

State of the States

Lessons from Technical Reviews
Thursday, August 21, 2008, 3:15-5:15 p.m.

Goals

- Describe SAMHSA performance management framework.
- Use framework to share lessons from other states.
- Outline strengths and challenges facing State systems.
- Provide technology transfer opportunities.

Caveats

- 43 states reviewed.
- Selective sample.
- Use of guidelines.
- Data collected over three years.
- Personnel interviewed may vary.

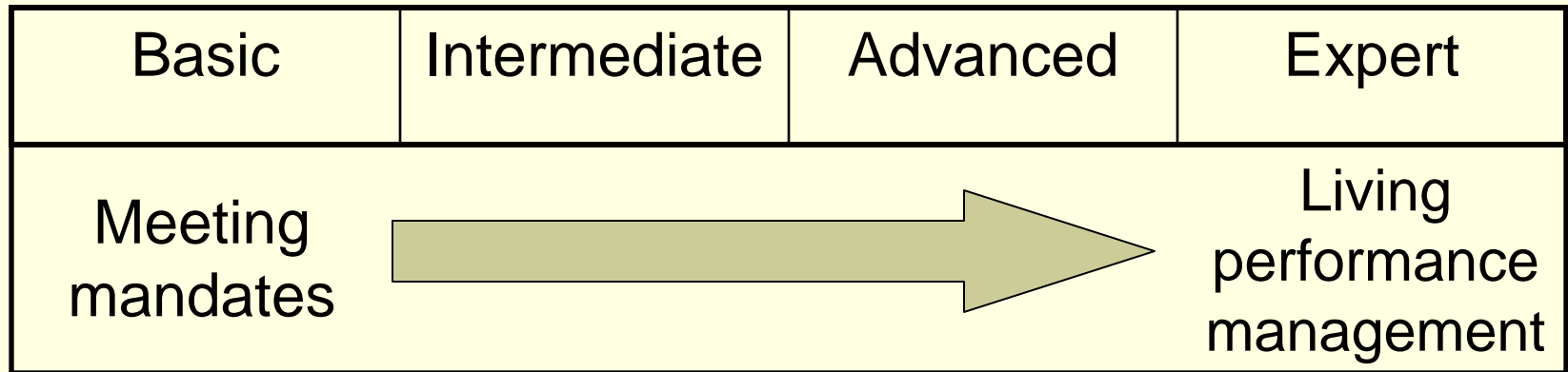
Framework

Center for Substance Abuse Treatment:
*Performance Management: Improving State
Systems Through Information-Based
Decisionmaking.*

Capacities

- **Data System:**
Capacity of stakeholders for collecting, moving, and manipulating data.
- **Cultural:**
Internal culture regarding the use of data in planning and decisionmaking.
- **Analysis and Management:**
Capacity to use data to manage services and influence practices at multiple levels.
- **Provider:**
Capacity of providers within the system to implement performance management.

See handout




Lesson One:

**You are
not alone.**

Extent of Data Use

Most
effective



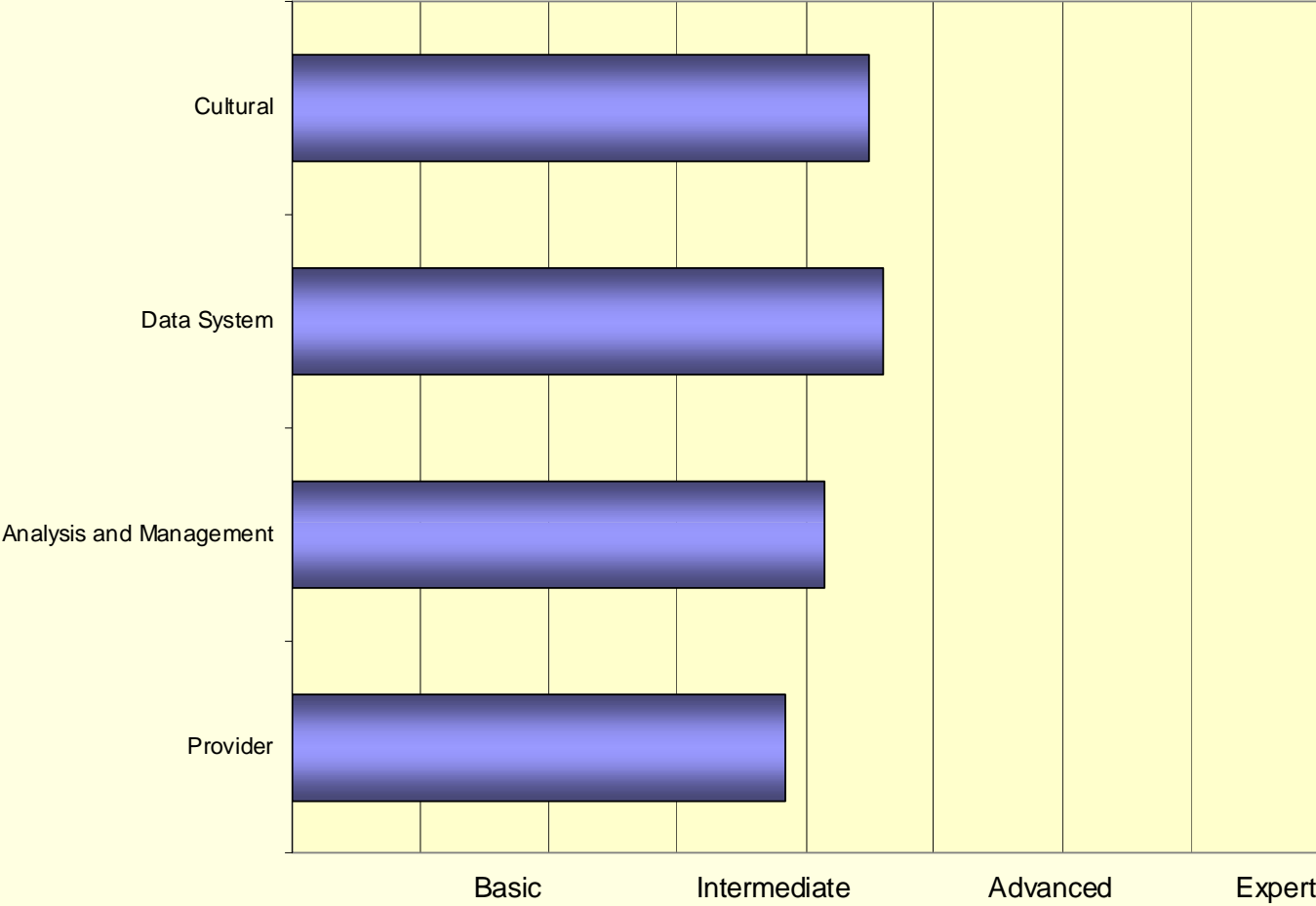
- Reporting mandated data
- General oversight
- Internal (ad hoc) initiatives
- Funding / contracting decisions
- Advocacy
- Policymaking and policy decisions
- Strategic planning
- Utilization review and/or managed care decisions

Barriers

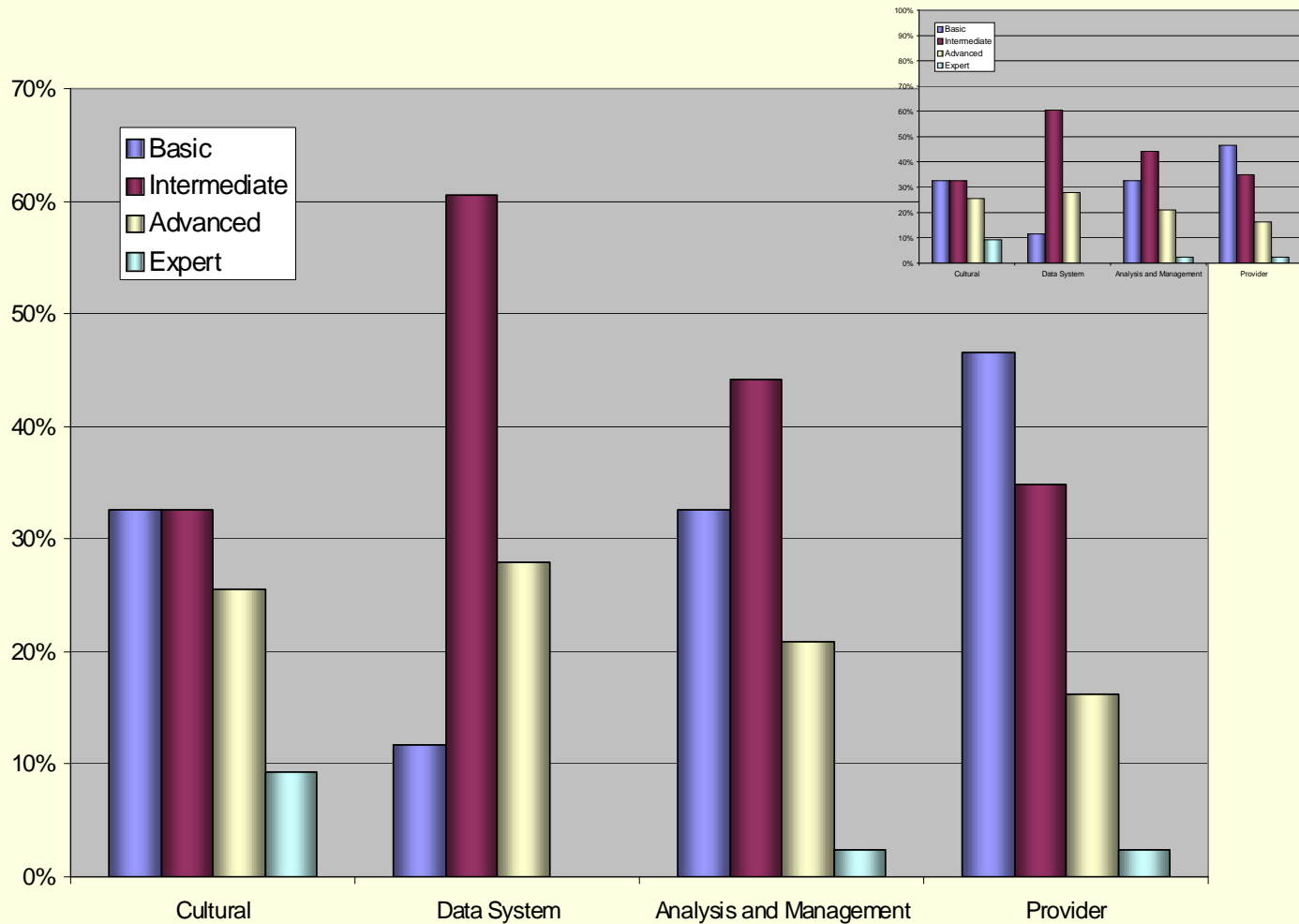
- Aging or obsolete data systems (32%)
- Resources – both money and staff (22%)
- Poor quality archival (and current) data (20%)
- Staff analytical skills (17%)
- Ability to link data (5%)
- Other - planning, politics, confidentiality, competing priorities, provider culture (15%)

12% saw no barriers!!

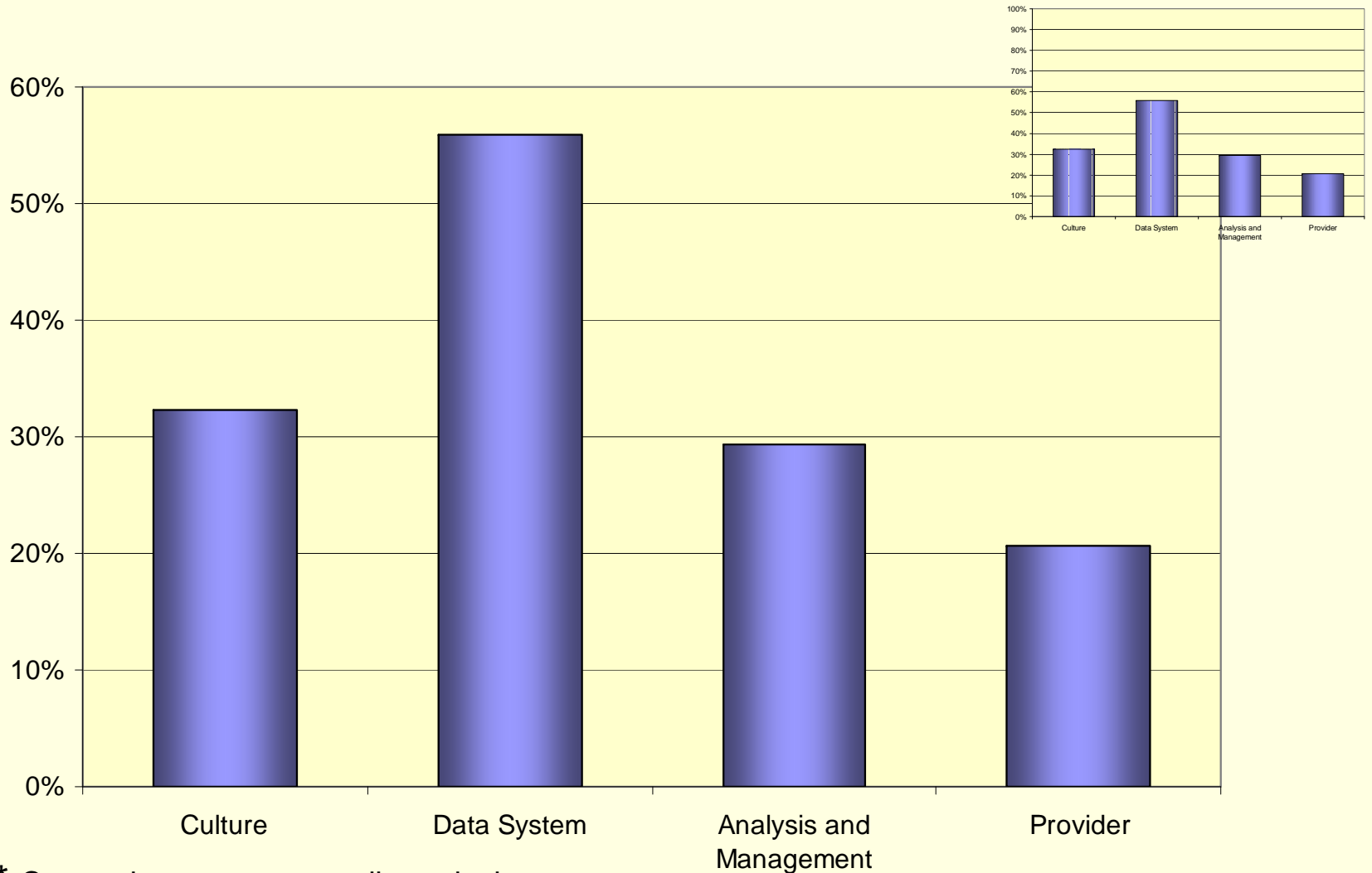
States on Average



The Details



Needed Changes*



* Categories are not mutually exclusive.

Specific Changes Needed

CULTURE

- Old ways of doing business.
- Competing priorities.

DATA SYSTEMS

- Quality of data.
- Quality of data systems.
- Need for linkages among systems.

ANALYSIS/MANAGEMENT

- Analytical skills.
- Less data, more information.
- Using data without punishing.

PROVIDER

- “Buy-In”.
- Agreement/collaboration.

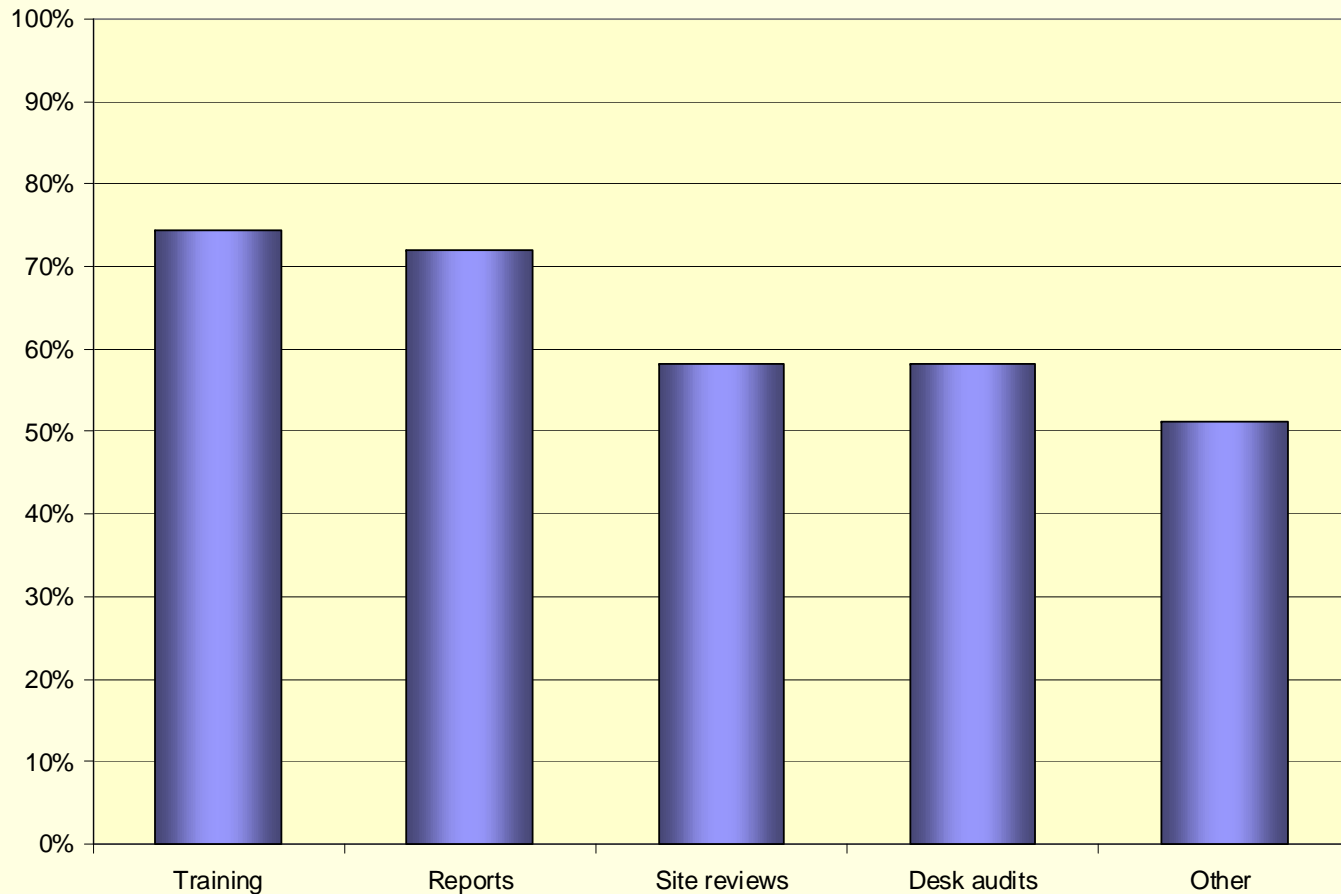
Lesson Two

**There are lots
of great ideas
out there!**

Analysis and Management

- Point in Time and Over Time
- Performance Is Luck and Skill
- Multiple Measures
- Transparency

Ensuring Data Quality

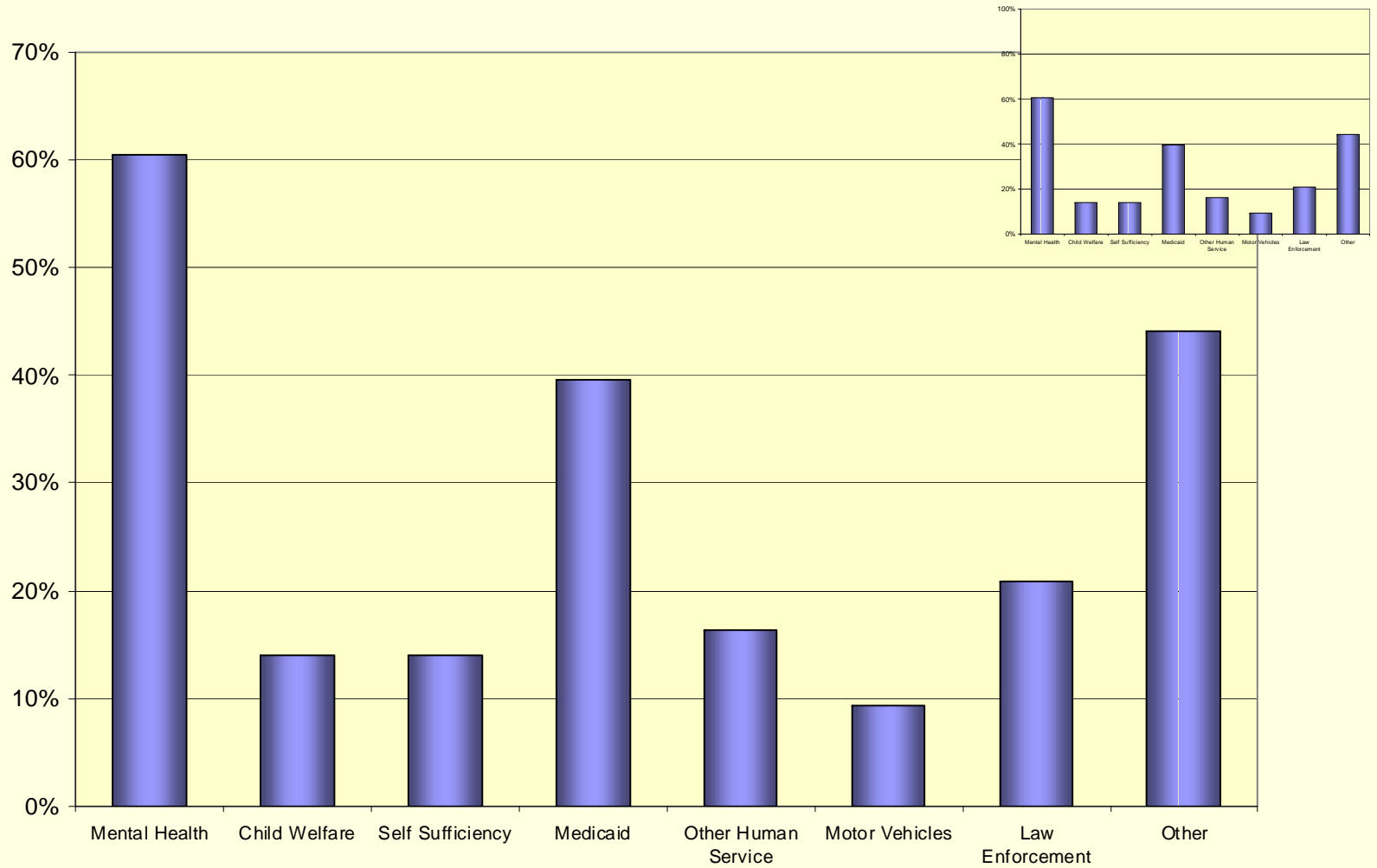


“Other” includes data edits, payment dependent on data, user groups, helpdesks and monitoring contracts

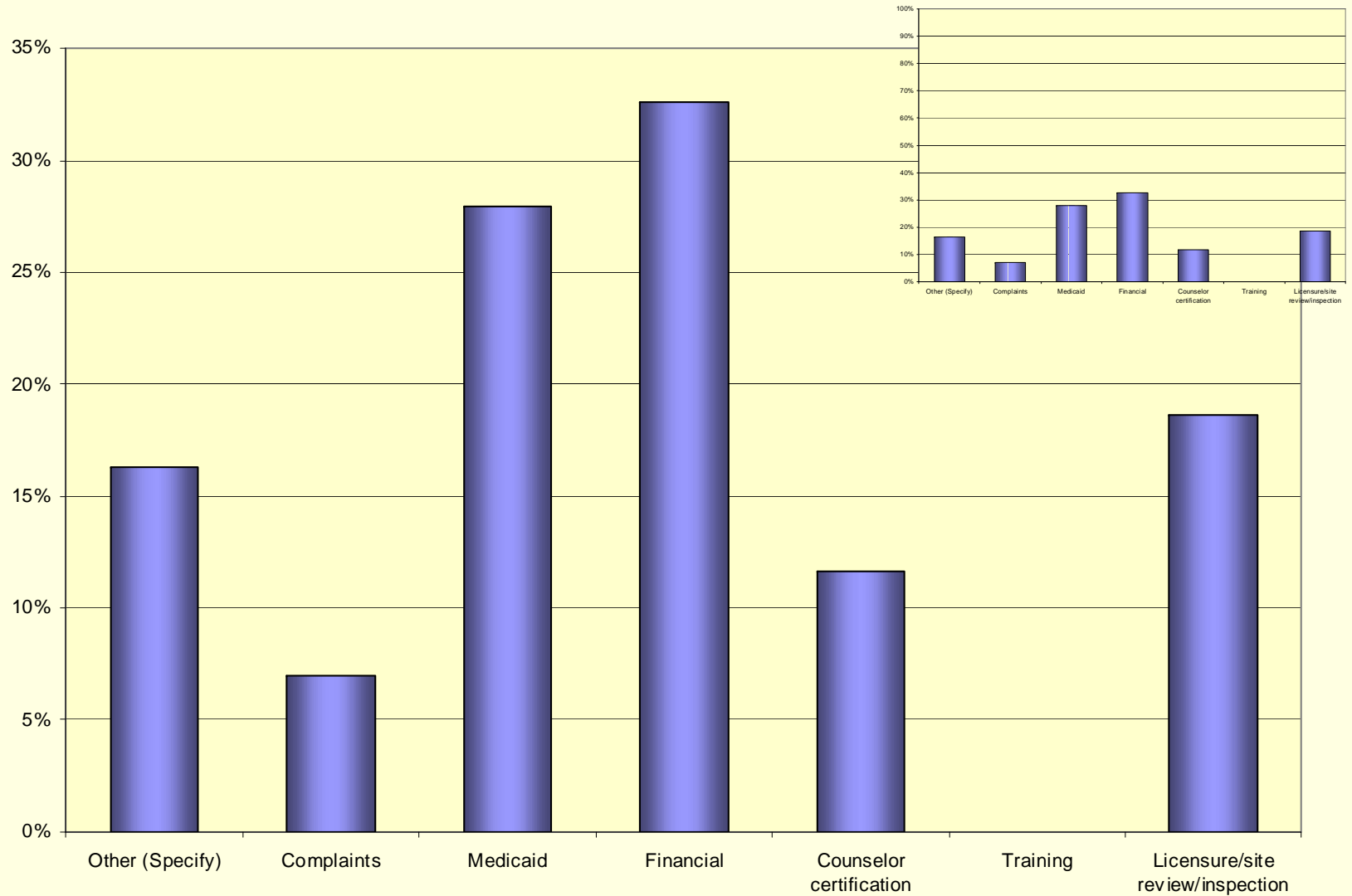
Training

- 74% of states say they have training programs for provider staff who work with data.
- 23% of states say they have training programs for internal staff who work with data.

External Data Links



Internal Data Links



NOMS

- Almost all of the states are collecting and reporting the NOMS
but ...
- Many states are struggling to figure out how to use the NOMS
and ...
- Some states are supplementing NOMS with other measures.

For Example...

- 24 States involved in NIATx, Advancing Recovery or STAR-SI.
 - Reduce waiting times
 - Reduce no-shows
 - Increase admissions
 - Increase continuation in treatment
- Handouts

Technology Transfer Opportunities

With more specifics from:

- Florida
- Oregon
- New York
- South Carolina

And ...

- Alaska

Contact Information

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South Carolina Alcohol and Other Drug Abuse Authorities' Performance Management & Improvement System

Collaborative ... Proactive

These adjectives describe the development of our Performance Management and Improvement System (PMIS).

Our PMIS has been developed as a collaborative effort between DAODAS and BHSA through the Performance Subcommittee of the Finance and Accountability Committee (FAC).

Instead of waiting for mandates resulting from the anticipated National Outcome Measures (NOMS) [partially released, fall 2005] we began proactive development of our PMIS in the fall of 2003, when the FAC started developing a list of possible measures and then evaluated them one-by-one for feasibility. Our PMIS not only captures the treatment measures required by the NOMS, but it also provides tools to manage and evaluate underlying processes that affect NOMS performance; thereby, giving our providers tools to excel in NOMS performance.

Our PMIS will assist the state and individual providers in evaluating individual and collective performance on key measures that reflect good clinical practice and are indicative of success, so that we may improve our services and our system. This can ultimately give our state a competitive edge as anticipated performance-based funding emerges.

Purpose

To ultimately improve the availability and quality of substance abuse treatment services provided by South Carolina County Alcohol and Other Drug Abuse Authorities; thereby, reducing illness, death, disability and cost to South Carolina resulting from substance abuse. Additionally, coupled with the implementation of the KIS Enterprise client management system at the state level, these performance measures will lay the foundation to establish client data collection standards and uniform data evaluation; demonstrate treatment effectiveness and cost effectiveness of services; identify effective treatment practices; and enhance the Authorities' potential for obtaining new funding initiatives.

Indicators were developed to be:

- Results oriented
- Specific
- Meaningful
- Easily measured and understood
- Adjustable for exceptions
- Auditable (not easily manipulated)
- Feasible (already available or easy to add)
- Accountable

The intent is not to find fault with individual providers, but to improve our service delivery system by measuring indicators that are considered important to achieving effective quality services that lead to successful outcomes. To help providers achieve desired results, each measure includes recommended staff development training and system improvements necessary for optimal performance.

Performance Management System Components



Performance Management Systems consist of four broad components. All are very important. The first three components (planning, collecting and measuring) must all work effectively to produce the results needed for the fourth component to be successful, which by itself is as important as the other three, and that is using the results to manage agency and system practices to achieve optimal performance.

There will be management factors at the local and state levels and there will also be some management factors that will require system collaboration.

A performance management system that is excellent at collecting and measuring data is a failure if that data is not used properly to manage performance. This is why it is of utmost importance that all stakeholders understand and embrace the system. It is why

education, training and attaining trust is critical. It is why everyone must understand that feedback (both negative and positive) is important for the system to be successful. It is also important that appropriate channels are used to voice feedback and that concerns are voiced in a constructive manner rather than as an attack of the system.

Planning, collecting and measuring must be flexible enough to change as needs change and as caveats are identified that may warrant modifications or additions.

All the best planning in the World cannot foresee certain types of problems or obstacles that may be found once the data is analyzed. Finding these types of problems does not mean that planning has failed, but discovering and compensating for them means that the process is working. Understanding that the system is dynamic is very important, especially in the beginning, until the system becomes somewhat stable.

Structure

The performance measures are structured in four domains as follows. The measures with checkmark bullets have been approved for implementation in KIS. Remaining measures will be implemented as feasible. Delays in implementation of these measures are due to obstacles that must be addressed prior to implementation such as form and/or software modifications and/or staff training.

Access, Retention & Persons Served

- ✓ Penetration rates
- ✓ Proportion of clients who begin a bio-psycho-social-familial assessment within 2 working days of their intake
- ✓ Proportion of clients that begin a qualified service within 6 working days of their assessment
- Proportion of clients with 30 days of retention in services with at least 4 clinical services
- Proportion of no shows that are followed up with case management or client support service within 2 working days
- Proportion of clients leaving services prior to a planned discharge
- Proportion of eligible clients entering treatment (admitted clients)
- Proportion of total unique client population that is Medicaid

Effectiveness

- ✓ Proportion of clients with sustained reduction of use
- ✓ Increase in/no change in number of clients employed or in school at date of last service compared to first service
- ✓ Number of clients with increase in/no change in a stable housing situation from date of first service to date of last service
- ✓ Proportion of successful buys during the annual youth access to tobacco project

- ✓ Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service
- Proportion of clients participating in voluntary recovery or self-help activities in the last 30 days at 90-days post-discharge follow-up
- Reduction of emergency room use by clients
- Proportion of clients that completed services with “Major” or “Moderate” improvement at discharge
- Proportion of clients without a primary health physician with documented referral to one

Quality of Care & Client Satisfaction

- ✓ Proportion of clients that indicate they were satisfied with services received
- Proportion of surveyed clients who reported the care that they received was sensitive to their cultural background (race, religion, language, etc.)
- Proportion of clients who reported that services were available at times that were convenient for them
- Proportion of clients who report improved functioning as a result of services (deal with daily problems better, better control of life, better dealing with crisis, get along with family, better in social situations, better in school or work, better able to get and keep a job, housing situation has improved)
- Proportion of clients who report that their basic rights are respected

Administrative & Financial

- ✓ Proportion of clients surveyed around 90 days from their discharge
- ✓ Proportion of discharges dated within 30 days of the last service received
- Timeliness of MIS and REBA data submission
- Proportion of batched MIS data within 10 calendar days from the batch build date

Other possible administrative and financial measures are still under review.

Planning - Collecting - Measuring

Planning

A lot of planning has gone into this project. Some of the relevant aspects that resulted from planning that are not discussed elsewhere are discussed below.

All efforts have been made to fully define each measure and identify exclusions and risk adjustments to be considered during report design. Negative or positive factors are also defined in cases where exclusions cannot be made for variables that could affect results for a measure. Measure definitions are documented, and when the document is finalized, copies will be available on the DAODAS Website.

Some measures are prescriptive in that they are required through existing measurement systems such as contract objectives, the Governor's goals, state outcome measures, NOMS, contract requirements or the Government Performance Results Act of 1993 (GPRA). Other measures have been added to provide additional information in the form of management reports that can be used to evaluate underlying processes that may directly affect effectiveness or outcomes. The definition for each measure details whether the measure is already required by other management systems.

Some measures are new and will not have targets initially. If the data has been collected for some time, but hasn't been analyzed before, benchmarks will be set on historical data. If both the measure and the data are new, targets will be set after about a year of data collection when benchmarks can be set based on the data collected. If SAMHSA sets targets on any of the NOMS, at a minimum, those will be adopted.

All measures will be reviewed at least annually and evaluated for modification or removal based on standard review criteria and observations and feedback received during the year. Additional measures would also be evaluated at this time to meet evolving needs.

Collecting

Most treatment measures are based on data that is already collected through our Substance Abuse Agencies' Management Information System (SAAMIS) and will not require modifications to forms, screens or procedures. However, a few modifications will be necessary and training will be offered to cover these.

Collecting complete and accurate data and submitting it on time is a critical element to the accuracy and completeness of performance data.

Providers may discover the need for some changes in the way that they currently collect and report data as they research and evaluate their performance. Additional data collection standards will evolve from this process. System-wide standards will be developed by the FAC. This is addressed further under Managing.

Measuring

Performance monitoring reports are being developed in KIS Enterprise so that providers have access to the same reports used by the state. These reports are very flexible and can be produced by additional parameters that are not used by the state - reporting units and cost centers are examples of these parameters.

Access to these reports allows agencies to verify state reports using the same exact criteria, but the real benefit of the availability of these reports is that providers can run these reports well in advance of quarterly state reports and use the details provided to investigate cases that fail to meet a certain measure, and when the reasons for the

failure are due to data entry or data submission problems, these issues can be corrected and resubmitted prior to the official performance report. Therefore, the local reports are excellent supplemental QA tools.

These investigations of unqualified cases is where problems will be identified that may require changes with local practices, and in the beginning, may identify additional exceptions or exclusions that may need to be considered when reports are produced. This will be an excellent tool that must be used for the PMIS to succeed. As a warning, there may be some exceptional situations that occur on an infrequent basis that may not be possible to program as exceptions in a report because allowing certain exceptions may interfere with other processes that must be accounted for that may be of more importance. In other words, sometimes exceptions are in direct conflict with a standard to the point that you can't allow one without disallowing the other, and when the exception is not frequent, the standard must be maintained.

Managing

Local Level

Managing agency data will not only consist of using the data to identify data entry and submission problems mentioned above, but also evaluating the cases that remain.

For those cases that legitimately did not meet the measure, what could the agency do differently to raise performance levels in these cases? Are changes in agency practice needed? Are changes in system practice needed? Is in-house training needed? Is system-wide training needed? What are the roadblocks? How can better results be achieved?

Look for changes that could be made in

- Clinical practice
- Administrative practice
- Data collection
- Paper/data flow
- Data entry
- Data submission

The managing process, is not just managing your own agency in response to the performance data, but providing assistance for managing and improving the PMIS process. The proper channel for providing PMIS feedback is through the FAC. FAC membership is provided at the end of this document.

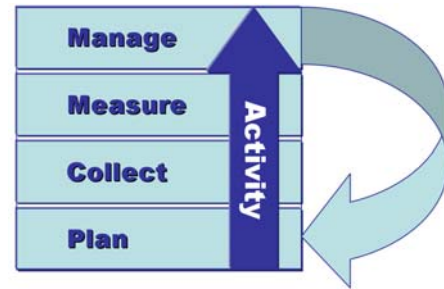
For those cases that didn't meet the measure due to an underlying cause that occurs regularly that you feel should be excluded from the measure, provide feedback to FAC.

If you find certain measures and reports to be particularly helpful, provide feedback to FAC.

If you have suggestions for system-wide changes or if you make agency changes that you feel may be helpful to others or that you think may need to be incorporated into data collection standards, share those with FAC.

State Level

The FAC will review provider feedback and DAODAS will develop additional edits and specify changes to reports as deemed necessary to ensure that data is as clean as possible and to ensure that the reports only measure cases that are appropriate for each measure.



DAODAS will be available to provide technical assistance to providers during the collecting, measuring and managing phases and must develop protocols and policies for:

- Incentives/Recognition/Rewards
- Improvement plans
- Real consequences for continued poor performance

It is our desire to eventually use the performance data along with other outcome data to produce an annual state report that will emphasize our successes.

Joint Management

Over the years some agencies or individuals have strayed from standard procedures, and this may influence analyzed data negatively or positively as compared to agencies that continue to follow standard practices. Also, some aspects of data collection may have never been standardized and the differences between various agency-developed standards or the lack of standards may also influence results.

The FAC will develop data collection standards to ensure that all agencies follow the same principles and procedures. These standards will further help providers meet established measures and will make comparisons of performance more equitable as all parties will be following the same procedures. These standards, along with all MIS modifications, will be documented in the SAAMIS Operations Manual and training will be provided to cover existing and new procedures, as well as all coding modifications.

FAC Representatives

Region I

Linda Doud
James Foster
Dan Neel

Region II

Anne Henry
Mary Irby
Phil Keenan

Region III

Winston McElveen
Paul Pittman
Wally Quinn

Region IV

Christine Durant
Cheryl Long
Ron Rickenbaker, Co-chair

DAODAS

Carol Hammond
Carl Kraeff
Jim Maxwell
Michelle Nienhius
Lillian Roberson, Co-chair

Performance Subcommittee Members

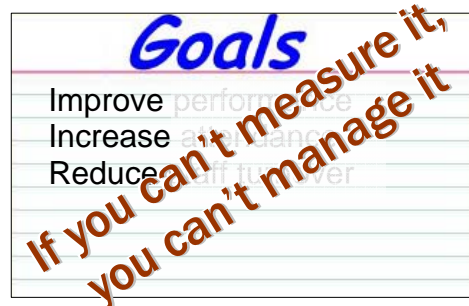
Carol Hammond, Chair
Anne Henry
Jim Maxwell
Paul Pittman
Ron Rickenbaker

Performance Measures For South Carolina County Alcohol and Other Drug Abuse Authorities

Purpose: To ultimately improve the availability and quality of substance abuse treatment services provided by South Carolina County Alcohol and Other Drug Abuse Authorities; thereby, reducing illness, death, disability and cost to South Carolina resulting from substance abuse. Additionally, coupled with the implementation of KIS Enterprise, these performance measures will lay the foundation to establish client data collection standards and uniform data evaluation; demonstrate treatment effectiveness and cost effectiveness of services; identify effective treatment practices; and enhance the Authorities' potential for obtaining new funding initiatives.

Indicators were developed to be:

Results oriented
Specific
Meaningful
Easily measured and understood
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Auditable (not easily manipulated)
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The intent is not to find fault with individual providers, but to improve our service delivery system by measuring indicators that are considered important to achieving effective quality services that lead to successful outcomes. To help providers achieve desired results, each measure includes recommended staff development training and system improvements necessary for optimal performance.

All efforts have been made to fully define each measure and identify [exclusions and risk adjustments](#) to be considered during report design. [Negative or positive factors](#) are also defined in cases where exclusions cannot be made for variables that could affect results for a measure.

Some measures are prescriptive in that they are required through existing measurement systems such as contract objectives, the Governor's goals, state outcome measures, national outcome measures (NOMs), contract requirements or the Government Performance Results Act of 1993 (GPRA). Other measures have been added to provide additional information in the form of management reports that can be used to evaluate underlying processes that may directly affect effectiveness or outcomes.

All measures will be reviewed annually and evaluated for modification or removal based on standard review criteria and observations and feedback received during the year. Additional measures would also be evaluated at this time to meet evolving needs.

Measures fall into four domains:

- Access, Retention & Persons Served
- Effectiveness
- Quality of Care & Client Satisfaction
- Administrative & Financial

Note that the priorities assigned to individual measures do not necessarily reflect the value of the measure. Priorities are based on the feasibility of implementation with consideration of limited resources.

All general client outcomes are based on surveys conducted on clients aged 12 and up. Surveys for children below 12 should be tailored for that age group.

These performance measures have been developed as a joint venture between the South Carolina Department of Alcohol and Other Drug Abuse Services (SC DAODAS) and the Behavioral Health System Association (BHSA) through the Finance and Accountability Committee and its Performance Subcommittee.

Measure:	Proportion of clients who begin a bio-psycho-social-familial assessment within 2 working days of their intake
Domain:	<input checked="" type="checkbox"/> Access/Retention/Persons Served <input type="checkbox"/> Quality of Care/Client Satisfaction <input type="checkbox"/> Effectiveness <input type="checkbox"/> Administrative/Financial
Type of Measure:	Prescriptive <input type="checkbox"/> National Outcome <input type="checkbox"/> GPRA <input type="checkbox"/> State Outcome <input type="checkbox"/> Governor's Goal <input checked="" type="checkbox"/> Contract Objective <input type="checkbox"/> Contract Requirement Non-Prescriptive <input type="checkbox"/> Management Report
Definition/Purpose:	Efficiency measure regarding timely access to services. It indicates the proportion of intakes that are followed by an assessment (020, 050 or 155) within 2 working days. Intake = full PCRf present
Exclusions/Risk Adjustments:	Excludes cases that are terminated within 2 working days following intake (this should exclude all clients that are inappropriate for care and referred outside of the agency for services). Excludes certain criminal justice cases where educational services are either mandated by law or requested by referral source, because these clients do not typically receive a bio-psycho-social assessment. For cases where the intake date is near the report end date, records are to be examined past the end date to determine if the objective was met.
Negative or Positive Factors:	None identified
Reporting Guidelines:	A full PCRf should be completed during the first face-to-face contact with the client. Administrative staff can complete the PCRf. An intake will no longer be assumed from the submission of orientation (011) or intake (010) services. A full PCRf must be present.
Training Issues:	None identified
Denominator(s):	Number of qualified intake records for the time period examined
Numerator(s):	Number of records from denominator with an assessment (defined above) service within 2 working days of the intake date
Data Source:	SAAMIS PCRf and DCSL records
Status:	Fully implemented. Changes are slated for FY10 to exclude detox and residential episodes of care; a review will be made to determine appropriateness of a goal adjustment due to changes in the definition of the measure. This should be an outpatient measure since assessment should be immediate in detox and residential levels of care and including these levels of care give the providers who offer them an unfair advantage over those who do not.
Goal:	75%
Frequency of State Report:	Quarterly
Recommended Frequency for Local Reports:	Monthly

Measure:	Proportion of clients that begin a qualified service within 6 working days of their assessment
Domain:	<input checked="" type="checkbox"/> Access/Retention/Persons Served <input type="checkbox"/> Quality of Care/Client Satisfaction <input type="checkbox"/> Effectiveness <input type="checkbox"/> Administrative/Financial
Type of Measure:	Prescriptive <input type="checkbox"/> National Outcome <input type="checkbox"/> GPRA <input type="checkbox"/> State Outcome <input type="checkbox"/> Governor's Goal <input checked="" type="checkbox"/> Contract Objective <input type="checkbox"/> Contract Requirement Non-Prescriptive <input type="checkbox"/> Management Report
Definition/Purpose:	<p>Efficiency measure regarding agency's ability to respond to the assessed needs of the person served. It measures the proportion of clients that receive a qualified service within 6 working days of their last assessment (020, 050 or 155).</p> <p><u>Qualified Services:</u> Detox or residential bed day (DRDL) or group counseling (060, 061), individual counseling (030, 031), IOP (195), day treatment (189), crisis intervention (040), IFS (050), TCT (155), gambling curriculum (095) NOVA curriculum (096), women's trauma curriculum (098), treatment team meeting with client present (142)</p>
Exclusions/Risk Adjustments:	<p>Level .5 admissions; admissions with discharges within 6 days of the assessment. For cases when the last assessment occurs near the end date of the report, records are examined past the end date to determine if the objective was met.</p>
Negative or Positive Factors:	Residential clients would raise the proportion for agencies that provide this service
Training Issues:	None identified
Denominator(s):	Number of qualified admissions with an assessment (defined above) during the time period examined.
Numerator(s):	Number of admissions from denominator with a qualified service (defined above) within 6 working days of the last assessment.
Data Source:	SAAMIS admission and service records
Status:	<p>Fully implemented.</p> <p>Changes are slated for FY10 to exclude detox and residential episodes of care; a review will be made to determine appropriateness of a goal adjustment due to changes in the definition of the measure. This should be an outpatient measure since assessment and service provision should be immediate in detox and residential levels of care, and including these levels of care, give the providers who offer them an unfair advantage over those who do not.</p>
Goal:	50%
Frequency of State Report:	Quarterly
Recommended Frequency for Local Reports:	Monthly

Glossary

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<p>AOD Diagnoses Back</p>	<p>2910, 2911, 2912, 2913, 2915, 29181, 29189, 2919, 2920, 29211, 29212, 29281, 29282, 29283, 29284, 29289, 2929, 30300, 30390, 30400, 30410, 30420, 30430, 30440, 30450, 30460, 30480, 30490, 30500, 30520, 30530, 30540, 30550, 30560, 30570, 30590</p>						
<p>Clinical Service Back</p>	<p>020, 021, 022, 023, 030, 040, 050, 060, 075, 076, 090, 091, 095, 096, 098, 142, 150, 155, 156, 170, 180, 189, 190, 191, 195</p>						
<p>Co-Occurring Disorders (Dual Diagnosis) Back</p>	<p>Primary qualified alcohol or drug diagnosis <u>and</u> secondary qualified mental health diagnosis</p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: center; border: none;">Primary AOD</th> <th style="text-align: center; border: none;">Secondary MH</th> </tr> </thead> <tbody> <tr> <td style="border: none;"> Alcohol Intoxication Alcohol Withdrawal Alcohol Induced Disorder Specified Alcohol Related Disorder Not Specified Alcohol Abuse Alcohol Dependence Cocaine Abuse Cocaine Dependence Marijuana Abuse Marijuana Dependence Heroin-Opioid Abuse Heroin-Opioid Dependence Stimulant Abuse Stimulant Dependence Sedative-Tranquilizer Abuse Sedative-Tranquilizer Dependence Hallucinogen Abuse Hallucinogen Dependence Inhalant-Other-Unspecified Drug Abuse Inhalant-Other-Unspecified Drug Dependence Drug Withdrawal Drug Induced Disorder Specified Multiple Alcohol-Drug Dependence </td> <td style="border: none;"> Major Depression Anxiety/Stress/Panic/Phobia/Obsessive Compulsive Schizophrenia Bipolar Disorders </td> </tr> <tr> <td style="border: none;"> <p>Qualified AOD Diagnoses: 30300, 29181, 2910, 2911, 2912, 2913, 2915, 29189, 2919, 30500, 30390, 30560, 30420, 30520, 30430, 30550, 30400, 30570, 30440, 30540, 30410, 30530, 30450, 30590, 30460, 30490, 2920, 29211, 29212, 29281, 29282, 29283, 29284, 29289, 2929, 30480</p> </td> <td style="border: none;"> <p>Qualified MH Diagnoses: 29620, 29621, 29622, 29623, 29624, 29625, 29626, 29630, 29631, 29632, 29633, 29634, 29635, 29636, 29690, 3004, 311, 29384, 29389, 30000, 30001, 30002, 30021, 30022, 30023, 30029, 3003, 3009, 3083, 30981, 29510, 29520, 29530, 29540, 29560, 29570, 29590, 29600, 29601, 29602, 29603, 29604, 29605, 29606, 29640, 29641, 29642, 29643, 29644, 29645, 29646, 29650, 29651, 29652, 29653, 29654, 29655, 29656, 29660, 29661, 29662, 29663, 29664, 29665, 29666, 2967, 29680, 29689, 30113</p> </td> </tr> </tbody> </table>	Primary AOD	Secondary MH	Alcohol Intoxication Alcohol Withdrawal Alcohol Induced Disorder Specified Alcohol Related Disorder Not Specified Alcohol Abuse Alcohol Dependence Cocaine Abuse Cocaine Dependence Marijuana Abuse Marijuana Dependence Heroin-Opioid Abuse Heroin-Opioid Dependence Stimulant Abuse Stimulant Dependence Sedative-Tranquilizer Abuse Sedative-Tranquilizer Dependence Hallucinogen Abuse Hallucinogen Dependence Inhalant-Other-Unspecified Drug Abuse Inhalant-Other-Unspecified Drug Dependence Drug Withdrawal Drug Induced Disorder Specified Multiple Alcohol-Drug Dependence	Major Depression Anxiety/Stress/Panic/Phobia/Obsessive Compulsive Schizophrenia Bipolar Disorders	<p>Qualified AOD Diagnoses: 30300, 29181, 2910, 2911, 2912, 2913, 2915, 29189, 2919, 30500, 30390, 30560, 30420, 30520, 30430, 30550, 30400, 30570, 30440, 30540, 30410, 30530, 30450, 30590, 30460, 30490, 2920, 29211, 29212, 29281, 29282, 29283, 29284, 29289, 2929, 30480</p>	<p>Qualified MH Diagnoses: 29620, 29621, 29622, 29623, 29624, 29625, 29626, 29630, 29631, 29632, 29633, 29634, 29635, 29636, 29690, 3004, 311, 29384, 29389, 30000, 30001, 30002, 30021, 30022, 30023, 30029, 3003, 3009, 3083, 30981, 29510, 29520, 29530, 29540, 29560, 29570, 29590, 29600, 29601, 29602, 29603, 29604, 29605, 29606, 29640, 29641, 29642, 29643, 29644, 29645, 29646, 29650, 29651, 29652, 29653, 29654, 29655, 29656, 29660, 29661, 29662, 29663, 29664, 29665, 29666, 2967, 29680, 29689, 30113</p>
Primary AOD	Secondary MH						
Alcohol Intoxication Alcohol Withdrawal Alcohol Induced Disorder Specified Alcohol Related Disorder Not Specified Alcohol Abuse Alcohol Dependence Cocaine Abuse Cocaine Dependence Marijuana Abuse Marijuana Dependence Heroin-Opioid Abuse Heroin-Opioid Dependence Stimulant Abuse Stimulant Dependence Sedative-Tranquilizer Abuse Sedative-Tranquilizer Dependence Hallucinogen Abuse Hallucinogen Dependence Inhalant-Other-Unspecified Drug Abuse Inhalant-Other-Unspecified Drug Dependence Drug Withdrawal Drug Induced Disorder Specified Multiple Alcohol-Drug Dependence	Major Depression Anxiety/Stress/Panic/Phobia/Obsessive Compulsive Schizophrenia Bipolar Disorders						
<p>Qualified AOD Diagnoses: 30300, 29181, 2910, 2911, 2912, 2913, 2915, 29189, 2919, 30500, 30390, 30560, 30420, 30520, 30430, 30550, 30400, 30570, 30440, 30540, 30410, 30530, 30450, 30590, 30460, 30490, 2920, 29211, 29212, 29281, 29282, 29283, 29284, 29289, 2929, 30480</p>	<p>Qualified MH Diagnoses: 29620, 29621, 29622, 29623, 29624, 29625, 29626, 29630, 29631, 29632, 29633, 29634, 29635, 29636, 29690, 3004, 311, 29384, 29389, 30000, 30001, 30002, 30021, 30022, 30023, 30029, 3003, 3009, 3083, 30981, 29510, 29520, 29530, 29540, 29560, 29570, 29590, 29600, 29601, 29602, 29603, 29604, 29605, 29606, 29640, 29641, 29642, 29643, 29644, 29645, 29646, 29650, 29651, 29652, 29653, 29654, 29655, 29656, 29660, 29661, 29662, 29663, 29664, 29665, 29666, 2967, 29680, 29689, 30113</p>						
<p>Dependence Diagnoses Back</p>	<p>303.90, 304.40, 304.30, 304.20, 304.50, 304.60, 304.00, 304.60, 304.10, 304.80, 304.90</p>						
<p>Exclusions & Risk Adjustments Back</p>	<p>Excludes records that meet criteria that would be inappropriate or could negatively impact the intent of the measure. Example – “Proportion of admitted clients” excludes clients with diagnoses or problems other than AOD in nature and clients that are referred elsewhere for services. This means that the measure would only include AOD clients that were appropriate for care at your agency and determines the proportion that was admitted.</p>						
<p>Negative or Positive Factors Back</p>	<p>When exclusions cannot be made for variables that could affect results for a measure, those variables are defined as negative or positive factors including how they could impact a provider’s results, if those variables exist.</p>						

<p>Outside Referral</p> <p>Back</p>	<p>A referral to an outside entity including the following referral codes:</p> <table border="0"> <tr> <td>520, General Medical Hospital</td> <td>650, AA</td> </tr> <tr> <td>521, Emergency Room/Trauma Center</td> <td>660, Al-A-Non, Alateen</td> </tr> <tr> <td>540, VA Hospital</td> <td>665, NA</td> </tr> <tr> <td>550, Private Physician</td> <td>700, Social or Community Service Agency</td> </tr> <tr> <td>555, DHEC</td> <td>701, DSS</td> </tr> <tr> <td>560, State Psychiatric Hospital</td> <td>702, DSS, TANF</td> </tr> <tr> <td>565, Private Psychiatric Hospital</td> <td>703, Housing Assistance</td> </tr> <tr> <td>570, Community Mental Health Center</td> <td>704, DSS, Child Protective Services</td> </tr> <tr> <td>575, Private Psychiatrist/Psychologist</td> <td>705, VR</td> </tr> <tr> <td>580, Morris Village</td> <td>706, DSS, Food Stamps</td> </tr> <tr> <td>581, Palmetto Center</td> <td>710, Employment Services Agency</td> </tr> <tr> <td>582, Holmesview</td> <td>722, Family Court</td> </tr> <tr> <td>585, County AOD Inpatient Program</td> <td>760, Law Enforcement</td> </tr> <tr> <td>589, Other AOD Inpatient Program</td> <td>766, DJJ</td> </tr> <tr> <td>590, County Detoxification Unit</td> <td>770, Pre-trial Intervention</td> </tr> <tr> <td>593, Other Detoxification Unit</td> <td>780, Attorney/Legal Aid</td> </tr> <tr> <td>600, County AOD Halfway House</td> <td>870, School, Grades 1-12</td> </tr> <tr> <td>610, Other AOD Halfway House</td> <td>871, School, Post High School</td> </tr> <tr> <td>630, County AOD Outpatient Program</td> <td>920, Church</td> </tr> <tr> <td>635, County AOD IOP</td> <td>960, Other</td> </tr> <tr> <td>640, Other AOD Outpatient Program</td> <td></td> </tr> </table>	520, General Medical Hospital	650, AA	521, Emergency Room/Trauma Center	660, Al-A-Non, Alateen	540, VA Hospital	665, NA	550, Private Physician	700, Social or Community Service Agency	555, DHEC	701, DSS	560, State Psychiatric Hospital	702, DSS, TANF	565, Private Psychiatric Hospital	703, Housing Assistance	570, Community Mental Health Center	704, DSS, Child Protective Services	575, Private Psychiatrist/Psychologist	705, VR	580, Morris Village	706, DSS, Food Stamps	581, Palmetto Center	710, Employment Services Agency	582, Holmesview	722, Family Court	585, County AOD Inpatient Program	760, Law Enforcement	589, Other AOD Inpatient Program	766, DJJ	590, County Detoxification Unit	770, Pre-trial Intervention	593, Other Detoxification Unit	780, Attorney/Legal Aid	600, County AOD Halfway House	870, School, Grades 1-12	610, Other AOD Halfway House	871, School, Post High School	630, County AOD Outpatient Program	920, Church	635, County AOD IOP	960, Other	640, Other AOD Outpatient Program	
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<p>Qualified Services</p> <p>Back</p>	<p>Certain measures are based on services that qualify as appropriate for a particular measure. This is usually a subset of clinical services.</p>																																										
<p>Unique Client</p> <p>Back</p>	<p>Excludes multiple intakes or admissions during the examined period. Each client is counted once versus counting the total number of intakes or the total number of admissions during the time period. A unique client is normally determined by agency code and client number, but periodic analysis of the data using other identifying information reveals clients that have multiple client numbers with the same provider. In the future, these situations will be brought to the attention of the provider and they will be asked to merge the duplicate client numbers and submit corrected data to DAODAS. SAMHSA wants the states to be able to identify unique clients across providers. This is a challenge that we will be addressing in the coming year.</p>																																										

DAODAS Performance Management System

Access, Retention, Persons Served		Effectiveness		Quality of Care / Client Satisfaction		Administrative / Financial	
Measure	Minimum Goal	Measure	Minimum Goal	Measure	Minimum Goal	Measure	Minimum Goal
Proportion of clients who begin an assessment within 2 working days of intake	75%	Proportion of clients with sustained reduction of use	40%	Proportion of clients that indicate they were satisfied with services received	TBD	Proportion of clients surveyed around 90 days (70 to 1110 days) from their discharge	15%
Proportion of clients that begin a qualified service within 6 working days of their assessment	50%	Increased or sustained numbers of clients employed or in school at date of last service compared to first service	20%	Proportion of clients who reported the care they received was sensitive to their cultural background	TBD	Proportion of discharges dated within 30 days of the last service received	99%
Penetration Rate (clients served compared to citizens in need)	TBD	Increased or sustained numbers of clients in stable housing from date of first service to date of last service	40%	Proportion of clients who report improved functioning as a result of services	TBD	Timeliness of weekly MIS data submission	No more than 2 weeks late (with reasonable justification)
Proportion of Clients with 30 days of retention in services and at least 4 clinical services	TBD	Proportion of successful buys during the annual youth access to tobacco project	10%	Proportion of clients who report that their basic rights are respected	TBD	Timeliness of REBA (Revenue, Expenditure and Budget Analysis) data submission	TBD
Proportion of no shows that are contacted within 2 working days	TBD	Reduction of emergency room use by clients	40%			Proportion of MIS data that is within 10 calendar days from the weekly batch build date	TBD
Proportion of clients leaving services prior to a planned discharge	TBD	Reduced or sustained numbers of arrests in past 30 days	TBD			Average cost per person by type of service	TBD
Proportion of admitted clients (clients admitted compared to clients with an intake)	TBD	Proportion of clients participating in voluntary recovery or self-help activities in the last 30 days at post-discharge follow-up	TBD				
Proportion of client population that is Medicaid	TBD	Proportion of clients that completed services with major or moderate improvement at discharge	TBD				
Proportion of clients who reported that services were available at times that were convenient for them	TBD	Proportion of clients without a primary health physician with documented referral to one	TBD				

TBD = To be determined based on baseline data. Some measures do not yet have established goals due to various reasons; largely because some measures are either in the early stages of implementation or have not yet been implemented.