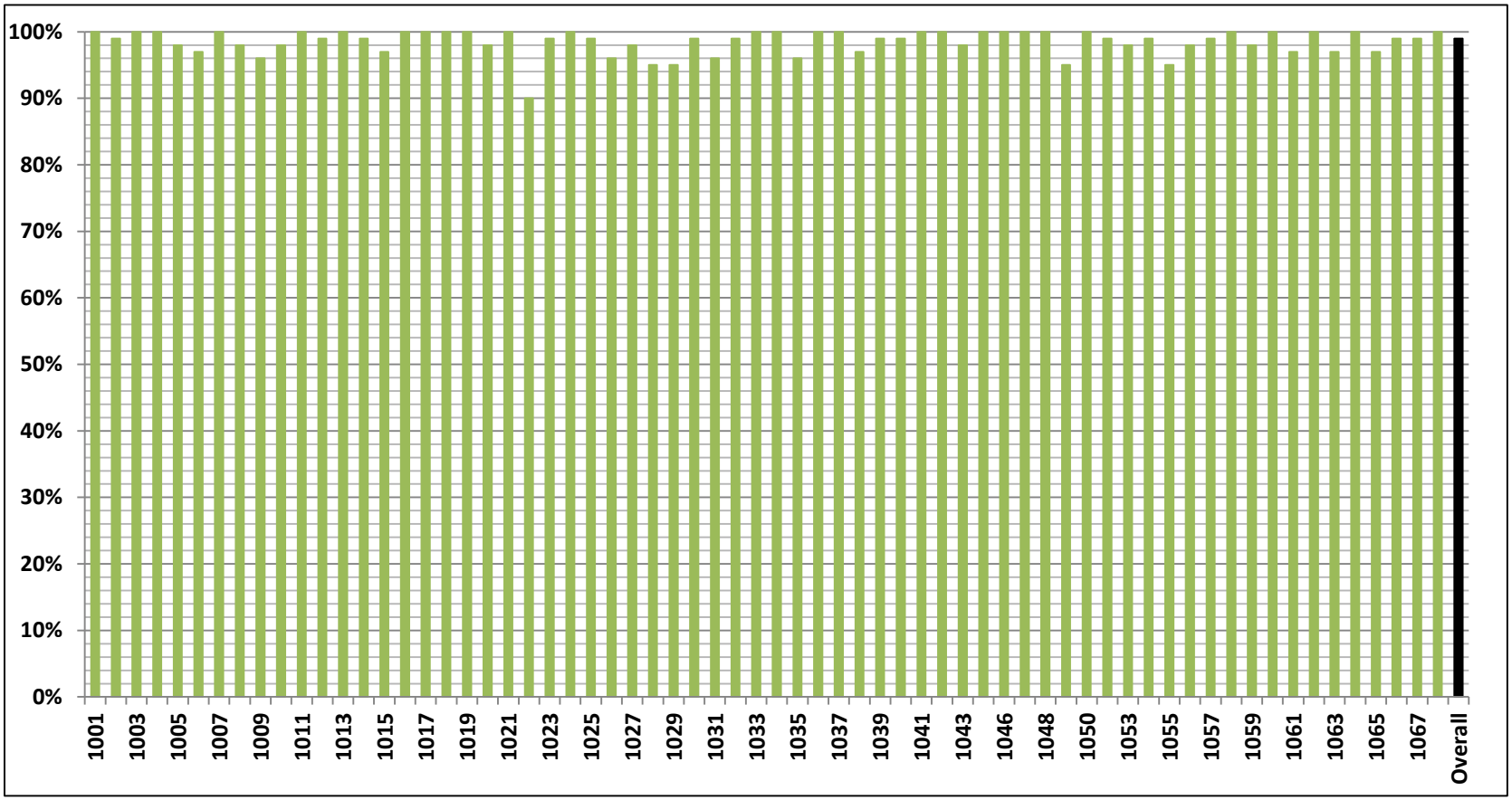
SA21: Not Arrested

The performance level for SA21 represents percent of DSHS-funded clients who ended a specific service type during the fiscal year to date and were not arrested during a specific reporting month.

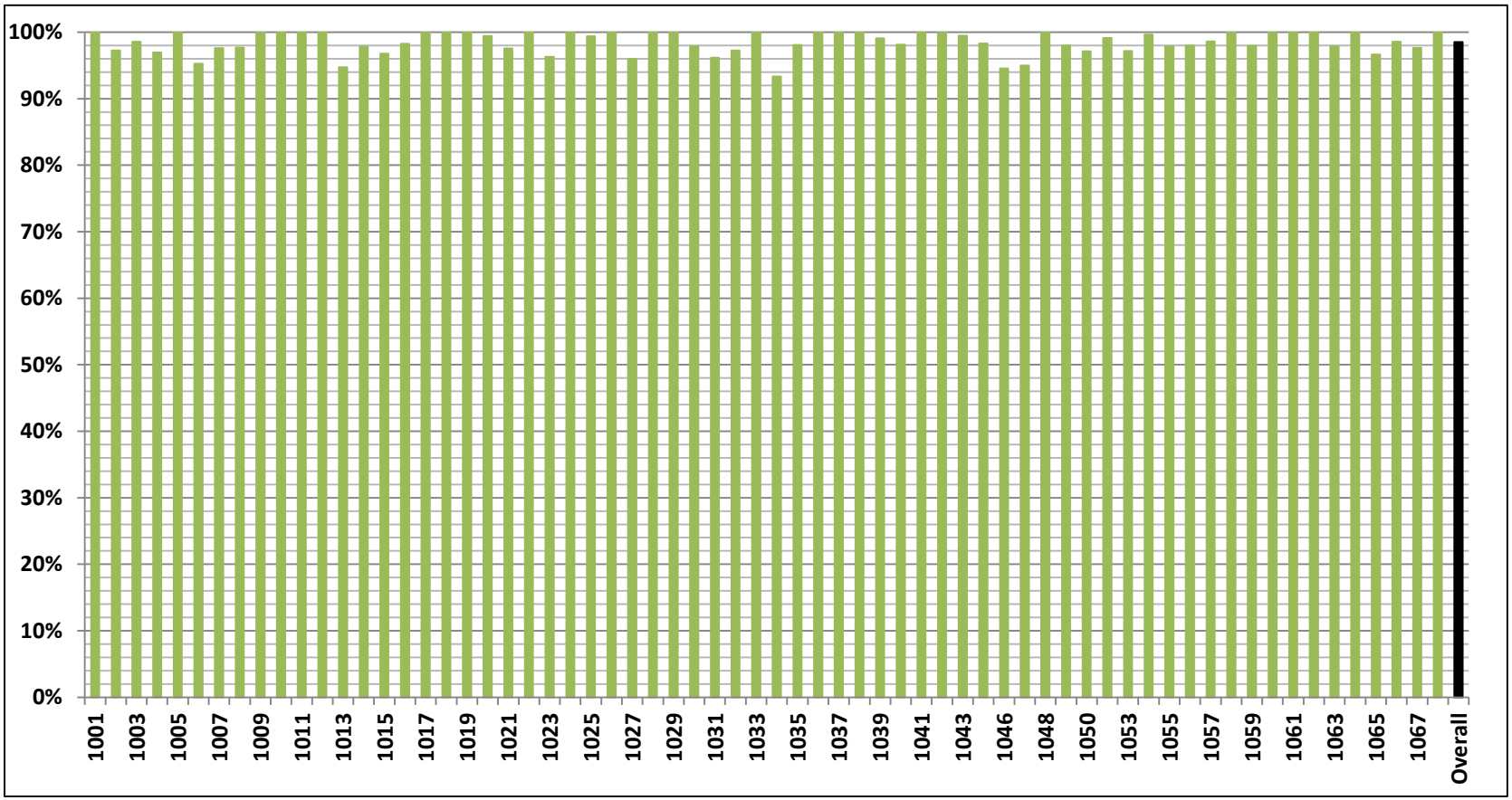
Performance level (%) for the overall SA21 (n=66)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
1st Half FY 2015	99	2	90	100	3	98	99	100
2nd Half FY 2015	99	2	93	100	2	98	99	100
*IQT=Interquartile range								

Variation between substance use providers

SA21 Not Arrested Performance Level during the Reporting Period for 1st Half FY 2015



SA21 Not Arrested Performance Level during the Reporting Period for 2nd Half FY 2015



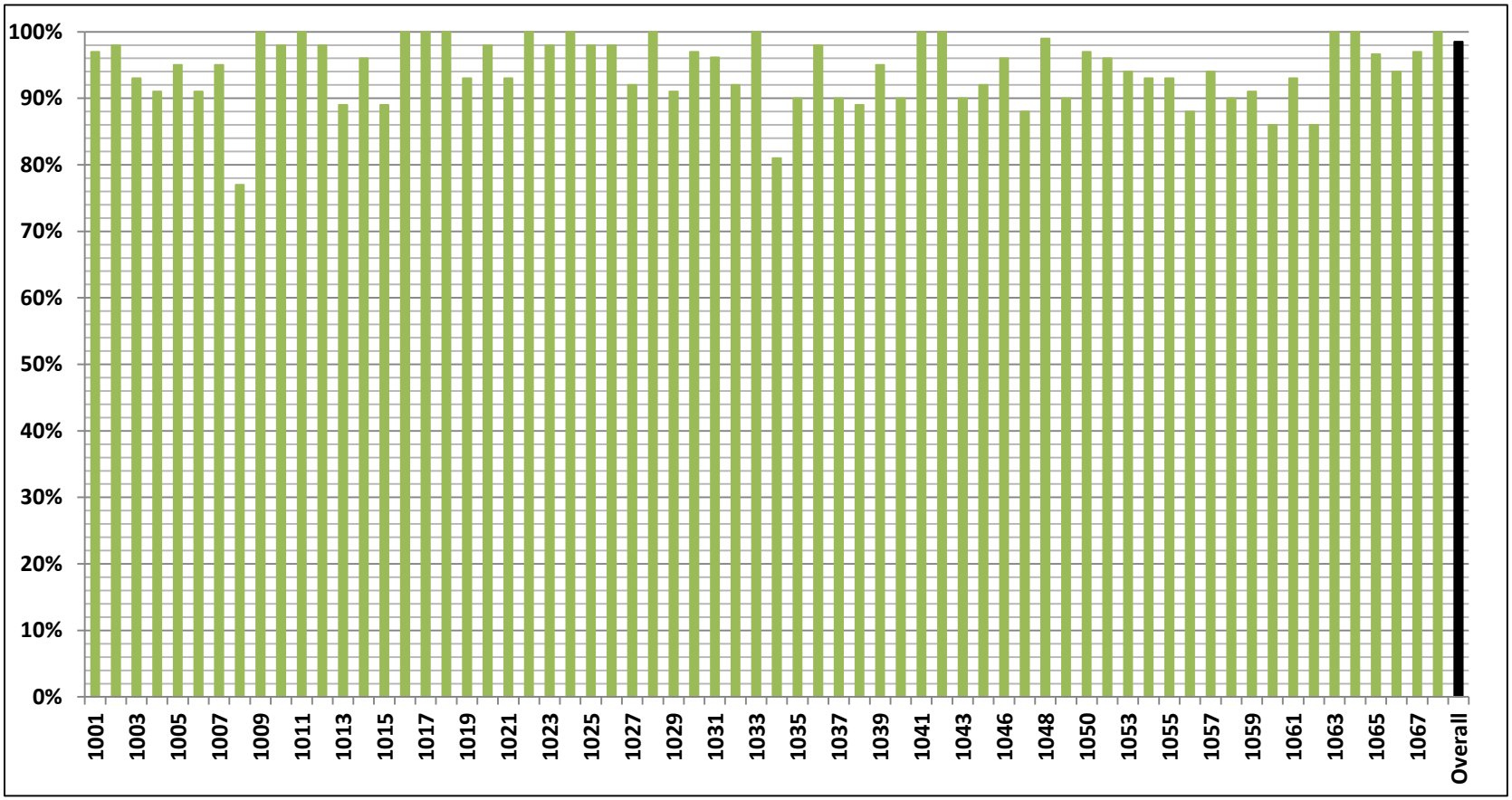
SA22: Abstinence

The performance level for SA22 represents DSHS-funded clients that were listed as abstinent from all substances for the past 30 days on the substance abuse portion of the service end or discharge assessment.

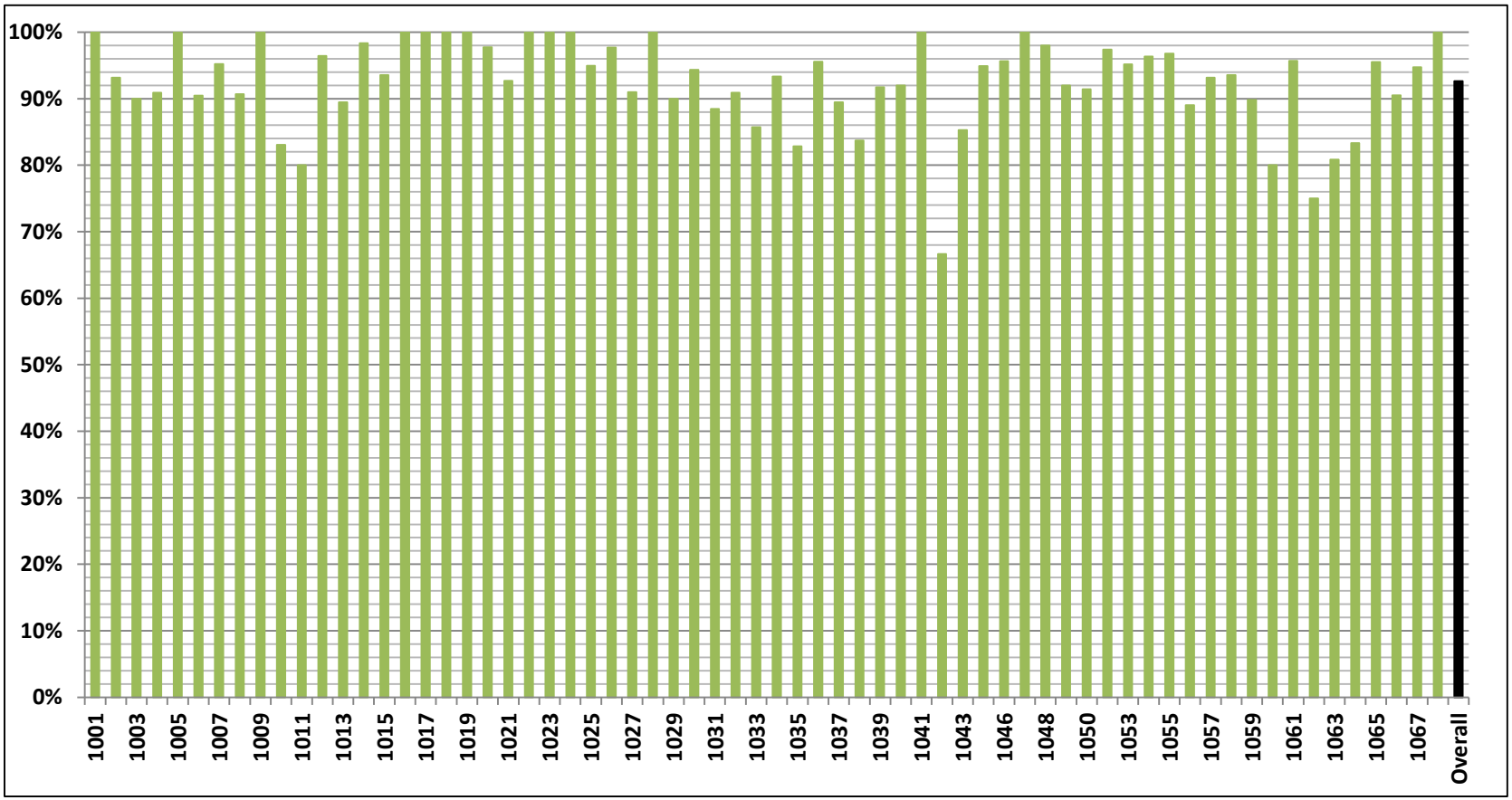
Performance level (%) for the overall SA22 (n=66)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
1st Half FY 2015	94	5	77	100	7	91	95	98
2nd Half FY 2015	93	7	67	100	8	90	94	98
*IQT=Interquartile range								

Variation between substance use providers

SA22 Abstinence Performance Level during the Reporting Period for 1st Half FY 2015



SA22 Abstinence Performance Level during the Reporting Period for 2nd Half FY 2015



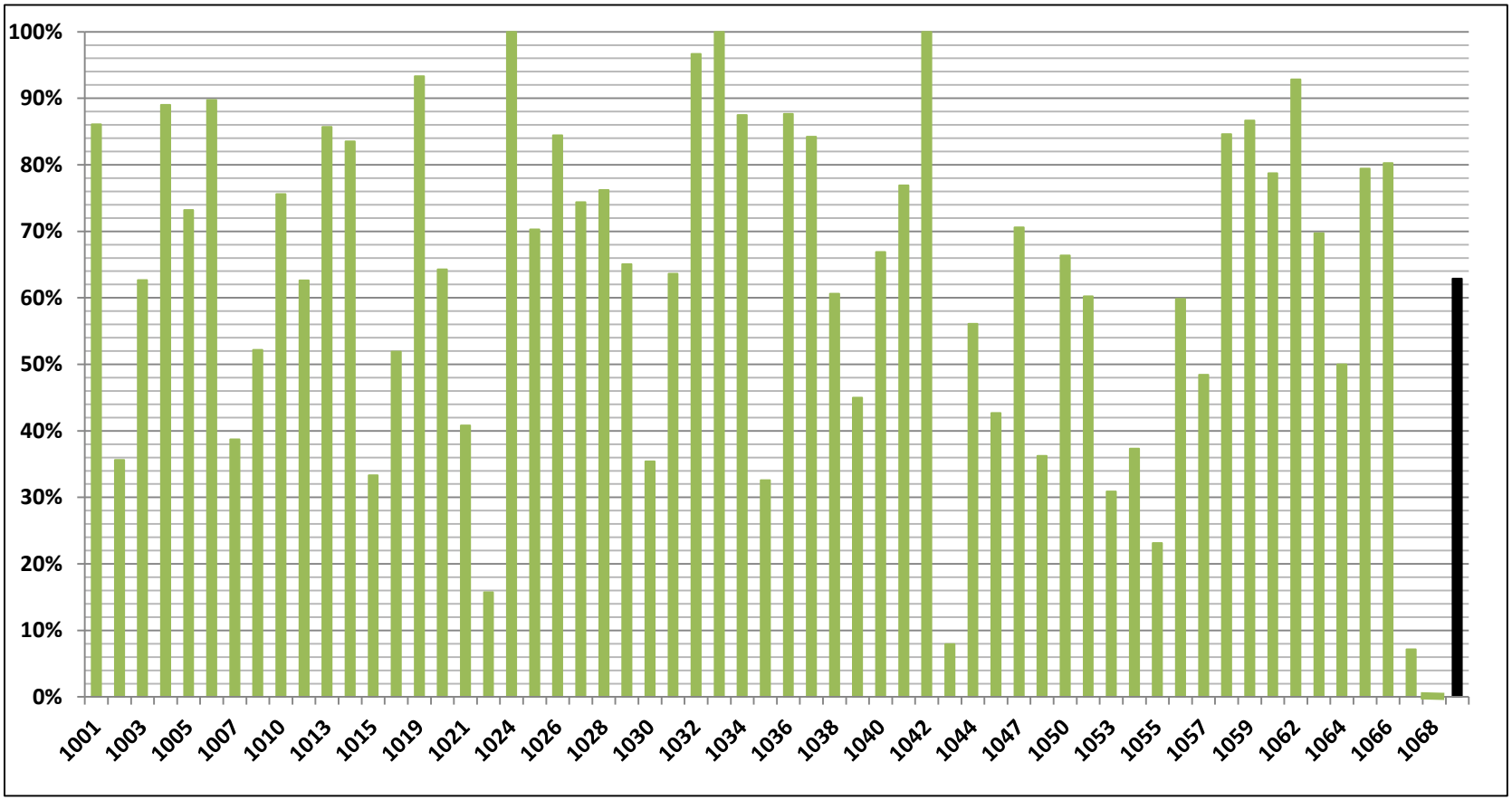
SA23: Employment

The performance level for SA23 represents the percent of DSHS-funded clients with a client's employment status as employed "full time", "part time", or "not in the labor force" on the service end or discharge assessment.

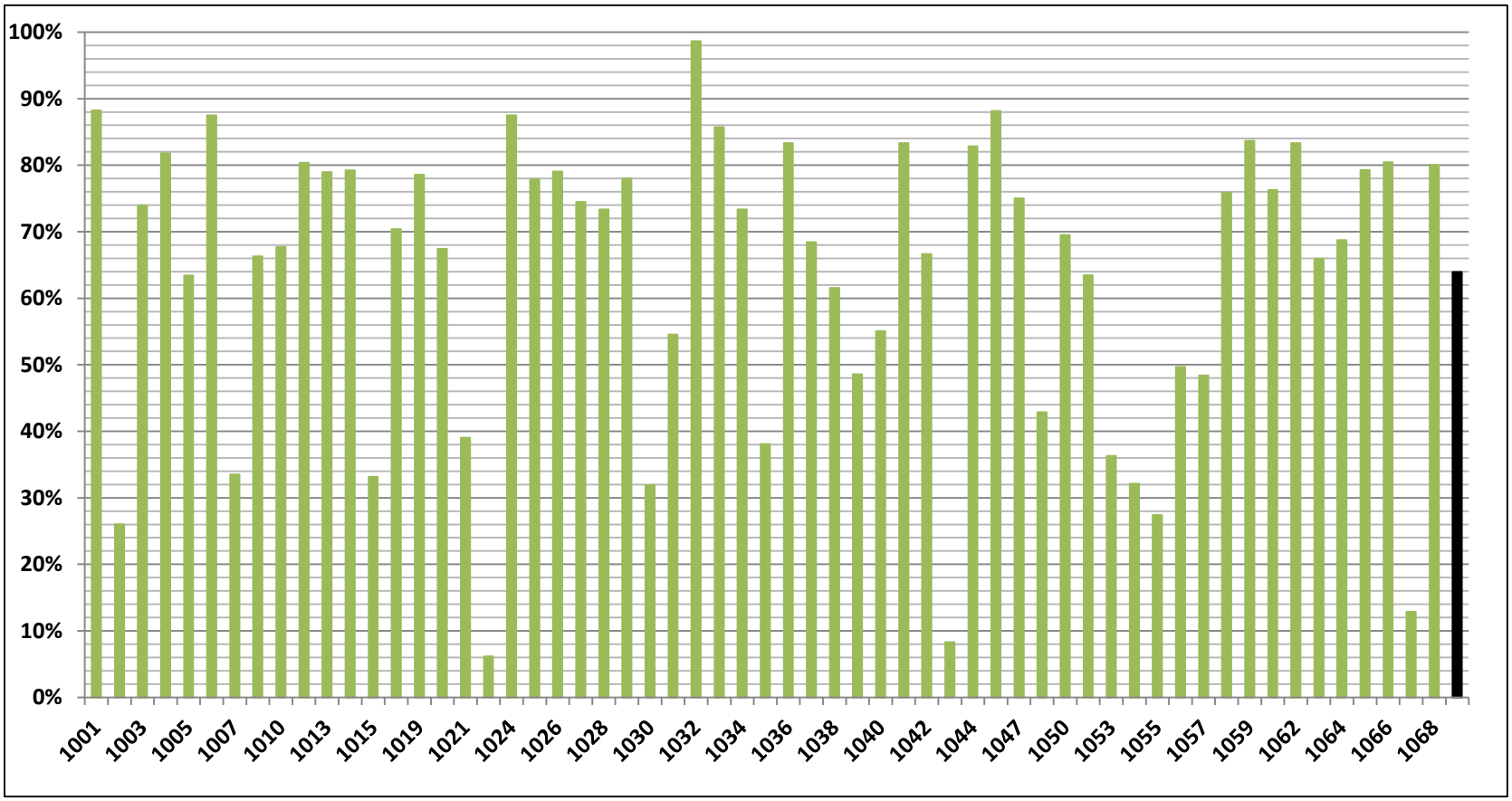
Performance level (%) for the overall SA23 (n=59)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
1st Half FY 2015	63	25	0	100	42	43	66	84
2nd Half FY 2015	64	22	6	99	31	49	70	80
*IQT=Interquartile range								

Variation between substance use providers

SA23 Employment Performance Level during the Reporting Period for 1st Half FY 2015



SA23 Employment Performance Level during the Reporting Period for 2nd Half FY 2015



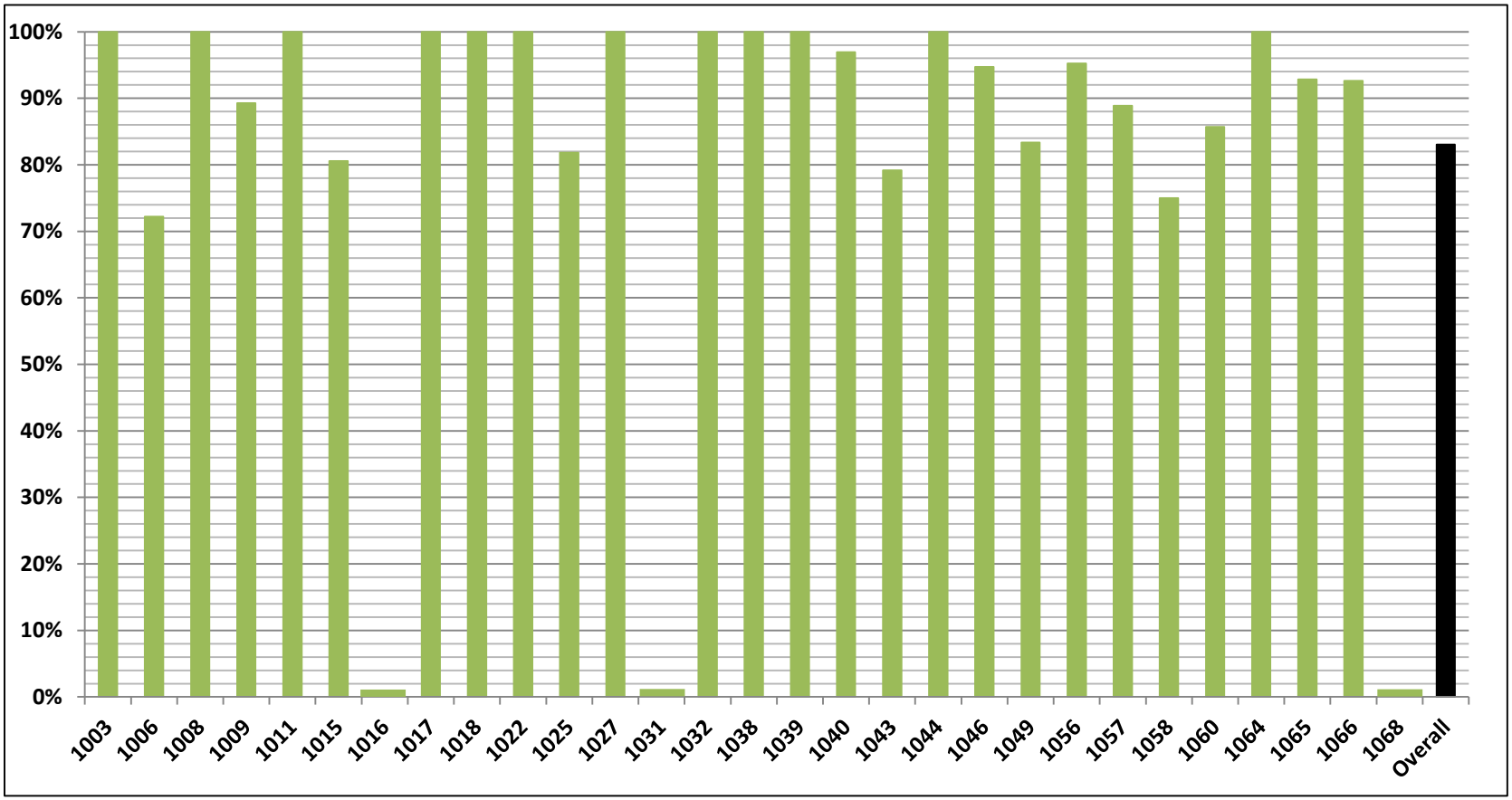
SA24: School Attendance

The performance level for SA24 represents the percent of DSHS-funded clients who ended a specific service type during the fiscal year to date and on the service end or discharge assessment, the answer to "Is the client enrolled in school?" is "yes".

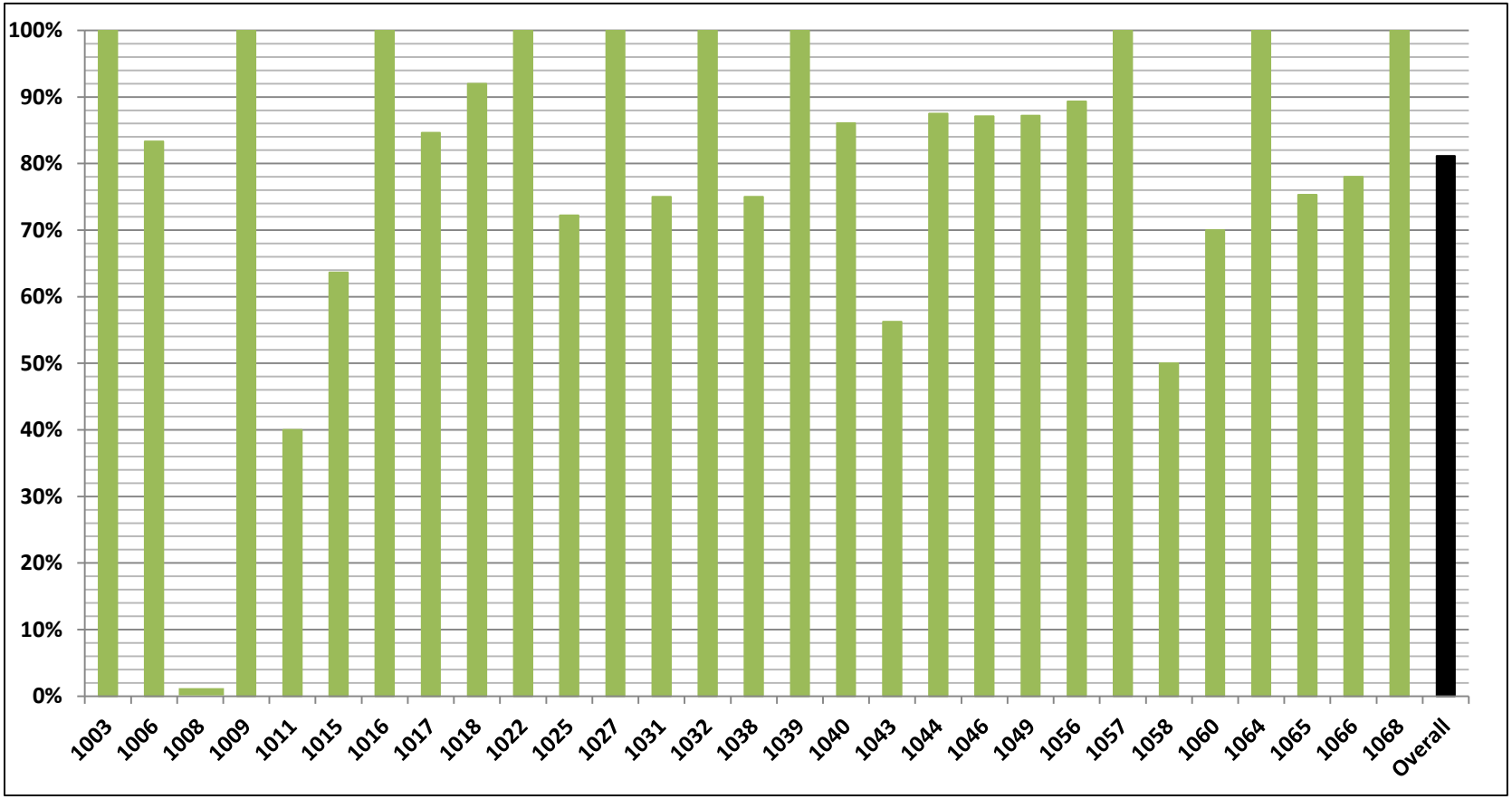
Performance level (%) for the overall SA24 (n=29)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
1st Half FY 2015	83	30	0	100	18	82	95	100
2nd Half FY 2015	81	23	0	100	25	75	87	100
*IQT=Interquartile range								

Variation between substance use providers

SA24 School Attendance Performance Level during the Reporting Period for 1st Half FY 2015



SA24 School Attendance Performance Level during the Reporting Period for 2nd Half FY 2015



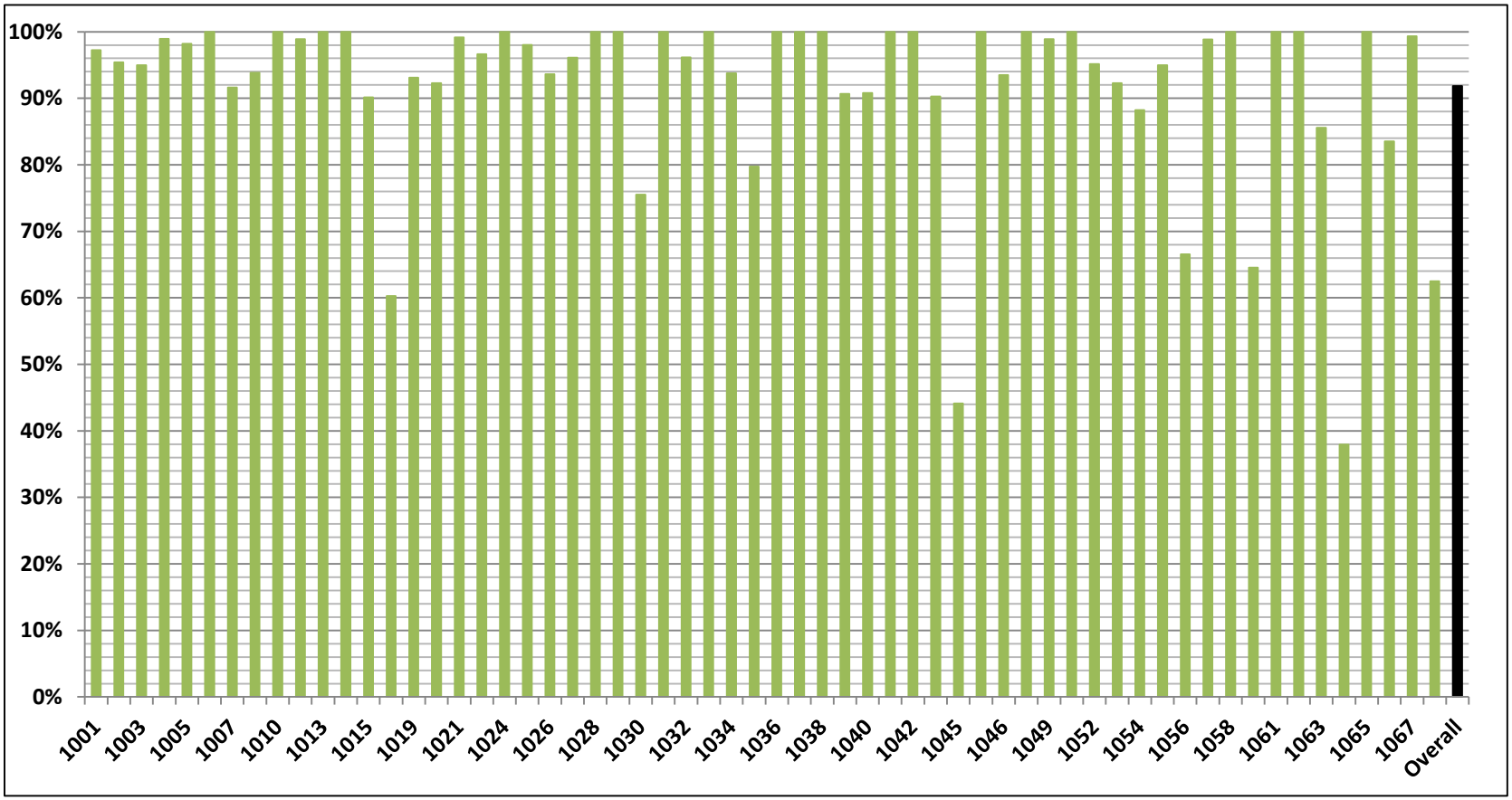
SA25: Stable Housing

The performance level for SA25 represents DSHS-funded clients who ended a specific service type during the fiscal year to date and were not listed with a current living situation as "homeless" or "shelter".

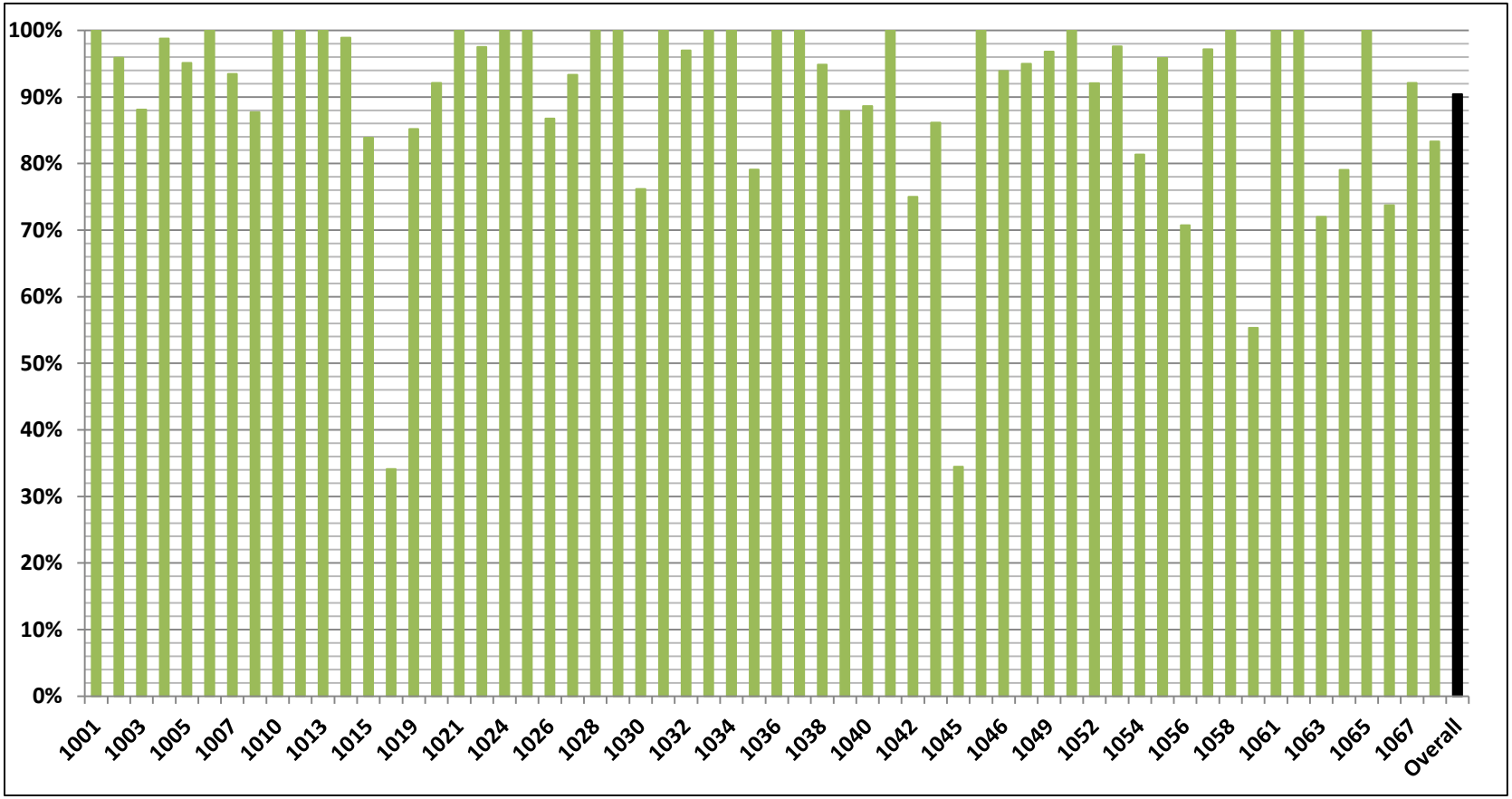
Performance level (%) for the overall SA25 (n=60)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
1st Half FY 2015	92	14	38	100	9	91	97	100
2nd Half FY 2015	90	14	34	100	13	87	96	100
*IQT=Interquartile range								

Variation between substance use organizations

SA25 Stable Housing Performance Level during the Reporting Period for 1st Half FY 2015



SA25 Stable Housing Performance Level during the Reporting Period for 2nd Half FY 2015



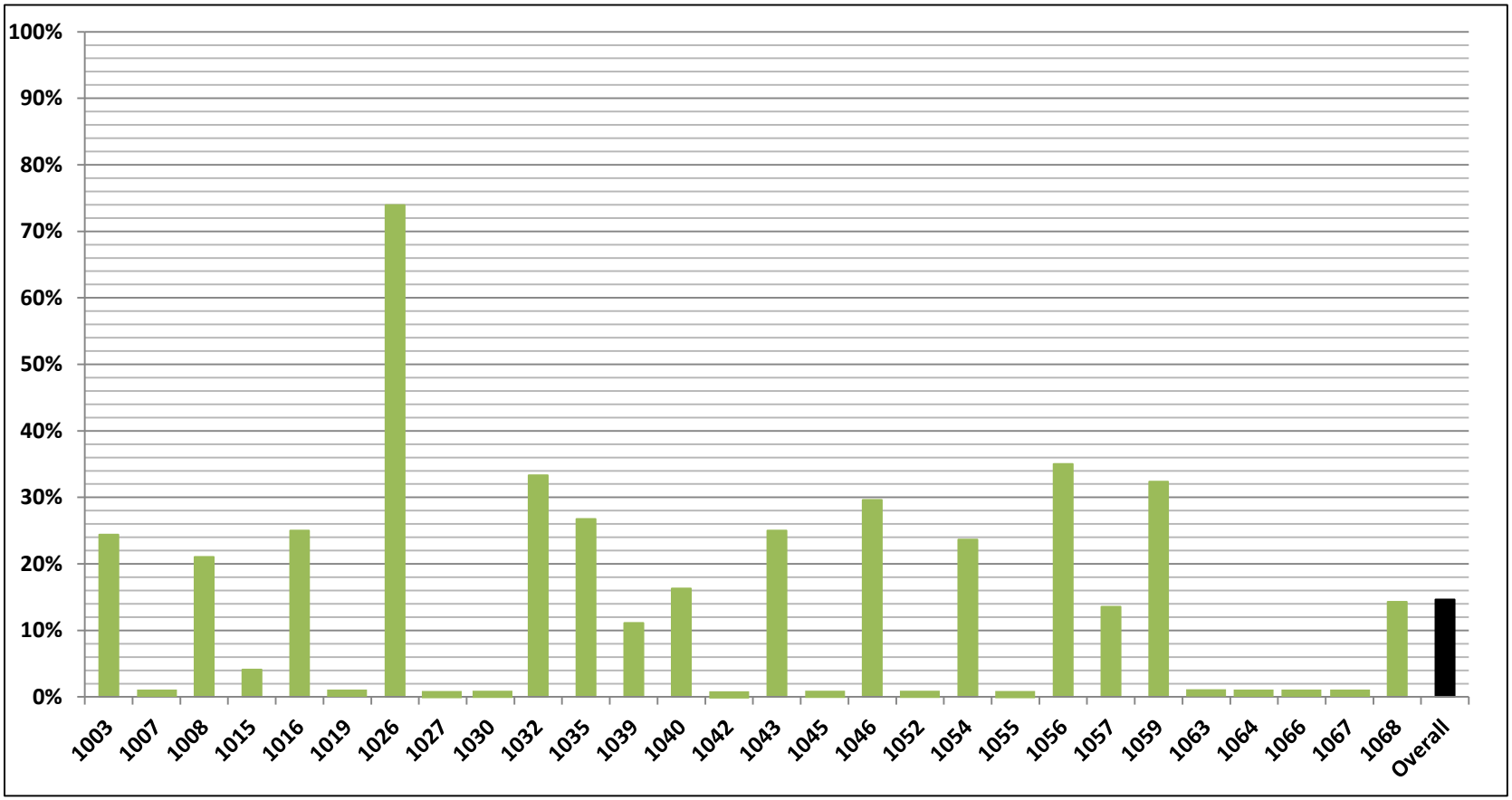
SA26: Mental Health Treatment at Discharge

The performance level for SA26 represents target percentage of DSHS-funded clients who ended a COPSD service during the fiscal year to date and who have activity associated with mental health services during the episode at same or different provider or a referral with a referral type of "Mental Health Treatment (Inpatient)" or "Mental Health Treatment (Outpatient)".

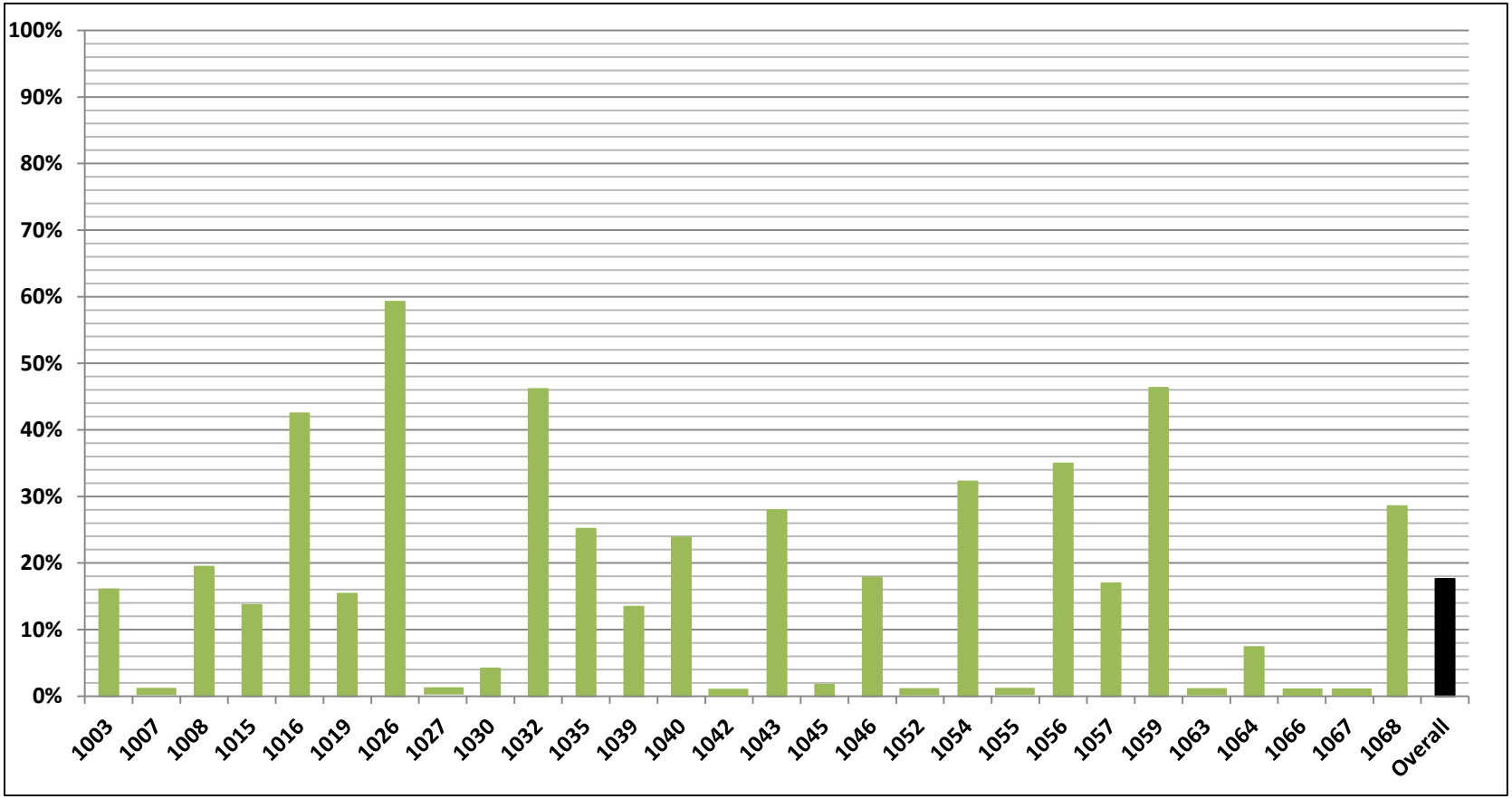
Performance level (%) for the overall SA26 (n=28)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
1st Half FY 2015	15	17	0	74	25	0	12	25
2nd Half FY 2015	18	17	0	59	28	0	16	28
*IQT=Interquartile range								

Variation between substance use organizations

SA26 Mental Health Treatment at Discharge Performance Level during the Reporting Period for 1st Half FY 2015



SA26 Mental Health Treatment at Discharge Performance Level during the Reporting Period for 2nd Half FY 2015



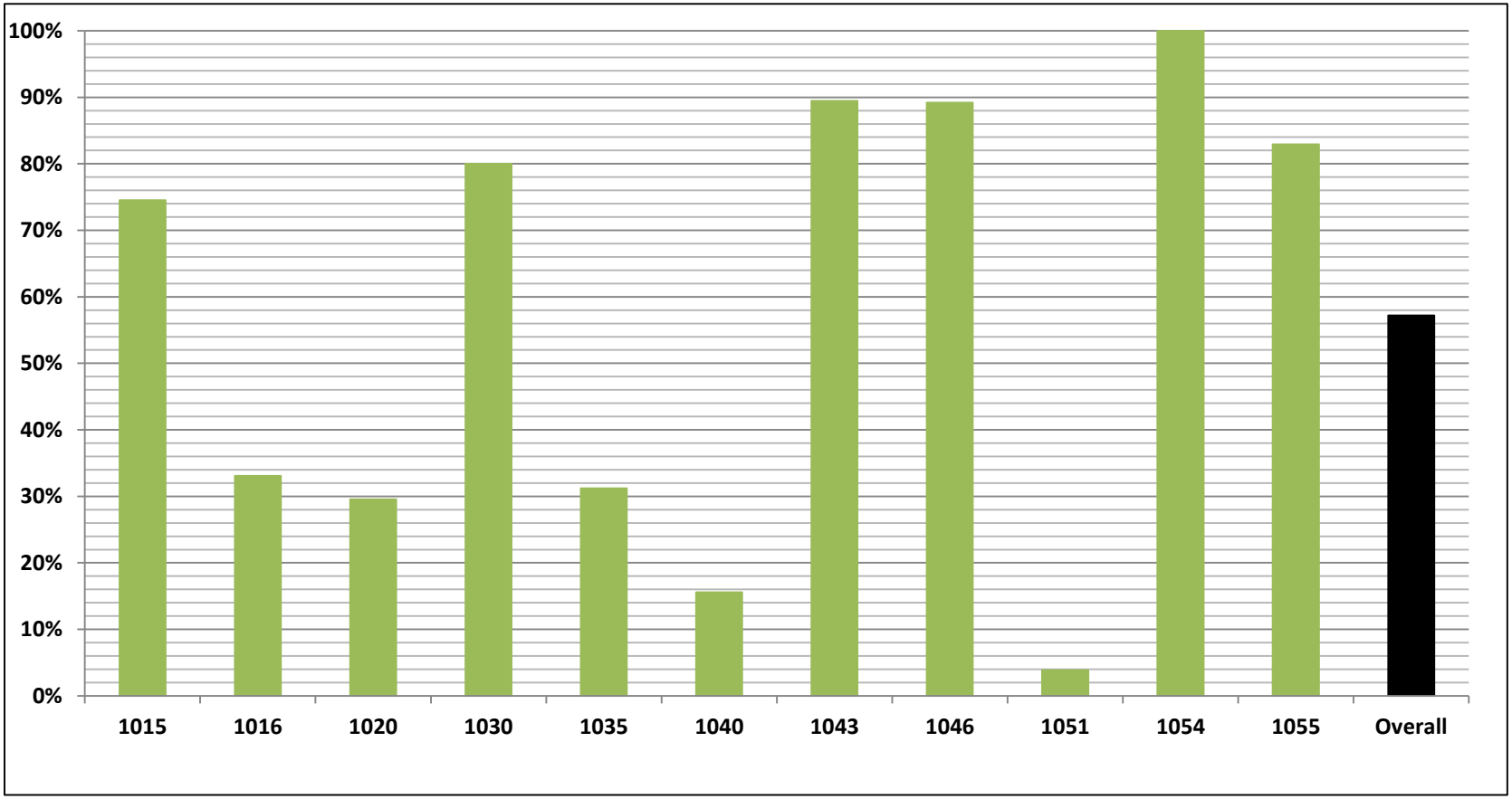
SA27: Residential Detoxification w/Referral After Initial Episode

The performance level for SA27 represents DSHS-funded clients who ended a residential detoxification service for the fiscal year to date after initial episode.

Performance level (%) for the overall SA27 (n=11)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
1st Half FY 2015	57	35	4	100	56	30	75	86
2nd Half FY 2015	51	34	0	100	55	24	38	79
*IQT=Interquartile range								

Variation between substance use organizations

SA27 Residential Detoxification w/Referral After Initial Episode Performance Level during the Reporting Period for 1st Half FY 2015



SA27 Residential Detoxification w/Referral After Initial Episode Performance Level during the Reporting Period for 2nd Half FY 2015

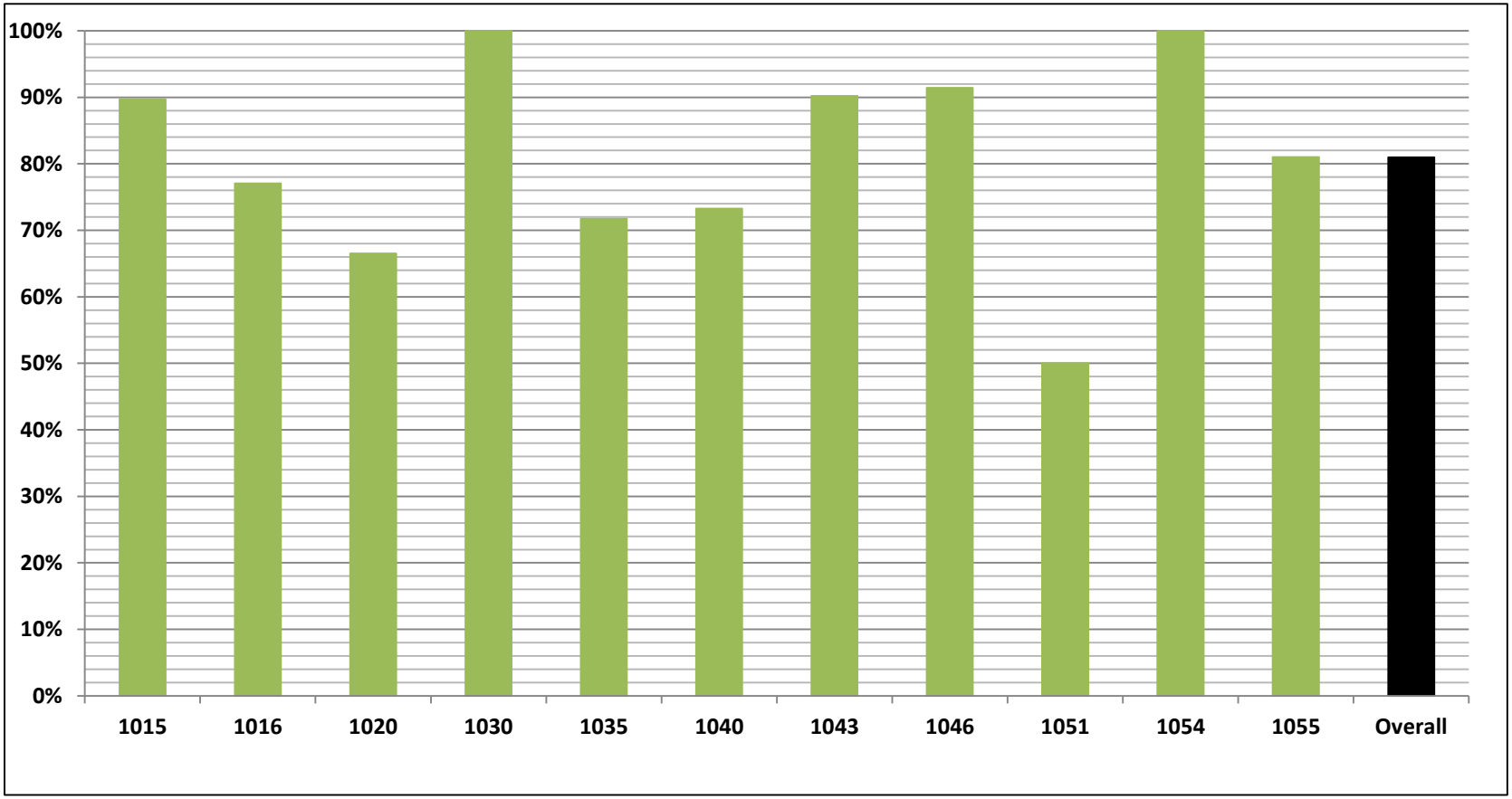
SA28: Residential Detoxification w/Referral After Multiple Episodes

The performance level for SA28 represents DSHS-funded clients who ended a residential detoxification service for the fiscal year to date after multiple episodes.

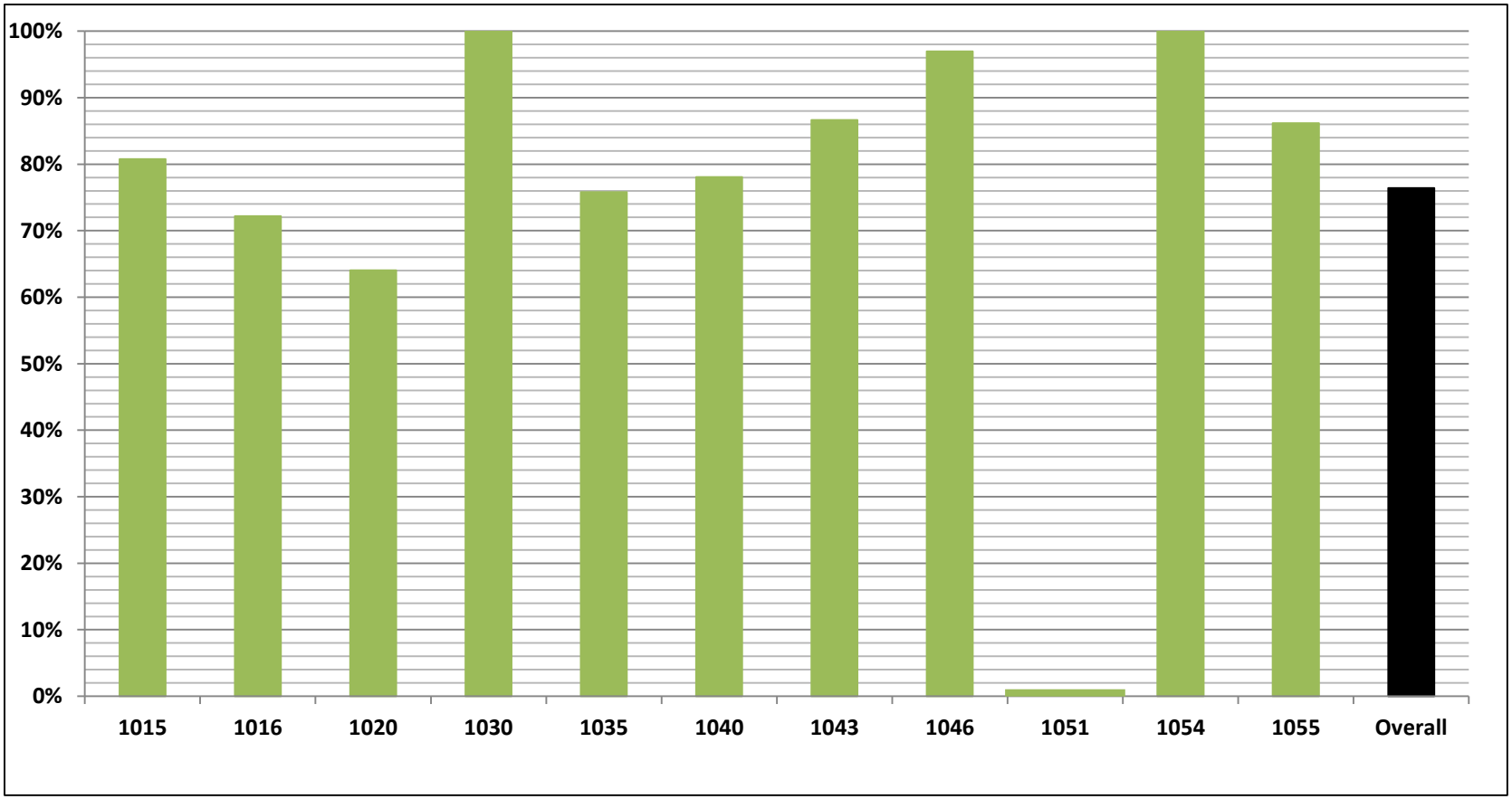
Performance level (%) for the overall SA28 (n=11)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
1st Half FY 2015	81	15	50	100	18	72	81	91
2nd Half FY 2015	76	28	0	100	18	74	81	92
*IQT=Interquartile range								

Variation between substance use organizations

SA28 Residential Detoxification w/Referral After Multiple Episode Performance Level during the Reporting Period for 1st Half FY 2015



SA28 Residential Detoxification w/Referral After Multiple Episode Performance Level during the Reporting Period for 2nd Half FY 2015



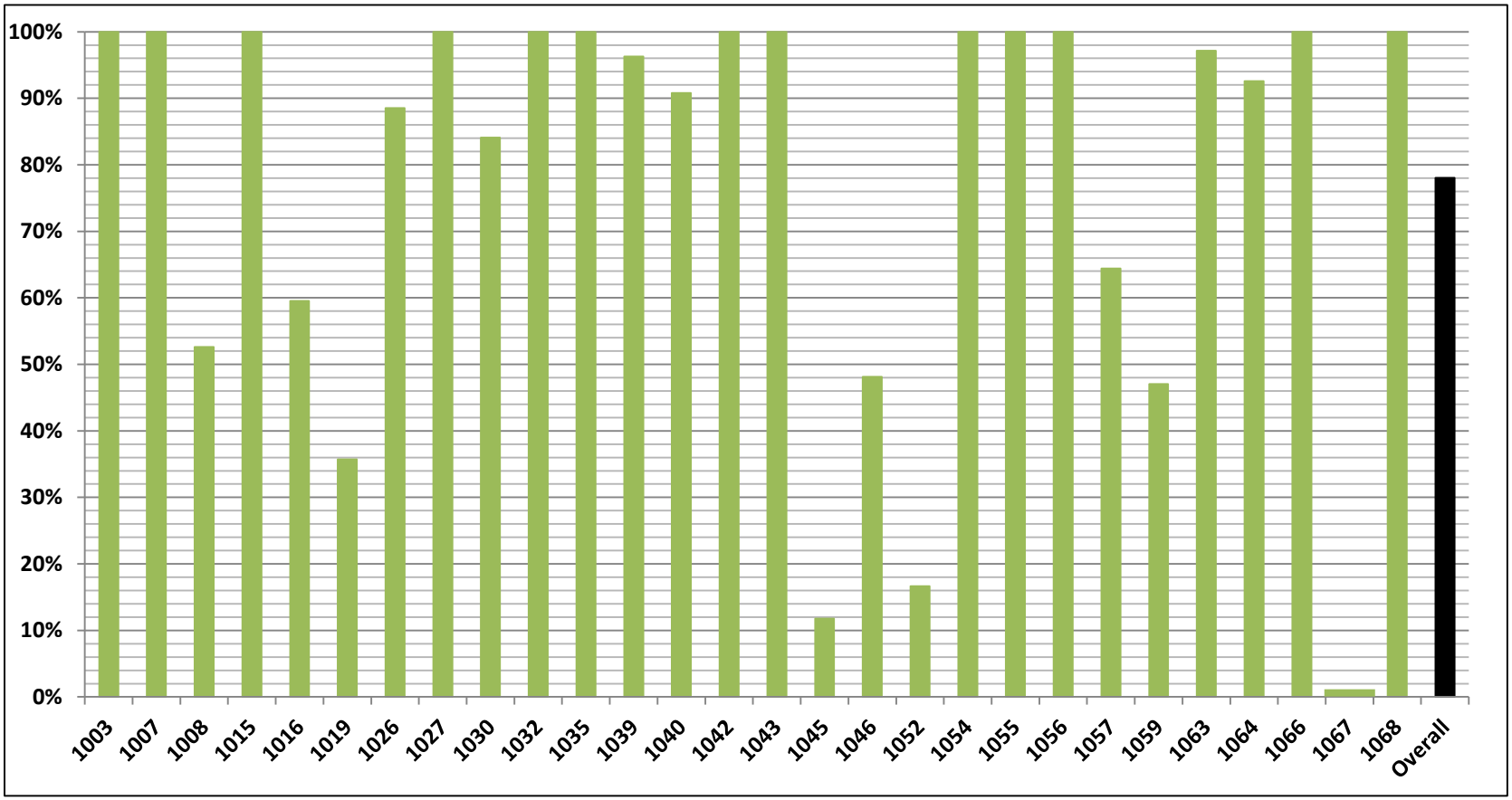
SA29: Substance Abuse Treatment at Discharge

The performance level for SA29 represents the percent of DSHS-funded clients who ended a COPSD service during the fiscal year to date.

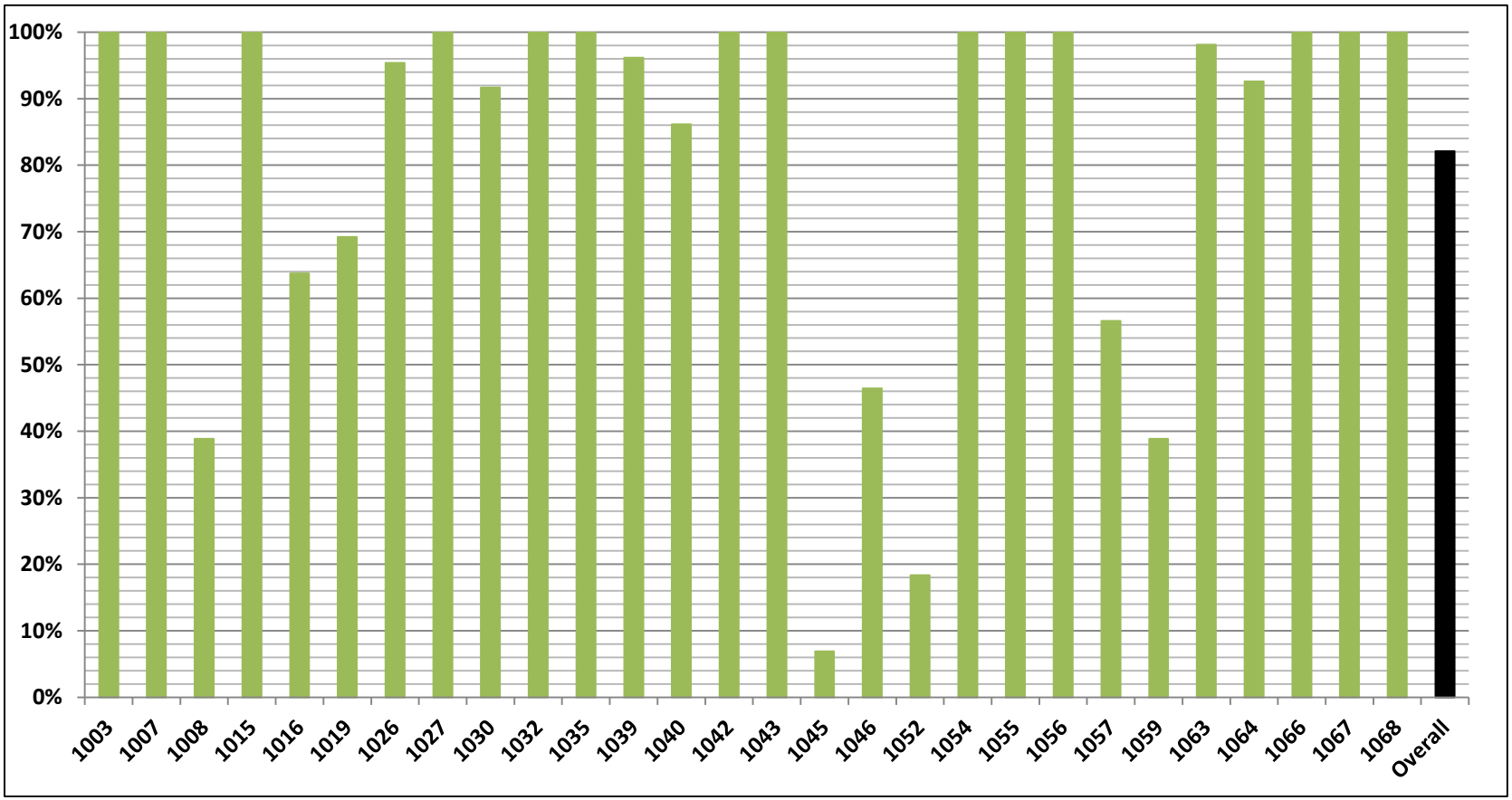
Performance level (%) for the overall SA29 (n=28)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
1st Half FY 2015	78	31	0	100	42	58	97	100
2nd Half FY 2015	82	28	7	100	32	68	99	100
*IQT=Interquartile range								

Variation between substance use organizations

SA29 Substance Abuse Treatment at Discharge Performance Level during the Reporting Period for 1st Half FY 2015



SA29 Substance Abuse Treatment at Discharge Performance Level during the Reporting Period for 2nd Half FY 2015



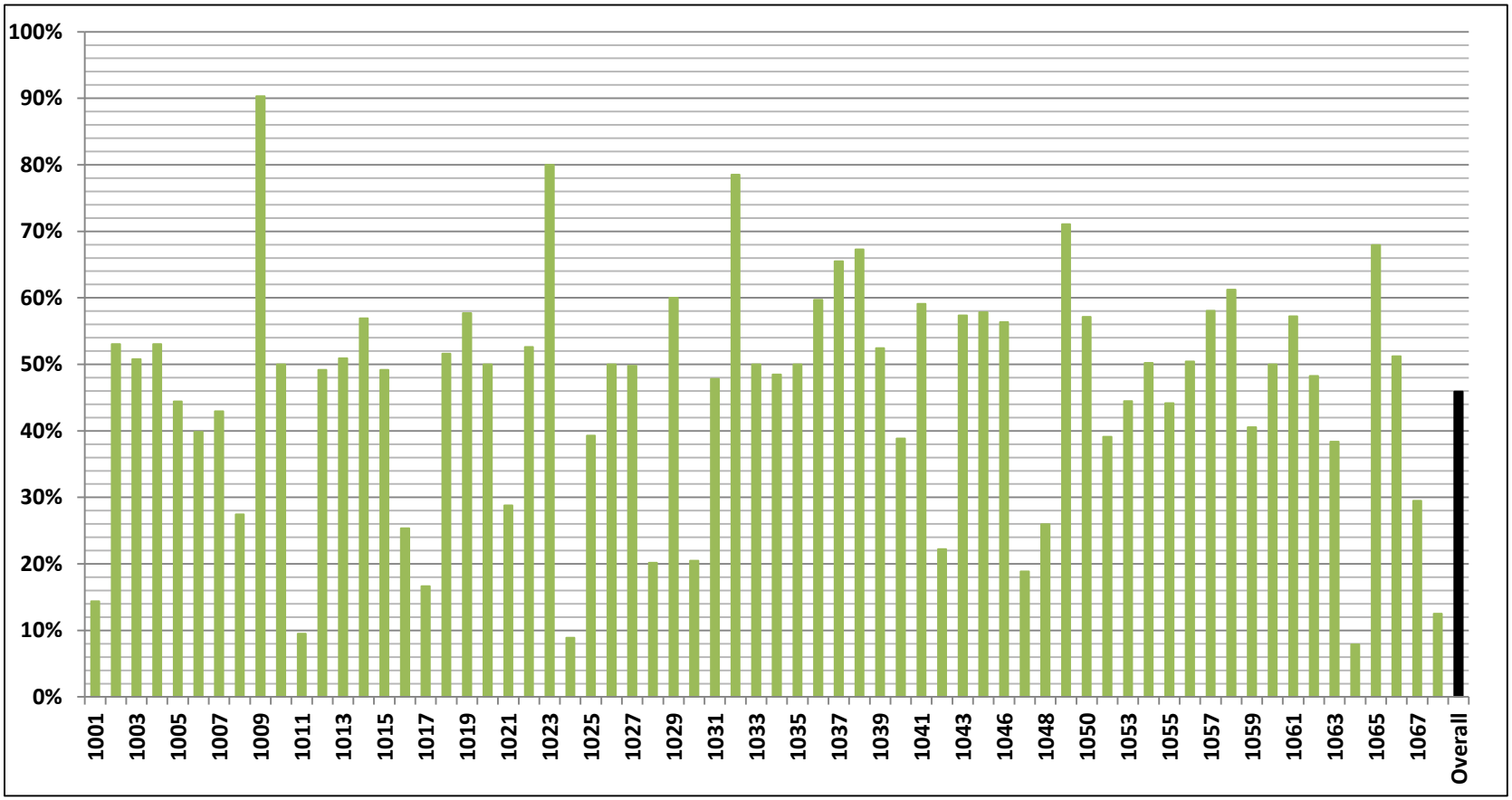
SA30: Treatment Completion

The performance level for SA30 represents percent of DSHS-funded clients who ended a specific service type during the fiscal year to date where the service end reason was not "non-compliant with service", "discharged without completing service", "client left service against professional advice" or blank due to an administrate discharge.

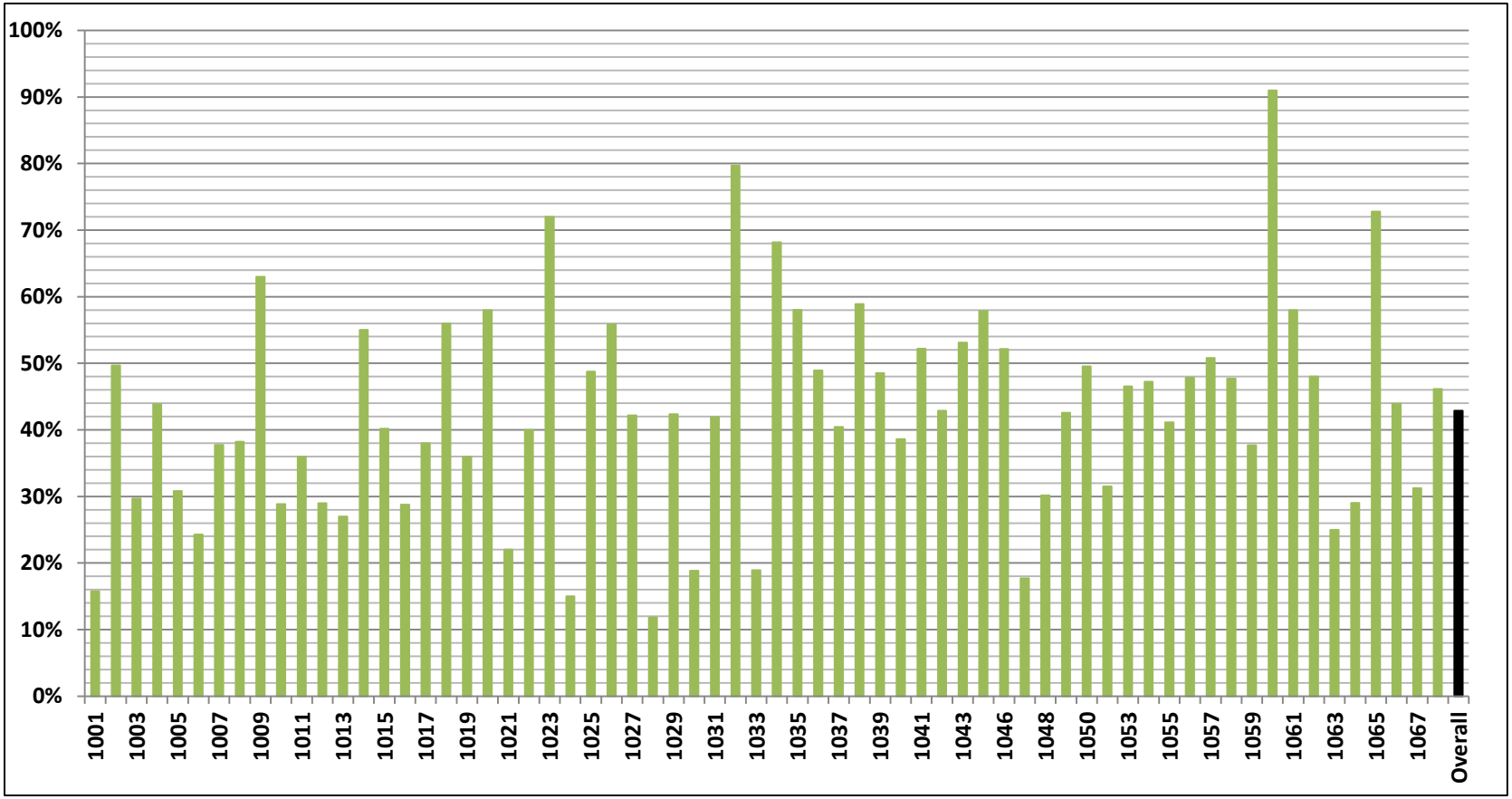
Performance level (%) for the overall SA30 (n=66)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
1st Half FY 2015	46	18	8	90	18	39	50	57
2nd Half FY 2015	43	16	12	91	22	31	43	52
*IQT=Interquartile range								

Variation between substance use organizations

SA30 Treatment Completion Performance Level during the Reporting Period for 1st Half FY 2015



SA30 Treatment Completion Performance Level during the Reporting Period for 2nd Half FY 2015



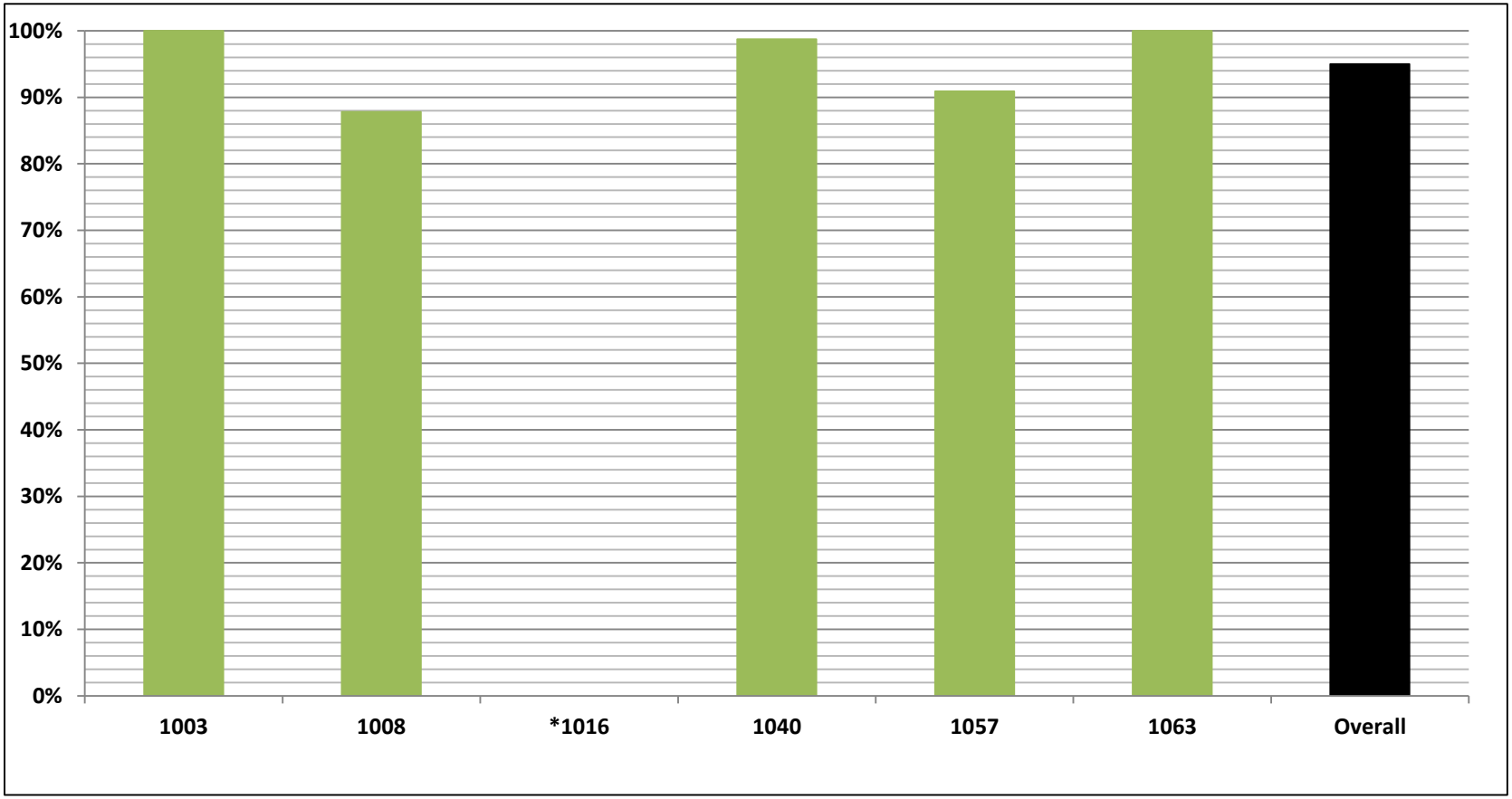
SA31: Ambulatory Detoxification with Concurrent Outpatient Admission

The performance level for SA31 represents DSHS-funded clients who ended an ambulatory detoxification service during the fiscal year to date, and who also had an overlapping service begin for an outpatient service, either at the same or another provider.

Performance level (%) for the overall SA31 (n=6)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
1st Half FY 2015	95	6	88	100	11	89	99	100
2nd Half FY 2015	96	5	89	100	7	92	98	100
*IQT=Interquartile range								

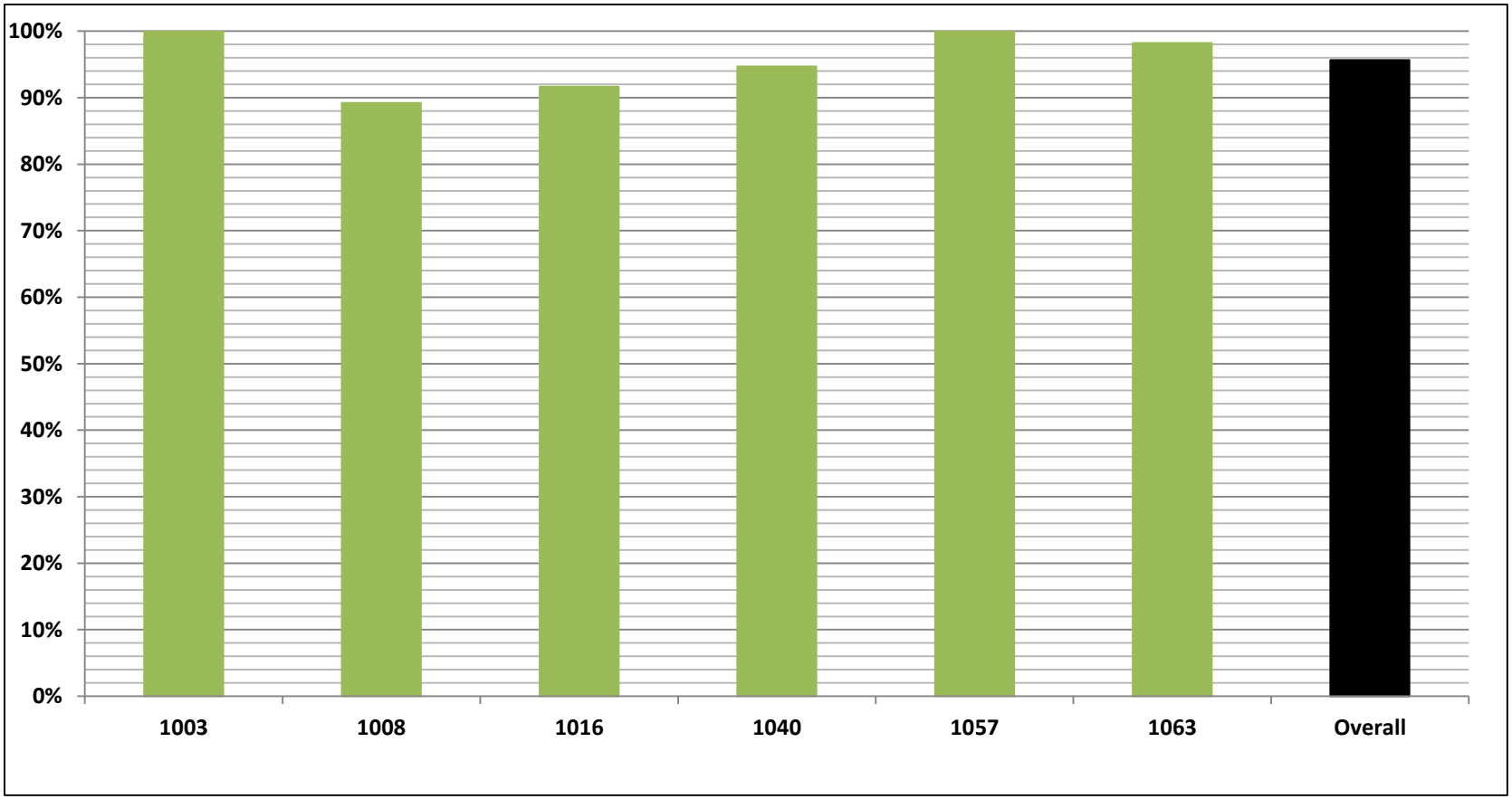
Variation between substance use organizations

SA31 Ambulatory Detoxification with Concurrent Outpatient Admission Performance Level during the Reporting Period for 1st Half FY 2015



*Data was not available.

SA31 Ambulatory Detoxification with Concurrent Outpatient Admission Performance Level during the Reporting Period for 2nd Half FY 2015



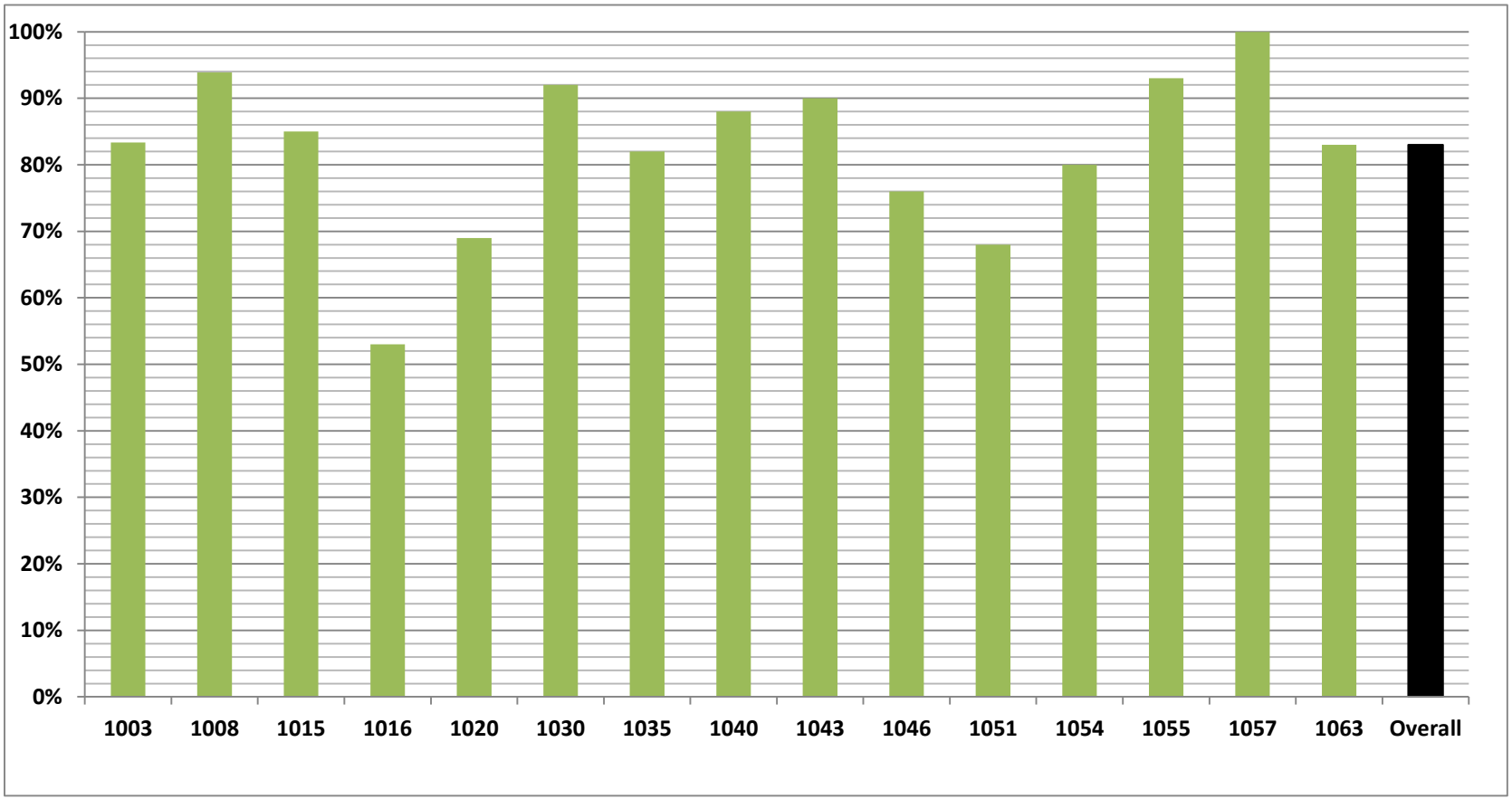
SA32: Detoxification Completion

The performance level for SA32 represents the percent of DSHS-funded clients who ended a detoxification service during the fiscal year to date where the service end reason is not "non-compliant with service", "discharged without completing service", "client left service against professional advice" or blank due to an administrative discharge.

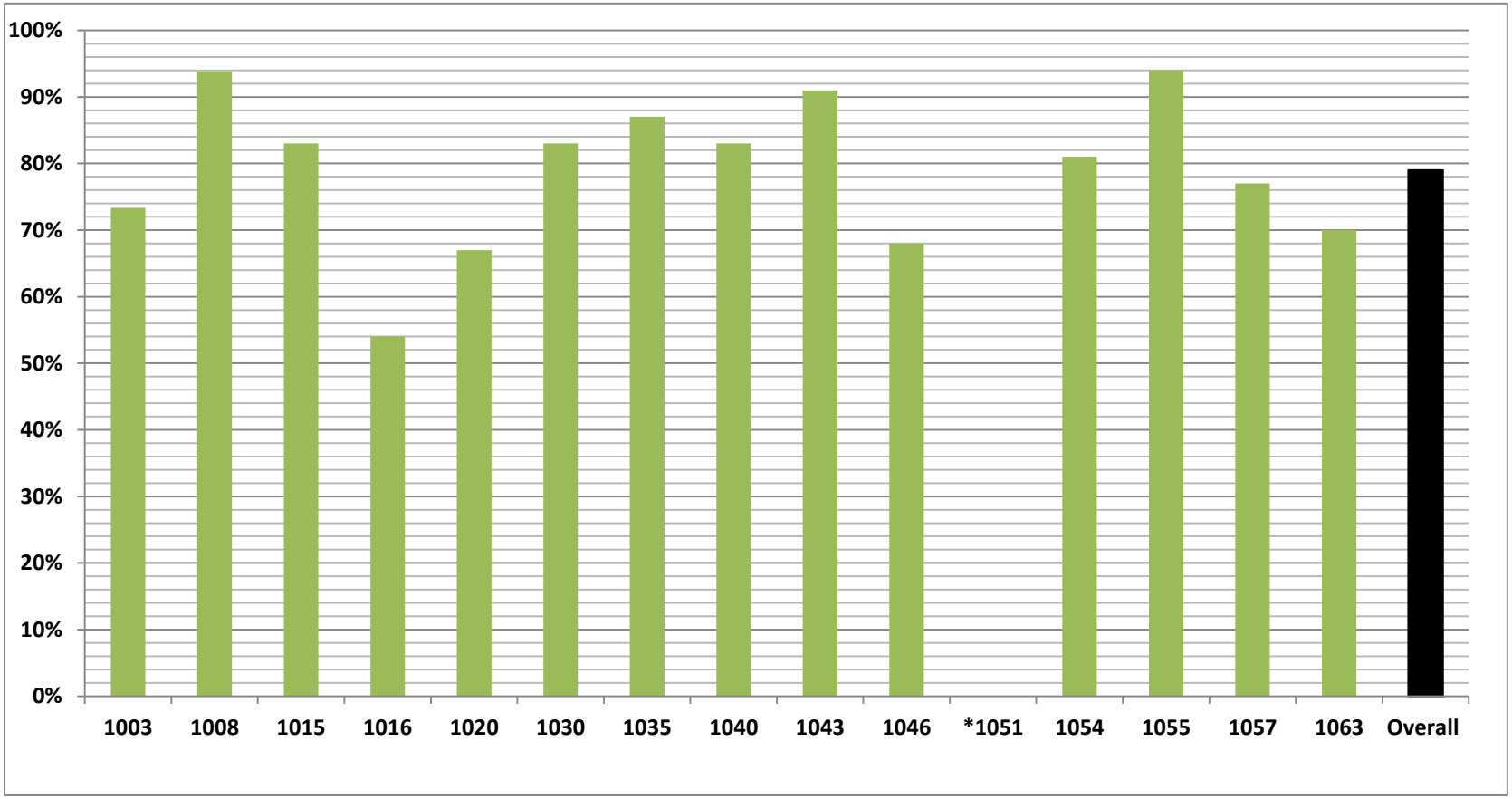
Performance level (%) for the overall SA32 (n=20)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
1st Half FY 2015	84	12	53	100	14	79	84	93
2nd Half FY 2015	79	12	54	94	18	70	82	88
*IQT=Interquartile range								

Variation between substance use organizations

SA32 Detoxification Completion Performance Level during the Reporting Period for 1st Half FY 2015



SA32 Detoxification Completion Performance Level during the Reporting Period for 2nd Half FY 2015



*Data was not available.

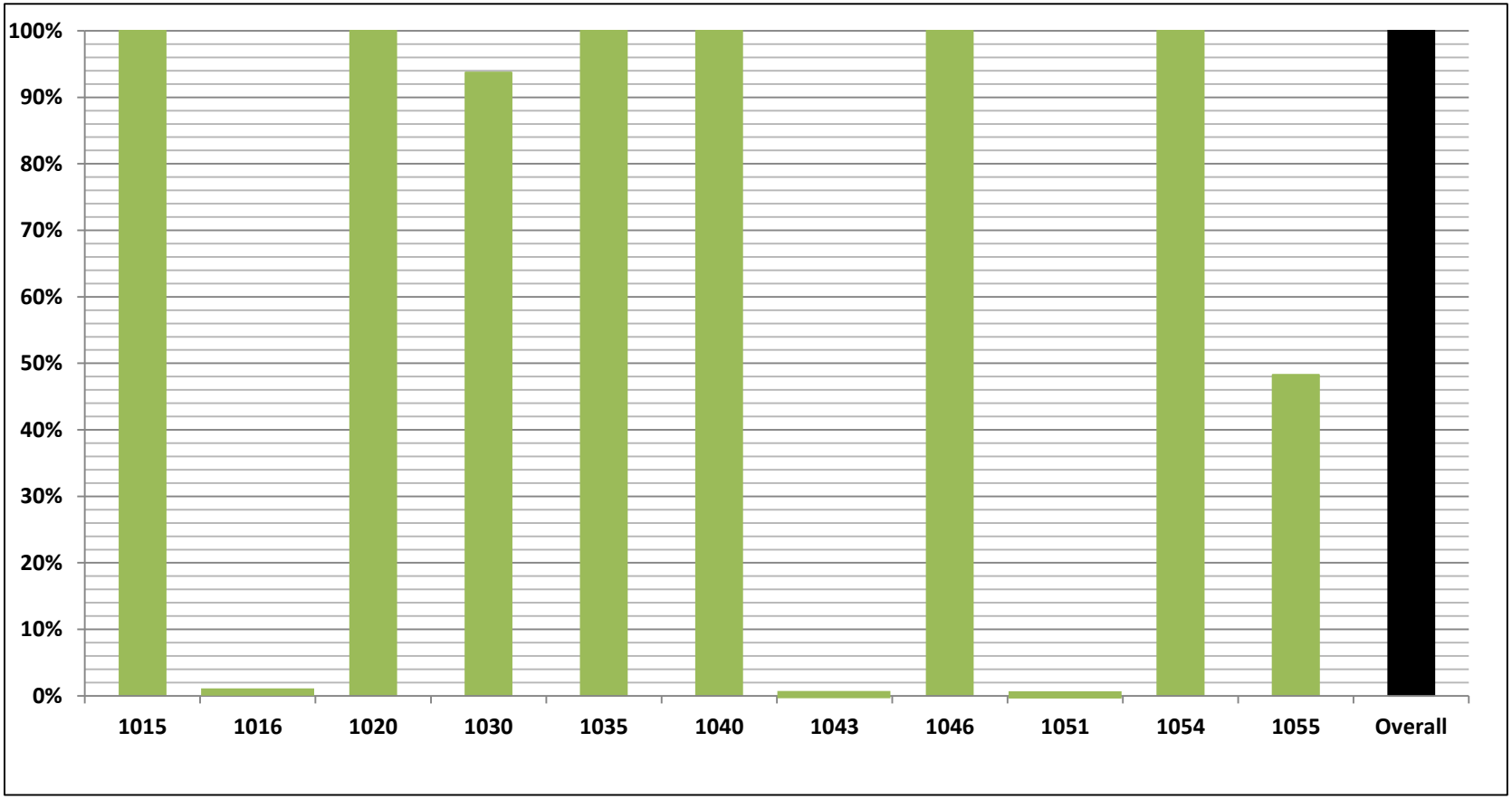
SA33: Number of Motivational Sessions per Client with Multiple Residential Detoxification Episodes

The performance level for SA33 represents the average number of administrative notes with a note type of "motivational interviewing" for DSHS-funded clients who ended a residential detoxification service during the fiscal year to date.

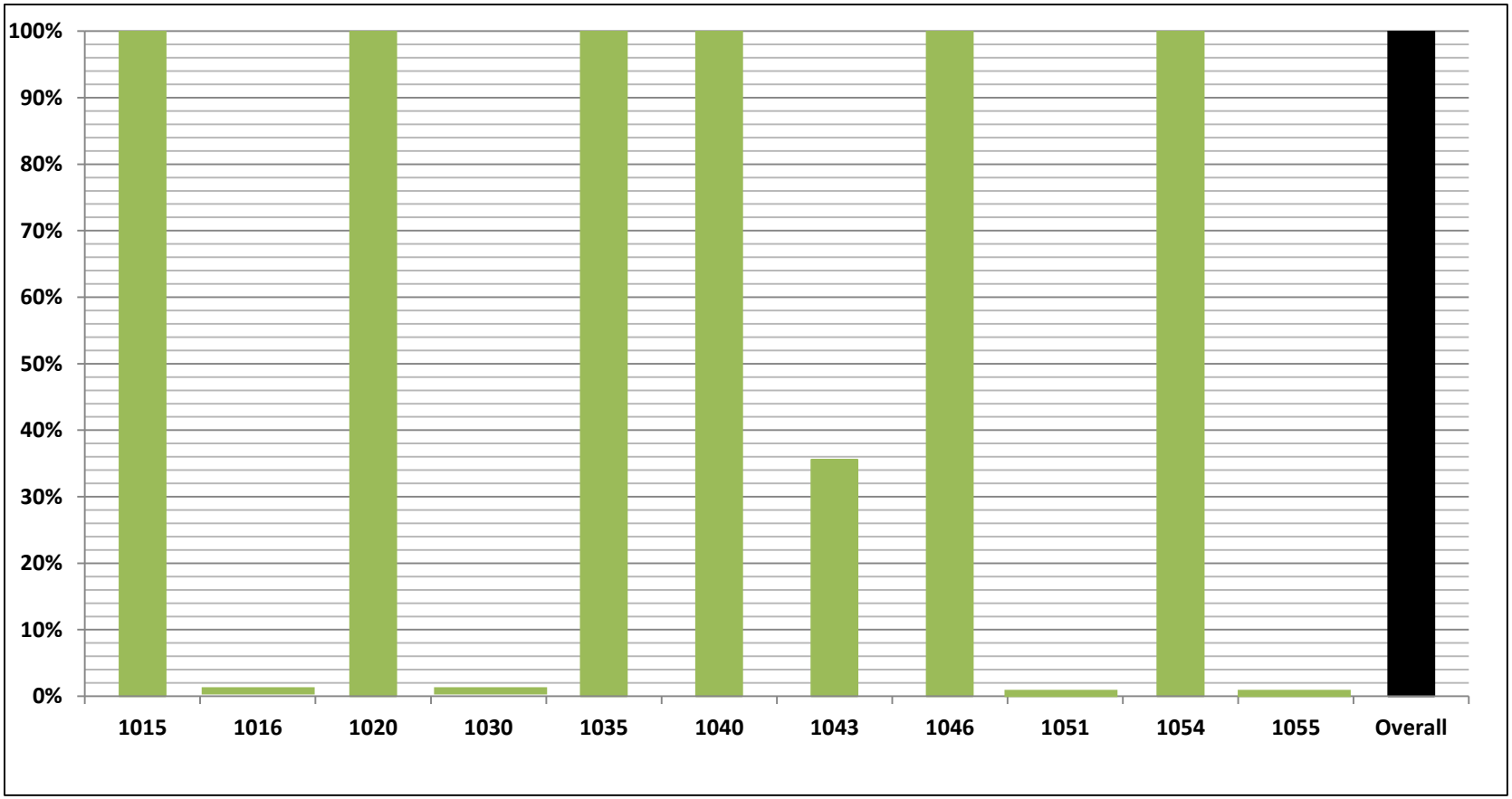
Performance level (%) for the overall SA33 (n=20)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
1st Half FY 2015	128	128	0	403	168	24	103	192
2nd Half FY 2015	128	140	0	430	205	0	101	205
*IQT=Interquartile range								

Variation between substance use organizations

SA33 Number of Motivational Sessions per Client with Multiple Residential Detoxification Episodes Performance Level during the Reporting Period for 1st Half FY 2015



SA33 Number of Motivational Sessions per Client with Multiple Residential Detoxification Episodes Performance Level during the Reporting Period for 2nd Half FY 2015



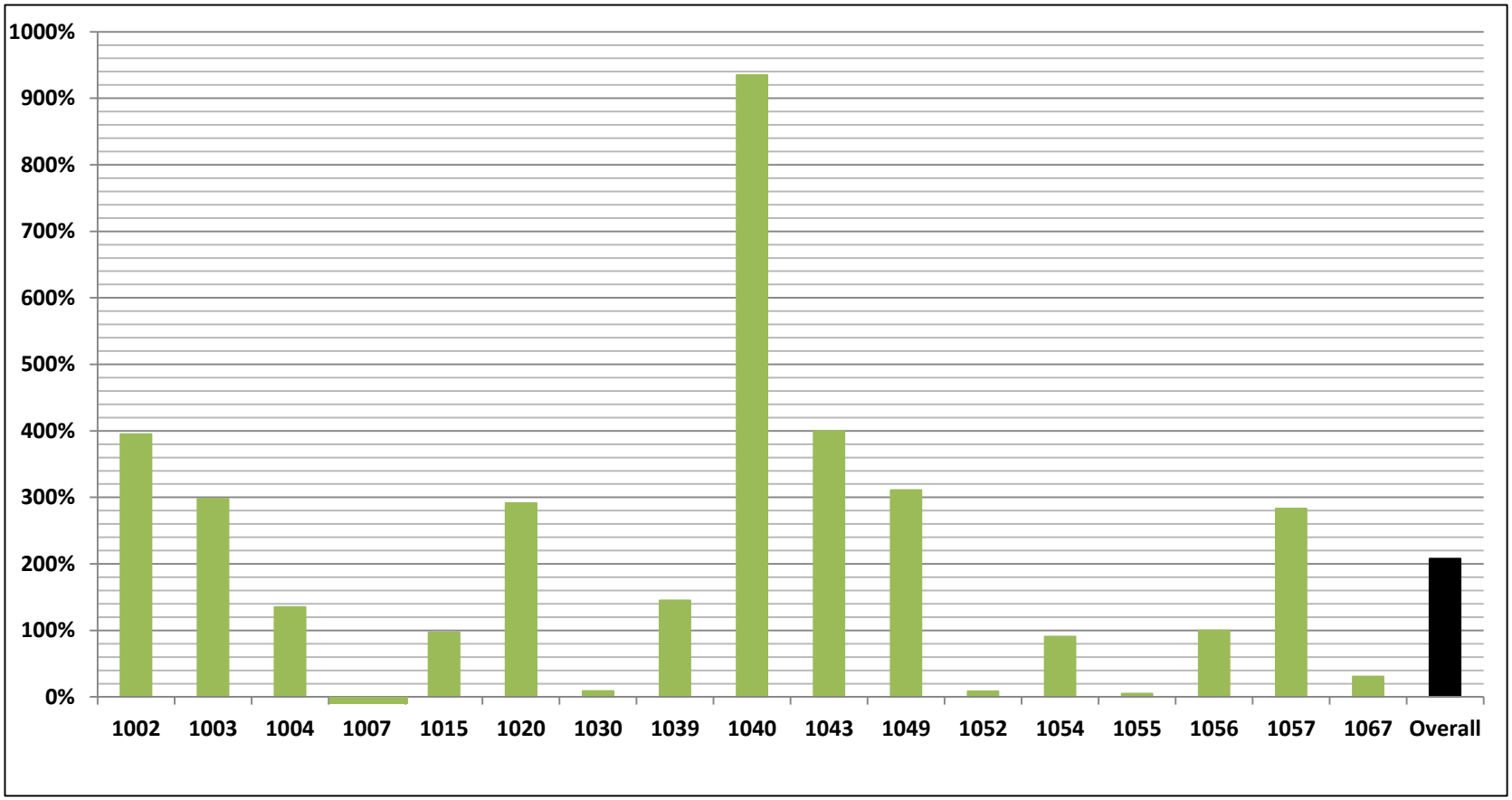
SA34: Community Support Referrals

The performance level for SA34 represents the average number of referrals with referral follow-up on DSHS funded clients who ended a specific service type during the fiscal year to date.

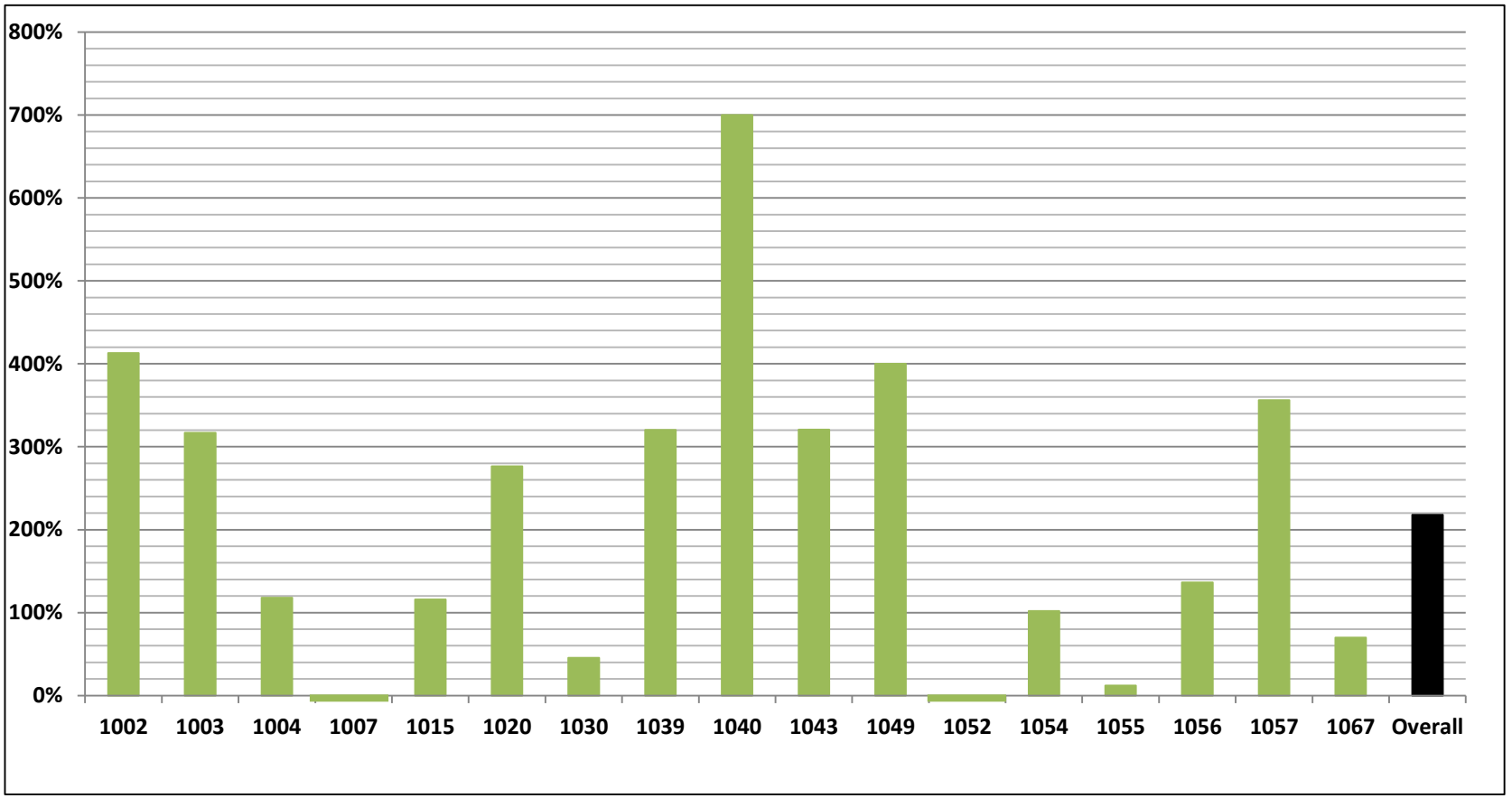
Performance level (%) for the overall SA34 (n=20)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
1st Half FY 2015	208	234	0	935	268	31	135	298
2nd Half FY 2015	218	191	0	700	251	70	136	321
*IQT=Interquartile range								

Variation between substance use providers

SA34 Community Support Referrals Performance Level during the Reporting Period for 1st Half FY 2015



SA34 Community Support Referrals Performance Level during the Reporting Period for 2nd Half FY 2015



Section III. State Hospitals

A. Performance measures

List of The 2015 Joint Commission and Centers for Medicare & Medicaid Services performance measures				
Code	**Measure Name**	**Measure Description**	**Measure Numerator**	**Measure Denominator**
HBIPS 1	Admission screening for risk of violence to self, risk of violence to others, substance use, psychological trauma history, and patient strengths. Required by TJC	Patients admitted to a hospital-based inpatient psychiatric setting who are screened by the third day post admission for all of the following: risk of violence to self, risk of violence to others, substance use, psychological trauma history and patient strengths.	Psychiatric inpatients with admission screening by the third day post admission for all of the following: risk of violence to self, risk of violence to others, substance use, psychological trauma history and patient strengths.	All psychiatric inpatient discharges.
HBIPS 2	Hours of physical restraint use Required by TJC & CMS	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint (per 1,000 inpatient hours).	The total number of hours that all psychiatric inpatients were maintained in physical restraint.	Number of psychiatric inpatient days.
HBIPS 3	Hours of seclusion use Required by TJC & CMS	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion (per 1,000 inpatient hours).	The total number of hours that all psychiatric inpatients were held in seclusion.	Number of psychiatric inpatient days.
HBIPS 4	Patients discharged on multiple antipsychotic medications	Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications.	Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications.	Psychiatric inpatients discharged on one or more routinely scheduled

	Required by TJC & CMS			antipsychotic medications.

The table below presents the performance measures included for analysis for state hospitals. The selection of the measures was made based on the most recent complete data submitted to The Joint Commission (TJC) that aligned with Texas FY2015.

Continuation

Code	Measure Name	Measure Description	Measure Numerator	Measure Denominator
HBIPS 5	Patients discharged on multiple antipsychotic medications with appropriate justification Required by TJC & CMS	Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification.	Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification.	Psychiatric inpatient discharges on two or more routinely scheduled antipsychotic medications.
SUB 1	Alcohol use screening Required by CMS	Hospitalized patients who are screened within the first three days of admission using a validated screening questionnaire for unhealthy alcohol use.	The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking within the first three days of admission.	The number of hospitalized inpatients 18 years of age and older.
TOB 1	Tobacco use screening Required by CMS	Hospitalized patients who are screened within the first three days of admission for tobacco use (cigarettes, smokeless tobacco, pipe, and cigars) within the past 30 days.	The number of patients who were screened for tobacco use status within the first three days of admission.	The number of hospitalized inpatients 18 years if age and older.
TOB 2	Tobacco use treatment provided or offered Required by CMS	Hospitalized patients identified as tobacco product users within the past 30 days who receive or refuse practical counseling and receive or refuse FDS-approved cessation medications during the first three days after admission.	The number of patients who received or refused practical counseling to quit and received or refused FDA-approved cessation medications during the first three days after admission.	The number of hospitalized inpatients 18 years if age and older identified as current tobacco users.
TOB 2a	Tobacco use treatment Required by CMS	Hospitalized patients who received counseling and medication as well as those who received counseling and had reason for not receiving the medication during the first three days after admission.	The number of patients who received practical counseling to quit and received FDA-approved cessation medications during the first three days after admission.	The number of hospitalized inpatients 18 years if age and older identified as current tobacco users.

B. State Hospitals

The table below presents the list of State Hospitals that participate in the Behavioral Healthcare Performance Measurement System (BHPMS) of the NRI. These facilities submit monthly data to the BHPMS to meet minimum requirements from TJC and from the Centers for Medicare & Medicaid Services (CMS). Each regulatory entity, TJC and CMS, has its own requirements on how to determine patient eligibility and what data should be submitted.

For TJC, an initial patient population algorithm is used to determine the patients eligible for the HBIPS core measure file (HBIPS 1, HBIPS 2, HBIPS 3, HBIPS 4, & HBIPS 5). The criteria include: presence of at least one mental disorder (as defined by ICD-10), age at least 1 year, and resident of a unit not defined as either alcohol and drug treatment only or medical unit. Population counts are determined separately for four age strata: children, adolescents, adults, and older adults.

For CMS, the initial patient population is all patients discharged from inpatient psychiatric units that receive reimbursement under the CMS Inpatient Psychiatric Facility Prospective Payment System having a length of stay less than or equal to 120 days. Data for eligible patients must be submitted for: HBIPS 2, HBIPS 3, HBIPS 4, HBIPS 5, SUB 1, TOB 1, TOB 2, & TOB 2a.

For comparison purposes, the NRI Rate shown in blue on each graph represents the overall rate for all state hospitals that report data to NRI for the measure.

List of State Hospitals	
Code	**Name**
TX01	Austin State Hospital
TX02	Big Spring State Hospital
TX03	Kerrville State Hospital
TX04	North Texas State Hospital
TX05	Rusk State Hospital
TX06	San Antonio State Hospital
TX07	Terrell State Hospital
TX08	Waco Center for Youth
TX09	Rio Grande State Center
TX11	El Paso Psychiatric Center

C. Results

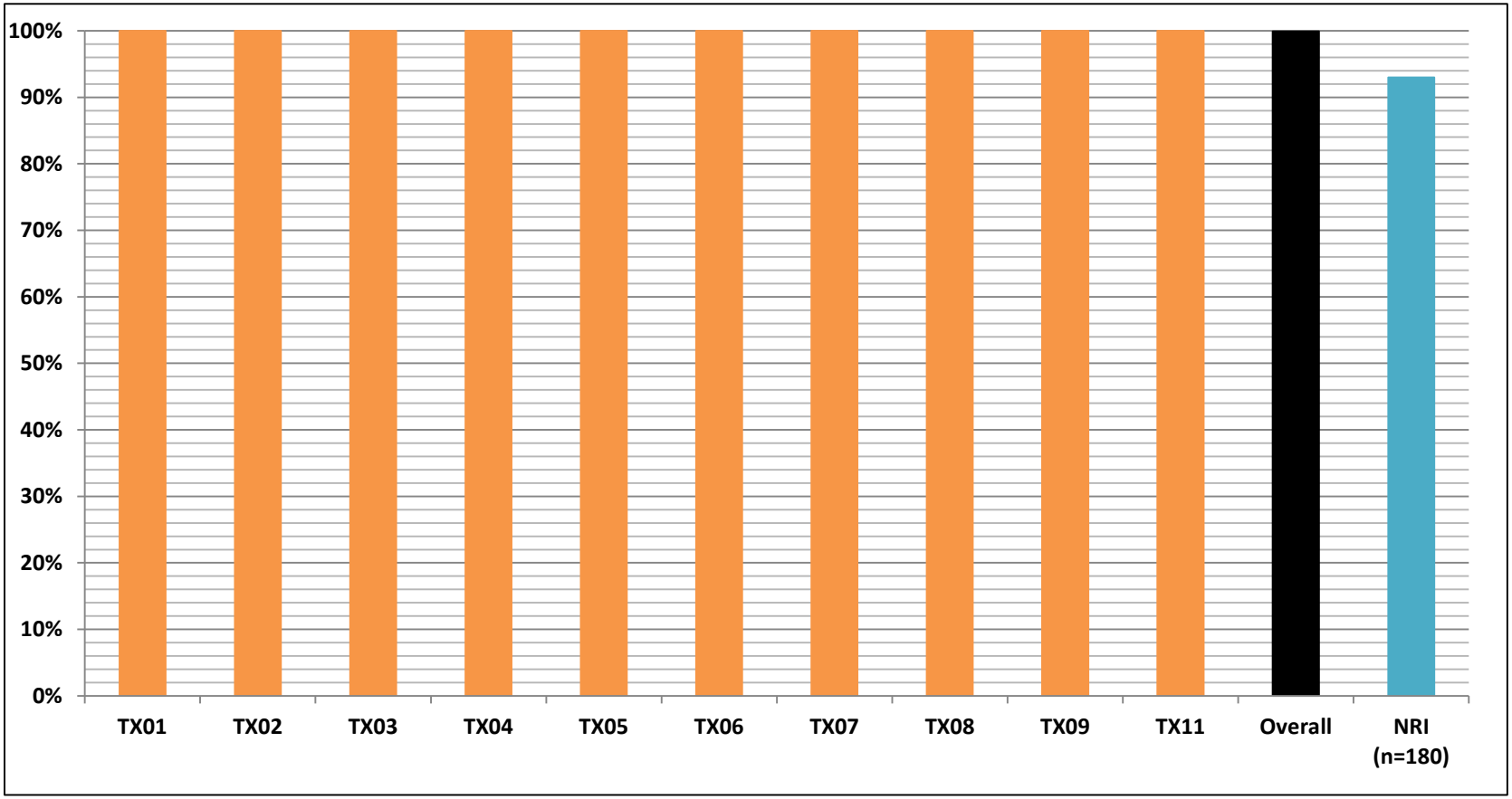
HBIPS 1: Screening at admission for risk of violence to self, risk of violence to others, substance use, psychological trauma history, and patient strengths

The performance level for HBIPS 1 represents the percent of patients admitted to a hospital-based inpatient psychiatric setting who are screened by the third day post admission for all of the following: risk of violence to self, risk of violence to others, substance use, psychological trauma history and patient strengths.

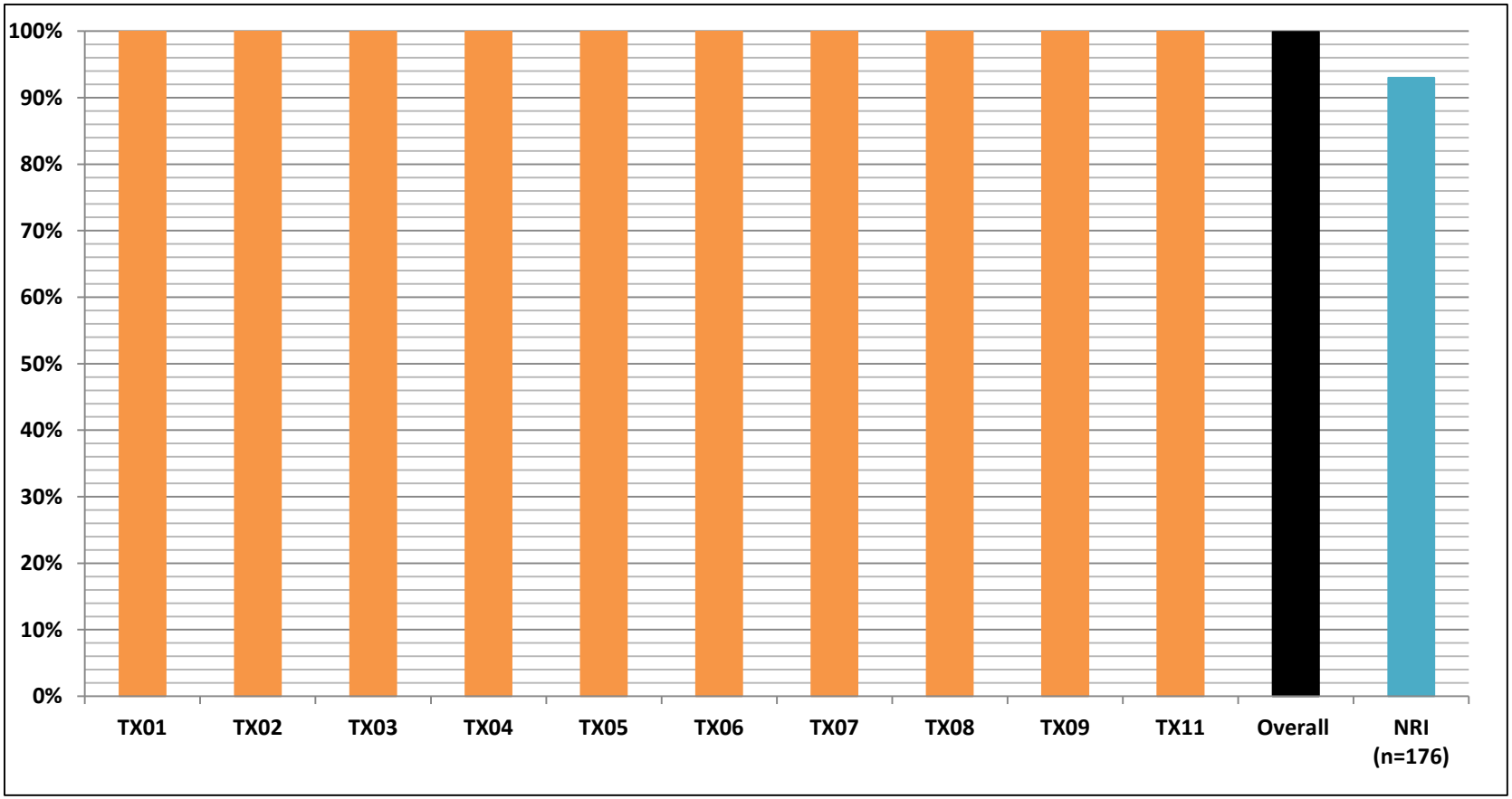
Performance level (%) for the overall HBIPS 1 (n=10)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
2nd Half FY 2015	No variation							
1st Half FY 2016	100	.05	100	100	0	100	100	100
*IQT=Interquartile range								

Variation between state hospitals

HBIPS 1 Screening at admission for risk of violence to self, risk of violence to others, substance use, psychological trauma history, and patient strengths for 2nd Half FY 2015



HBIPS 1 Screening at admission for risk of violence to self, risk of violence to others, substance use, psychological trauma history, and patient strengths for 1st Half FY 2016



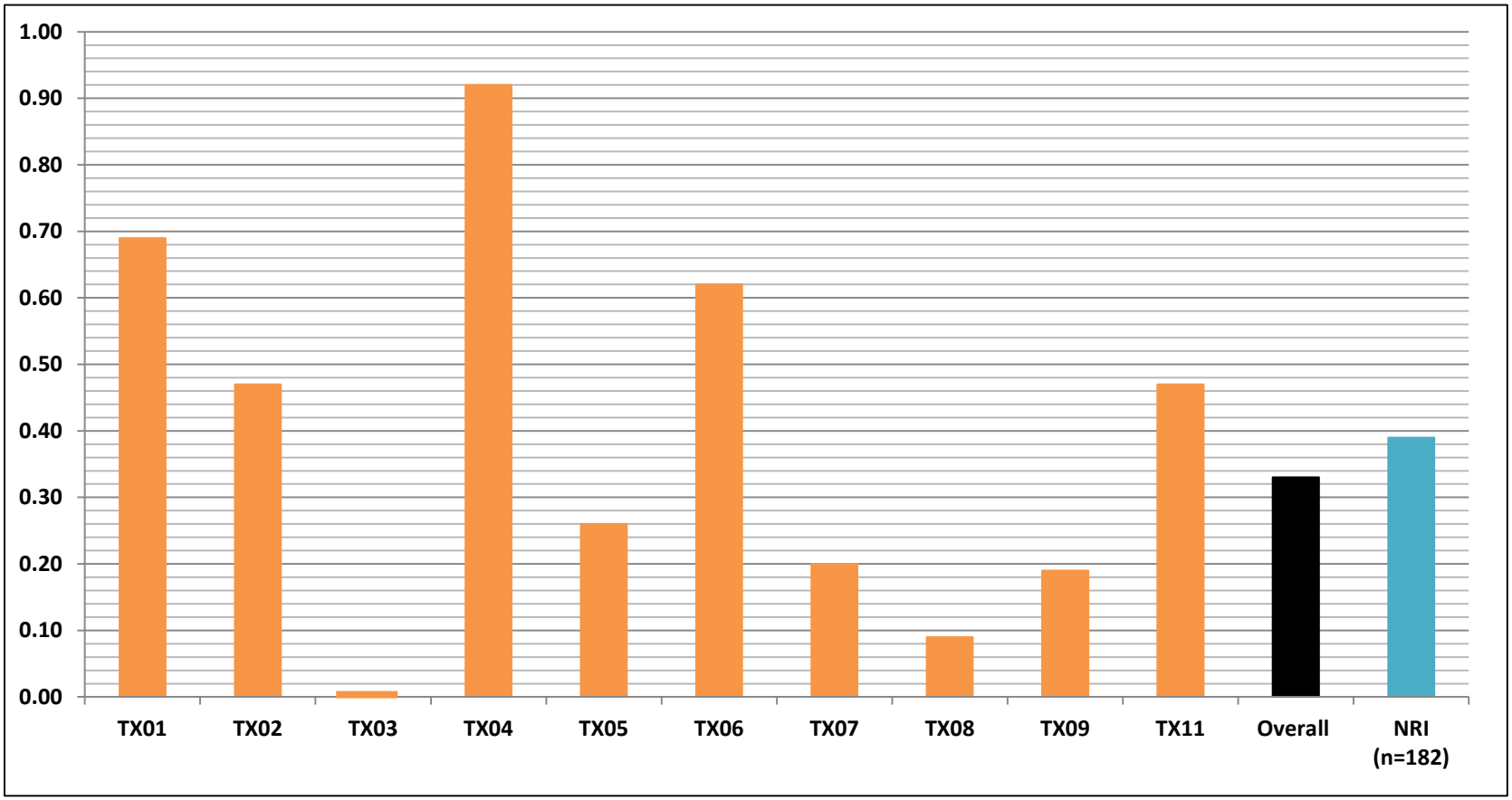
HBIPS 2: Hours of Physical Restraint Use

The performance level for HBIPS 2 represents the total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint (per 1,000 inpatient hours).

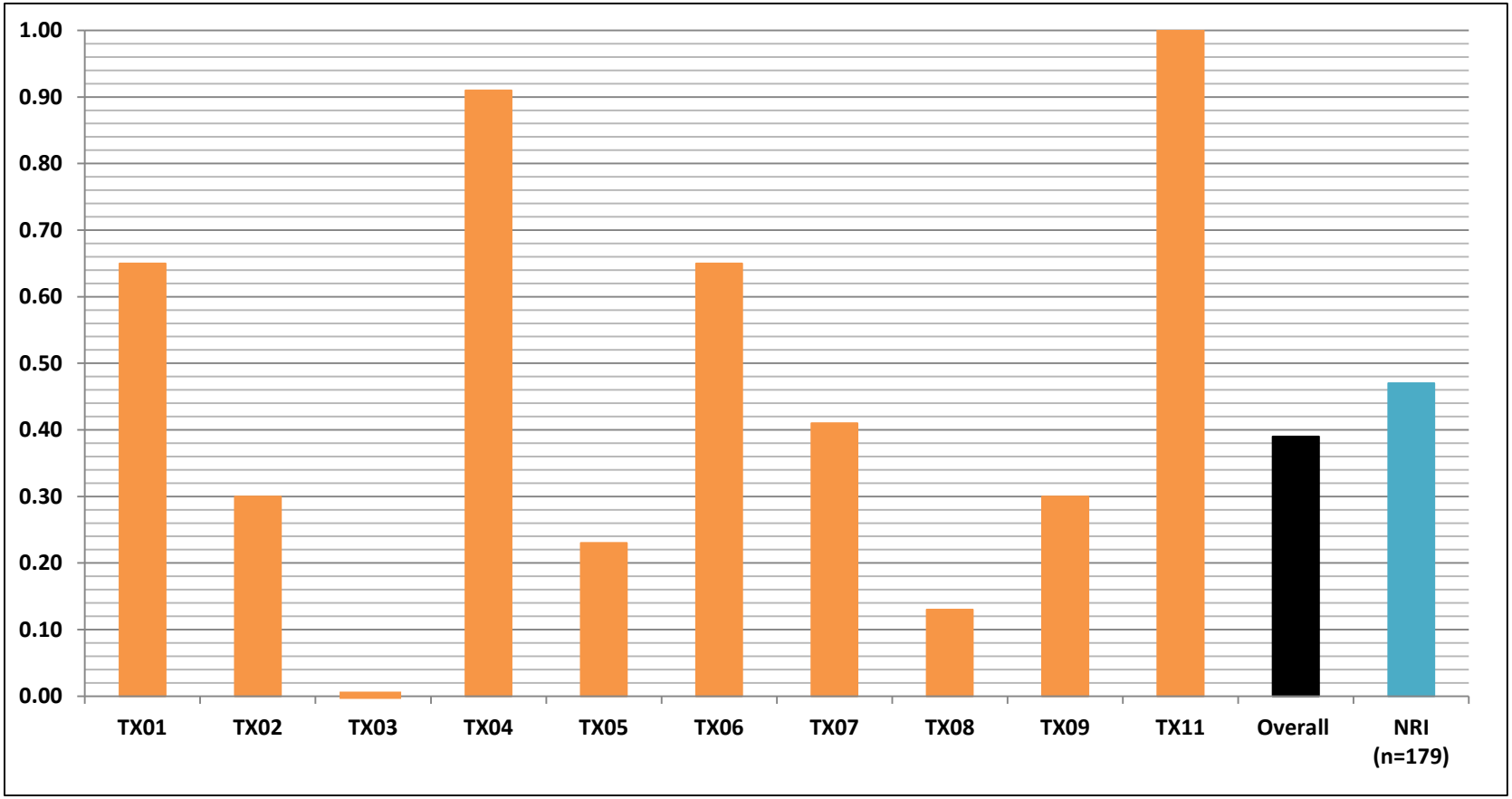
Performance level (%) for the overall HBIPS 2 (n=10)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
2nd Half FY 2015	.39	.29	0	.92	.47	.17	.36	.64
1st Half FY 2016	.47	.35	0	1.09	.51	.21	.36	.71
*IQT=Interquartile range								

Variation between state hospitals

HBIPS 2 Hours of Physical Restraint Use for 2nd Half FY 2015



HBIPS 2 Hours of Physical Restraint Use for 1st Half FY 2016



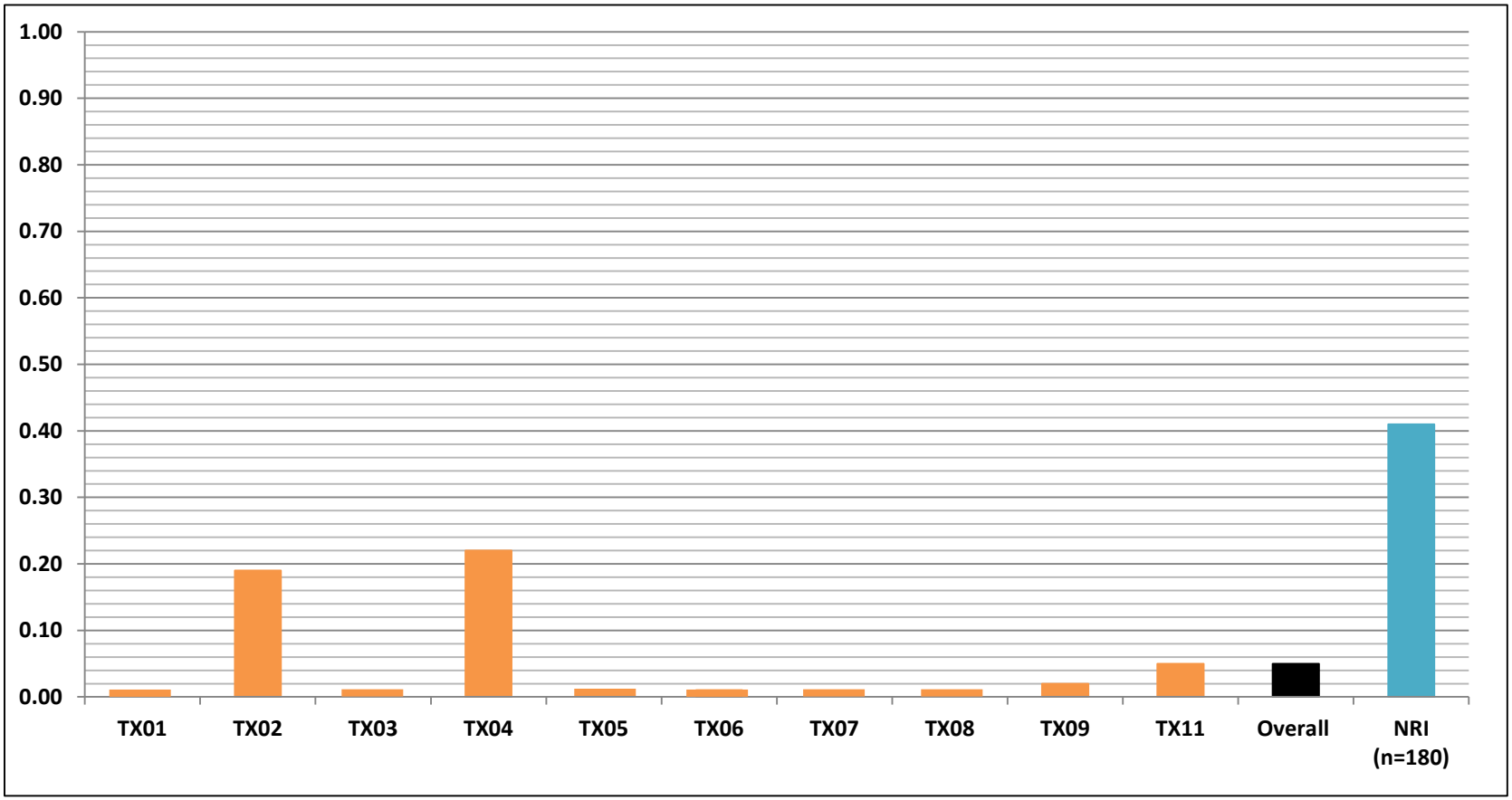
HBIPS 3: Hours of Seclusion Use

The performance level for HBIPS 3 represents the total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion (per 1,000 inpatient hours).

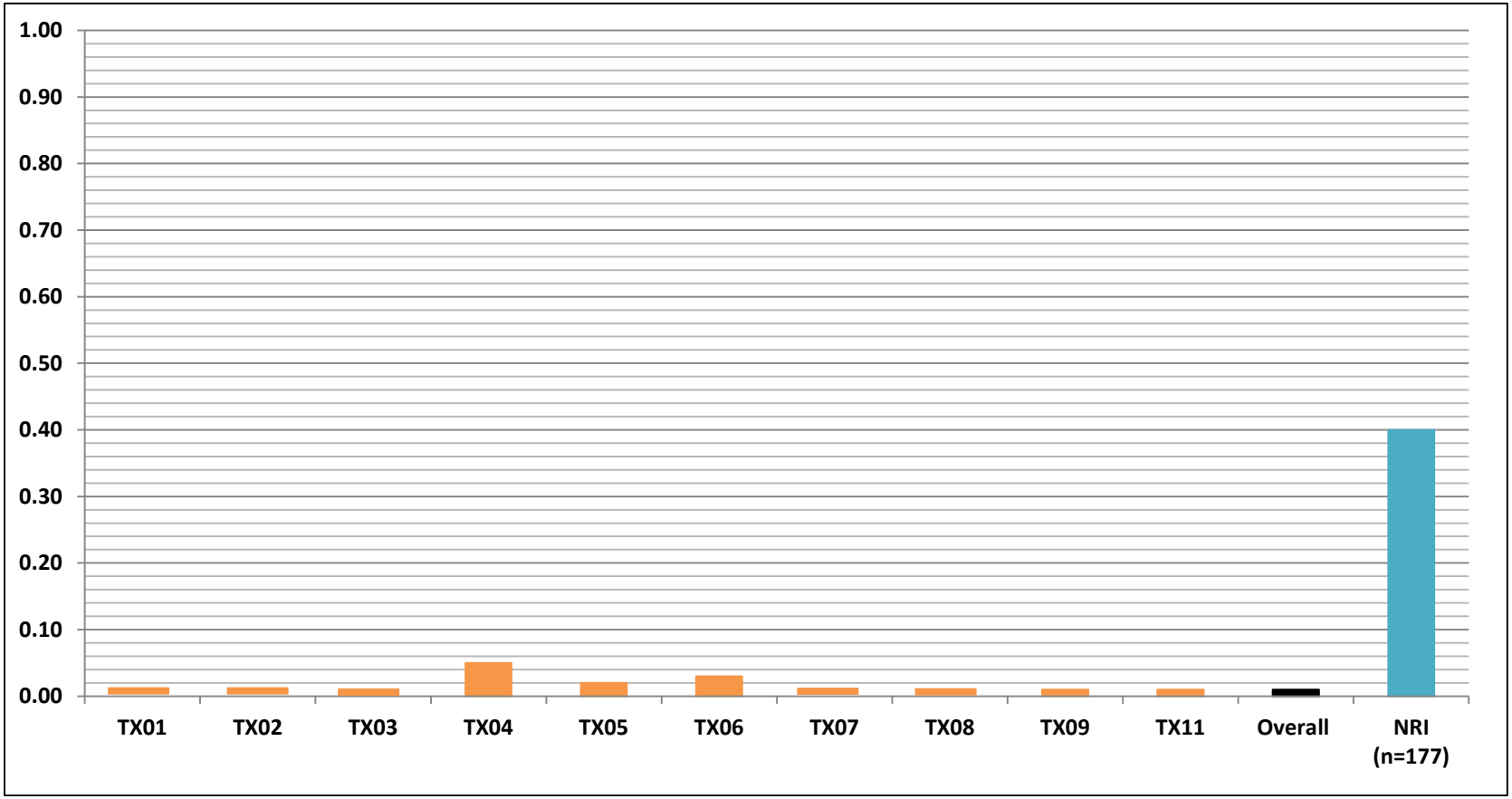
Performance level (%) for the overall HBIPS 3 (n=10)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
2nd Half FY 2015	.05	.09	0	.22	.09	0	0	.09
1st Half FY 2016	.01	.02	0	.05	.02	0	.01	.02
*IQT=Interquartile range								

Variation between state hospitals

HBIPS 3 Hours of Seclusion Use for 2nd Half FY 2015



HBIPS 3 Hours of Seclusion Use for 1st Half FY 2016



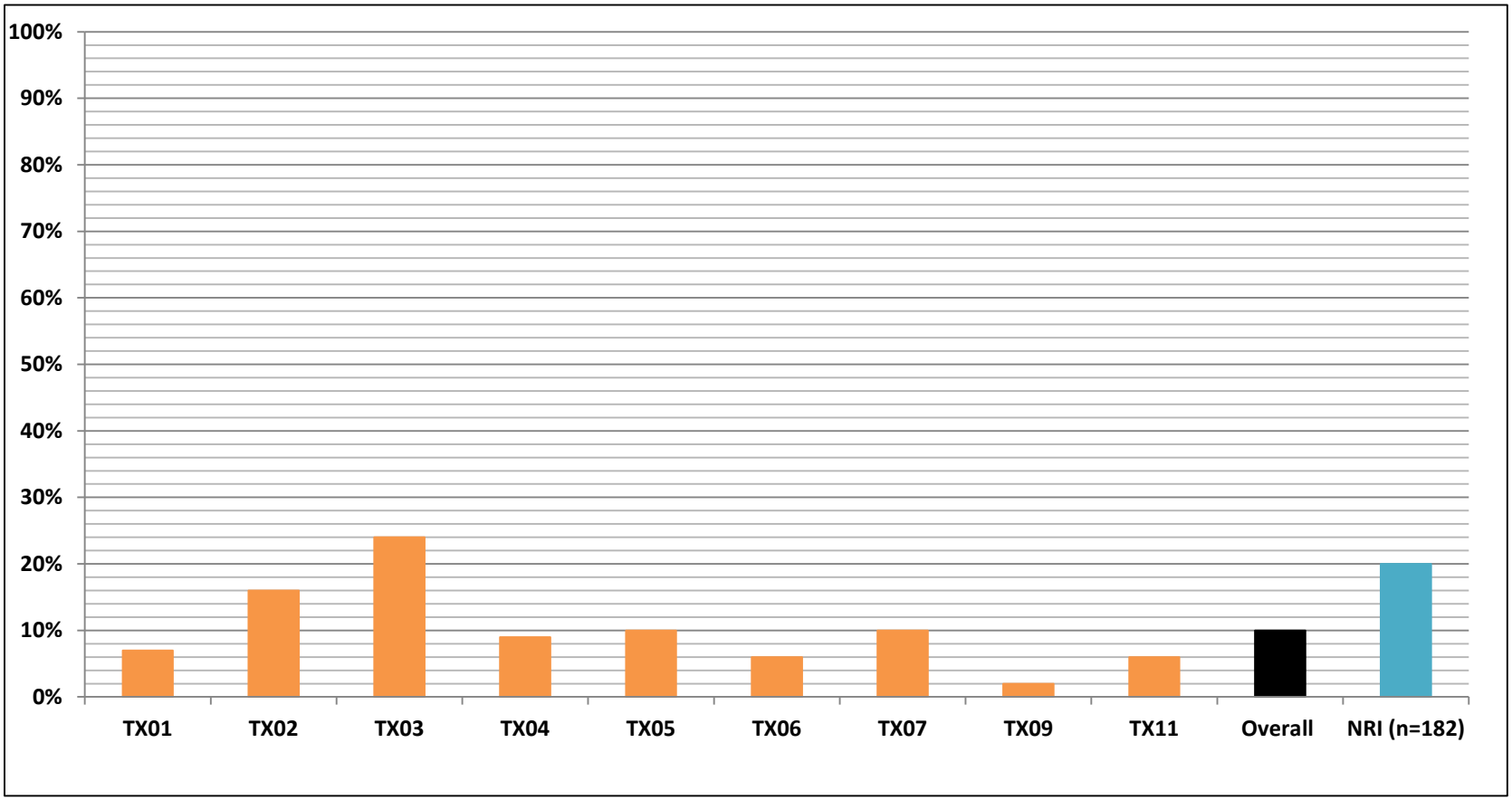
HBIPS 4: Patients Discharged on Multiple Antipsychotic Medications

The performance level for HBIPS 4 represents the percent of patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications.

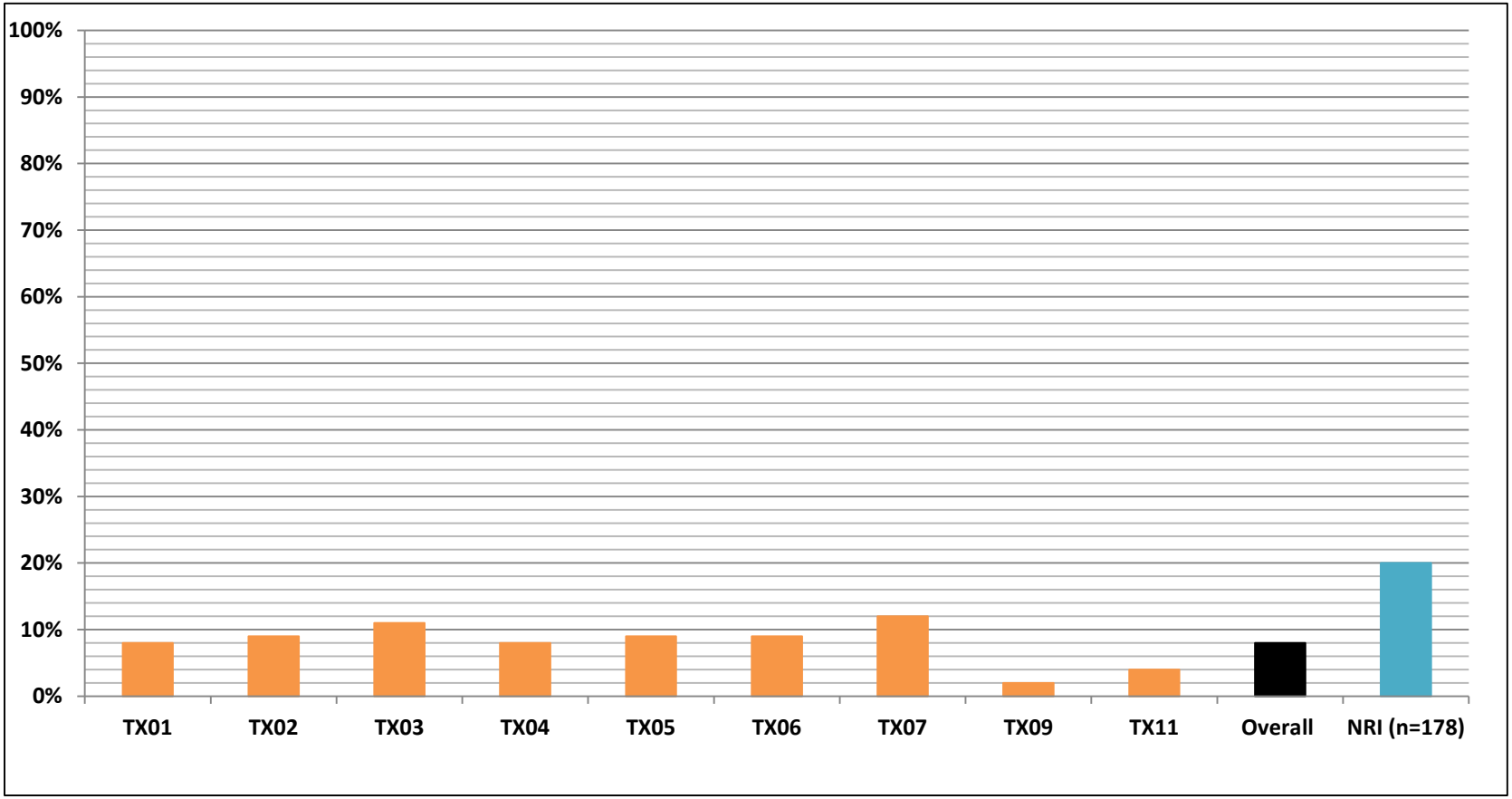
Performance level (%) for the overall HBIPS 4 (n=9)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
2nd Half FY 2015	10	7	2	24	8	6	9	14
1st Half FY 2016	8	3	2	12	4	6	9	10
*IQT=Interquartile range								

Variation between state hospitals

HBIPS 4 Patients Discharged on Multiple Antipsychotic Medications for 2nd Half FY 2015



HBIPS 4 Patients Discharged on Multiple Antipsychotic Medications for 1st Half FY 2016



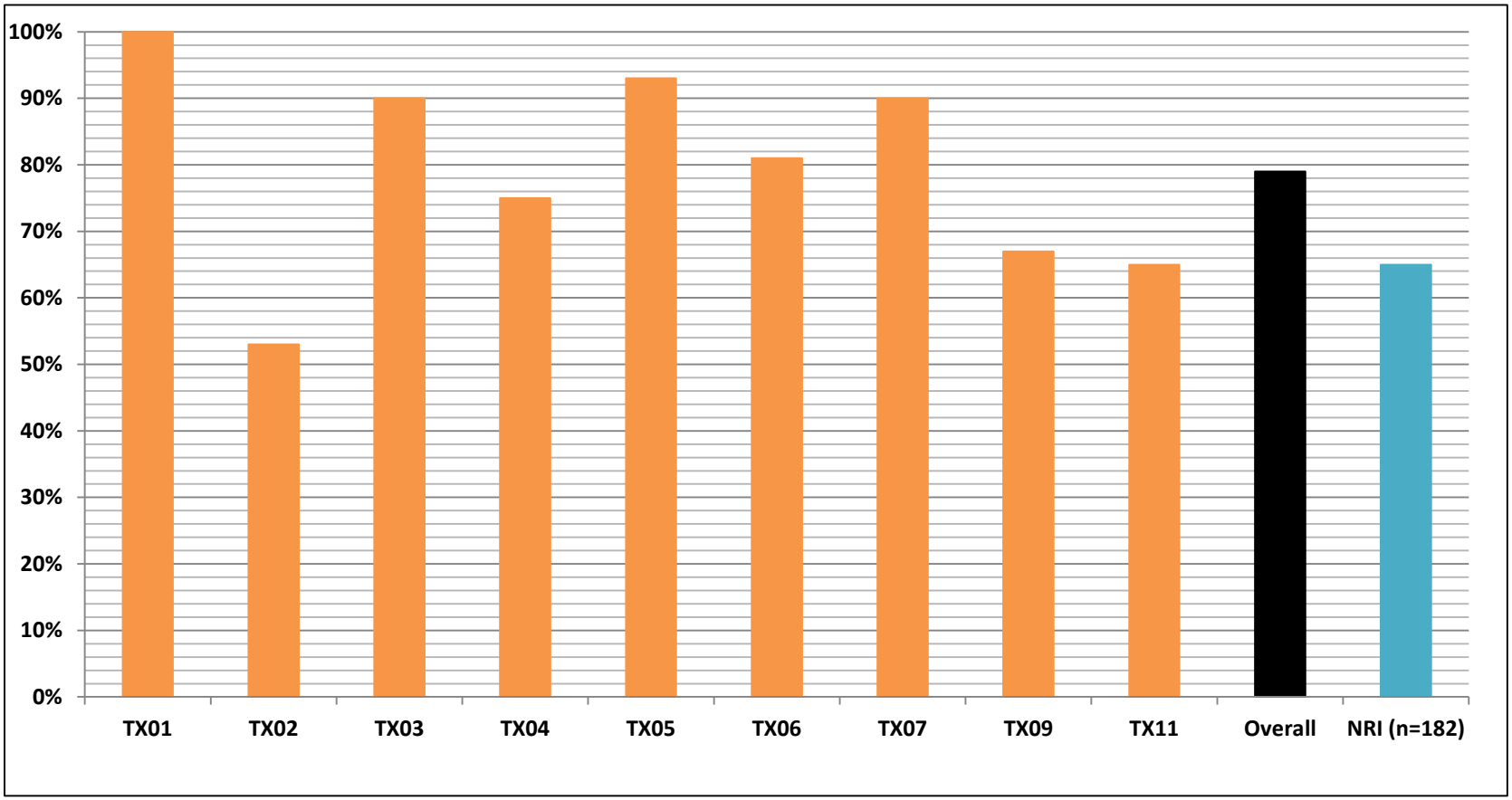
HBIPS 5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification

The performance level for HBIPS 5 represents the percent of patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification.

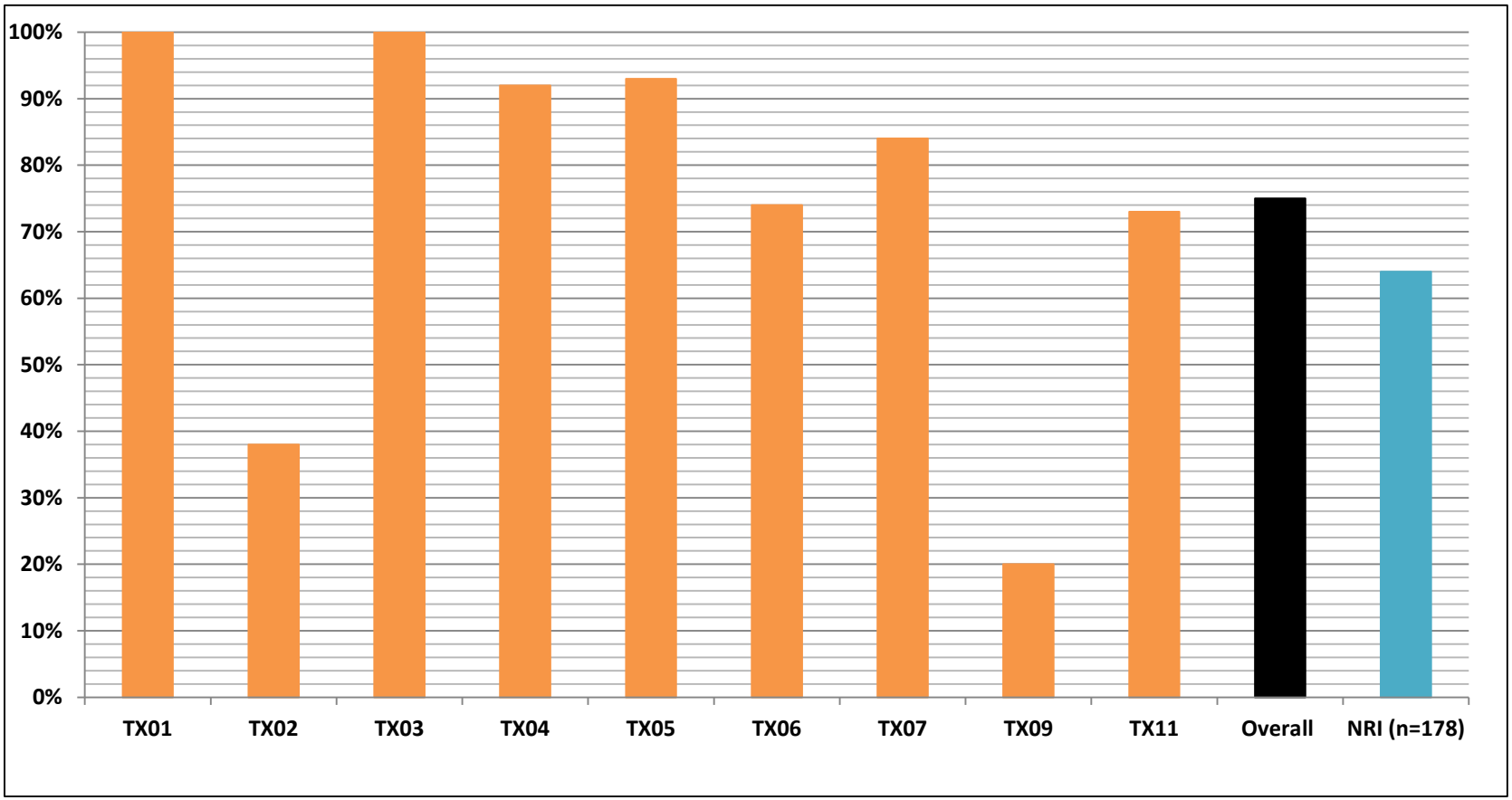
Performance level (%) for the overall HBIPS 5 (n=9)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
2nd Half FY 2015	79	16	53	100	26	66	81	92
1st Half FY 2016	75	28	20	100	41	55	84	96
*IQT=Interquartile range								

Variation between state hospitals

HBIPS 5 Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification for 2nd Half FY 2015



HBIPS 5 Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification for 1st Half FY 2016



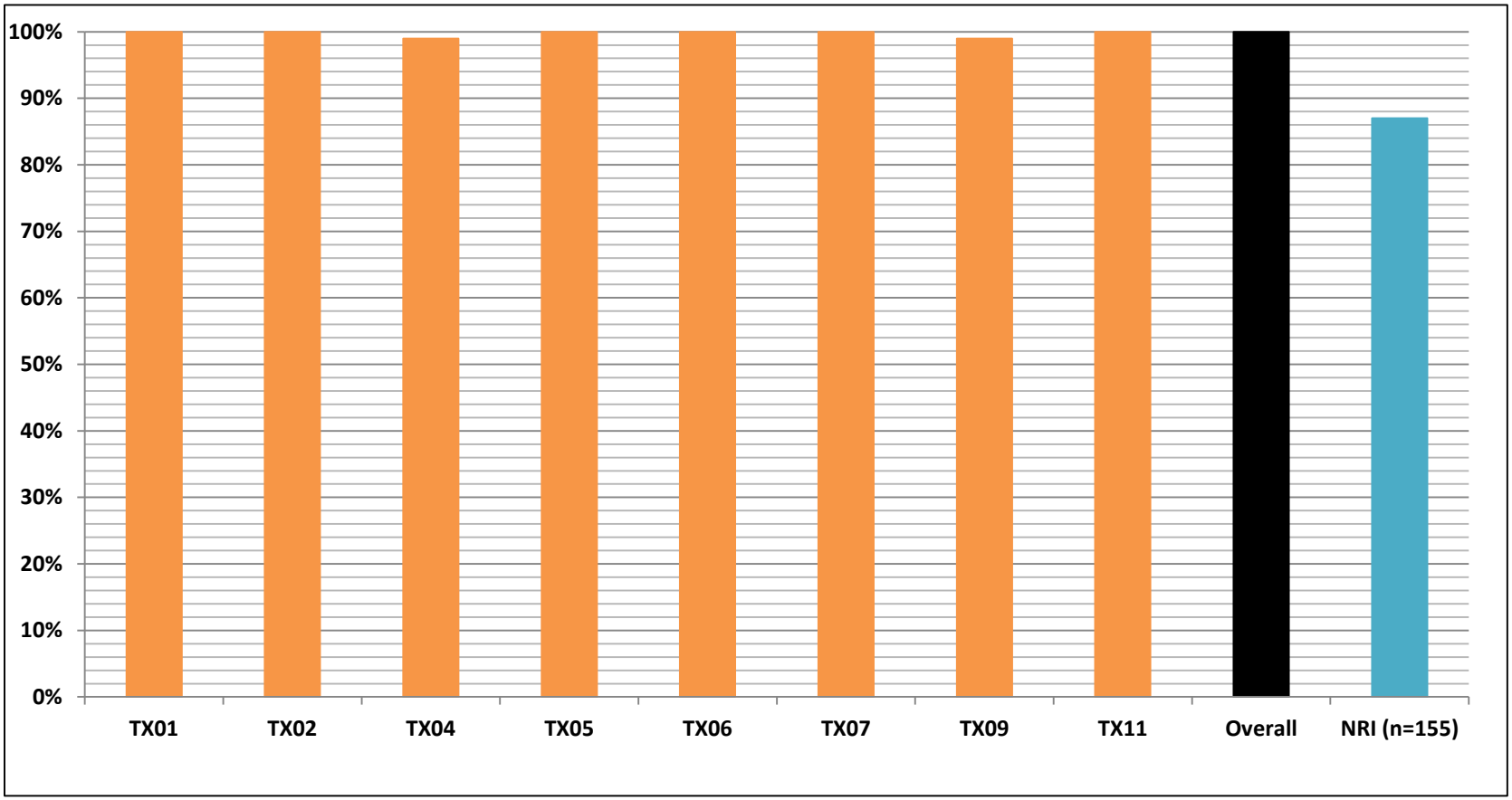
SUB 1: Alcohol Use Screening

The performance level for SUB 1 represents the percent of hospitalized patients who are screened within the first three days of admission using a validated screening questionnaire for unhealthy alcohol use.

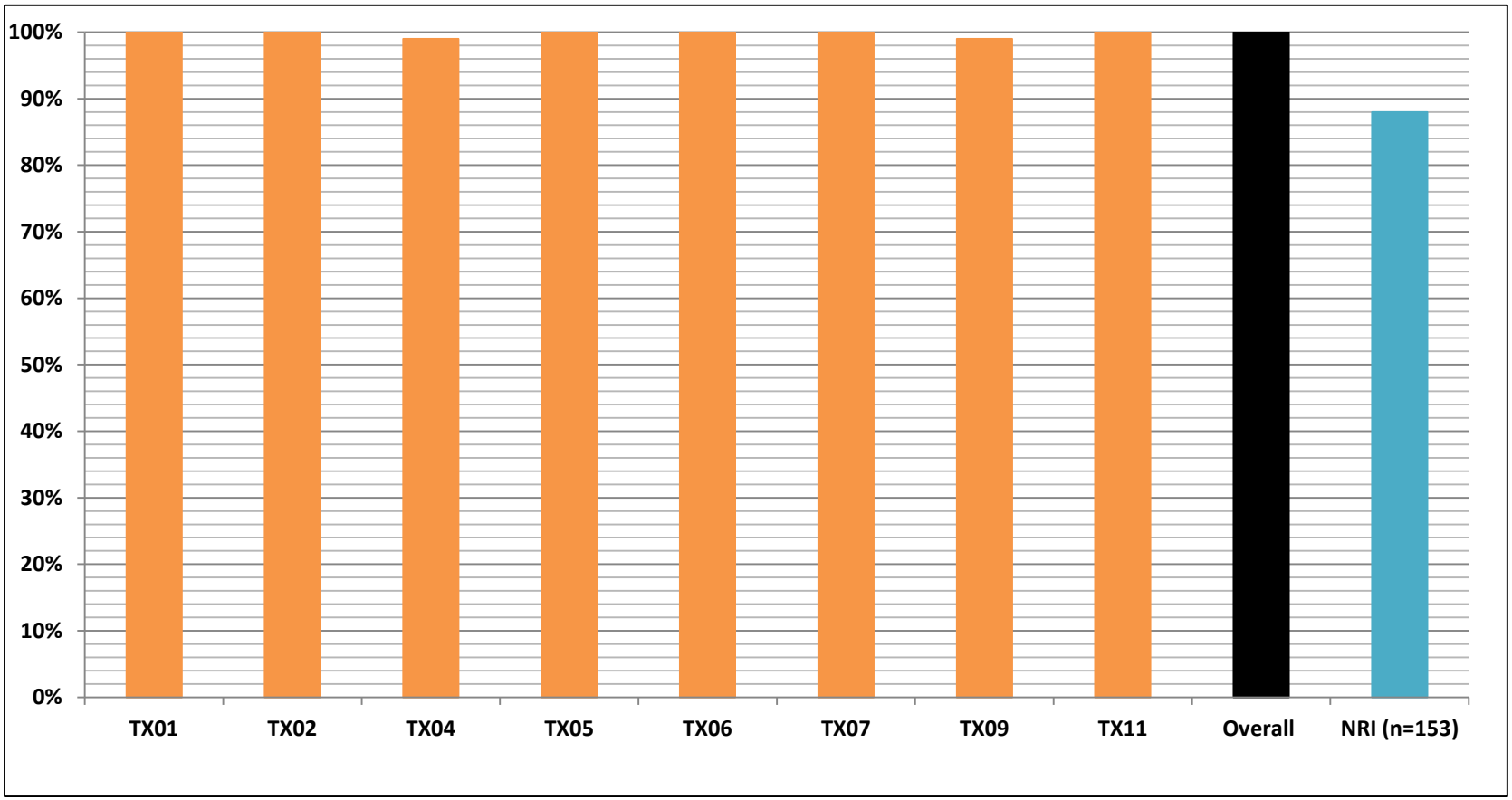
Performance level (%) for the overall SUB 1 (n=8)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
2nd Half FY 2015	100	.5	99	100	1	99	100	100
1st Half FY 2016	100	.4	99	100	.1	99	100	100
*IQT=Interquartile range								

Variation between state hospitals

SUB 1 Alcohol Use Screening for 2nd Half FY 2015



SUB 1 Alcohol Use Screening for 1st Half FY 2016



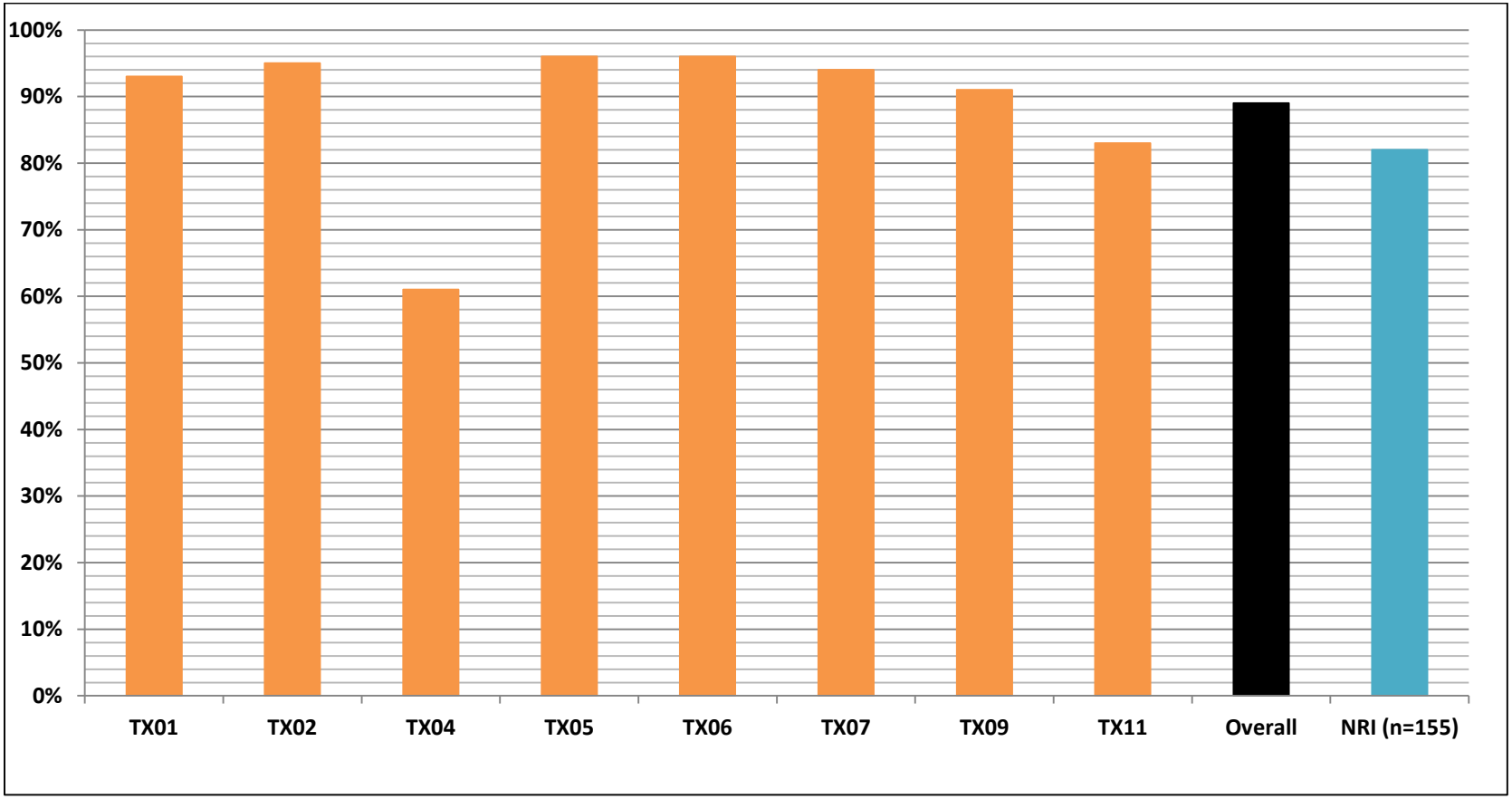
TOB 1: Tobacco Use Screening

The performance level for TOB 1 represents the percent of hospitalized patients who are screened within the first three days of admission for tobacco use (cigarettes, smokeless tobacco, pipe, and cigars) within the past 30 days.

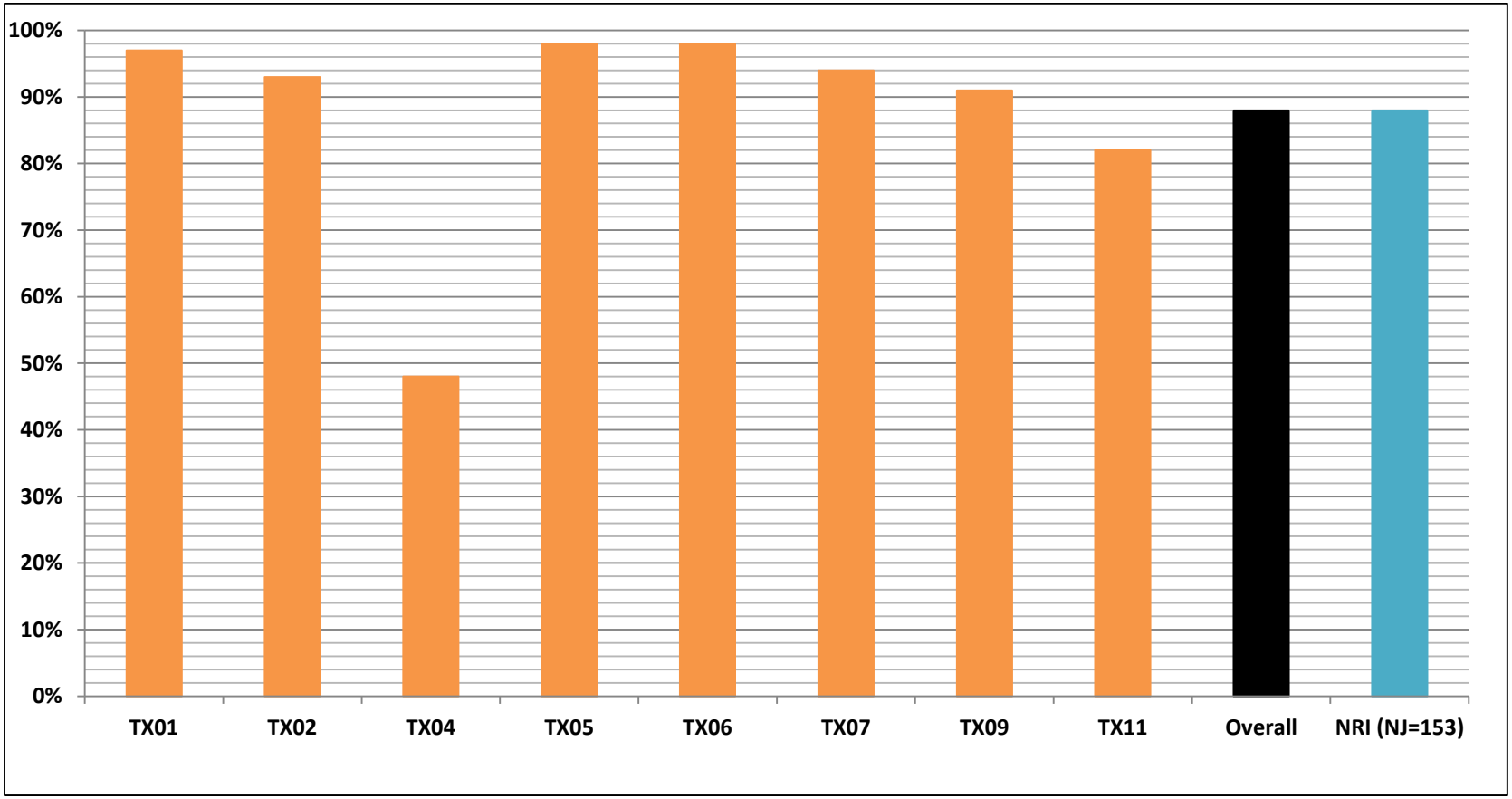
Performance level (%) for the overall TOB 1 (n=8)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
2nd Half FY 2015	89	12	61	96	11	85	93	96
1st Half FY 2016	88	17	48	98	14	86	93	98
*IQT=Interquartile range								

Variation between state hospitals

TOB 1 Tobacco Use Screening for 2nd Half FY 2015



TOB 1 Tobacco Use Screening for 1st Half FY 2016



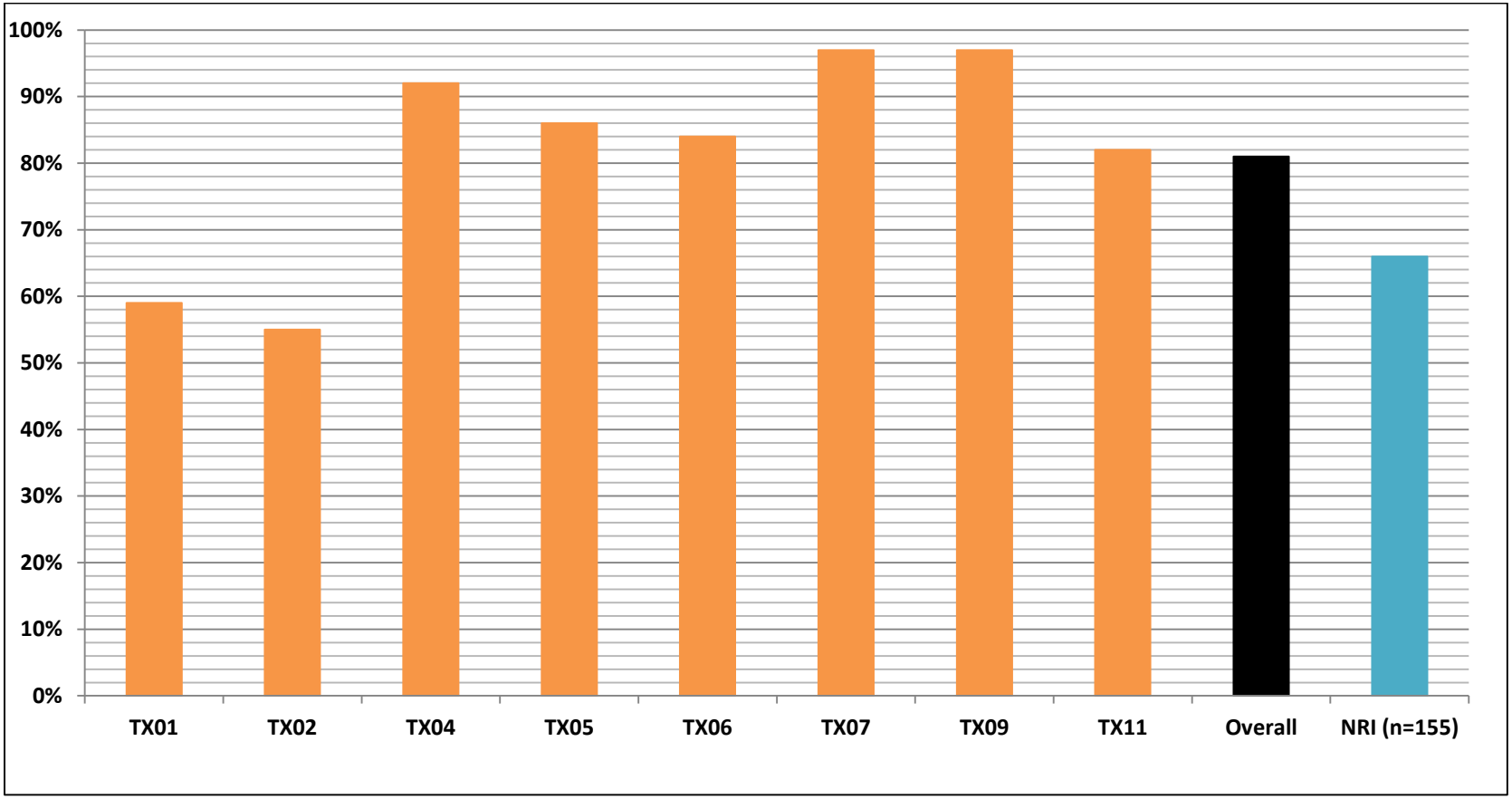
TOB 2: Tobacco Use Treatment Provided or Offered

The performance level for TOB 2 represents the percent of hospitalized patients identified as tobacco product users within the past 30 days who receive or refuse practical counseling and receive or refuse FDS-approved cessation medications during the first three days after admission.

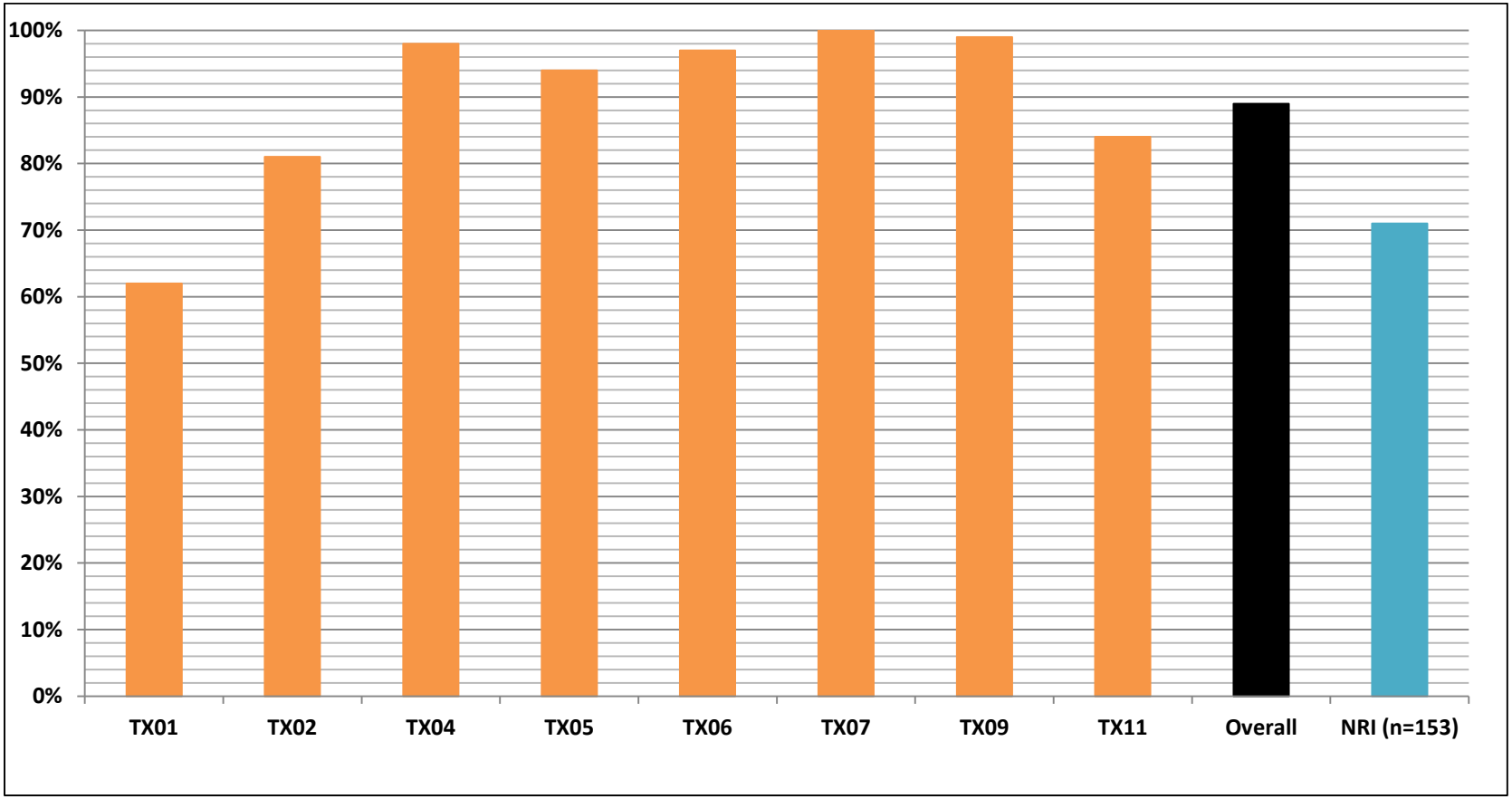
Performance level (%) for the overall TOB 2 (n=8)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
2nd Half FY 2015	81	16	55	97	31	65	85	96
1st Half FY 2016	89	13	62	100	17	81	95	98
*IQT=Interquartile range								

Variation between state hospitals

TOB 2 Tobacco Use Treatment Provided or Offered for 2nd Half FY 2015



TOB 2 Tobacco Use Treatment Provided or Offered for 1st Half FY 2016



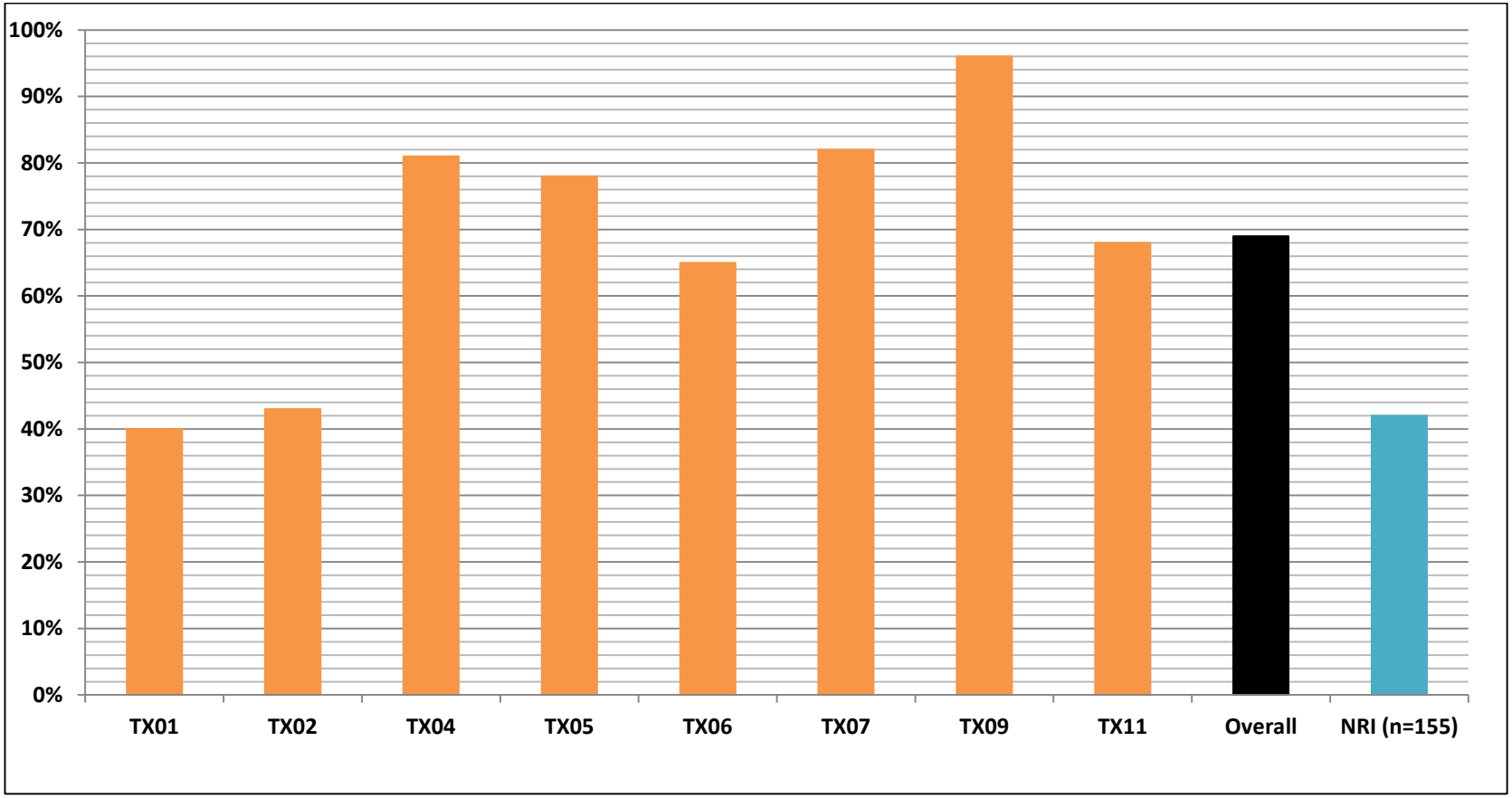
TOB 2a: Tobacco Use Treatment

The performance level for TOB 2a represents the percent of hospitalized patients who received counseling and medication as well as those who received counseling and had reason for not receiving the medication during the first three days after admission.

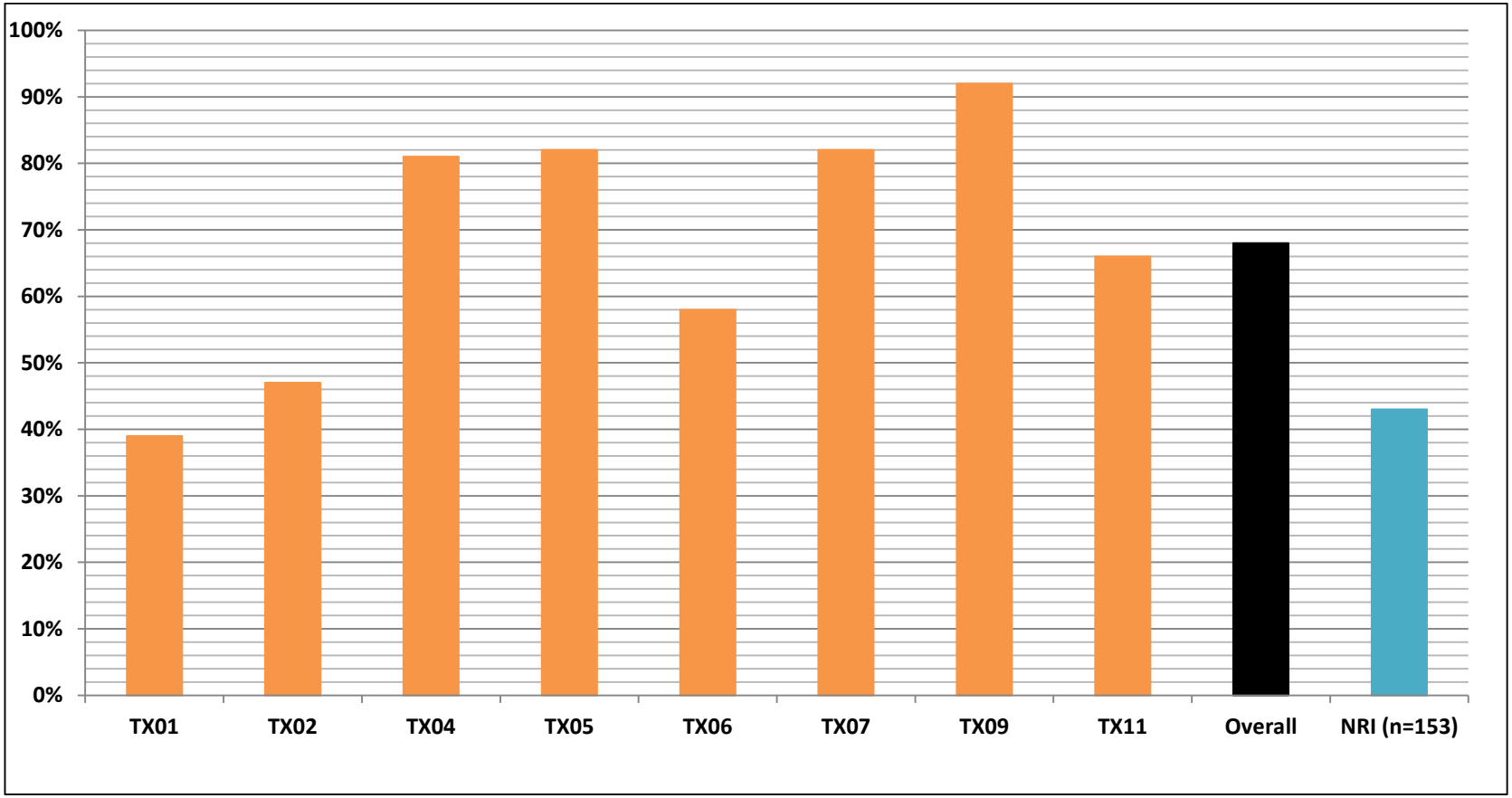
Performance level (%) for the overall TOB 2a (n=8)								
	Mean	SD	Min	Max	IQT*	25th	50th	75th
2nd Half FY 2015	69	20	40	96	34	48	73	82
1st Half FY 2016	68	19	39	92	32	50	74	82
*IQT=Interquartile range								

Variation between state hospitals

TOB 2a Tobacco Use Treatment for 2nd Half FY 2015



TOB 2a Tobacco Use Treatment for 1st Half FY 2016



Appendix A.3 – Mental Health Contract Measures Tied to Payment FY2016

Measures with Sanctions

Measure	Automatic Sanction	Sanction Type	Sanction Parameters
Service Target Adult % (>=100%)	Y	% of Adult Allocation	>=100 = 0% 99-90 = 1.4% 89-85 = 2.8% 84-80 = 5.6% 79-75 = 11.2% <75 = 22%
Uniform Assessment Completion Rate Adult % (>=95%)	Y	% of Adult Allocation	>=95 = 0% 94-85 = 1.4% 84-75 = 2.8% 74-65 = 5.6% <65 = 11.2%
Service Target Child % (>=100%)	Y	% of Child Allocation	>=100 = 0% 99-90 = 1.4% 89-85 = 2.8% 84-80 = 5.6% 79-75 = 11.2% <75 = 22%
Uniform Assessment Completion Rate Child % (>=95%)	Y	% of Child Allocation	>=95 = 0% 94-85 = 1.4% 84-75 = 2.8% 74-65 = 5.6% <65 = 11.2%
Family Partner Supports Target for LOCs 2, 3, 4 and YC % (>=10%)	Y	% of Child Allocation	>=10 = 0% 9-5 = 0.15% 4-0 = 0.3%

Percent withheld General Revenue Measures

Measure	Automatic Sanction	Sanction Type	Sanction Parameters
Employment % (>=9.8%)	Y	10% Withhold: Payment Contingent on Performance	Non-Payment of a proportional amount of allocated funds.
Community Tenure % (>=96.4%)	Y	10% Withhold: Payment Contingent on Performance	Non-Payment of a proportional amount of allocated funds.
Improvement Measure % (>=20%)	Y	10% Withhold: Payment Contingent on Performance	Non-Payment of a proportional amount of allocated funds.
Monthly Service Provision % (>=65.6%)	Y	10% Withhold: Payment Contingent on Performance	Non-Payment of a proportional amount of allocated funds.
Hospitalization % (<=1.9%)	Y	10% Withhold: Payment Contingent on Performance	Non-Payment of a proportional amount of allocated funds.

Measure	Automatic Sanction	Sanction Type	Sanction Parameters
Jail Diversion % (=<10.46%)	Y	10% Withhold: Payment Contingent on Performance	Non-Payment of a proportional amount of allocated funds.
Effective Crisis Response % (>=75.1%)	Y	10% Withhold: Payment Contingent on Performance	Non-Payment of a proportional amount of allocated funds.
Frequent Admission % (<=0.3%)	Y	10% Withhold: Payment Contingent on Performance	Non-Payment of a proportional amount of allocated funds.
Access to Crisis Response Services % (>=52.2%)	Y	10% Withhold: Payment Contingent on Performance	Non-Payment of a proportional amount of allocated funds.
Juvenile Justice Avoidance % (>=95%)	Y	10% Withhold: Payment Contingent on Performance	Non-Payment of a proportional amount of allocated funds.
Community Tenure % (>=98.1%)	Y	10% Withhold: Payment Contingent on Performance	Non-Payment of a proportional amount of allocated funds.
Improvement Measure % (>=25%)	Y	10% Withhold: Payment Contingent on Performance	Non-Payment of a proportional amount of allocated funds.
Monthly Service Provision % (>=65%)	Y	10% Withhold: Payment Contingent on Performance	Non-Payment of a proportional amount of allocated funds.

Benchmark Measures

Measure	Automatic Sanction	Sanction Type	Sanction Parameters
Employment (RCI Benchmark <= -1.645)	N/A	Benchmarking FY16	N/A
Residential Stability (RCI Benchmark <= -1.645)	N/A	Benchmarking FY16	N/A
Strengths (RCI Benchmark <= -1.645)	N/A	Benchmarking FY16	N/A
Life Domain Functioning (RCI Benchmark <= -1.645)	N/A	Benchmarking FY16	N/A
Educational or Volunteering Strengths (RCI Benchmark <= -1.645)	N/A	Benchmarking FY16	N/A
School (RCI Benchmark <= -1.645)	N/A	Benchmarking FY16	N/A
Family and Living Situation (RCI Benchmark <= -1.645)	N/A	Benchmarking FY16	N/A

Measures Subject to Liquidated Damages

Measure	Automatic Sanction	Sanction Type	Sanction Parameters
Legislative Budget Board: Community Support Plan % (>=95% Annual Measure)	Y	Liquidated Damages	$3,000 for first and second instance, and $6,000 for each instance thereafter.

Measure	Automatic Sanction	Sanction Type	Sanction Parameters
Follow-Up Within 7 Days: Face-to-Face % (>=75% Annual Measure)	Y	Liquidated Damages	$3,000 for first and second instance, and $6,000 for each instance thereafter.
Follow-Up Within 7 Days: Disposition % (>=95% Annual Measure)	Y	Liquidated Damages	$3,000 for first and second instance, and $6,000 for each instance thereafter.
Medicaid Recipient Waitlist Removal > 60 Days Client Count (=0)	Y	Liquidated Damages	$3,000 for first and second instance, and $6,000 for each instance thereafter.
Counseling Target % (>= 12%)	N	May be Subject to Liquidated Damages	$3,000 for first and second instance, and $6,000 for each instance thereafter.
ACT Target % (>=54%)	N	May be Subject to Liquidated Damages	$3,000 for first and second instance, and $6,000 for each instance thereafter.
TANF Transfer to Title XX Services	N	May be Subject to Liquidated Damages	$3,000 for first and second instance, and $6,000 for each instance thereafter.
Long-Term Services and Support Screen (>=70%)	N	May be Subject to Liquidated Damages	$3,000 for first and second instance, and $6,000 for each instance thereafter.
TANF Transfer to Title XX Services	N	May be Subject to Liquidated Damages	$3,000 for first and second instance, and $6,000 for each instance thereafter.
Community Linkage % (>=23% Annual Measure)	N	May be Subject to Liquidated Damages	$3,000 for first and second instance, and $6,000 for each instance thereafter.
Crisis Follow-Up Within 30 Days % (>=90%)	N	May be Subject to Liquidated Damages	$3,000 for first and second instance, and $6,000 for each instance thereafter.

Source: Source obtained from HHSC information, “MH Contract Measures Overview FY16”.