Table of Contents.

Section 1

Steering Committee Report 2

Section II – Sub-Committee Reports

ARORA Sub-Committee Report 17

Assessment Sub-committee Report 25

Consumer Satisfaction Sub-Committee Report 38

Appendices

Appendix A: MH Performance Measures Project Framing Document 54

Appendix B: List of Project Participants 62

I. Mental Health Performance Measures Project – Phase One.

A. Background.

1. Project Objectives. The Mental Health Performance Measures Project is an outgrowth of two similar previously existing projects, the Alaska Mental Health Board's (AMHB) Outcomes, Indicators and Performance Measures project (1999) and the Alaska Division of Mental Health and Developmental Disabilities Alaska (DMHDD) Performance Indicator Project (1998-2000). The purpose of the Mental Health Performance Measures Project is to integrate the two efforts in pursuit of a common goal: the identification and implementation of performance measures for public community mental health services in Alaska. The performance measures selected by this project must also include those required by the federal Community Mental Health System block grant process. The project accomplishes three short-term objectives:

    a. Review, combine, and modify the performance measures recommended by the two Alaska mental health evaluation projects cited above and described below under items 2 and 3;

    b. Verify the data sources to be used to gather the performance measure information; and

    c. Identify key implementation issues and recommend implementation strategies fo gathering the performance measure information.

    The project is divided into two phases. Phase One, the planning and development phase, concluded on December 31, 2000. This report addresses the process and conclusions of this phase. Phase Two, the implementation phase, is scheduled to begin in February 2001.

2. The Alaska Division of Mental Health and Developmental Disabilities Alaska Performance Indicator Project (1998 - 2001). The primary purpose of this federally funded project is to build a set of performance indicators that have "buy-in" by all stakeholders and are used to evaluate the quality of services provided by the Alaska mental health service system. Participants at the Alaska Mental Health Consumers and Families Summit previously identified two-thirds of the 16 performance measures chosen for use in this project as "important" in March 1998. In addition, the indicators are consistent with emerging national standards (Mental Health Statistics Improvement Project (MHSIP), National Association of State Mental Health Program Directors (NASMHPD) Five-State Study) thereby providing the possibility of across-state comparison of service delivery performance and consumer perception of service quality. The intended data sources for these indicators are:

    a. ARORA Data System;

b. Medicaid Files (via the DHSS Data Warehouse); and

c. Psychiatric and General Hospitals in Alaska.

The project requires significant consumer participation both in the design of the performance indicator system and in its implementation. To this end, one-third of the advisory committee is composed of consumers or family members.

3. Alaska Mental Health Board Outcomes, Indicators, and Performance Measures Project (March – July 1999). This project, which was completed in July 1999, examined different mental health evaluation systems nationally, including the MHSIP, the NASMPD Five State Study and Standardized Framework, and others. From the various systems, the project identified those measures most frequently used for which data sources are either available or could be readily developed. This project recommended measures in the areas of access to care, appropriateness and quality of care, consumer outcomes, and management/structure. The proposed data sources for these measures are:

   a. Alaska Recipient Outcome Research Application (ARORA) Data System;

   b. MHSIP Consumer Survey; and

   c. Periodic Client Assessment.

   Implementation plans for this project are similar to those for the DMHDD project in that they involve consumers and consumer groups, administration staff, and program provider staff.

4. Integration of AMHB and DMHDD Projects. A key focus of the current project is to integrate the two existing projects and develop a viable plan for moving the effort forward. Forward motion requires agreement by all stakeholders on a meaningful and practical set of performance measures. In examining the performance measures selected by each project, the vast majority of the measures selected by the DMHDD project were also selected by the AMHB project. The initial approach, therefore, was to bring forward a combined list of the two groups of measures as a draft set of final performance measures.

   A strong component of the DMHDD project was consumer involvement, both in the final performance measure selection and implementation planning. In combining these two projects, this strong emphasis was continued and involvement by the mental health service providers was added. The combined project assured balanced representation by providers and consumers. In implementing the integrated project, a Steering Committee was established with representation from all participating groups to manage and oversee the project. Sub-committees were also appointed to determine which measures to include and address the issues of implementing consumer surveys, data system needs, and periodic client assessment to collect the required data.

5. Project Management Structure.

   a. Steering Committee. The Steering Committee was comprised of 10 members drawn from the various stakeholder groups as outlined below.

Karl Brimner (DMHDD), Co-Chair	Walter Majoros (AMHB), Co-Chair
Leonard Abel (DMHDD)	Jane Franks (Rural MH Providers)
Robyn Henry (NAMI Alaska)	Bill Hogan (AK MH Service Provider Assn)
Gail Igo (MH Consumers)	Jan McGillivary (MH Assn of AK)
Pat Murphy (AMHB)	Lauren Swift (MH Consumers)

Steven Hamilton, C & S Management Associates, provided logistics and staff support. The members of the Steering Committee were assigned a number of responsibilities and duties including representing the interests of their various constituency groups and acting as liaison to the project sub-committees.

B. Overview of the Process.

1. Period of Performance. The process of selecting performance measures and defining methodology was conducted at the sub-committee level from March through September 2000. The Steering Committee integrated the sub-committee reports to develop this final phase one report during the period October through December 2000.

2. Steering Committee Phase One Goals and Objectives.

   a. Oversee implementation of Performance Measures Project. The primary task of the Steering Committee was to provide oversight and coordination for the implementation of the Mental Health Performance Measures Project. This included the overall planning function, tracking progress, and producing written progress reports for the various stakeholder groups.

   b. Assign tasks and objectives to sub-committees. The Steering Committee, as a part of its planning and coordination function, assigned tasks and objectives to the various sub-committees.

   c. Review and approve preliminary list of performance measures for sub-committee work. The Steering Committee provided a preliminary list of performance measures to the sub-committees for their consideration.

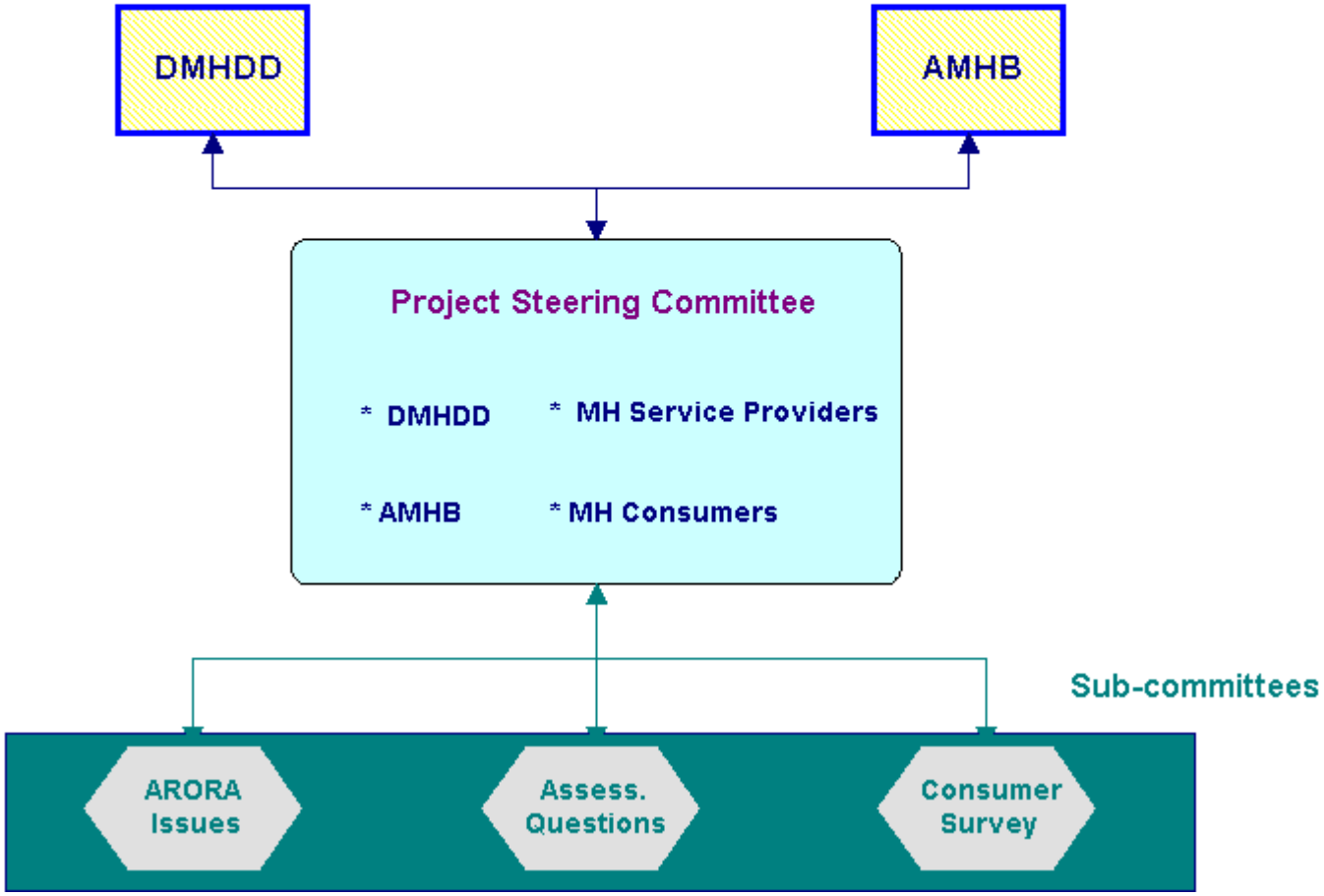
   d. Integrate the work of the sub-committees. As the sub-committees finished their tasks, the Steering Committee integrated the finished products into an overall evaluation design and implementation plan.

   d. Make recommendations to AMHB/DHSS. This report constitutes the findings and recommendations of the Steering Committee to the Alaska

Mental Health Board and the Alaska Division of Mental Health and Developmental Disabilities based on the work of the three sub-committees.

3. Project Management Organization Chart**.** A chart showing the relationships and structure of the project management is presented on the following page.

Mental Health Performance Measures Project
Phase One
Management Structure



3. Sub-Committee Process. The three sub-committees each defined their process and methodology to suit their unique needs. The following is a brief description of the process for each sub-committee.

   a. ARORA Sub-Committee. The ARORA Sub-Committee met in person three times during the course of the project to select performance measures and to assess the ability of ARORA to collect the measures. Leonard Abel from DMHDD chaired the sub-committee with support and coordination assistance from other DMHDD staff and from C & S Management Associates, the project contractor. Areas of concern addressed by the ARORA Sub-Committee included:

      (1) The ability of ARORA, as designed, to collect the selected measures;

      (2) The impact of provider participation on the effectiveness of performance measure data collection;

      (3) Issues surrounding the interface of the ARORA system and the proprietary systems used by the various mental health providers; and

      (4) The use of unique client identifiers and the necessity for ensuring consumer privacy and confidentiality.

      The ARORA Sub-Committee developed a set of recommended performance measures, including several that will need additional work prior to implementation. They also recognized that many of the measures initially considered for collection by ARORA are also recommended for collection through the assessment process. The sub-committee recommended that, in cases where there is overlap in data collection, that data be collected through the assessment process. The ARORA Sub-Committee recommended that DMHDD use unique identifiers for reporting to allow performance evaluation system-wide.

      The complete report of the ARORA Sub-Committee, which includes the details of the process and recommendations, is included in Section II of this report.

   b. Functional Assessment Sub-Committee. The Assessment Sub-Committee met by teleconference a total of 12 times between March and September 2000. Bill Hogan, representing the mental health providers, chaired the sub-committee and C & S Management Associates provided process support. The sub-committee worked on four interrelated issues:

      (1) Defining and understanding the context in which the performance measurement will occur;

(2) Identification and recommendation of appropriate performance measures;

(3) Consideration of cross-cultural issues that will affect data collection; and

(4) Development of a recommended set of questions with which to capture the assessment information.

The sub-committee organized performance measures around the life domain areas identified by the Alaska Mental Health Trust Authority. These domains are health, safety, economic security, productive engagement/contribution, and being dignified and valued members of society. Using these domains, the sub-committee identified specific measures that described consumer progress and outcomes within these domains. The sub-committee also considered the impact of cross-cultural differences on the assessment process. They concluded that assessment of cultural competence or appropriateness was a process better suited to the Integrated Quality Assurance program coordinated by DMHDD. Finally, the sub-committee developed a recommended data collection methodology that included a set of recommended questions to be used in the assessment process.

The complete report of the Assessment Sub-Committee, which includes the details of the process and recommendations, is included in Section II of this report.

c. Consumer Satisfaction Sub-Committee. The Consumer Satisfaction Sub-Committee met by teleconference seven times between March and September 2000. The sub-committee was chaired by Robyn Henry, representing mental health consumers, with sub-committee support provided by C & S Management Associates.

The Consumer Satisfaction Sub-Committee addressed the following issues:

(1) The intended use of the information developed from the measurement process and the benefit to consumers;

(2) Identification of the population to be surveyed and the need to be as inclusive as possible;

(3) Selection of performance measures based on initial recommendations by the Steering Committee;

(4) Selection of an appropriate consumer satisfaction measurement instrument;

(5) The need to capture demographic information and development of a suitable instrument;

(6) Publication of information resulting from data collection and accessibility of the information; and

(7) The need to continue evaluation and refinement of the selected consumer satisfaction instrument to ensure sensitivity to rural and cultural issues and to enhance the ability to assess children and family services.

The Consumer Satisfaction Sub-Committee recognized that the initial scope of data collection would be those consumers who are either receiving services at the time of the survey or have received services during the year prior to the survey. They recommended, however, that ongoing efforts be made to gather data from consumers who fall outside this specific group. The sub-committee recommended the adoption of the initial set of performance measures identified by the Steering Committee. To collect the data to support these measures, they recommended the use of the latest version of the MHSIP Consumer Satisfaction Survey instrument. The sub-committee considered modifications to the instrument but concluded that changing the wording of questions would require greater resources and time than was available. Members considered it important to maintain the validity of the instrument. They recommended that the instrument be reviewed after the initial round of data collection and modified as appropriate. They also developed a set of demographic questions to be used in concert with the satisfaction survey. The sub-committee recommended that the results of the survey be published in a variety of ways to ensure access to the information by consumers, providers, other stakeholders, and the general public.

The complete report of the Consumer Satisfaction Sub-Committee, which includes the details of the process and recommendations, is included in Section II of this report.

d. Steering Committee Action. The Steering Committee met eight times during the period March through November 2000 to hear sub-committee reports, assess progress, and provide guidance and amplification to the sub-committees. Following the completion of the sub-committee work, they received and reviewed the reports and developed an aggregate set of measures and defined the recommended methodology. Finally, the Steering Committee developed a recommended approach to project implementation that defines project oversight and scheduling.

C. Conclusions and Recommendations.

1. Conclusions. The Steering Committee concluded, based on the efforts of the three sub-committees, that the performance measurement system envisioned in this project

is practical and consistent with performance measurement efforts nationally. The individual performance measures selected by the three sub-committees are generally consistent with those suggested by the Steering Committee. The efforts of the sub-committees and the resulting recommendations represent an exciting opportunity to implement a statewide performance evaluation system that provides objective data and examines the service delivery system from the perspectives of the different stakeholders.

The Steering Committee adopted five questions that the Assessment Sub-Committee felt should be addressed by any evaluation system.

a. Are the services delivered in a manner that is equitable and fair?

b. Are agencies able to meet the need for services?

c. Are the services of high quality?

d. Is the mental health system efficient, productive, and effective?

e. Do services produce the desired impact on the quality of life of consumers?

The Steering Committee recommends that these five questions form the basis for ongoing evaluation of the Mental Health Performance Measures Project.

2. Recommended Performance Measures. The primary goal of Phase One of the Mental Health Performance Measures Project was to select the recommended performance measures to be used in evaluating the public mental health service delivery system statewide. The ARORA, Assessment, and Consumer Satisfaction sub-committees, working from an initial list of candidate measures, each developed a set of recommended performance measures to be collected in the respective data collection processes. Based on the work of the three sub-committees, as well as review and modification by the Steering Committee, the following performance measures are recommended for inclusion in the Performance Measures System. Several of these measures, as reflected in the table below, require further development and study before implementation. In addition, the Steering Committee foresees Phase Two attention on fine-tuning performance measures and their collection instruments for children and minorities.

Performance Measure	Collection Methodology	Immediate Implementation	Further Development
Utilization/penetration information	ARORA	X	
Participation in treatment planning	ARORA	X	
Level of productive involvement	Assessment	X	
Legal status/involvement	Assessment	X	
General safety status	Assessment	X	
Economic security status	Assessment	X	
Housing status	Assessment	X	
General health status	Assessment	X	
Problems due to substance abuse	Assessment	X	
Improved functioning	Assessment	X	
Patients hospitalized	Assessment	X	
Consumer perception of good access	Consumer Satisfaction Survey	X	
Participation in treatment planning (from consumer perspective)	Consumer Satisfaction Survey	X	
Consumer perception of appropriateness and quality	Consumer Satisfaction Survey	X	
Family Involvement in children's treatment planning	Consumer Satisfaction Survey	X	
Staff cultural diversity and sensitivity	Consumer Satisfaction Survey	X	
Consumer perception of positive change as a result of services	Consumer Satisfaction Survey	X	
Recovery/Personhood/Hope	Consumer Satisfaction Survey	X	
Contact by community provider within seven days of discharge from hospital	ARORA		X
Number of people discharged from emergency care that receive ambulatory care within five days.	ARORA		X
Re-admission to psychiatric hospitalization within 30 days of discharge from hospital	ARORA		X
Mortality rate (requires interface with DHSS Data Warehouse	ARORA		X
Consumers having current advance directives on file with their provider.	ARORA		X
Involuntary treatment	ARORA		X
Wait list duration	ARORA		X

3. Implementation Recommendations. The Steering Committee's implementation recommendations are based on the recommendations of the three sub-committees, although some modifications have been applied. The performance measurement system proposed through this project will apply only to community mental health programs.

    a. Implementation of a Pilot Data Collection and Analysis Component. Before implementation of a statewide performance measures data collection and analysis program system-wide, implementation of a pilot project is strongly recommended. This pilot project should reflect the following features:

        (1) ***Selection of Sites***. The selection of pilot sites should be representative of the providers in the state and should reflect a diversity of size, location (both region and size of community), and ethnicity of client population. All providers selected to participate in the pilot should meet the following criteria:

            (a) Be willing to participate;

            (b) Have the technical expertise to participate; and

            (c) Be willing to commit to the entire pilot project period.

        (2) ***Phase-in of Full System***. The first phase of implementation should consist of a number of pilot sites. Following initial data collection using pilot sites, the design of the performance measures system should be reviewed and a determination made with regard to the need for an intermediate pilot phase adding additional sites. This phased pilot approach will allow for more efficient management during the early stages, which will be more labor intensive as the initial infrastructure is developed. It will also allow for development of comprehensive documentation prior to implementation system-wide. System-wide implementation is expected on July 1, 2002.

    b. Project Oversight and Management. The Steering Committee recommends that DMHDD and AMHB jointly determine the appropriate organizational structure to provide management and oversight of the project, drawing on the most knowledgeable and contributing members from the first phase of the project. A project oversight group should be convened to provide input on the pilot design and implementation plan including a detailed schedule. They should also address issues of data collection and data analysis. Data collection should be considered as part of the pilot design and implementation plan. All data analysis should be coordinated by DMHDD and AMHB and results distributed to consumers, providers, other stakeholders, and the general public.

c. Consumer Involvement. Consumer involvement is critical to the success of this project. It is the recommendation of the Steering Committee that consumers remain involved in the project in accordance with the oversight and management structure to be determined by DMHDD and AMHB.

d. Scheduling. The Steering Committee recommends that a detailed project schedule be developed prior to the beginning of the pilot phase of the project. In general, the pilot projects are expected to begin on or about February 15, 2001. System-wide implementation is expected to begin on July 1, 2002. The project oversight committee assigned to coordinate the implementation of the system should help determine the frequency of collection for data from each source.

4. ARORA Data Collection. The Steering Committee recommends the following with regard to data collection from the ARORA system.

   a. The performance measures considered for collection through the ARORA system are divided into three categories:

      (1) Data that is already being collected by ARORA;

      (2) Data that is not currently being collected but which could be collected without modification of the ARORA system; and

      (3) Data for which collection would require modification of the ARORA system.

   Performance measures for which data is already collected and available are the highest priority and should be implemented first. No additional effort on the part of providers is required. Division staff should ensure that the information can then be extracted from the system in a format that supports performance measurement. The prioritization of the performance measures is not meant to diminish the importance of measures in the second two categories but is based on the ability to capture the information in an efficient manner and on the capabilities of the pilot sites. The project oversight group should consider moving beyond the first category of data based on the pilot sites selected and their capabilities. Data collection through the ARORA system could be either in electronic or paper form.

   b. Certain measures recommended by the ARORA Sub-Committee were not selected by the Steering Committee. These measures are:

      - Persons received services only once per year; and

      - Persons changing MH provider during the year.

The Steering Committee did not select these two measures because they felt that the measures failed to provide clear, unambiguous information about program performance.

c. Prior to implementation of the performance measures project system-wide, a reliable method should be identified and implemented for integrating the data submitted by consolidated programs through the Division of Alcoholism and Drug Abuse management information system (MIS).

d. As DMHDD assesses the need for future changes to ARORA, providers and consumers from the Performance Measures Project should be allowed to participate in the process.

e. Organizations selected to participate in the pilot program should have fully functioning MIS components that reliably transfer data to ARORA.

5. Assessment Data Collection. The Steering Committee recommends the following implementation provisions with regard to data collection through the periodic client assessment process. Assessment should be conducted of clients' function levels in several domains.

a. The performance measures selected by the Assessment Sub-Committee should be adopted as presented.

b. The questions developed to support the assessment performance measures should be adopted. Providers should be allowed to ask any other assessment questions that they deem appropriate, provided that they include the core questions from this project. Additional questions asked by providers should not be reported as a part of the Performance Measures Project.

c. Providers should document the responses to the assessment questions on the form designed by the Assessment Sub-Committee (or similar locally developed form). These forms should not include client-identifying data. The assessment questions were based on data collection semi-annually, although the final frequency determination should be part of the pilot design. At the end of the measurement, all forms should be forwarded to DMHDD, or its agent, for input, analysis, aggregation, and reporting. An alternative would be for providers to forward the forms to DMHDD as they are completed, allowing for data entry throughout the period.

d. The cultural sensitivity questions presented by the Assessment Committee are more appropriate for the Integrated Quality Assurance Program managed by DMHDD than for performance measurement. The Steering Committee recommends that the questions developed by the Assessment Sub-Committee be forwarded to DMHDD (Integrated Quality Assurance Program) for consideration, further development, and use as appropriate.

6. Consumer Satisfaction Data Collection. The Steering Committee recommends the following implementation provisions with regard to consumer satisfaction data collection.

    a. The performance measures selected by the Consumer Satisfaction Sub-Committee should be adopted as presented.

    b. The latest version of the MHSIP Consumer Satisfaction Survey instrument should be used to gather satisfaction information from consumers. Additionally, the demographic questionnaire and draft cover letter from the Consumer Satisfaction Sub-Committee should be adopted for use as presented.

    c. For the initial pilot data collection effort, the Steering Committee recommends that the target population be all consumers currently receiving services and consumers receiving services within the year prior to each survey.

    d. Providers should mail forms prepared by DMHDD to consumers who will return them to DMHDD or its agent.

    e. The Steering Committee agrees that the results of data collection and analysis should be reviewed after each survey in an effort to identify any needed changes to the instrument that might be required in order to make it more relevant to rural areas or diverse cultures and to provide a more sensitive assessment of services to seriously emotionally disturbed (SED) youth and other family services.

    f. Although the initial target population for the consumer satisfaction surveys will be those consumers currently or recently receiving services, the Steering Committee recommends that future efforts be targeted at identifying appropriate methods of expanding that population to include those consumers who have not recently received needed services and even those who have never received needed services. This is a much larger and more difficult undertaking and will require collaborative effort between DMHDD, AMHB, and consumer groups. AMHB, DMHDD, and consumer advocates recognize the importance of removing barriers to services and will seek to do so through the means available to them so that consumers can have access to needed services.

7. Data Analysis and Reporting**.** Analysis of data is a task separate and distinct from the data collection effort. The analysis of all data obtained through the performance measurement process should be coordinated by DMHDD and AMHB. The Steering Committee recommends that an annual report be published by DMHDD with the results of all data collection efforts from the three data collection sources. This report should, as a minimum, be published in the following ways to ensure the widest possible dissemination:

a. Full printed report available to the public;

b. Full report posted on Internet web sites (DMHDD, AMHB, consumers sites, etc.);

c. Summary of the report (2-3 pages) in printed form distributed to providers and all consumers on the mailing list for the consumer satisfaction surveys; and

d. In-person summary presentations as opportunities arise.

II. Sub-Committee Reports.

ARORA Sub-Committee Report

A. Introduction. The goal of the ARORA Sub-Committee was defined as identifying and recommending the performance measures to be used, identification of changes necessary in the ARORA system to accommodate these measures, and to address other related issues such as provider participation and unique client identifiers.

B. The ARORA Sub-Committee: Organization and Responsibilities. The ARORA Sub-Committee, one of three appointed by the Steering Committee, had its membership defined at the beginning but was free to define its own process, work plan, and schedule.

1. Membership. The membership of this sub-committee reflected a balance between consumers, providers, and representatives of the Division.

Leonard Abel (DMHDD) – Chair	Don Roberts (Consumer)
Thia Falcone (AK AMI)	Kelly Behen (AMHB)
Steve Krall (Provider)	Jane Franks (Rural Provider)
Jan McGillivary (MH Assn in Alaska)	Lynn Hutton (DMHDD)
Fred Kopacz (Southcentral Counseling)	

   Steven Hamilton from C & S Management Associates, the project contractor, provided logistics support for the sub-committee process

2. Responsibilities. The sub-committee was provided with a set of draft of recommended performance measures by the Steering Committee at the beginning of the project. Using this as a starting point, the committee had the responsibility of developing a final set of performance measures including a recommendation for collection. They had the responsibility of considering the existing data systems in use not only by the Division but by the individual providers and how any changes would need to be implemented system-wide. They also considered other issues that will impact implementation such as emerging technology, provider participation, consumer involvement, and unique client identifiers. The group defined its own process, developed a meeting schedule, and approved a work plan. Periodic reports were made to the Steering Committee, both orally and in writing. The contractor, Steve Hamilton, had the responsibility for documentation and distribution of materials associated with the process.

3. Meeting Schedule. Because of the diverse membership and individual scheduling demands, the group had several full-day face-to-face meetings rather than more frequent short teleconferences. The group held full-day meetings on the following dates:

   June 19, 2000
   August 17, 2000
   September 1, 2000

The agenda and minutes for each meeting were distributed, in addition to sub-committee members, to all project participants and are contained in the master project files.

4. Sub-Committee Process. In advance of each meeting, Lynn Hutton (DMHDD) prepared background and process material for the sub-committee members. This material included ARORA descriptions and forms, background material on the proposed performance measures, and related material. Leonard Abel (DMHDD) chaired the face-to-face meetings using a consensus model of decision-making. Group discussions were centered on three basic areas of concern:

    a. Selection of performance measures

        - Discussion and decision regarding measures proposed by the Steering Committee; and

        - Discussion and decisions regarding additional performance measures proposed by sub-committee members.

    b. Changes necessary in ARORA in order for it to be effective as a performance measurement tool.

    c. Enhancement of provider participation in the ARORA system.

5. Initial Set of Recommended Performance Measures. When the ARORA Sub-Committee was convened, the Steering Committee provided a draft set of performance measures that had been previously developed through two other projects. This draft list served as the starting point for discussions:

    a. Wait list duration

    b. People who had service once per year

    c. Utilization and Penetration information

    d. Consumers receiving case management services

    e. Change of MH Provider in one year

    f. Contact by a community provider within 7 days of discharge from the hospital

    g. Participation in treatment planning

    h. Adults in supported employment

i. Adults in supported housing

j. Adults receiving new generation medications

k. Children receiving in-home services

l. Re-admission to psychiatric hospitalization within 30 days of discharge

m. Involuntary treatment

n. Mortality rate: Health status of the served population as measured by the standardized mortality rate and average age at death

o. Percentage of consumers living independently

p. Percentage of consumers who are homeless

C. ARORA Issues.

1. System Compatibility. ARORA, Alaska Recipient Outcome Reporting Application is the management information system (MIS) for mental health services funded through the Division of Mental Health and Developmental Disabilities. Providers gather information at their programs and, depending on the specific program, enter the data into a local MIS. Programs in Alaska use a number of different MIS systems locally with the two major vendors being CMHC and Echo. Once data is in the local system, an onboard system utility extracts the information in a compatible format that is needed for ARORA. This interface between the local systems and ARORA has been a source of continuing data problems over the years. There are a number of providers who have worked with their vendor to ensure that the utility performs correctly, however, other providers in the state continue to have problems. This issue has two implications for performance measure data collection.

   a. If the interface between local MIS and ARORA does not provide for integrity in transfer of data then the performance measurement effort will be flawed at the beginning.

   b. Any changes necessary in ARORA to accommodate the performance measurement process will necessitate changes in the local MIS utility that moves data between the two systems.

   One of the difficulties that providers face in keeping their systems compatible is the expense of software modification both to bring their system into compliance and to keep it compatible as changes are made in ARORA. Smaller programs have the additional difficulty of limited computer expertise in keeping these complex systems functional.

Many smaller, rural programs that provide both mental health and substance abuse services are currently submitting the required mental health services data using the MIS from the Division of Alcoholism and Drug Abuse. Although there is reportedly a mechanism for moving the mental health data from the ADA database to the DMHDD system, it is not currently functional.

2. Provider Participation. There are a number of barriers that impact provider ability and desire to participate by providing data to ARORA. There has always been, and continues to be concern for the privacy of consumers. One of the features of ARORA is that it uses a unique client identifier that is an algorithm developed from different client information. The provider has the tools for encrypting the data submitted to the division. If data arrives at the division unencrypted, it is immediately destroyed. Still, even with these protections in place, there is concern among some providers that client identity could somehow be obtained by unauthorized persons if the provider fully participates in ARORA.

   Even when the provider is willing to participate, there are certain reporting requirements that impact integrity of data. For example, when a client is first seen for services, a Client Admission Form must be completed. If this is not done, then all of the data on that client that is submitted during the course of treatment is not usable. For every discharge or activity data submitted, there must be a corresponding admission form. These linkages between the different data sets must be kept intact. Currently, a high percentage of data submitted have breaks in these linkages rendering it unusable. In order for the ARORA system to be effective as a performance measurement tool, providers must uniformly agree to fully participate and staff must rigorously complete all required forms.

3. Unique Client Identifiers. When providers deliver services to clients, the provider assigns the client an exclusive client case number. This number allows the client to be distinguished from others without the use of a name as long as the issue or discussion remains within the organization. Each organization issues its own client case numbers so that a client who is receiving services from more than one provider or changes providers cannot be identified as a single person but would show up with two different client case numbers. In order to assess performance system-wide, a method is needed that can track client activity and service provision across providers.

   For example, one of the proposed performance measures is the percentage of clients discharged from the hospital that are seen by a community provider within 7 days. Measurement of this requires that the system be able to identify the person both from hospital data and from community service provider data as the same individual. This can be done through the use of an algorithm that creates a unique client identifier. Identifiers such as these use elements from different client information such as date of birth, last four digits of the social security number, and first four digits of the last name to create an identity that is unique to a specified probability. While a unique identifier does not readily identify a client by name, many providers and consumers feel that the information contained is easily obtainable and would allow an observer to obtain the identity easily enough. To address this concern, DMHDD issued

encryption programs to all providers. Encrypted information is submitted to DMHDD where it is used and stored within a multi-password protected database. Without unique identifiers of some kind, measurement of system performance, including true utilization data, is not possible.

4. Required Changes in ARORA. While most of the performance measures recommended for collection through ARORA are already addressed in some manner within the system, some changes will be necessary. The specific changes needed are identified along with the performance measures recommended by the sub-committee. An example of such a change is the addition of an allowed response to an existing field such as adding "Supported Housing" as an acceptable response for the clients' housing situation. Making such changes requires both programming at the DMHDD level within ARORA and possibly at the individual provider level to ensure that the data interface between the local system and ARORA accepts the new data. Finally, once all of the data collection mechanisms are in place, specialized queries may need to be written to extract the information based on the new data being collected in order to use it for performance measurement.

D. Selection of Performance Measures. The following performance measures are recommended by the ARORA sub-committee in support of the Mental Health Performance Measures Project.

1. Percentage of consumers with current advance directives on file. Advance directives (as used within the mental health field) are documents prepared by consumers that detail their treatment preferences and wishes. Providers and hospitals should use these documents in their treatment planning and delivery process. This measure would require that a new field be added to the ARORA system. The most likely form would be a date field in which the date of the latest advance directive on file for the consumer would be entered. Conceptually, the objective is to have the age of advance directives as low as possible. For measurement purposes, the age of the advance directive would be obtained by comparing the date of the report with the date of the advance directive. The age could then be compared either to a standard or evaluated over time to show improvement.

2. Wait List Duration. This measure represents the time between an initial request for services and the provision of the service. This information is already collected and provided to ARORA by programs, however, the sub-committee recommends that an additional field be added that would identify the category of service (emergency, urgent, or regular) sought. This is necessary because waiting periods for emergency services should not be compared with waiting periods for regular services. This performance measure would apply only to initial request for services; not for scheduling of ongoing services.

3. People who had service only once during the year. This measure would be collected by using the unique client identifier and developing queries to identify those individuals who had services delivered only once. Unlike most other measures, this examines performance system-wide.

4. Utilization and Penetration Information. ARORA already collects extensive demographic information. This information can be extracted and then compared with census and prevalence information to determine the success of programs/the system in reaching the target populations.

5. Change of Mental Health Provider in One Year. This measure would be collected by comparing the admission sheets from all programs and looking for duplicate unique client identifiers.

6. Contact by a Community Provider within 7 Days of Discharge from the Hospital. The measure examines the collaboration between hospitals and community mental health providers and the extent to which there is appropriate discharge planning for hospitalized patients. In order to collect data to support this measure, a field would need to be added to ARORA that would allow identification of a "contact." Currently, ARORA data is initiated on admission, which may occur later than initial contact. The MIS for the Division of Alcoholism and Drug Abuse uses a similar concept that could serve as a model for accomplishing this.

7. Participation in Treatment Planning. Data to support this measure is already collected by ARORA.

8. Adults in Supported Housing. This measure can be collected through ARORA but will require the addition of another response to the Housing Situation field. This means programming both at the Division level as well as ensuring the provider MIS interface will recognize it.

9. Children Receiving In-home Services. This measure can be collected through ARORA although it would also require the addition of allowed responses to a field.

10. Re-admission to psychiatric hospitalization within 30 days of discharge from hospital. Psychiatric hospitalization within 30 of discharge from the hospital can be collected through ARORA but will only reflect hospitalizations at facilities that participate in the system. Additionally, it will require the use of a unique client identifier since we are interested in any re-admission to psychiatric services provided at any hospital, not just the hospital from which they were discharged.

11. Number of people discharged from emergency care that receive ambulatory care within five days. This measure is supported by data already collected but, as with the previous two measures, will require the use of a unique client identifier in order to develop the queries.

12. Involuntary Treatment. This performance measure can be collected through ARORA for providers that participate. It will not capture involuntary treatment data for facilities outside the system. Additionally, it will require the addition of a field that will distinguish involuntary from voluntary treatment.

13. Mortality Rate. The mortality rate assesses the health status of consumers by comparing their mortality rate and average age of death with the same data for the general population. This would be done by comparing unique identifiers with similar data in the Department of Health and Social Services Data Warehouse.

E. ARORA Recommendations. The ARORA Sub-Committee members recommend the following.

1. Performance Measures. We recommend that the performance measures listed above be collected using the ARORA system or its successor should the Division decide to replace it.

2. The ARORA System. From the discussions with Division staff and providers, it seems clear that the existing system is not working with sufficient integrity for use as a performance measure tool. We recommend that the Division consider replacing the system incorporating the following specific recommendations: This needs clarification, the ARORA system is capable of doing these functions, but many providers either are not submitting data at all, submit old or occasional data, or most frequently incomplete or wrong/bad data. (According to the DP staff—not Lynn, there is no problem with ARORA other than the lack of good data.)

    a. That the system be an Internet web-based system that could be implemented statewide and not require significant hardware or software investments by providers and would remove the necessity for computer expertise in maintaining the system at the local provider level.

    b. That the Division negotiate with the Division of Alcoholism and Drug Abuse to develop or procure a system that will work for both types of providers as well as those providers who provide joint services. There are currently several efforts ongoing to examine the issue of integration of data collection efforts.

    c. That a sub-committee be established to assist in the development of any request for proposal and to participate in the proposal evaluation process. This sub-committee should include providers and consumers as well as Division staff.

    d. That the features associated with each recommended performance measure be included in any new system.

    e. There should be strong consumer involvement in the development and/or modification of the ARORA MIS. This includes the proposal evaluation process and oversight during development.

    We do not recommend the use of the system as it is currently operating as a performance measurement tool due to the lack of data integrity.

3. Pilot Data Collection. There currently are several programs in Alaska that are able to provide good data to the ARORA system. As a means of testing the performance measurement construct, we propose that the existing ARORA system be modified as noted in paragraph 4 (A-M) above and a pilot data collection effort be mounted using only those providers. Data collection to support performance measurement in the pilot program should be the same process that now exists, however, for any new system; we recommend that web-based data entry be used.

4. Unique Client Identifiers. The sub-committee recommends the use of the algorithm to create a unique client identifier as a means of tracking consumer activity across different providers without the disclosure of personally identifying information such as name or social security number. The members further recommend the continued use of data encryption to enhance the protection of consumer privacy.

5. Data Analyses. The ARORA system and /or its successor should be designed or modified to report on the data fields that support the performance measures. This will likely require the use of specialized queries and reporting programs, which should be developed by the Division.

6. ARORA AXIS IV Fields. The domains that are contained in Axis IV in the ARORA should be replaced with the domains that have been adopted by the Mental Health Trust Authority. These Life Domains are: Housing, Transportation, Vocational, Community Support, Health Care, Education, and Legal. The use of a five point Likert scale is recommended to allow for quantification. This is consistent with the existing data field allocations in the current ARORA MIS. As a result, little modification is required at the provider sites or at the state level. The sub-committee recommends that the Assessment Sub-Committee members or representatives be consulted on this issue since the information for these fields would likely be obtained in the client assessment process.

7. ARORA Sub-Committee. We recommend that the ARORA Sub-Committee be kept in tact to monitor and assist with the pilot data collection process associated with this project.

8. Use of Federal Grant Funds to Support Consumer Participation. The federal grant that partially supports the Performance Indicator project provides for extensive consumer involvement, including payment for their participation on project committees. We recommend that the Steering committee review the current grant conditions and consider increasing support for, and input by, consumers.

Assessment Sub-Committee Report

A. Introduction. The goal of the Assessment Sub-Committee was defined as identifying and recommending the performance measures to be used, recommending a data collection methodology, and identifying other issues that will impact the collection of assessment information such as sub-population groups and cultural issues.

B. The Assessment Sub-Committee: Organization and Responsibilities. The Assessment Sub-Committee, one of three appointed by the Steering Committee, had its membership defined at the beginning but was free to define its own process, work plan, and schedule.

1. Membership. The membership of this sub-committee reflected a balance between consumers, providers, and representatives of the Division.

Bill Hogan (Provider) – Chair
Anne Henry (DMHDD)
Virginia Hostman (Consumer)
Gina MacDonald (Provider)
Israel Nelson (Provider)
Ken Taylor (Provider)
Thad Baldridge (Provider)
Esther Hopkins (Consumer)
Jan MacClarence (Consumer)
Faye Nieto (Provider)
Jean Steele (Consumer)

Steven Hamilton from C & S Management Associates, the project contractor, provided logistics support for the sub-committee process

2. Responsibilities. The sub-committee was provided with a set of draft or recommended performance measures by the Steering Committee at the beginning of the project. Using this as a starting point, the committee had the responsibility of developing a final set of performance measures including a recommendation for collection. They had the responsibility of considering the impact of rural and cultural issues on collection methodology as well as any issues related to sub-populations. The group defined its own process, developed a meeting schedule, and approved a work plan. Periodic reports were made to the Steering Committee, both orally and in writing. The contractor, Steve Hamilton, had the responsibility for documentation and distribution of materials associated with the process.

3. Meeting Schedule. Meetings were conducted by teleconference, with one exception, every two weeks. The group decided to meet on Friday from 11:00 am until 12:30 pm and followed a pre-determined agenda. The meeting dates for the Assessment Sub-Committee were:

March 3, 3000
March 24, 2000
April 6, 2000
April 20, 2000
May 5, 2000
May 19, 2000

June 2, 2000
June 16, 2000
June 29, 2000
July 14, 2000
August 11, 2000
August 25, 2000

The agenda and minutes for each meeting were distributed, in addition to sub-committee members, to all project participants and are contained in the master project files.

4. Sub-Committee Process. The sub-committee met via teleconference with no face-to-face meetings. Meeting agenda and minutes from the previous meeting were distributed via e-mail ahead of time. The major work of the sub-committee was accomplished in small workgroups outside the regular meetings. Tasks were developed and approved in the meetings and small work groups were assigned to carry out the tasks, reporting back at the next meeting. We found this method productive because it kept the main meetings from getting bogged down in detail and kept the group on schedule. We found the small work group model effective because individuals with skills and interests in the specific tasks volunteered for the assignments and the work coming out of the small groups was thoroughly developed. For the most part, the decision-making process was one of consensus. E-mail and small group teleconferences were used extensively to share information during the process.

   In addition to these processes, the sub-committee conducted a mail survey of all mental health and substance abuse providers in the state to determine if there were any consistencies in the use of assessment instruments. We found that there was considerable consistency among substance abuse providers in the use of the Substance Abuse Subtle Screening Index (SASSI) but little consistency among mental health providers regarding assessment tools.

5. Initial Set of Recommended Performance Measures. When the Assessment Sub-Committee was convened, the Steering Committee provided a draft set of performance measures that had been previously developed through two other projects. This draft list served as the starting point for discussions:

   a. Consumers linked to primary health services;

   b. Change in employment status after services;

   c. Percentages of consumers with maintained or improved level of functioning;

   d. Percentages of consumers experiencing symptom relief;

   e. Percentage of consumers who experience reduced impairment due to substance abuse;

f. Percentage of consumers arrested; and

g. Average level of involuntary movement resulting from psychotropic medications.

C. Project Context/Global Considerations. Prior to beginning the detail work involved in selecting performance measures and collection methodology, the sub-committee considered the context within which this project was proceeding. In this process, the group identified five questions that they felt should be addressed by any evaluation system. These questions were extracted from material developed by the New Hampshire Mental Health System:

1. Are the services delivered in a manner that is equitable and fair?

2. Are agencies able to meet the need for services?

3. Are the services of high quality?

4. Is the mental health system efficient, productive, and effective?

5. Do services produce the desired impact on the quality of life of consumers?

These questions were first presented to the Steering Committee following the March 24 meeting of the Assessment Sub-Committee. The Steering Committee agreed with the questions and directed that the Sub-Committee continue the dialogue around these questions as they developed the performance measures. In their interim reported, presented at the June 19 Steering Committee meeting, they were again presented to the Steering Committee for consideration. The Steering Committee determined that the questions presented by the Assessment Sub-Committee should serve as a guide for the process and that whatever evaluation system evolves from this process should have these questions at its core.

The sub-committee also decided to structure their efforts by looking at the life domains adopted by the Alaska Mental Health Trust Authority and examining the performance measures within that context. These life domains are:

- Health
- Safety
- Economic Security
- Productively engaged, employed, contributing
- Living with dignity, to be valued members of society

D. Selection of Performance Measures.

1. Initial List of Inventory of Performance Measures. The sub-committee, using the life domains noted above, first developed a list of all performance measures appropriate to the assessment process and important for measuring process and outcomes from both the provider and consumer perspective.

    a. Consumer General Health Status

    b. Linkage to Health Care Services

    c. Impairment of Clients due to Substance Abuse

    d. Consumers Experiencing Negative Effects of Medication

    e. Symptom Reduction

    f. Functional Improvement

    g. General Safety Status

    h. Attempted and Completed Suicides

    i. Homicidal Gestures or Acts

    j. Consumers Arrested

    k. Consumers Hospitalized

    l. Economic Security Status

    m. Employment Status

    n. Homelessness

    o. Level of Vocational Involvement

    p. Consumers Actively Involved

    q. General Improvement

    r. Intensity/Frequency of Services

    s. Stigma and Prejudice

    The sub-committee recognized that this listing, while containing valuable measures, was too large considering that the final list of performance measures would need to

include measures from the other two assigned sub-committees. The target for the group was to narrow this selection down to a range of eight to ten measures to be recommended to the Steering Committee.

2. Selection Process. The selection process spanned several meetings and consisted of several sub-processes.

    a. The first process was to examine the listing to determine which measures might be combined to form a single measure and still maintain validity and relevance.

    b. The second process was to identify measures within the original inventory that were ambiguous or where collection would clearly be a problem.

    c. Finally, the sub-committee used a modified Nominal Group Technique to select the final set of eight to ten measures. Each member selected five measures from the total inventory that they believed were the most meaningful and most practical to collect. Aggregating the votes, the sub-committee came up with nine measures that had a strong core of support from most members. The tentative list of measures from this process was:

        - ***Level of Productive Involvement*** – Level of productive involvement includes subsistence activities, full or part-time employment, volunteer work, social or political activity, recreation, or church activity.

        - ***Legal Status/Involvement*** – This measure examines the breadth and depth of legal involvement by a consumer including pending legal (criminal or civil) action, incarceration, and the hardships that they convey to the consumer.

        - ***General Safety Status*** – General safety status addresses issues of domestic or family violence, reliable transportation, the safety of your neighborhood or village, and prejudice or stigma in the community.

        - ***Economic Security Status*** – This examines the extent to which the consumer and clinician (working together) views the consumer's financial condition. It examines the issue both from the perspective of the consumer and from the perspective of the clinician based on external or corroborative reports. Examples of threats to economic security include bankruptcy, unmanageable debt, or inability to provide for basic life needs.

        - ***Housing Status*** – Housing status describes the setting in which the individual lives most often. It places identical value on living independently and living with others (such as family) as a matter of choice. The low end of the scale contains institutional living (hospital or correctional facility) and homelessness.

- ***General Health Status*** – General health status, which combines the original health status and linkage to health services, seeks to determine access and utilization of regular health services by consumers.

- ***Problems due to Substance Abuse*** – This measure assesses whether the consumer has a problem with substance abuse. It does not measure the severity of that problem. Measurement of severity requires a more in-depth assessment targeted specifically to substance abuse.

- ***Improved Functioning*** – This measure examines how consumers' functioning in their daily lives has improved as a result of services.

- ***Patients Hospitalized*** – Patients hospitalized measures the number of consumers hospitalized and the frequency with which they were hospitalized over a period of time.

Note: The recommended questionnaire also contains a question about health care insurance coverage. This question is not part of the performance measures but rather is an attempt to gather information on the extent to which insurance coverage (or the lack of) impacts consumers' ability to access physical or mental health care.

Another measure, symptom reduction, was initially selected but dropped when it became clear that (1) assessing symptom reduction would pose data collection problems and (2) symptom reduction is only relevant if it is directly related to improved functioning in all of the life domains covered in the other measures.

E. Collection Methodology Recommendations. With the list of performance measures selected, the sub-committee undertook the task of developing a method of collecting data and information to represent the measures. The initial work on this task was performed in small work groups that developed questions and scales for each measure. The questions and scales for each of the above performance measures are contained in Appendix A to this report.

1. Collection Methodology. We recommend that the performance measures listed above be collected using the questions and scales contained contained at the end of the Assessment Sub-Committee section. The questions were designed to be most effective when read by the consumer directly from the page rather than having someone read the question for them. We recommend that consumers, as a part of the assessment process, complete this short questionnaire and, if necessary, ask for help from the clinician.

2. Frequency of Data Collection. The sub-committee considered collection of data annually and every six months. The recommendation of the sub-committee is that the assessment process take place every six months. The questions were designed around this concept, looking at events and conditions over periods ranging from two months to six months, depending on the measure.

3. Scoring/Quantification. For ease of analyses, most questions have responses set up in a Likert Scale that yields a number 1 through 5. Analyses ranging from simple frequency distributions to descriptive statistics to more sophisticated processes can be performed on the data.

4. Data Analysis Issues. Once the data is collected, analysis and reporting become a challenge. Some of the larger providers have the infrastructure to perform this task, however, most medium and small providers would not be able to do this. It would also be helpful if a standard set of analyses were conducted using standard statistical software. The most likely scenario that would produce positive results would be for the Division to coordinate analysis, either in-house or via contract. Transmission of the data to the Division could be accomplished in one of two ways. First, the ARORA system has forms that are used for client situation updates. These forms have data fields currently labeled as DSM IV Axis IV, which would be re-formatted to accept the clinical assessment numbers. Another option would be for providers to mail the clinical assessment data collection forms (with no personally identifying information) to the Division directly. From this, a menu of reports could be developed depending on the needs of the providers, consumers, Division, Board, and other stakeholders. This would also allow for ad hoc reporting as needed.

F. Other Issues. In the process of developing these performance measures and data collection recommendations, the sub-committee addressed a number of related issues that were either integrated into the recommendations above or referred to the Steering Committee for resolution.

1. Cultural Issues. As the group considered the measures and related questions, they consistently considered the extent to which these measures and questions would be culturally valid. We had input from rural providers based on their experiences and we believe that the measures and questions, as structured, are relevant to the extent that any single set of measures and questions suffice for various cultures. In addition, our sub-committee developed a set of cultural sensitivity/competency satisfaction questions that, while not related to our specific measures, are of value in assessing the cultural sensitivity and competence of providers. These questions, previously forwarded to the Steering Committee, are included at the end of the Assessment section of this report. We recommend that they be considered by both the Steering Committee and Consumer Satisfaction Committee and used as appropriate.

2. Sub-population Issues. In developing the measures, we considered the extent to which the measures might be expected to vary among different sub-populations. The relevant sub-populations identified were:

   - Children and Adolescents
   - Adults
   - Seniors

   We addressed these issues by considering the likely conditions and response patterns from the different groups to the measures and questions selected. Rather than

developing three sets of instruments, we chose to have one set that could be used for any of the three groups.

3. ARORA Issues. Early in the process, the sub-committee identified several modifications and changes that would be helpful in ARORA. These recommendations, listed below, were transmitted to the Steering Committee and the ARORA Sub-Committee.

    - Inclusion of ethnicity in addition to race in the Admission Sheet
    - Inclusion of two additional allowable responses for residential setting – foster home and group home
    - The use of residence codes to clearly identify location rather than ZIP codes, which can be shared by several rural villages
    - The development and use of the severity and acuity fields within ARORA

4. Issues with the Global Assessment of Functioning (GAF). The GAF is an instrument or methodology used to assess functioning in mental health clients. While it is widely used, it has some serious flaws; some technical and some systemic. The technical flaws are that it is subjective and does not allow for different levels of functioning in different areas. It defines a level of functioning as a single score. On a systemic level, some third party payors pay for services only if the GAF score of the client is 50 or below. This forms a natural ceiling in GAF scores since assigning a GAF score above 50 creates the danger of a client losing access to services. Using this as a measure of performance is likely to contain bias and lack validity.

5. Trial Data Collection. With the completion of the initial phase of the project, the sub-committee recommends that the data collection system described here, consisting of the measures, questions, and methodology, be subjected to a trial. While there are many issues that impact the implementation of a trial, we do make the following recommendations:

    - The data collection trial last at least one year;
    - The pilot program involve only a sample of programs, probably five to seven;
    - Programs be selected to participate based on size of community, region, willingness to participate, and number of clients.
    - That the Division coordinates the pilot effort, receiving and entering the raw data and analyzing and reporting the results. This can be done either with Division staff or through a contract.
    - That the sub-committee be kept in tact to review the results and make further recommendations for improvement.

Client Assessment Worksheet

*Program Name*_____

Client Number _____ *Date* _____

1. During the last few (2-3) months, how often have you engaged in productive activity? Productive activities include subsistence activities, full or part time employment, volunteer work, church activities, school, sports, or social activity.

χ	1	Usually every day
χ	2	2 – 5 days a week
χ	3	5 – 10 days a month
χ	4	1 – 4 days a month
χ	5	Not active

2. Which of the following best describes your legal status during the last few (2-3) months?

χ	1	No legal involvement at all
χ	2	Some non-criminal problems but no threat of jail such as truancy or minor litigation
χ	3	Legal issues that are now pending
χ	4	Probation, parole, awaiting sentencing or extreme impact, non-criminal problems such as divorce or child custody or attending court-ordered outpatient mental health treatment
χ	5	Incarcerated: Lock-up or non-lock-up or mandatory hospitalization

3. During the last few (2-3) months, how would you best describe your feeling of general safety? General safety refers to issues such as domestic violence, homelessness, safety of community or village, reliable transportation, prejudice, or parental discord.

χ	1	I feel safe all of the time
χ	2	I feel safe most of the time
χ	3	I feel safe sometimes but feel unsafe other times
χ	4	I feel unsafe most of the time
χ	5	I feel unsafe all of the time

4. During the past few (2-3) months, how would you describe your economic security?

χ 1 Very secure economically
χ 2 I am more often than not economically secure, very few concerns
χ 3 Somewhat secure economically, my problems are tolerable
χ 4 I am more often than not economically insecure; I have many economic concerns.
χ 5 Extreme economic hardship; unable to meet basic life needs.

5. During the last few (2-3) months, how would you describe your housing status?

χ 1 Independent Living. Most of the time, I owned or rented my own habitable house or apartment; or I chose to live with others.
χ 2 Lives with others. Most of the time, I lived with family or others in a custodial relationship where they helped care for me.
χ 3 Sheltered care. Most of the time, I lived in a supervised SRO, adult foster home, supported apartment program; or Residential. I lived in a residential program such as a domiciliary, group home, staffed apartment, or halfway house with 24 hour per day, seven days a week supervision.
χ 4 Homeless. Most of the time, I was homeless, lived in a shelter or barely habitable, inadequate place.
χ 5. Institutional. Most of the time, I lived in a hospital or institution most of the time.

6. Dual diagnosis (substance abuse) is a common problem that often goes along with being mentally ill. We are not here to judge you but to get information that will help improve your treatment. Please answer the following questions:

a. Have friends or relatives asked you to **C**ut down on alcohol, tobacco, or other drugs, or quit entirely?

χ Yes χ No

b. Are you **A**nnoyed by friends or relatives who question your use?

χ Yes χ No

c. Have you experienced **G**uilt because of your drinking or use?

χ Yes χ No

d. Do you need an **E**ye opener in the morning (alcohol, tobacco, or other drugs) to get started?

χ Yes χ No

To how many of the above questions you answer "Yes"

χ 1 I answered "Yes" to none of the questions
χ 2 I answered "Yes" to only one of the questions
χ 3 I answered "Yes" to two of the questions
χ 4 I answered "Yes" to three of the questions
χ 5 I answered "Yes" to all four questions

7. During the last six months, how many times have you been hospitalized for mental health treatment?

χ 1 None
χ 2 1 time
χ 3 2 times
χ 4 3 times
χ 5 4 or more times

8a. Which of the following best describes how you get your regular medical care? Regular health care is defined as health care received from your primary or family physician in a physician's office or clinic.

χ 1 I have access to regular health care all of the time.
χ 2 I have access to regular health care most of the time.
χ 3 I have access to regular health sometimes but occasionally go to the emergency room or use emergency medical technicians for my health care.
χ 4 I have limited access to regular health care and get most of my health care at the emergency room or with emergency medical technicians.
χ 5 I do not have access to regular health care. I use the emergency room or emergency medical technicians for all of my health care.

8b. During the last few (2-3) months, how often have physical medical problems interfered with your normal activities?

χ 1 Never
χ 2 Only a few times in the last six months
χ 3 At least once a month
χ 4 At least once a week
χ 5 Usually every day

9. Which of the following best describes how your health care is paid for?

χ	1	I do not have to pay for any of my health care. I am either fully insured (including Medicaid) or receive my health care through an Indian Health Service facility with no charges.
χ	2	I have health care insurance (including Medicaid or Medicare) or receive service at an Indian Health Service facility but have to pay for some of the charges myself.
χ	3	I have some health care insurance but I have to about half of the charges for my health care.
χ	4	I have very little health care insurance and I have to pay for most of the costs for my health care.
χ	5	I have to pay all of the costs for my health care out of pocket.

Cultural Sensitivity Questions

Compiled by Jean Steele

Set 1 – All consumers

1. Have you been treated with respect by a professional (therapist, doctor, case manager) of your own cultural background?

2. Have you been given adequate time to become acquainted with the mental health professionals who treat you?

3. Do you feel that cultural differences have caused you problems?

4. Has the staff and/or caregivers been trained in your cultural practices and beliefs?

5. Do the staff/caregivers treat you with respect due to their training?

Set 2 – Rural consumers

1. Are you receiving tribal assistance in accordance with your treatment plan?

2. Have you had to be treated outside of your community and for how long?

3. Has the treatment been effective as to the standards of your community as a whole?

4. Is there alcohol counseling/treatment available where you live?

5. Have you been in a treatment facility outside of your community?

6. Has there been adequate transfer assistance back into your community?

Consumer Satisfaction Sub-Committee

A. Introduction.

1. Importance of Consumer Feedback. It is critical to have the consumer perspective when evaluating services because, in the end, it is the impact of services on consumers that really matters. The purpose of the service provision is to help bring about positive changes in the lives of consumers and evaluating the services without the consumers' perspective would miss this critical piece of information.

2. Uniqueness/Challenges of the Consumer Satisfaction Sub-Committee. The Consumer Satisfaction Sub-Committee is unique among the three sub-committees appointed by the Steering Committee. While the other two sub-committees, ARORA and Assessment, were considering performance measures obtained from a pre-defined population (those consumers being served by the mental health care system), the Consumer Satisfaction Sub-Committee was appointed to consider performance from the consumers' perspective. Consumers, however, comprise a population that goes beyond those currently receiving services or even those recently discharged. There are different definitions of consumers varying from those receiving services, to anyone who is mentally ill or in need of mental health services. So in addition to merely deciding on performance measures, this sub-committee was required to address the issue of population definition – who is included in the definition of "consumers?" While this may seem like a technicality, the issue has major impact on issues such as methodology, analysis, and selection of the actual performance measures.

3. Purpose. The scope of work of the Consumer Satisfaction Sub-Committee included defining the population to be surveyed, identifying and recommending the performance measures to be used, and recommending a data collection methodology. The Committee also identified other issues that will impact the collection of consumer satisfaction information including response rates, publication of the resulting information, and the intended use of the information.

B. Special Issues and Recommendations. Aside from the selection of the performance measures and survey instrument, the Consumer Satisfaction Sub-Committee spent considerable time researching, identifying, and developing recommendations for five critical issues that will impact this component.

1. Expansion of the Target Population. At the direction of the Steering Committee, the target population for the consumer satisfaction survey will be those consumers currently receiving services and those discharged within the year previous to the survey. The Steering Committee recognizes that there is an expanded population but believes that reaching that population is beyond the capacity of the initial phase of the project.

   While understanding these limitations and constraints, the Consumer Satisfaction Sub-Committee recommends initial targeting of consumers receiving services and

discharged within the year just prior to the survey. We also strongly recommend that the Steering Committee build in to the ongoing project an effort to expand this target population. Surveying only those individuals who are currently or recently receiving services has the potential to introduce a strong bias into the results. Those who become disenfranchised from the system and are very dissatisfied with services have a higher probability of dropping out of the system. Further, there are institutions, such as the Department of Corrections, that cannot easily be included in a consumer satisfaction survey but are major focus points or providers for persons with mental illness. Another such example is homeless shelters. In addition to those individuals who have stopped receiving services because they were dissatisfied, there also exists a group of consumers for whom services have made a difference and who have moved on and are no longer receiving services. They have the potential to provide excellent information on the types of services that made a difference in their recovery. Reaching these populations is admittedly difficult, however, we could gain a great deal of insight into needed changes in the system through individuals for whom the system did not work.

To help facilitate this population expansion, the sub-committee recommends the following initiatives:

a. The Consumer Satisfaction Sub-Committee recommends that a core of consumers, distributed geographically within the various regions of the state, be identified and trained to assist in the process of gathering consumer satisfaction information. The first recommended effort is to select and train the individuals to conduct outreach and promotion of the survey in their regions to help ensure the highest possible response rate. This effort should coincide with the promotional effort by the Division and the providers to get as many consumers as possible to respond to the survey. Consumers should also be used, where possible, in the implementation of the survey in logistics and support roles.

b. The second effort would be to have regional consumers conduct outreach surveys in locations such as homeless shelters and correctional facilities to try and access consumers who are not in the initial target population but whose input is needed if we are to improve services. This would mean conducting face-to-face interviews using a modified instrument.

c. The final element would be to use consumers to conduct focus groups to gain qualitative information on the reaction of consumers to the available services. This would focus on consumers who were not necessarily receiving regular services from the local provider.

A key element in this strategy would be for consumers to be trained and compensated for their efforts, as would any other professional providing the service.

2. Intended and Potential Uses of the Information/Data. The committee feels very strongly that if the state asks consumers their opinion about services, the state has an

obligation to use the data from that survey responsibly. Far too often consumers have been asked their opinion and once that opinion has been given, very little is done with the information. In asking consumers to provide their perspective on mental health services, it is only fair that they be informed of the intended and potential uses of the resulting information. Will it be used in resource allocation decisions? Will it be used by the Division and providers to improve services? We strongly recommend that clear statements of intention be published to advise consumers of these intended uses. Further, we recommend that some level of accountability be established to ensure that the intended uses of the information actually occurs and that it is not just used for public relations purposes.

3. Publication and Availability of Information/Data. Along with responsible use of the data, the Consumer Satisfaction Sub-Committee feels that it is imperative that, once the data from these surveys is received and analyzed, the resulting information be published in a variety of forums and formats to ensure maximum consumer access. Some of the forums and formats that we recommend are:

    a. Formal written report – distributed through providers;

    b. Written summary mailed to each consumer on the original survey mailing list (this would have an added advantage of stressing the importance of the survey and increasing response rate in future efforts.);

    c. Publication on Web Sites; and

    d. Toll-free number that consumers could call to have a copy of the formal report mailed directly to them.

    In addition, consumers could be asked, as a part of the survey, how they would like to have the information made available to them. The information on consumer satisfaction should be sorted, as a minimum, by provider to allow consumers to make informed decisions about their care.

4. Analysis of Trial Data/Modification of Instrument. The MHSIP Consumer Satisfaction Survey instrument, which was developed and tested in the Lower 48, is well suited for urban populations. The Consumer Satisfaction Sub-Committee has concerns that it may have deficiencies in rural areas with Alaska Native populations and may not appropriately address children's mental health services. While we, as a sub-committee, do not have the expertise or resources to modify this instrument during the time allowed and still ensure validity, we recommend that resources and effort be focused in this area following several trial data collection efforts.

5. Enhancement of Response Rate. As with any mail survey, response rate will be a problematic issue. Typical mail survey response rates run from 20% to 40%. We recommend that the Division and providers use established and tested methods to maximize these response rates. Some of these methods are:

a. Advance notification letters from the Division;

b. Advertising to publicize the effort and its importance;

c. Engagement of consumer groups to support and publicize efforts;

d. The use of consumers under contract to help administer the survey;

e. Straightforward, relatively short survey instruments;

f. The use of self-addressed, stamped return envelopes; and

g. Publication of results.

We believe that using these methods will help to ensure the highest possible response rates. This will be true, however, only if consumers believe that the information gathered is being used to improve services.

C. The Consumer Satisfaction Sub-Committee: Organization and Responsibilities. The Consumer Satisfaction Sub-Committee, one of three appointed by the Steering Committee, had its membership defined at the beginning but was free to define its own process, work plan, and schedule.

1. Membership. The membership of this sub-committee reflected a balance between consumers, providers, and representatives of the Division.

Robyn Henry (NAMI Alaska) – Chair
Beth LaCrosse (AMHB)
Jan McGillivary (ACMHSA)
Gail Igo (Parents, Inc.)
Yvonne Jacobson (DMHDD)
Bruce Ruttenberg (Rural MH Services)
Jeri Lanier (MH Association in Alaska)
Jeanette Grasto (AK AMI)
Patty Ogino (MH Consumers of Alaska)

Steven Hamilton from C & S Management Associates, the project contractor, logistically supported the sub-committee process.

2. Responsibilities. The sub-committee was provided with a set of draft or recommended performance measures by the Steering Committee at the beginning of the project. Using this as a starting point, the committee had the responsibility of developing a final set of performance measures including a recommendation for collection. They also had the responsibility of identifying any special issues that would impact the effectiveness of the process. The group defined its own process, developed a meeting schedule, and approved a work plan. Periodic reports were made to the Steering Committee, both orally and in writing. The contractor, Steven Hamilton, had the responsibility for documentation and distribution of materials associated with the process. Individually, sub-committee members were chosen to represent various stakeholder groups. Each member, as they participated, had a responsibility to both represent the interests of their group in the discussions and

deliberations and to convey information about progress and issues back to their group.

3. Meeting Schedule. Meetings were conducted by teleconference at dates and times determined by the sub-committee members. Meetings typically lasted about one and a half to two hours.

   Meeting Dates
   May 1, 2000
   May 22, 2000
   June 21, 2000
   July 6, 2000
   July 27, 2000
   August 16, 2000
   August 30, 2000

   The agenda and minutes for each meeting were distributed, in addition to sub-committee members, to all project participants and are contained in the master project files.

4. Sub-Committee Process. The sub-committee met via teleconference with no face-to-face meetings. Meeting agenda and minutes from the previous meeting were distributed via e-mail ahead of time. Sub-committee members studied the material and developed discussion issues and recommendations ahead of time, allowing a full and participative discussion to take place on each issue. The meeting process employed was to introduce the topics in accordance with the published agenda and invite discussion. At the close of the discussion for each item, the Chair reviewed the key points and verified that a consensus decision had been reached. Both e-mail and fax were used extensively to distribute documents.

5. Initial Set of Recommended Performance Measures. When the Consumer Satisfaction Sub-Committee was convened, the Steering Committee provided a draft set of performance measures that had been previously developed through two other projects. This draft list served as the starting point for discussions:

   a. Consumer perception of good access

   b. Participation in treatment planning

   c. Consumer perception of appropriateness and quality

   d. Family involvement in children's treatment planning

   e. Percentage of consumers in self-help groups

   f. Staff cultural diversity and sensitivity

g. Consumer perception of positive change as a result of services

h. Recovery/Personhood/Hope

D. Selection of Performance Measures. The members of the sub-committee agreed early in the process that the measures selected, within the context of this specific project, were valuable and decided to accept these as the final listing.

E. Collection/Analysis Methodology Recommendations. The method of collecting the data to support the selected performance measures was simplified somewhat by the fact that considerable effort has been expended at the national level to develop and test a valid consumer satisfaction instrument (MHSIP Consumer Satisfaction Survey). In addition, prior research identified the key questions within the survey address the specific performance measures. The following is a listing of other key issues relevant to data collection addressed by the sub-committee:

1. Cover Letter. The group agreed that a clear and informative cover letter from the Division was a critical piece. A recommended cover letter is included at the end of the Consumer Satisfaction Sub-Committee section of this report. The cover letter should explain the survey, stress the anonymity of the consumer, indicate that some portions (demographics) are optional, and provide an explanation as to the intended use and availability of the data after analyses.

2. Demographic Questionnaire. The sub-committee spent considerable time examining the issue of sorting or organizing the information resulting from the survey. The survey itself will tell how consumers feel about services. The group believes that this information needs to be further broken down to determine how the different sub-populations feel about services. These sub-division delineators include:

   a. Typical demographics (age, gender, race);

   b. Types of services received;

   c. Length of time receiving services;

   d. Frequency of service; and

   e. Whether the respondent is a current or past recipient of services.

   These sub-divisions can help to clarify the responses. To gather the data necessary, the sub-committee designed a short demographic/service questionnaire to accompany the MHSIP Survey. As a part of this survey, the members decided against asking about diagnosis. Instead, through the crafting of questions about the types and frequency of services, relevant information about severity and acuity can be developed. These demographic and service-related questions are critical in helping us understand how different groups of consumers are impacted by services. This

questionnaire is also included at the end of the Consumer Satisfaction Sub-Committee section of this report.

3. Collection Methodology. To protect consumer confidentiality, we recommend that the surveys be mailed out by the providers using mailing lists generated from the population criteria (consumers in service or discharged within the year prior to the survey). The survey instruments and cover letters, however, should be prepared by the Division. The appropriate number of survey envelopes should be provided to each provider, who will then affix the mailing labels and send them out. The return envelopes, enclosed with the survey, will be addressed to the Division. We recommend that the data be analyzed and the results published by the Division. Publication recommendations are contained in sub-paragraph B.3 above. We recommend that the survey be administered every year with each provider sending out surveys at the same time. Using this approach, data entry and analysis could be focused and completed within a reasonable period of time and the results published. Allowing providers to conduct the survey at different times would lead to timing and scheduling problems.

   In addition to defining methodology for reaching the population initially targeted, the sub-committee also recommends the following methodology to enhance response rate and expand the target population:

   a. ***Use of Consumers for Increasing Response Rate***. The sub-committee recommends that consumers be identified, trained, and used regionally to conduct outreach and promotion of the survey process. This would include contacting other consumers, meeting with consumer groups, and interacting individually to develop a sense of enthusiasm for the survey. Consumers performing this function should be compensated accordingly.

   b. ***Use of Consumers to Expand the Target Population***. The sub-committee recognizes the need to initially target consumers receiving services. As stated earlier, however, we strongly believe that this population must ultimately be expanded to include other consumers to provide the most complete picture. We recommend that consumers identified and trained (see sub-paragraph 1 above) also be used to conduct outreach and on-site interviews in locations such as homeless shelters and correctional facilities to gain the perspective of consumers who are found in those locations.

   c. ***Use of Consumers to Conduct Focus Groups***. Finally, we recommend that the consumers identified in sub-paragraphs (1) and (2) above also conduct regional focus groups to get qualitative information on consumer satisfaction and reaction to services.

   The sub-committee members recognize that these three specific recommendations will require considerable planning and coordination. We also recognize that this effort represents the opportunity to ensure that consumer opinions and perspectives

become an integral part of the evaluation process. We stand ready to help in that ongoing process – to help design and implement this particularly important piece.

4. MHSIP Survey/Performance Measure Relationship. The Consumer Satisfaction Sub-Committee recommends the use of the MHSIP Consumer Satisfaction Survey to gather the data necessary to support the selected performance measures. The MHSIP Consumer Satisfaction Survey is included at the end of the Consumer Satisfaction Sub-Committee section of this report. The following list identifies the questions within the survey that address each of the selected performance measures.

Performance Measure	Specific MHSIP Survey Questions
Consumer Perception of Good Access	Questions 5 through 8
Participation in Treatment Planning	Questions 9 and 12
Consumer Perception of Appropriateness and Quality	Questions 11, 13, 17, 18, 20, and 21
Family Involvement in children's treatment planning	Questions 2, 3, and 7
Consumers participating in self help groups	Question 23
Staff cultural diversity and sensitivity	Question 20
Consumer perception of positive change as a result of services	Questions 26, 28. 30, 31, 32, 33, and 36.
Recovery/Personhood/Hope	Questions 26, 27, 29, 39, 40

Proposed Sample Consumer Survey Cover Letter

<Date>

State of Alaska
Division of Mental Health and Developmental Disabilities
PO Box 110620
Juneau, AK 99811-0620

Re: Mental Health Consumer Satisfaction Survey

Dear Mental Health Consumer:

We would like to know how you feel about the mental health services that you receive. You will find a Consumer Satisfaction Survey form attached to this letter. Please take a few minutes to complete the survey and return it in the self-addressed, stamped envelope provided. The information will help us, as well as mental health providers, improve services to consumers. It will also help us to analyze overall trends and address system-wide concerns. When the data from this survey is compiled and analyzed, it will be made available to anyone who is interested. To obtain the results, you can contact ***<Division Representative Name>*** at ***<Telephone Number>***.

Although this survey is from the Division of Mental Health and Developmental Disabilities, it is being mailed to you by your local mental health provider since the State does not have access to individual consumer information. There is no place on the form for your name or other identifying information nor have we added any coding that would allow us to identify you. <u>This is a completely anonymous survey</u>! The name of your mental health service provider is already on the survey form. This will allow us to better understand the strengths and weaknesses of each provider and will help them in their efforts to improve services. The questionnaire that asks for information about your ethnicity, gender, age, and services that you receive, is completely optional and you should answer only those questions with which you are comfortable.

If you have any questions or concerns about this survey, you can reach us at ***<number>***. Thank you for your help.

Sincerely,

<Signature>

Mental Health Consumer Satisfaction Survey

Attached to this cover sheet is a consumer survey developed by the Mental Health Statistics Improvement Program (MHSIP). We have added this cover sheet with demographic questions to help us better understand the diverse people that we are serving in Alaska and the impact that services have on our diverse population. Please note that there is no place that asks for your name or any other identifying information. Neither have we placed any codes on the forms or envelopes that would enable someone to identify you. This is a completely anonymous survey.

Demographic Questions

1. Which of these groups includes your age on your last birthday?

χ Less than 18 years old
χ 18 – 22 years old
χ 23 – 59 years old
χ 60 or older

2. Which of the following best describes the race/ethnicity that you consider yourself?

χ African American
χ Alaska Native/American Indian
χ Asian/Pacific Islander
χ Caucasian
χ Hispanic/Latino
χ Other _____

3. Gender χ Female χ Male

4A. Which of the following services have you received in the last year from <***Specific Provider***> (please check all that apply)?

χ Therapy/Counseling
χ Case Management
χ Housing Services
χ Assistance with Employment Issues
χ Family Services
χ Substance Abuse Treatment Services
χ Transportation Services
χ Advocacy Services
χ Psychiatric Services/Medication Management
χ Other Services (please specify) _____

4B. Are you still receiving services from <***Specific Provider***>?

χ Yes χ No

5. How long have you been receiving, or did you receive, services from <***Specific Provider***>?

χ Less than six months χ 6 months to 2 years

χ 2 to 5 years χ More than 5 years

6. About how often do (or did) you receive direct services from **<*Specific Provider*>**?

χ Daily χ Weekly

χ Bi-weekly χ Monthly

χ Every three months χ Other _____

7. Comments. Is there anything else that you would like to tell us about yourself or the services that receive that might help us to better serve you?

_____

_____

_____

_____

_____

Thank you for taking the time to answer these questions about yourself. Please go on and answer the questions on the Consumer Satisfaction Survey that is attached.

Note: ***The notation "<Specific Provider>" in the above questions designates the location where a word processing merge operation would place the name of the specific provider in this space so that the consumer would know exactly which provider was being discussed.***

Mental Health Statistics Improvement Program (MHSIP)
Task Force on Mental Health Report Card
Consumer Survey

In order to improve mental health services to people like you, we need to know what you think about the treatment that you received, the people who provided it, and the results of this treatment.

Please indicate your agreement/ disagreement with each of the following statements by circling the number that best represents your opinion. If the question is about something you have not experienced, circle the number 9, to indicate that this item is "not applicable" to you.	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. I like the services that I receive here…….	1	2	3	4	5	9
2. If I had other options, I would still choose to get services from this agency……	1	2	3	4	5	9
3. I would recommend this agency to a friend or family member	1	2	3	4	5	9
4. I was able to get some services I wanted even if I could not pay for them…….	1	2	3	4	5	9
5. The location of services was convenient (parking, public transportation, distance. etc...	1	2	3	4	5	9
6. Staff were willing to see me as often as I felt it was necessary…….	1	2	3	4	5	9
7. Staff returned my call within 24 hours……..	1	2	3	4	5	9

8. Services were available at times that were good for me……..	1	2	3	4	5	9
9. I was able to get the services I thought I needed…….	1	2	3	4	5	9
10. I was able to see a psychiatrist when I wanted to	1	2	3	4	5	9
11. Staff here believe that I can grow, change, and recover…….	1	2	3	4	5	9
12. I felt comfortable asking questions about my treatment and medication……	1	2	3	4	5	9
13. I felt free to complain…….	1	2	3	4	5	9
14. Staff respected my rights……	1	2	3	4	5	9
15. I was given information about my rights……	1	2	3	4	5	9
16. Staff encouraged me to take responsibility for how I live my life……	1	2	3	4	5	9
17. Staff told me what side effects to watch for……	1	2	3	4	5	9
18. Staff respected my wishes about who is, and is not, to be given information about my treatment	1	2	3	4	5	9
19. I, not staff, decided my treatment goals……..	1	2	3	4	5	9
20. Staff were not sensitive to my cultural/ethnic background (race, language, religion, etc.)……	1	2	3	4	5	9

21. Staff helped me obtain the information I needed so that I could take charge of managing my illness……..	1	2	3	4	5	9
22. Staff believe that I can choose what is best for me…….	1	2	3	4	5	9
23. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone lines, etc.)	1	2	3	4	5	9
24. All of the services I received were helpful……	1	2	3	4	5	9
25. Staff I worked with were competent and knowledgeable	1	2	3	4	5	9

As a Direct Result of Services I Received:

26. I deal more effectively with daily problems…….	1	2	3	4	5	9
27. I feel better about myself……..	1	2	3	4	5	9
28. I am better able to control my life…….	1	2	3	4	5	9
29. I experienced harmful medication side effects….	1	2	3	4	5	9
30. I am better able to deal with crisis…….	1	2	3	4	5	9
31. I am getting along better with my family……..	1	2	3	4	5	9
32. I do better in social situations……	1	2	3	4	5	9
33. I do better in school and/or work……	1	2	3	4	5	9
34. I do better with my leisure time…….	1	2	3	4	5	9

35. My housing situation has improved……...	1	2	3	4	5	9
36. My symptoms are not bothering me as much……	1	2	3	4	5	9
37. I have become more independent……..	1	2	3	4	5	9
38. The medications I am taking help me control the symptoms that used to bother me……..	1	2	3	4	5	9
39. I have become more effective in getting what what I need……	1	2	3	4	5	9
40. I can deal better with people and situations that used to be a problem for me…….	1	2	3	4	5	9

Appendices.

Appendix A: Project Framing Document

Appendix B: Project Participants

Appendix A: Project Framing Document

Mental Health Performance Measures Project

1. Project Objectives. This project is an outgrowth of two similar existing projects, the Alaska Mental Health Board's Outcomes, Indicators and Performance Measures project (1999) and the Alaska Division of Mental Health and Developmental Disabilities Alaska Performance Indicator Project (1998-2000). The purpose of this project is to integrate the two efforts in pursuit of a common goal: the identification and implementation of common performance measures for mental health services in Alaska. This planning project will accomplish two short-term objectives:

A. Integrate the work accomplished to date by the two Alaska mental health evaluation projects cited above; and

B. Make recommendations for an integrated mental heal performance measures system in Alaska.

2. Alaska Mental Health Board Outcomes, Indicators, and Performance Measures Project. This project, which was completed in July 1999, examined different mental health evaluation systems nationally, including the Mental Health Statistics Improvement Project (MHSIP), the National Association of State Mental Health Program Directors (NASMPD) Five State Study and Standardized Framework, and others. From the various systems, the project identified those measures most frequently used for which data sources are either available or could be readily developed. This project recommended measures in the areas of access to care, appropriateness and quality of care, consumer outcomes, and management/structure. The proposed data sources for these measures are:

A. ARORA Data System;
B. MHSIP Consumer Survey; and
C. Periodic Client Assessment.

Implementation plans for this project are similar to those for the DMHDD project in that they will involve consumers and consumer groups, administration staff, and program provider staff.

3. The Alaska Division of Mental Health and Developmental Disabilities Alaska Performance Indicator Project. The primary purpose of this federally funded project is to build a set of performance indicators that have "buy-in" by all stakeholders and which will be used to evaluate the quality of services provided by the Alaska mental health service system. Participants at the Alaska Mental Health Consumers and Families Summit previously identified the two thirds of the 16 indicators chosen for use in this project as important in March 1998. In addition, the indicators are consistent with emerging national standards (MHSIP, 5 State Study) thereby providing the possibility of across-state comparison of service delivery performance and consumer perception of service quality. The intended data sources for these indicators are:

A. ARORA Data System;
B. Medicaid Files (via the DHSS Data Warehouse); and

C. Psychiatric and General Hospitals in Alaska.

The project requires significant consumer participation both in the design of the performance indicator system and in its implementation. To this end, one-third of the advisory committee is to be composed of consumers or family members. The project also contains an internal evaluation function that serves to evaluate the project itself in order to insure that project goals are documented and met. Components of the evaluation include:

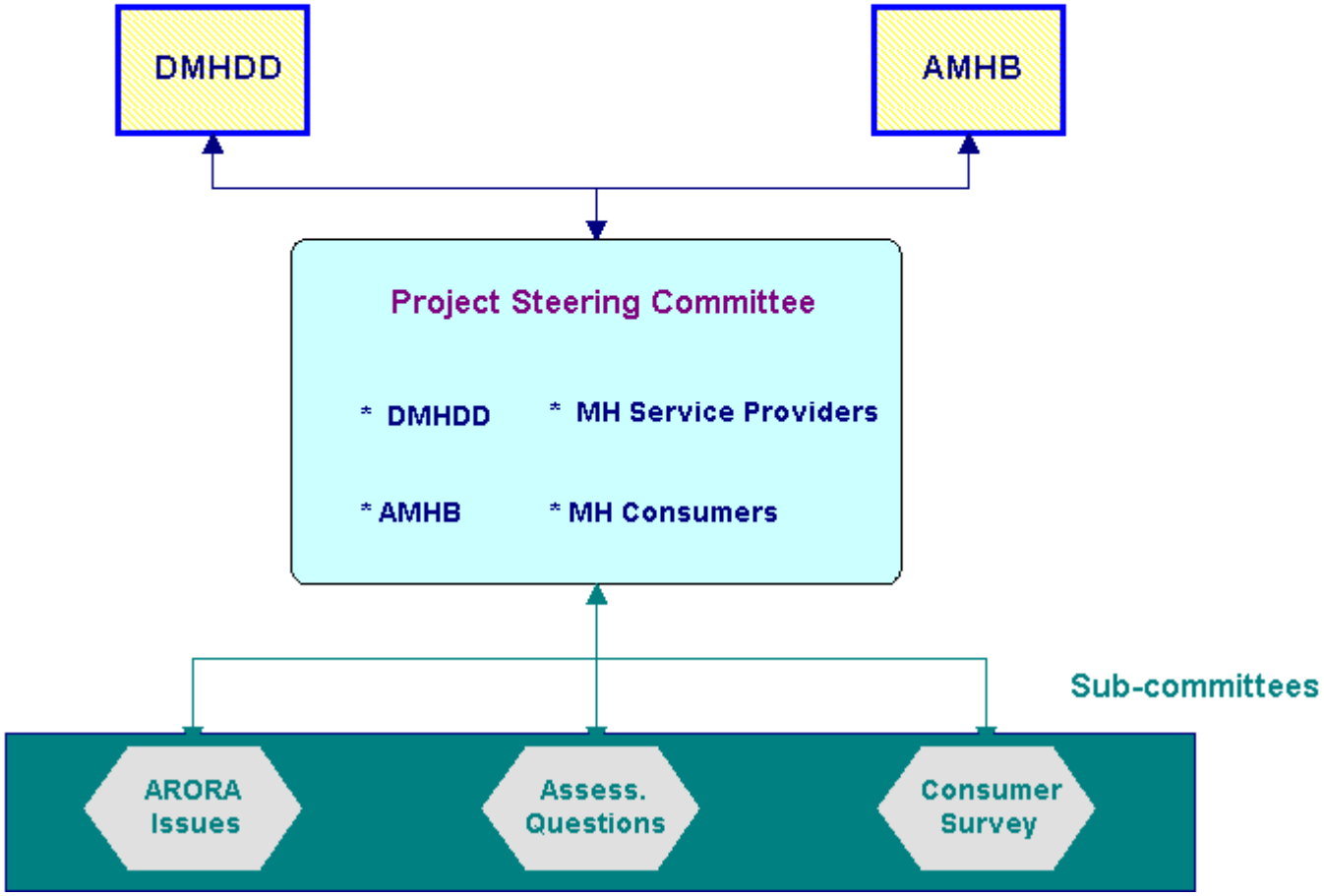
- Degree to which project members actively participate;
- Degree to which project members independently pursue development of performance indicators; and
- The impact of the project on the larger behavioral health care delivery system.

4. Integration of AMHB and DMHDD Projects. A key focus of this project is to integrate the two existing projects and develop a viable plan for moving the effort forward. In examining the performance measures selected by each project, we found that the vast majority of the measures selected by the DMHDD project were also selected by the AMHB project. The initial approach, therefore, will be to bring forward a combined list of the two groups of measures as a draft set of final performance measures.

A strong component of the DMHDD project is consumer involvement, both in the final indicator selection and implementation planning. In combining these two projects, this strong emphasis will be continued and involvement by the mental health service providers will be added. In implementing the integrated project, a Steering Committee will be established with representation from all participating groups to manage and oversee the project. There will also be sub-committees to address the issues of implementing consumer surveys, data system needs, and periodic client assessment. The objectives, structure, membership, and issues for these groups in this project are outlined below.

5. Project Management Organization Chart. A chart showing the relationships and structure of the project management is shown on the following page.

Mental Health Performance Measures Project
Phase One
Management Structure



6. Work Plan/Management Structure for Implementation

A. Steering Committee. The Steering Committee will be comprised of 8 members drawn from the various stakeholder groups as outlined below.

(1) ***Membership***.

- AMHB (1 member)
- DMHDD (1 member)
- Mental Health Providers Association (1 member)
- Rural Mental Health Providers Association (1 member)
- Mental Health Consumers/Family Members and Groups (4 members)

(2) ***Member Roles and Responsibilities***. The members of the Steering Committee will have a number of responsibilities and duties.

- Represent interests of constituency group. For individuals who sit on the Steering Committee, it will be critical that they represent the interests, concerns and perspectives of their respective constituency groups. As discussion and debate takes place, it is also critical that the results be conveyed accurately and fairly back to the groups.

- Other project work as decided by the committee. While we expect most work to be accomplished in sub-committees (sub-paragraph B below), there may be occasions where some review, research or integration work is needed at the Steering Committee level. This work will assigned consistent with resources available.

- Liaison to Sub-committees. Each sub-committee (sub-paragraph B below) will have a member of the Steering Committee who will serve as the primary liaison back to the Steering Committee. This individual will provide clarification on issues to the sub-committee and will report back progress and issues to the Steering Committee.

- Co-chaired and Co-staffed by AMHB and DMHDD. Representatives from the Alaska Mental Health Board and the Division of Mental Health and Developmental Disabilities will chair the Steering Committee and provide administrative support.

- AMHB/DMHDD Roles. The AMHB will bring to this project its planning and advocacy roles and responsibilities. The DMHDD will ensure that conditions of their Alaska Performance Indicator Project grant are fulfilled and provide information and guidance to all parties regarding available resources and implementation constraints. The AMHB and DMHDD Directors will also make the final determination on chairs and membership for the three sub-committees.

(3) ***Tasks and Objectives***

- Oversee implementation of Performance Measures Project. The primary task of the Steering Committee will be to provide oversight and coordination for the implementation of the Mental Health Performance Measures Project. This will include the overall planning function, tracking progress, and producing written progress reports for the various stakeholder groups.

- Assign tasks and objectives to sub-committees. The Steering Committee, as a part of its planning and coordination function, will assign tasks and objectives to the various sub-committees.

- Integrate the work of the sub-committees. As the sub-committees finish their tasks, the Steering Committee will integrate the finished products into an overall evaluation design and implementation plan. The completed plan will specify implementation components and responsibilities as well as estimates of cost and time requirements.

- Review and approve preliminary list of performance measures for sub-committee work. The Steering Committee will be provided with a preliminary list of performance measures that were identified in the AMHB project and the DMHDD grant. They will review and recommend modifications to the list before forwarding to the sub-committees.

- Make Recommendations to AMHB/DHSS. The Steering Committee, upon completion of work, will make recommendations to the DMHDD Director and the Alaska Mental Health. The DMHDD Director will, in turn, submit recommendations to the DHSS Commissioner.

(4) ***Meetings***. Meetings of the Steering Committee will be through a combination of teleconferences and face-to-face meetings. Where face-to-face meetings are held, every attempt will be made to schedule these meetings to coincide with meetings of the Alaska Mental Health Board. This joint scheduling will provide two key benefits:

- Efficiency. By taking advantage of travel already scheduled, the cost of the meetings can be reduced significantly.

- Reporting Opportunity. If meetings are conducted coincidentally with the AMHB meetings, then progress reports can be made directly to the Board at that time.

(5) ***Timelines.***

- Project Start Date 11/19/99
- Recommendations on performance measures complete 9/15/00
- ARORA and Consumer Questionnaire Issues complete 9/30/00
- All sub-committee recommendations complete 12/31/00
- Implementation and evaluation complete 9/30/01

(6) ***Authority***. The Steering Committee will be tasked with making recommendations to the Alaska Mental Health Board and to the Department of Health and Social Services through the Division of Mental Health and Developmental Disabilities. They will retain authority over their work processes and the processes of the sub-committees.

B. Sub-committees

(1) ***ARORA data issues***. A sub-committee will be convened to address issues and develop recommendations dealing with the evaluation information to be drawn from the ARORA data system operated by DMHDD any additions or changes necessary.

- Leadership/Staffing. The ARORA Data Issues sub-committee will be chaired and supported by the DMHDD.

- Membership. Membership in this committee is drawn from the same groups that are represented in the Steering Committee. With the exception of the liaison person, however, the individuals sitting on this committee may be different than those on the Steering Committee. It is expected that this sub-committee will include the following representation:
  - DMHDD (Chair/Liaison to Steering Committee)
  - AMHB
  - Mental Health Providers
  - Mental Health Consumers and Groups

- Tasks and Objectives.
  - Review all proposed measures.
  - Agree on the data fields necessary to support the proposed indicators.
  - Develop an implementation strategy for modifying ARORA to accommodate the data requirements.
  - Identify queries necessary for reporting on existing data.
  - Develop a viable implementation schedule and work plan.
  - Develop cost estimates for implementation.

2. ***Assessment question issues***. This sub-committee will deal with issues regarding the core assessment questions necessary to support the selected indicators.

- Leadership/Staffing. The Assessment Question Issues sub-committee will be chaired and supported by a member of the mental health service providers who will also be a member of the Steering Committee.

- Membership. Membership in this committee is drawn from the same groups that are represented in the Steering Committee. With the exception of the liaison person, however, the individuals sitting on this committee may be different than those on the Steering Committee. It is expected that this sub-committee will include the following representation:
    - Mental Health Service Providers (Chair/Liaison to Steering Committee)
    - DMHDD
    - AMHB
    - Mental Health Consumers

- Relevant Issues. This group will be tasked with examining the following issues and developing recommendations for implementation of periodic assessment questions supporting the selected indicators.
    - Questions for different sub-populations.
    - How do we assure that questions are culturally relevant?
    - Data collection issues – how and by whom will the questions be administered?
    - Data analysis issues – who will analyze the responses? What analyses will be conducted?
    - Selection of questions.
    - Frequency of question administration – since most of the assessment questions seek to determine improvement or progress, we expect that they would be administered to clients periodically. The group will need to determine the frequency of administration and if that frequency might vary by sub-population.
    - Develop a viable implementation schedule and work plan.
    - Develop cost estimates for implementation.

(3) ***Consumer survey issues***. Some of the selected indicators will draw data from consumer surveys. This sub-committee will work on issues relating to the survey instrument, its administration, and analysis.

- Leadership/Staffing. The Consumer Survey Issues sub-committee will be chaired by a member from a consumer organization and supported by those organizations and DMHDD.

- Membership. Membership in this committee is drawn from the same groups that are represented in the Steering Committee. With the exception of the liaison person, however, the individuals sitting on this committee may be different than those on the Steering Committee. It is expected that this sub-committee will include the following representation:

- Mental Health Consumers and Groups (Chair/Liaison to Steering Committee)
- DMHDD
- AMHB
- Mental Health Service Providers

- Relevant Issues.
  - Selection of an appropriate survey instrument – The MHSIP project developed and tested a consumer survey that addresses the data needed in this area. The group will need to examine that or other survey instruments, recommend any changes, and develop a final version to recommend to the Steering Committee.
  - Survey Implementation/Data Collection – This sub-committee should address the issues of how and by whom the instrument will be distributed and collected.
  - Data Analysis – Once data is received, it must be organized, entered into an automated analysis program, analyzed and reported. This group should address these issues.
  - Frequency of Survey – The sub-committee should recommend a frequency of administration.
  - Size/Scope of Universe/Sample – Part of the implementation problem for this survey will be to determine the universe of persons to be surveyed, i.e. all current clients, all current clients plus those discharged in the previous year, all clients current or discharged? Once the universe has been established, the group should make recommendations regarding the use of sampling techniques or surveying the entire universe.
  - Develop a viable implementation schedule and work plan.
  - Develop cost estimates for implementation.

C. Scheduling. The Steering Committee will convene November 19, 1999 and the primary focus of that meeting should be to:

(1) Welcome and Introductions.
(2) Review overall project objectives.
(3) Review management structure.
(4) Determine objectives/tasks for sub-committees.
(5) Review draft performance indicator list.
(6) Review timeline and milestones.
(7) Set schedule for next/future meetings.

Appendix B: Project Participants.

Participant	Representing	Project Role
Leonard Abel	DMHDD	Steering Committee/Chair, ARORA Sub-Committee
Thad Baldridge	Eastern Aleutians Tribes	Assessment Sub-Committee
Kelly Behen	AMHB	ARORA Sub-Committee
Karl Brimner	DMHDD	Steering Committee, Co-Chair
Thia Falcone	Alaska AMI	ARORA Sub-Committee
Jane Franks	Rural MH Providers	Steering Committee/ARORA Sub-Committee
Jeanette Grasto	Alaska AMI	Assessment Sub-Committee
Anne Henry	DMHDD	Assessment Sub-Committee
Robyn Henry	NAMI Alaska	Steering Committee/Chair, Consumer Satisfaction Sub-Committee
Bill Hogan	AK MH Service Providers	Steering Committee/Chair, Assessment Sub-Committee
Esther Hopkins	Alaska AMI	Assessment Sub-Committee
Virginia Hostmann	MH Association in Alaska	Assessment Sub-Committee
Lynn Hutton	DMHDD	ARORA Sub-Committee
Gail Igo	Parents, Inc.	Steering Committee/Consumer Satisfaction Sub-Committee
Yvonne Jacobson	DMHDD	Consumer Satisfaction Sub-Committee
Fred Kopacz	Southcentral Counseling	ARORA Sub-Committee
Steve Krall	Juneau Youth Services	ARORA Sub-Committee
Beth LaCrosse	AMHB	Consumer Satisfaction Sub-Committee
Jeri Lanier	MH Association in Alaska	Consumer Satsifaction Sub-Committee
Jan MacClarence	AMHB	Assessment Sub-Committee
Walter Majoros	AMHB	Steering Committee, Co-Chair
Gina McDonald	JAMI	Assessment Sub-Committee
Jan McGillivary	MH Association in Alaska	Steering Committee/ARORA Sub-Committee
Pat Murphy	AMHB	Steering Committee
Israel Nelson	Four Rivers Counseling	Assessment Sub-Committee
Faye Nieto	Parents, Inc.	Assessment Sub-Committee
Patty Ogino	MH Consumers of Alaska	Consumer Satisfaction Sub-Committee
Don Roberts, Jr.	MH Consumers of Alaska	ARORA Sub-Committee
Bruce Ruttenburg	Maniilaq Counseling Svcs	Consumer Satisfaction Sub-Committee
Jean Steele	MH Consumers of Alaska	Assessment Sub-Committee
Lauren Swift	MH Consumers of Alaska	Steering Committee
Ken Taylor	Southcentral Counseling	Assessment Sub-Committee
Margo Waring	AMHB	Project Logistics and Support
Tim Weiss	Parents, Inc.	ARORA Sub-Committee