

INDICATORS OF **M**ENTAL **H**EALTH
PROGRAM **P**ERFORMANCE

TREATMENT **O**UTCOMES

ACESS TO **C**ARE

SERVICES **P**ROVIDED AND **R**ECEIVED

Recommendations of

Vermont's
Mental Health Performance Indicator Project
Multi-Stakeholder Advisory Group

February 1999 - June 2000

INTRODUCTION AND OVERVIEW

The recommendations for indicators for mental health program performance that are presented here are the product of the multi-stakeholder advisory group to Vermont's federally funded Mental Health Performance Indicator Project. One of the explicit goals of this advisory group was to recommend specific performance indicators for inclusion in a publicly available Mental Health Report Card.

This report includes the recommendations for indicators of treatment outcomes, access to care, and services provided/received that were developed and adopted by this group during 1998 through 2000, and a list of members of the advisory group. With the publication of this document, one part of the work of the advisory group is completed.

During this three year period, the advisory group met two to four times each year for a full day. These meetings included morning and afternoon meetings of the advisory group, and noon-time "brown bag luncheon" presentations by the staff of the project. These presentations provided an opportunity to share formal presentations that had been prepared for out of state professional meetings. These presentations were attended by members of the advisory group, other state and local mental health staff and advocates, and the staff of other state departments,

The process by which these recommendations were developed differs from traditional approaches to the development of performance indicators in at least three ways: It is data based, it is strengths based, and it is perspectivistic. These elements are at the core of Vermont's attempt to develop a data friendly culture.

The process has been data based in that it begins with what we know now and moves from factual knowledge to next questions, rather than working from assumptions and suppositions to first questions. In order to do this, the process is based almost exclusively on existing data resources (data we have laying around the house) and involves the distribution of weekly performance indicators to members of the advisory group and to other interested parties. The process explicitly works to remain strengths-based in that it focuses on what the findings tell us, not on what they do not tell us. Methodologically, the process focuses on the strengths of research methods, not their weaknesses. We always try not to let "the perfect" be the enemy of "the good". Finally, the process is perspectivistic. Each participant brings his or her own perspective to the discussion, but each participant also recognizes and respects that fact that others may interpret findings differently. Openness to different interpretations is essential to the development of a data based culture of learning about our system of care.

The staff of Vermont's Mental Health Performance Indicator Project looks forward to working with its multi-stakeholder advisory group toward the achievement of the ambitious goals outlined in this document.

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Principle Investigator, Vermont Mental Health Performance Indicator Project

TREATMENT OUTCOMES

Recommendations
of Vermont's Mental Health Performance Indicator Project
Multi-Stakeholder Advisory Group
December 17, 1999

The Vermont Performance Indicator Project Advisory Group recommends that the indicators of mental health treatment outcomes listed below be published on an annual basis and that the indicators be presented for the most recent year and historically to the extent that the data are available. Indicators should be published for the community mental health service delivery system as a whole, and for the children's and adult mental health components separately. Within the adult mental health component, indicators should also be published separately for the Adult Mental Health Outpatient Program, the Community Rehabilitation and Treatment Program, and Emergency Services Program; within the children's services program component, indicators should also be published separately for Success Beyond Six programs. Indicators should be published for the state as a whole and for each of the state's service areas. Whenever possible, indicators should also be calculated for the general population. The results of this analysis should be used for purposes of comparing people who receive services with the general population of the community.

All indicators should be computed for all clients served, for distinct age and gender categories, and for specified target populations. Whenever possible, performance on outcome indicators should be compared to the same indicators prior to treatment.

Specified target populations for adult mental health programs should include major diagnostic categories. Specified target populations for children's mental health programs should include children and adolescents in SRS custody, children and adolescents receiving special education services for emotional and behavioral disorders, and children and adolescents enrolled in the Medicaid program.

Composite "kite diagrams" of indicators of treatment outcomes should be prepared for each program at each provider.

Collaboration with other child serving agencies (especially SRS and Education) in the production and publication of performance indicators should be encouraged.

Educational Participation and Attainment

Educational participation and attainment should be measured for both children and adults as appropriate. Educational indicators should include school attendance/suspension/ expulsion, educational test score results, exiting special education, high school graduation (or GED completion) or advanced degree, literacy, and continuing education.

Economic Independence

Indicators of economic independence should be published for both children and adults as appropriate. Economic indicators for children's programs should include employment status (if not in school) and SSI/SSDI eligibility. Economic indicators for adult programs should include employment status, income, ANFC participation, and SSI/SSDI eligibility. Both current economic status and change in economic status should be measured and reported.

Residential Situation

Indicators of residential situation should include the type of residence, ownership, and financial subsidy. Rates of intensive residential placement and participation in intensive day programs should be reported as well.

Clinical/Social Assessment

Clinical, functional, and social measures should be used for measuring treatment outcomes. These measures should include the Global Assessment of Functioning scale (anchored version), clinical assessment tools, and measures of social interdependence.

Please note that CMHC Children's Services Programs will be willing to conduct standardized assessments of children and adolescents in treatment if all costs are reimbursed by the state.

Additional Significant Indicators

Indicators of significant life events should include maternity/paternity by children and adolescents, criminal justice involvement, emergency service utilization, hospitalization for mental health or substance abuse treatment, self-injurious behavior and attempted suicide, completed suicide, and mortality.

Consumer Survey

In order to obtain consumer evaluation of community mental health programs, surveys of consumers of mental health services should be conducted on an annual basis by an organization external to the CMHCs. At least one target population will be surveyed each year. These surveys should include consumer evaluation of their own treatment outcomes that include clinical, functional, and social dimensions. In addition, periodic surveys of family members, other service providers, other stakeholders, and the general population should be conducted (by an organization external to the CMHCs) to determine their perception of the outcomes of community programs

Distribution

A formal report that includes the measures specified above should be prepared by DDMHS on an annual basis and be made available to all stakeholder groups, including consumers, providers, advocate organizations, mental health and other state agency staff, schools, local and statewide program standing committees, and legislators. In addition, all performance indicators should be accessible through the DDMHS World Wide Web home page: <http://www.state.vt.us/dmh/>.

Published indicators of treatment outcomes should specify levels of significance and include detailed methodological appendices on data sources and analytical methods. Stakeholders (providers, consumers, and others) should be given the opportunity to comment on the performance indicators and to provide interpretation of the results and DDMHS should respond.

ACCESS TO MENTAL HEALTH SERVICES

Recommendations
of Vermont's Mental Health Performance Indicator Project
Multi-Stakeholder Advisory Group
February 25, 1999

The Vermont Performance Indicator Project Advisory Group recommends that the indicators of access to mental health services listed below be published on an annual basis and that the indicators be presented for the most recent year and historically to the extent that the data are available. Indicators should be published for the community mental health service delivery system as a whole, for the children's and adult mental health components separately, and, within the adult mental health component, for the Adult Mental Health Outpatient Program, the Community Rehabilitation and Treatment Program, and Emergency Services Program. Indicators should be published for the state as a whole and for each of the state's service areas.

Recommended Indicators of Access to Care

Client-focussed Indicators

How many people receive services from the publicly funded system of care?

Client-focussed indicators should include utilization rates for the population as a whole, for distinct age and gender categories, and for specified target populations.

Specified target populations for adult mental health programs should include people with serious mental illness, people with depressive disorders, people with previous inpatient behavioral health care in the Vermont State Hospital and in other settings, people with a history of incarceration, and people who are homeless. Specified target populations for children's mental health programs should include children and adolescents in SRS custody, children and adolescents receiving special education services for emotional and behavioral disorders, and children and adolescents enrolled in the Medicaid program. Utilization rates for children and adolescents in various types of residential care should also be published.

A composite measure of indicators of access to care in the "kite diagram" format should be prepared for each program, component, and service area.

Fiscal Indicators

How much money do agencies spend to serve people in need?

Fiscal indicators should include revenues and expenditures per capita and per client for each program, for the adult and children's service components as a whole, and for the total mental health component in each of the state's service areas. Fiscal indicators should also include breakdowns of revenues by source.

A composite “kite diagram” of fiscal measures should be prepared for each program.

Consumer Satisfaction

How satisfied are consumers with access to services?

In order to obtain consumer evaluation of community mental health programs, DDMHS should conduct surveys of consumers of mental health services on an annual basis. In addition, periodic surveys of the general population, family members, other service providers, and other stakeholders should be conducted to determine the perceived accessibility of the community programs.

A composite “kite diagram” of consumer and community evaluation of access to services should be prepared for each program.

Distribution

A formal report that includes the measures specified above should be prepared by DDMHS on an annual basis and made available to all stakeholder groups, including consumers, providers, mental health and other state agency staff, local and statewide program standing committees, and legislators. In addition, all performance indicators should be posted on the DDMHS World Wide Web home page.

SERVICES PROVIDED / RECEIVED

Recommendations
of Vermont's Mental Health Performance Indicator Project
Multi-Stakeholder Advisory Group
June 23, 2000

The Vermont Performance Indicator Project Advisory Group recommends that the indicators of mental health services provided/received that are listed below be published on at least an annual basis. These indicators should be presented for the most recent year and historically to the extent that the data are available. Indicators should be published for the community mental health service delivery system as a whole, and for the children's and adult mental health components separately. Within the adult mental health component, indicators should also be published separately for the Adult Mental Health Outpatient Program, the Community Rehabilitation and Treatment Program, and Emergency Services Program; within the children's services program component, indicators should also be published separately for Success Beyond Six programs. Indicators should be published for the state as a whole and for each of the state's service areas.

All indicators should be computed for all clients served, for distinct age and gender categories, and for specified target populations. Specified target populations for adult mental health programs should include major diagnostic categories. Specified target populations for children's mental health programs should include children and adolescents in SRS custody, children and adolescents receiving special education services for emotional and behavioral disorders, and children and adolescents enrolled in the Medicaid program.

Composite "kite diagrams" of indicators of services provided/received should be prepared for each program and each provider in addition to tabular and standard graphic presentation of results.

Performance indicators that relate to services provided/received should relate to both community and hospital based services. These performance indicators should include a focus on the services provided, the people who provide the services, service system integration and consumer/stakeholder evaluation of the services received.

Services Provided

Indicators that focus on services provided should include data on the types of service provided overall and the combinations of services provided to individual service recipients. Information on the duration and frequency/intensity and cost of service provision should be published as well. The location in which services are provided is an important area of concern. The amount of service provided and the number of people served in clinic based locations, community settings, schools, residential facilities, and other settings should be reported. Finally, the degree to which services are accepted on a voluntary basis and the degree to which participation is involuntary should be

monitored and reported on a regular basis. All service indicators should be reported on at least a quarterly basis.

When possible, patterns of service provision should be compared to practice guidelines for the treatment of specific disorders. Sources of relevant practice guidelines should include DDMHS practice guidelines when they exist, state agencies, professional organizations, and managed care companies. Comparison of practice guidelines for the treatment of major depression to practice patterns in the treatment of major depression in community programs in Vermont is one promising area of investigation. The possibility of similar comparisons of practice guidelines for the treatment of schizophrenia to actual practice patterns in community programs should be explored as well.

The inclusion of substance abuse programs in the monitoring of patterns of service delivery is highly recommended.

Staff

The people who provide services are an important component of the service delivery process. Aggregate information on staff education, training, experience, and salaries should be reported. Similarly rates of staff turnover for different provider organizations and treatment programs should be monitored and reported. Finally, the size of the active caseload of professional staff (staff/client ratio) and the rate of direct contact with clients (percent of work hours) should be monitored and reported.

Service System Integration

The degree of caseload overlap between and among child serving agencies, and system wide segregation/integration ratios should be produced for Community Mental Health, SRS, and Special Education caseloads for each of the state's ten community mental health regions. To the degree possible, other child serving agencies (e.g. youth service bureaus, health care providers, and parent child centers) should be included as well.

For adults, the degree of service system integration should consider rates of access to general medical services by consumers of mental health services. In addition, the utilization of substance abuse treatment services, participation in supported employment and/or vocational rehabilitation services, and access to disability income and subsidized housing should be monitored.

Consumer Survey

In order to obtain consumer evaluation of community mental health programs, surveys of consumers of mental health services should be conducted on an annual basis by DDMHS. At least one target population will be surveyed each year. These surveys should include consumer evaluation of services provided by the community mental health programs. In addition, periodic surveys of family members, other service providers, other stakeholders, and the general population should be conducted (by DDMHS) to determine their perception of the services provided by community mental

health programs. Surveys should include fixed alternative and open ended questions which will be useful for staff training and professional development. Stakeholder input on the survey process will be solicited.

Services Provided/Received and Treatment Outcomes

DDMHS should conduct research and program evaluation that focuses on the relationship between the services provided/received and treatment outcomes. These research and program evaluation activities should be designed to identify patterns of service delivery that are associated with both positive and negative treatment outcomes.

Distribution

A formal report that includes the measures of services provided/received should be prepared by DDMHS on an annual basis and be made available to all stakeholder groups, including consumers, providers, advocate organizations, mental health and other state agency staff, schools, local and statewide program standing committees, and legislators. In addition, all performance indicators should be accessible through the DDMHS home page: <http://www.state.vt.us/dmh/>.

Published indicators of services provided/received should specify levels of statistical significance and include detailed methodological appendices on data sources and analytical methods in language that is understandable to a broad audience. Stakeholders (providers, consumers, and others) should be given the opportunity to comment on the performance indicators and to provide their interpretation of the results and DDMHS should respond.

MEMBERS

of Vermont's Mental Health Performance Indicator Project
Multi-Stakeholder Advisory Group
1998 - 2000

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Charlie Biss, Child Adolescent and Family Unit, DDMHS
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Sue Cano, Department of Education
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