

Kentucky Department for Behavioral Health,  
Developmental and Intellectual Disabilities

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# **BHDID Performance Indicator Implementation Guide**

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Applicable to State Fiscal Year 2025 Contracts

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## **KENTUCKY DBHDID CONTRACTUAL PERFORMANCE INDICATORS OVERVIEW 2025**

Annually, the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) contracting processes are becoming more performance based. The CMHC Payment section of the CMHC contract describes the accountability associated with Performance Indicators (PIs). This guide describes the PIs associated with the SFY25 Contracts and is posted at <https://dbhdid.ky.gov/cmhc/pi.aspx>.

Performance Indicators (PIs) focus on systemic outcomes of services provided by Kentucky's Community Mental Health Centers and other providers. The PIs are categorized into domains of measure including Access, Evidence-Based Services, Quality of Information, Engagement and Retention, Community Integration, and Continuity of Care. Within these domains, outcome aims are designed to improve the system of care and the integration of services provided in the community, residential crisis stabilization, and psychiatric hospitals.



Funding Source	Performance Indicator	Incentive Amount per Indicator
<p><b>DIVERTS:</b> Total of 6% DIVERTS funding</p>	<p><b>DIVERTS1: 14-Day Follow-up for Accessible Referrals Made to the Settlement Agreement Data Tracking Tool</b></p> <p>The DBHDID shall assess the percentage of accessible referrals made during the current monitoring period which received an InReach service. The CMHC must conduct an InReach service within fourteen (14) days of the referral date for 90% of the accessible referrals made during the monitoring period.</p> <p><b>Risk: 3% of DIVERTS funding</b></p> <p><b>DIVERTS2: Hospital Readmissions for CMHC Referrals – 30 Days</b></p> <p>The DBHDID shall assess the percentage of individuals discharged from state owned or state-operated psychiatric hospitals with a referral for treatment to the CMHC as a provider of community behavioral health services that were subsequently readmitted to any Kentucky state-owned or state-operated psychiatric hospital within thirty (30) days of the previous discharge date.</p> <p><b>Risk: 3% of DIVERTS funding</b></p>	<p><b>3%</b></p> <p><b>3%</b></p>
<p><b>SMI:</b> Total of 1% allocated SMI funding</p>	<p><b>SMI1: Peer Services for Adults with SMI</b></p> <p>The DBHDID shall assess the percentage of individuals receiving Peer Support Services from the CMHC as a provider of community behavioral health services. The assessment will compare the measure across two subsequent monitoring periods. The expected standard of performance is an increase in the percent of adults having SMI who receive Adult Mental Health Peer Services.</p> <p><b>Risk: 1% of SMI funding</b></p>	<p><b>1%</b></p>

Funding Source	Performance Indicator	Incentive Amount Per Indicator
<p><b>SED:</b> Total of 2.5% allocated SED funding</p>	<p><b>SED2: Child Population with SED Who Receive Targeted Case Management</b></p> <p>The DBHDID shall assess the percentage of the region’s estimated SED population that are served as SED clients and receive Targeted Case Management service. The region’s estimated SED population is defined as the estimated number of children and youth with SED in the region (5.0% of total child population per 2020 census). The expected standard of performance is 8% for the current monitoring period. That is, Regions serve 8% of the estimated 5% of the population under age 18.</p> <p><b>Risk: 2% of SED funding</b></p>	<p>2%</p>
	<p><b>SED3: Peer Services for Children and Youth</b></p> <p>The DBHDID shall assess the percentage of children and youth receiving Peer Support Services from the CMHC as a provider of community behavioral health services. The assessment will compare the measure across two subsequent monitoring periods. The expected standard of performance is an increase in the percent of children and youth who receive Peer Support Services.</p> <p><b>Risk: 0.5% of SED funding</b></p>	<p>0.5%</p>
<p><b>SU Prevention:</b> Total of 2% allocated Block Grant Prevention funding</p>	<p><b>SUP1: Regional Prevention Centers Use of Community-Based Process Strategy</b></p> <p><b>Measure #1 applies to all CMHC regions operating a Regional Prevention Center.</b></p> <p>The DBHDID shall assess the usage of the Center for Substance Abuse Prevention (CSAP)-supported strategy “Community-Based Process” (CBP). The DBHDID will use the Prevention Data System to calculate the percentage of completed activities that are appropriately reported by the center under the “Community-Based Process” CSAP Strategy. The expected standard of performance for each respective center is maintenance of a minimum of 70% of completed activities that are appropriately reported under “Community-Based Process” in the Prevention Data System during the current monitoring period.</p> <p><b>Risk: 1% of Block Grant Prevention funding</b></p>	<p>1%</p>
	<p><b>SUP2: Regional Prevention Centers Total Time of Prevention Activities Entered in the Prevention Data System</b></p> <p><b>Measure #2 applies to all CMHC regions operating a Regional Prevention Center</b></p> <p>The DBHDID’s evaluation of data submitted to the Prevention Data System indicated that our state needs to focus on ensuring that all activities are reported in the PDS. This performance indicator is intended to emphasize the importance of inputting all prevention activities delivered into the PDS</p>	<p>1%</p>

	<p>in order to accurately and completely articulate the prevention efforts delivered, as required by the Substance Use Prevention, Treatment and Recovery Services Block Grant and prevention-focused discretionary grants. The expected standard of performance for each respective center is entry of a minimum of 50% of available time, as measured on the 110D as submitted during the Plan &amp; Budget process.</p> <p><b>Risk: 1% of Block Grant Prevention funding</b></p>	
<p><b>SU Treatment:</b> Total of 4% allocated SU Treatment funding</p>	<p><b>SUD1: Percent of Census Population Served</b> This measure calculates the percentage of the census population served that are estimated in need of treatment. <b>Risk: 0% of SUD funding</b></p> <p><b>SUD2: Number of Services per Treatment Episode</b> This measure calculates the average number of outpatient services provided for Treatment Episodes Data Set (TEDS) episodes which lasted for thirty (30) days or longer. <b>Risk: 1% of SUD funding</b></p> <p><b>SUD3: Percent of Treatment Episodes Lasting Thirty (30) Days or Longer</b> This measure calculates the percent of outpatient TEDS Episodes which lasted thirty (30) days or longer. <b>Risk: 1% of SUD funding</b></p> <p><b>SUD4: Number of Services in the First Thirty (30) Days</b> This measure calculates the number of outpatient services provided during the first thirty (30) days post admission. <b>Risk: 1% of SUD funding</b></p> <p><b>SUD5: TEDS Data Accuracy</b> This measure monitors the accuracy of client fields reported in the Treatment Episode Data Set (TEDS). <b>Risk: 1% of SUD funding</b></p>	<p><b>0%</b></p> <p><b>1%</b></p> <p><b>1%</b></p> <p><b>1%</b></p> <p><b>1%</b></p>

Funding Source	Performance Indicator	Incentive Amount per Indicator
<p><b>Developmental and/or Intellectual Disabilities (DID):</b> Total of 2% allocated I/DD general funds</p>	<p><b>I/DD3: Consistency and accuracy of client’s reported receiving SGF services.</b></p> <p>The DBHDID shall assess the accuracy and consistency of information reported via the Form 140 with client listing report as due through the Department Periodic Report processes. The form is due by the end of the calendar month following the end of each quarter.</p> <p>Consistency and accuracy of information reported will be determined by review of form 140 with client listing to verify that the form is complete, submitted timely, and number of clients reported receiving each SGF service is the same on both reports for the same period.</p> <p><b>Risk: 1% of DDID funding</b></p> <p><b>I/DD5: Incident reporting follow up.</b></p> <p>The DBHDID must ensure that all reported critical incidents have follow-up completed and submitted timely for individuals receiving SGF or PASRR services who are identified as having an intellectual or developmental disability. CMHCS are required to submit follow-ups for all critical incident reports within 10 days of the discovery/submission of the incident report. DBHDID shall assess the rate of timely submitted follow-ups for the reporting period. The expected performance standard is that 75% of all critical incident follow-ups are submitted timely.</p> <p><b>Risk: 1% of DDID funding</b></p>	<p><b>1%</b></p> <p><b>1%</b></p>

**SECTION 2.01–KENTUCKY EMERGENCY RESPONSE AND CRISIS PREVENTION SYSTEM (CRISIS)**

**Domain: Continuity of Care CRISIS4A: Continuing Care Engagement Following Crisis Services for Adults**

**CRISIS4A applies to all CMHCs.**

The DBHDID must ensure that clients receive ongoing engagement of services following an episode of crisis care. DBHDID shall assess the rate of follow-up for the region’s clients who experienced an episode of residential crisis stabilization, or received a Mobile Crisis Response, Crisis Intervention, or I/DD Crisis Prevention service. The expected standard of performance is that clients must receive a service within thirty (30) calendar days after an episode of crisis care. The measure includes only services that occur between the first day of the monitoring period and thirty (30) or more calendar days before the end of the monitoring period. The rate of follow-up must be at or above 45%.

**Evidence of an episode of crisis care is defined by one or more of the following two circumstances:**

- 1) The occurrence of one or more days of consecutive residential crisis service events in the event file as specified in the table below.
- 2) The occurrence of Mobile Crisis Response, Crisis Intervention, or I/DD Crisis Prevention service in the event file as specified in the table below.

<b>Service Name</b>	SFY14 Service Code as entered in event file field NTE02 (DMHMRS_Modifier_1) “BHDID Service Code”	SFY15, SFY16, SFY17, SFY18, SFY19, SFY20, SFY21, SFY22, SFY23, SFY24 Service Code as entered in event file field NTE02 (DMHMRS_Modifier_1) “BHDID Service Code”
Mobile Crisis Response	076	176
I/DD Crisis Prevention	091	191
Crisis Intervention	n/a	200, 210, 211
Residential Crisis Stabilization (MH Adults)	138	138*
Residential Crisis Stabilization (MH Children & Youth)	139	139*

*\* Service Codes 138 and 139 will not apply to providers that do not have a CMHC-operated Crisis Stabilization Unit for adults or children.*

**Risk: 1% of total emergency services funding**

**Rationale:** Engagement is critical for treatment success and foundational for a recovery-oriented system. This measure demonstrates a high-performance gap area; evidence shows that follow-up is a significant problem for individuals having mental illness compared to the general population. Guidelines of the National Institute of Mental Health and the Centers for Mental Health Services indicate that outcomes are poorer when follow up does not occur. An outpatient visit with a mental health practitioner after discharge from crisis care is recommended to make sure that patients’ transitions to the home or work environment is supported and that gains made while in crisis care are not lost. This helps health care providers detect early post-hospitalization reactions or medication problems while providing continuing care. This contract performance measure is adapted from NCQA Guidelines to involve Kentucky’s billable crisis services.

Numerator: Of the clients counted in the denominator, the number of clients receiving at least one (1) service within thirty (30) calendar days following the last day of a residential crisis stabilization or a mobile crisis response, crisis intervention, or I/DD crisis prevention service(s). The service must be a valid service code according to the DBHDID Data Implementation Guide (specifically Appendix E) and reported in the Event file. The follow-up service does not have to be provided by the same CMHC that delivered the crisis service(s). Clients receiving only an episode of crisis care within the thirty days is not included in the numerator. Services that occur on the same day as the crisis service do not apply.

Denominator: The number of the region's clients that are age 18 or older having an episode of residential crisis stabilization lasting one (1) or more calendar days or receiving a Mobile Crisis Response, Crisis Intervention, or I/DD Crisis Prevention Service. "Region's client" is defined by clients having "client status" 1 in the client file and by the occurrence of a non-crisis service within ninety (90) calendar days prior to the current episode of crisis care. The service delivered 90 days prior to the current episode of crisis care are to be delivered by the same provider and will be followed by a gap in crisis events. The service delivered 90 days prior to the current crisis episode will not include the five crisis services in the table above (Residential Crisis Stabilization-MH Children & Youth, Residential Crisis Stabilization- Adults, Mobile Crisis Response, Crisis Intervention, and I/DD Crisis Prevention Service).

Benchmark: The expected standard of performance is that clients must receive a service within thirty (30) days after an episode of crisis care. The last completed three (3) years of data were used to determine the target.

Target: The 30-day rate of follow-up must be at or above 45%.

Monitoring Period: April 1, 2024, through March 31, 2025

Data Sources:

Numerator Source: Event Data Set (field "NTE02 DMHMRS\_Modifier\_1")

Denominator Source: Client Data Set (fields "Client Status" and diagnoses); Event Data Set (field "NTE02 DMHMRS\_Modifier\_1")

Baseline: The statewide median value for the last completed four (4) years of data.

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

References:

The National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS) 2015 technical specifications for Accountable Care Organization (ACO) measurement. Washington (DC): National Committee for Quality Assurance (\*NCQA); 2014. Measure #0576 (FUH-AD) which measures follow-up for persons having schizophrenia discharged from psychiatric hospital. This contract performance measure is adapted to involve Kentucky's system of Crisis Residential Service and billable crisis services.

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**Domain: Continuity of Care Proposed CRISIS4C: Continuing Care Engagement Following Crisis Services for Children**

**CRISIS4C applies to all CMHCs.**

The DBHDID must ensure that clients receive ongoing engagement of services following an episode of crisis care. The DBHDID shall assess the rate of follow-up for the region's clients who experienced an episode of residential crisis stabilization or received a Mobile Crisis Response, Crisis Intervention, or I/DD Crisis Prevention service. The

expected standard of performance is that clients must receive a service within thirty (30) calendar days after an episode of crisis care. The measure includes only services that occur between the first day of the monitoring period and thirty (30) or more calendar days before the end of the monitoring period. The rate of follow-up must be at or above 45%.

Evidence of an episode of crisis care is defined by one or more of the following two circumstances:

- 1) The occurrence of three or more days of consecutive residential crisis service events in the event file as specified in the table below.
- 2) The occurrence of Mobile Crisis Response, Crisis Intervention, or I/DD Crisis Prevention service in the event file as specified in the table below.

Service Name	SFY14 Service Code as entered in event file field NTE02 (DMHMRS_Modifier_1) "BHDID Service Code"	SFY15, SFY16, SFY17, SFY18, SFY19, SFY20, SFY21, SFY22, SFY23, SFY24 Service Code as entered in event file field NTE02 (DMHMRS_Modifier_1) "BHDID Service Code"
Mobile Crisis Response	076	176
I/DD Crisis Prevention	091	191
Crisis Intervention	n/a	200, 210, 211
Residential Crisis Stabilization (MH Adults)	138	138*
Residential Crisis Stabilization (MH Children & Youth)	139	139*

*\* Service Codes 138 and 139 will not apply to providers that do not have a CMHC-operated Crisis Stabilization Unit for adults or children.*

**Risk: 1% of total emergency services funding**

Rationale: Engagement is critical for treatment success and foundational for a recovery-oriented system. This measure demonstrates a high-performance gap area; evidence shows that follow-up is a significant problem for individuals having mental illness compared to the general population. Guidelines of the National Institute of Mental Health and the Centers for Mental Health Services indicate that outcomes are poorer when follow up does not occur. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that patients' transitions to the home or work environment are supported and that gains made during hospitalizations are not lost. It also helps healthcare providers detect early post-hospitalization reactions or medication problems and provide continuing care. This contract performance measure is adapted from NCQA Guidelines to involve Kentucky's billable crisis services.

Numerator: Of the clients counted in the denominator, the number of clients receiving at least one (1) service within thirty (30) calendar days following the last day of a residential crisis stabilization episode of care or a mobile crisis response, crisis intervention, or I/DD crisis prevention service(s). The service must be a valid service code according to the DBHDID Data Implementation Guide (specifically Appendix E) and reported in the Event file. The follow-up service does not have to be provided by the same CMHC that delivered the crisis service(s). Clients receiving another episode of crisis care within the thirty days is not included in the numerator. Services that occur on the same day as the crisis service do not apply.

Denominator: The number of the region's clients that are under age 18 having an episode of residential crisis stabilization lasting three (3) or more calendar days or receiving a Mobile Crisis Response, Crisis Intervention, or I/DD Crisis Prevention Service. "Region's client" is defined by clients having "client status" 1 in the client file and by

the occurrence of a non-crisis service within ninety (90) calendar days prior to the current episode of crisis care. The service delivered 90 days prior to the current episode of crisis care are to be delivered by the same provider and will be followed by a gap in crisis events. The service delivered 90 days prior to the current crisis episode will not include the five crisis services in the table above (Residential Crisis Stabilization-MH Children & Youth, Residential Crisis Stabilization- Adults, Mobile Crisis Response, Crisis Intervention, and I/DD Crisis Prevention Service).

Benchmark: The expected standard of performance is that clients must receive a service within thirty (30) days after an episode of crisis care as defined above. For current contracts, the last completed three (3) years of data were used to determine the target.

Target: The 30-day rate of follow-up must be at or above 45%.

Monitoring Period: April 1, 2024, through March 31, 2025

Data Sources:

Numerator Source: Event Data Set (field “NTE02 DMHMRS\_Modifier\_1”)

Denominator Source: Client Data Set (fields “Client Status” and diagnoses); Event Data Set (field “NTE02 DMHMRS\_Modifier\_1”)

Baseline: The statewide median value for the last completed four (4) years of data.

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

References:

The National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS) 2015 technical specifications for Accountable Care Organization (ACO) measurement. Washington (DC): National Committee for Quality Assurance (\*NCQA); 2014. Measure #0576 (FUH-CH) which measures follow-up for persons having schizophrenia discharged from psychiatric hospital. This contract performance measure is adapted to involve Kentucky’s system of billable crisis services and Crisis Residential Service since no psychiatric hospitals operate for children in the state. The children’s version of this measure (CRISIS4C) is modeled after the Centers for Medicare & Medicaid Services Core Set of Children’s Health Care Quality Measures (Child Core Set) which includes only ages 6 to 20 which is an adaption from the HEDIS measure of ages 6 and older.

Regarding the denominator used for the children’s measure (CRISIS04C), the three-day length of stay is included to intentionally exclude children and youth in Crisis Stabilization Units (CSUs) as an indirect consequence of legislation-driven system of care changes. For example, instead of children going into detention, they may be cared for in a CMHC-Operated CSU for a few days.

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**SECTION 2.02–DIRECT INTERVENTION: VITAL EARLY RESPONSIVE TREATMENT SYSTEM (DIVERTS) Domain:  
Community Integration DIVERTS1: 14-Day Follow-up for Accessible Referrals Made to the Settlement Agreement  
Data Tracking Tool**

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

**Goal: Follow-up on Accessible Referrals Risk: 3% of DIVERTS funding**

Rationale: The Amended Settlement Agreement (ASA) between the Cabinet for Health and Family Services and the Department for Public Advocacy was effective December 2, 2015, through September 30, 2018. The Third Amended Settlement Agreement (TASA) became effective on July 1, 2023. Embedded in these agreements are expected efforts to support adults with serious mental illness who desire to live in the community instead of a personal care home. Per the agreements, an In-Reach service is expected to be provided within 14 days of the referral date for persons referred to the Settlement Agreement Data Tracking Tool.

Numerator: The number of accessible referrals made to the Settlement Agreement Data Tracking Tool during the monitoring period for which a valid In-Reach service occurred within fourteen (14) calendar days of the referral date and for which this valid In-Reach service has a valid date recorded in the Data Tracking Tool.

Denominator: The number of accessible referrals made to the Settlement Agreement Data Tracking Tool during the monitoring period. Referrals will be grouped by CMHCs according to the county where the person resides, or the hospital discharge location as specified in the referral form.

Target: The CMHC must conduct an In-Reach service within fourteen (14) days of the referral date for 90% of the accessible referrals made to the Settlement Agreement Data Tracking Tool during the monitoring period which are assigned to the CMHC according to the location specified on the referral form.

Monitoring Period: April 1, 2024, through March 31, 2025

Data Sources:

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

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

Baseline: The original expectation was developed within the initial Interim Settlement Agreement (ISA) (2013) and was carried over into the Amended Settlement Agreement (ASA) in 2015, then into the Second Amended Settlement Agreement (SASA) on October 1, 2018, and then into the Third Amendment Settlement Agreement (TASA) effective July 1, 2023. This measure has remained constant throughout the life of ISA, ASA, SASA, & TASA.

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

Reference: The Third Amended Settlement Agreement (TASA) between the Department for Public Advocacy and the Cabinet for Health and Family Services.

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**Domain: Continuity of Care DIVERTS2: Hospital Readmissions for CMHC Referrals – 30 Days**

The DBHDID shall assess the percentage of individuals discharged from state-owned or state-operated psychiatric hospitals with a referral for treatment to the CMHC as a provider of community behavioral health services that were subsequently readmitted to any Kentucky state-owned or state-operated psychiatric hospital within thirty (30) days of the previous discharge date.

**Risk: 3% of DIVERTS funding**

Rationale: Expectations and deliverables in section 2.02 DIVERTS of the contract intend to build into the adult system of care transitions from acute care setting into the community. Additional expectations include attending Continuity of Care Committee meetings and working collaboratively with state psychiatric hospitals toward community integration and continuity of care. This performance indicator focuses on the transition from inpatient to outpatient care by monitoring the 30-day state psychiatric hospital readmission rate. The National Committee for Quality Assurance (NCQA) recognizes that lack of outpatient follow-up within a week of discharge from a 24-hour inpatient facility is associated with hospital readmissions. For persons with Serious Mental Illness, the period directly following hospitalization carries many risks. These include a relapse of their symptoms and the need for hospital readmission, an increased risk of homelessness and the possibility of violent behavior or suicide.

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

Denominator: The count of individuals discharged from state-owned or state-operated psychiatric hospitals (ARH Hazard Psychiatric Unit, Central State Hospital, Eastern State Hospital, Western State Hospital) with a referral for treatment to the CMHC as a provider of community behavioral health services. The discharge referral must be to the same CMHC who provided a service within forty-five (45) days prior to the psychiatric hospital admission. "Client Status 1" as indicated in Client field #6 and "Severe Mental Illness" as indicated in Client field #40 "SMI" (answer value 1 = yes) must apply to the client during the monitoring period.

Target: The CMHC's rate for the monitoring period must be equal to or less than the 75<sup>th</sup> quantile mark of the CMHC's rate calculated over the past five monitoring periods.

Monitoring Period: April 1, 2024, through March 31, 2025

Data Sources:

Numerator Source: Facility (psychiatric hospital) admission data

Denominator Source: Facility (psychiatric hospital) discharge data which have a treatment for referral to the CMHC. Client Data Set: field #6 (Client Status Code) = 1 and field #40 (SMI=1).

Baseline: The last five completed years of data are used to determine the target for each CMHC's rate.

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

Reference:

The Healthcare Effectiveness Data and Information Set (HEDIS), National Committee for Quality Assurance (NCQA). National Association of State Mental Health Program Directors (NASMHPD), Assessment #3, Care Transition Interventions to Reduce Psychiatric Re-Hospitalizations. Study supported by the Center for Mental Health Services (CMHS)/Substance Abuse and Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services (HHS).

Cuffel B.J., Held M., and Goldman W., Predictive Models and the Effectiveness of Strategies for Improving Outpatient Follow-Up under Managed Care. *Psych Serv* 2002; 53:1438 – 1443 (November 2002).

Nelson E.A., Maruish M.E., and Axler J.L., Effects of Discharge Planning and Compliance with Outpatient Appointments on Readmission Rates. *Psych Serv* 2000; 51(7):885 – 889 (July 2002).

Olfson M., Gameroff M.J., Marcus S.C., *et al*, Emergency Treatment of Young People Following Deliberate Self-Harm, *Arch Gen Psychiatry* 2005;62(10):1122 – 1128 (October 2005).

**SECTION 2.03—SERVICES FOR ADULTS WITH A SERIOUS MENTAL ILLNESS (SMI)**

**SMI1: Peer Services for Adults with SMI who meet criteria for the service**

The DBHDID shall assess the percentage of individuals receiving Peer Support Services from the CMHC as a provider of community behavioral health services. The assessment will compare the measure across two subsequent monitoring periods. The expected standard of performance is an increase in the percent of adults having SMI who receive Adult Mental Health Peer Services.

**Risk: 1% of SMI funding**

Rationale: Deliverables in section 2.02 DIVERTS of the contract include 2.0 FTE Adult Certified Peer Support Specialists targeted to serve individuals transitioning from an institutional setting which is in addition to the 0.50 FTE requirement for Assertive Community Treatment (ACT) teams. This performance indicator is intended to coordinate with the expectation that Peer Services are provided to persons having Serious Mental Illness outside of ACT. It is also the intention of the DBHDID to align priority areas of federal reporting requirements and deliverables within provider contracts. This Indicator design is parallel to that for multiple populations served by DBHDID (SED and SMI).

Time 1 (T1) The count of adult individuals having SMI who received any one of the following Peer Support Services from the CMHC as a provider of community behavioral health services during the last completed monitoring period. Persons having SMI are to be reported in the Client File field 40 (Serious Mental Illness) with the value “1 = yes”.

Service Name	BHDID Service Code as entered in event file field NTE02 (DMHMRS_Modifier_1) “BHDID Service Code”
Peer Support	145 (Individual); 146 (Group)

Time 2 (T2) The same calculation used to determine T1 is applied to the current monitoring period.

Target: T2 will show an increase in the total number of adults with SMI who receive Adult Mental Health Peer Services in the last completed monitoring period (T1). An expectation of percentage increase will be distributed across quartiles that indicate low to high previous performance. Low previous performance is assigned a minimum expectation of 20% increase and higher previous performance is assigned a quarter fraction of 20%. The following describes how previous performance is assigned to a quartile:

The number served will be placed in ordered row from lowest to highest. If the highest numbers served are statistically determined to be outliers, they will be removed from the remaining calculation. The four interquartile ranges will be determined using the median values. A flat percent of expected increase will be assigned to each of the four quartiles as described below.

The % increase over the previous year's performance will be assigned in the following manner according to the number served in the previous monitoring period.

If the region is in this Quartile Range	This is the expected % increase in number served from the previous monitoring period
Q1 (previously low performance)	20%
Q2 (previously median performance)	10%
Q3 (previously higher performance)	5%
Q4 (previously highest performance)	2.5%

Monitoring Period:

T1 Previous monitoring period: **April 1, 2023, through March 31, 2024**

T2 Current Monitoring Period: **April 1, 2024, through March 31, 2025**

Data Sources:

SMI Data Source: value “1 = yes” is recorded in the Client File field 40 (Serious Mental Illness).

Service Data Source: one of the values “145” or “146” is recorded in the Event File field NTE02 (FA0-12) – DMHMRS Modifier 1 (Service Code).

Baseline: Previous performance determines the percent of expected increase; see chart above.

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

**SECTION 2.04—BEHAVIORAL HEALTH SERVICES FOR CHILDREN/YOUTH AND FAMILIES**

**Domain: Evidence-Based Care SED2: Child Population with SED Who Receive Targeted Case Management**

The DBHDID shall assess the percentage of the region’s estimated SED population that are served as SED clients and receive Targeted Case Management service. The region’s estimated SED population is defined as the estimated number of children and youth with SED in the region (5.0% of total child population per 2020 census). The expected standard of performance is 8% for the current monitoring period. Regions serve 8% of the estimated 5% of the population under age 18. The SED/High Fidelity Wraparound marker is defined as answer options 1 “Yes (SED)” or 2 “SED - High Fidelity Wraparound” in field #41 “Severe Emotional Disability (SED)” in the client file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide. The Targeted Case Management service is defined as answer option “061” (Case Management Services Children with SED) in the field “NTE02 DMHMRS\_Modifier\_1 (DBHDID Service code)” in the event file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide.

**Goal: Increase the percentage of child population served with SED who Receive Targeted Case Management (TCM)**

**Risk: 2% of SED funding**

Rationale: Deliverables in section 2.04.2—Children/Youth and Families Deliverables section of the contract include provision of a Basic Benefit Package for children/youth with SED who are deemed eligible for DBHDID funded services. Targeted Case Management for SED is part of an appropriate array of services that are aligned with the

current Medicaid State Plan and are expected to be available. This performance indicator is intended to coordinate with the expectation that Targeted Case Management Services (an evidence-based practice) are provided to children/youth having Severe Emotional Disorder.

Numerator: The unduplicated count of SED children less than 18 years of age at the end of the monitoring period who received Targeted Case Management service. Specifically, the count of SED children and youth as defined by answer options 1 “Yes (SED)” or 2 “SED - High Fidelity Wraparound” in field #41 “Severe Emotional Disability (SED)” in the client file and have received Targeted Case Management as indicated by answer option “061” (Case Management Services Children or Youth with SED) in the field “NTE02 DMHMRS\_Modifier\_1 (DBHDID Service code)” in the event file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide.

Denominator: The estimated number of children and youth with SED in the region (5.0% of total child population per 2020census).

Target: The expected standard of performance is 8% for the current monitoring period. Monitoring

Period: April 1, 2024, through March 31, 2025

Data Sources:

Numerator Source: client data (field #41, answer option 1 “Yes (SED)” or 2 “SED - High Fidelity Wraparound”) and event data (field NTE02 DMHMRS\_Modifier\_1, answer option 061)

Denominator Source: 2020 census data (5.0% of total child population per 2010 census).

Baseline: The last five completed monitoring periods of data are used to determine the target for each CMHC and the statewide rate.

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

Reference: The Kentucky Department of Medicaid Services State Plan  
<https://chfs.ky.gov/agencies/dms/Documents/StatePlanr1.pdf>

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### **Domain: Evidence-Based Care SED3: Peer Services for Children who Meet Criteria for the Service**

The DBHDID shall assess the percentage of children and youth receiving Peer Support Services from the CMHC as a provider of community behavioral health services. The assessment will compare the measure across two subsequent monitoring periods. The expected standard of performance is an increase in the percent of children and youth who receive Peer Support Services.

#### **Risk: one half percent (0.5%) of SED funding**

Rationale: Deliverables in section 2.04.2–Children/Youth and Families Deliverables section of the contract include provision of a Basic Benefit Package, for children/youth who are deemed eligible for DBHDID funded services. This performance indicator is intended to coordinate with the expectation that Peer Services (an evidence-based practice) are provided to children/youth. It is also the intention of the DBHDID to align priority areas of federal reporting requirements and deliverables within provider contracts.

**Time 1 (T1)** The unduplicated count of children and youth who received any one of the following Peer Support Services from the CMHC as a provider of community behavioral health services during the last completed monitoring period.

<b>Service Name</b>	<b>BHDID Service Code as entered in event file field NTE02 (DMHMRS_Modifier_1) "BHDID Service Code"</b>
*Parent/Family Peer Support - Individual	147
*Parent/Family Peer Support – Group	148
Youth Peer Support - Individual	149
Youth Peer Support - Group	150

**Time 2 (T2)** The same calculation used to determine T1 is applied to the current monitoring period.

**Target:** T2 will show an increase in the total number of children/youth who receive Peer Support Services in the last completed monitoring period (T1). An expectation of 2.5% increase will be distributed across quartiles that indicate low to high previous performance. Low previous performance is assigned a minimum expectation of 2.5% increase and higher previous performance is assigned a quarter fraction of 2.5%. The following describes how previous performance is assigned to a quartile:

The number served will be placed in an ordered row from lowest to highest. If the highest numbers served are statistically determined to be outliers, they will be removed from the remaining calculation. The four interquartile ranges will be determined using the median values. A flat percent of expected increase will be assigned to each of the four quartiles as described below.

The % increase over previous year's performance will be assigned in the following manner according to the number served in the previous monitoring period.	
If the region is in this Quartile Range	This is the expected % increase in number served from the previous monitoring period
Q1 (previously low performance)	2.500%
Q2 (previously median performance)	1.875%
Q3 (previously higher performance)	1.250%
Q4 (previously highest performance)	0.625%

**Monitoring Period:**

T1 Previous monitoring period: **April 1, 2023, through March 31, 2024**

T2 Current Monitoring Period: **April 1, 2024, through March 31, 2025**

**Data Sources:**

**Service Data Source:** one of the values "147", "148", "149" or "150" is recorded in the Event File field NTE02 (FA0-12) – DMHMRS Modifier 1 (Service Code).

Baseline: Previous performance determines the percent of expected increase; see chart above.

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

Reference:

*\*Special note about the Parent/Family Peer Support Service:*

*In the system of care, Parent/Family Peer Support services may be provided for children and youth regardless of SED designation. At times, Parent/Family Peer Support services may be provided for family members of the child client. For the purposes of this measure, only services that are billed for the child client are included. For more information about the Peer Support Services, see the Service Standard at <http://dbhdid.ky.gov/kdbhdid/standards.aspx>.*

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## **SECTION 2.07—SUBSTANCE USE PREVENTION**

**Domain: Evidence-Based Strategies SUP1: Regional Prevention Centers (RPCs) Use of Community-Based Process Strategy Measure #1 applies to all CMHC regions operating a Regional Prevention Center (RPC)**

The DBHDID shall assess the usage of the Center for Substance Abuse Prevention (CSAP)-supported strategy “Community-Based Process”. The BHDID will use the Prevention Data System to calculate the percentage of completed activities that are appropriately reported by the center under the “Community-Based Process” CSAP Strategy. 70% of all activities delivered by all Regional Prevention Centers must be within the community-based process category of activities.

**Risk: 1% of Block Grant Prevention funding**

Rationale: The DBHDID’s evaluation of data reported on the utilization of Center for Substance Abuse Prevention (CSAP) strategies indicated that our state needed a focus on Community-Based Processes. This performance indicator is intended to emphasize the focus and align with the DBHDID’s RPC training and development plan which is built on using the Strategic Prevention Framework (SPF).

Numerator: Of the activities in the denominator, the number of activities that are appropriately associated with the CSAP Strategy “Community-Based Process”.

Denominator: The number of the Center’s activities completed during the monitoring period, and which are reported in the Prevention Data System.

Target: 70% of all activities delivered by all Regional Prevention Centers must be within the community-based process category of activities

Monitoring Period:

Previous: April 1, 2023, through March 31, 2024

Current: April 1, 2024, through March 31, 2025

Data Sources:

Numerator Source: Prevention Data System

Denominator Source: Prevention Data System

Baseline: Performance as reported in the Prevention Data System.

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

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**Domain: Evidence-Based Strategies**

**SUP2:** Regional Prevention Centers Total Time of Prevention Activities Entered in the Prevention Data System (PDS)

**Measure #2 applies to all CMHC regions operating a Regional Prevention Center**

The DBHDID’s evaluation of data submitted to the Prevention Data System indicated that our state needs to focus on ensuring that all activities are reported in the PDS. This performance indicator is intended to emphasize the importance of inputting all prevention activities delivered into the PDS in order to accurately and completely articulate the prevention efforts delivered, as required by the Substance Abuse Prevention and Treatment Block Grant and prevention-focused discretionary grants. The expected standard of performance for each respective center is entry of a minimum of 45% of available time, as measured on the 110D as submitted during the Plan & Budget process.

**Risk: 0% of Block Grant Prevention funding**

Rationale: The Prevention Data System (PDS) is the primary data collection system and source of information available for evaluating quantity of the types of prevention activities delivered to Kentucky’s communities. This system is used to evaluate impact of prevention work in Kentucky and to account for funding received. The DBHDID’s evaluation of data submitted to the Prevention Data System indicated that our state needs to focus on ensuring that all activities are reported in the PDS to accurately report these activities to funders and articulate the value of prevention services to key stakeholders. This performance indicator is intended to emphasize the importance of inputting all prevention activities delivered into the PDS to accurately and completely articulate the prevention efforts delivered, as required by the Substance Abuse Prevention and Treatment Block Grant and prevention-focused discretionary grants.

Numerator: The total time for all activities reported in the Prevention Data System

Denominator: The available time for prevention service delivery in the reporting period based on the number of hours available for prevention weekly and Full Time Equivalencies (FTE) as reported on the 110D Line 43, Column H.

Target: The percent calculated for the current monitoring period will be at least 50% of available time reported in the Prevention Data System. The PI is based on 50% of a 52-week total. The table below indicates how the target is calculated.

***Data for the following table for this performance indicator has changes pending due to the contract allocations schedule. The updated table will be provided in the final version of this 2025 PI Implementation Guide.***

SFY25 Performance Indicator Implementation Guide

A	B	C	D	E	To be Monitored	To be Monitored
CMHC RPC Name	Hours available per week	<b>DENOMINATOR:</b> Hours available to prevention per 110D (Column H, Row 43)	<b>TARGET PERCENT:</b> The % of required hours to total hours	<b>TARGET NUMERATOR:</b> The number of hours required to meet the PI	<b>ACHIEVED #:</b> The total time for all activities reported in the Prevention Data System	<b>ACHIEVED %:</b> The total percentage of available time for all activities reported in the Prevention Data System
	ColB/52	(Col B*52)		50% of Col C	Source: PDS	Source: PDS
	Source P&B Form 110D (Col H Row)	Source P&B Form 110D FY 24 Initial Submission; Sum of Col I, lines 618; Does not include agency supervision, administration, KMM, Girls/Boys Clubs, or PES				
	Four Rivers	9,360	50%	4,680		
	Pennyroyal	7,703	50%	3,852		
	River Valley	7,072	50%	3,536		
	Lifeskills	8,164	50%	4,082		
	Communicare	7,634	50%	3,817		
	Seven Counties	12,480	50%	6,240		
	NorthKey	9,880	50%	4,940		
	Comprehend	7,644	50%	3,822		
	Pathways	7,800	50%	3,900		
	Mountain	6,760	50%	3,380		
	Kentucky River	7,488	50%	3,744		
Cumberland River	7,470	50%	3,735			
Adanta	9,712	50%	4,856			
New Vista	13,584	50%	6,792			

Monitoring Period:

Previous: April 1, 2023, through March 31, 2024

Current: April 1, 2024, through March 31, 2025

Data Sources:

Numerator Source: Prevention Data System

Denominator Source: DBHDID Plan and Budget Form 110D Line 43, Column H

Baseline: Previous years' PDS time entry data was tested to determine the initial target used in SFY22.

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

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## **SECTION 2.08—SUBSTANCE USE DISORDER TREATMENT**

The DBHDID shall assess regional performance for achieving or exceeding established SUD benchmarks for access and retention.

**SUD1 Percent of Census Population Served - Risk is 0% of SUD funding SUD2 Number of Services per Treatment Episode - Risk is 1% of SUD funding SUD3 Percent of Treatment Episodes Lasting Thirty (30) Days or Longer – Risk is 1% of SUD funding SUD4 Number of Services in the First Thirty (30) Days - Risk is 1% of SUD funding SUD5 TEDS Data Accuracy - Risk is 1% of SUD funding**

### **SUD1: Percent of Census Population Served**

This measure calculates the percentage of the census population served that is estimated in need of treatment.

The DBHDID shall assess the percentage of the region's estimated population in need of Substance Use Disorder (SUD) treatment that is served by the center during the monitoring period. The region's estimated population in need of SUD Treatment is defined as 5% of the number of individuals aged 12 and older in the region per the 2020 census. The expected standard of performance is 7% for the current monitoring period. Regions serve 7% of the estimated 5% of the census population age 12 and older in need of SUD treatment.

**Goal: To serve a minimum of 7% of the estimated population age 12 and over that are estimated in need of Substance Use Disorder Treatment.**

**Risk: 0% of SUD funding**

Rationale: Expectations outlined in section 2.07.01 – SA Treatment Services includes the provision of serving clients having Substance Use Disorder (SUD). This includes the provision of SUD-specific services that are part of an appropriate array of services that are aligned with the current Medicaid State Plan and are expected to be available. This performance indicator is intended to coordinate with the expectations and deliverables in this section of the contract and the expectation of serving clients with Federal Block Grant funds.

Numerator: The count of clients age 12+ receiving outpatient SA treatment services

Denominator: The percentage of persons age 12+ in the region estimated to need treatment as determined by the National Survey on Drug and Health (NSDUH)) multiplied by (the region's 2020 census population of ages 12+)

Target: While the funding source for Kentucky's SAPT Block Grant has a goal of 10% of the at-risk population, Kentucky's expected standard of performance for this penetration rate is 7%.

Monitoring Period: April 1, 2024, through March 31, 2025

Data Sources:

Numerator Source: Client & Event data

Denominator Source: NSDUH and the region's 2020 county census population of ages 12 or older

Baseline: Kentucky's expected standard of performance for this penetration rate is 7%.

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports". Also, reference the Substance Abuse Access & Retention Report available under the CMHC secure login page.

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**Domain: Treatment Engagement SUD2: Number of Services per Treatment Episode**

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

**Risk: 1% of SUD funding**

Rationale: Through this performance indicator, the DBHDID intends to measure engagement in treatment for clients reported in the TEDS data as part of the federal reporting requirement.

Numerator: The count of mental health and substance use outpatient services provided between admission and discharge

Denominator: The count of outpatient Treatment Episodes Data Set (TEDS) episodes which lasted thirty (30) days or longer where the discharge date is during the current monitoring period

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

Monitoring Period: January 1, 2024, through December 31, 2024

Data Sources:

Numerator Source: Client and Event data, TEDS

Denominator Source: Client and Event data, TEDS

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

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**Domain: Treatment Retention SUD3: Percent of Treatment Episodes Lasting Thirty (30) Days or Longer**

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

**Risk: 1% of SUD funding**

Rationale: Through this performance indicator, the DBHDID intends to measure retention in treatment for clients reported in the TEDS data as part of the federal reporting requirement.

Numerator: The count of outpatient Treatment Episodes Data Set (TEDS) episodes which lasted thirty (30) days or longer.

Denominator: The count of outpatient Treatment Episodes Data Set (TEDS) episodes where the discharge date is during the current monitoring period

Target: At minimum, an average of 50% of all outpatient substance use treatment episodes will last more than thirty (30) days.

Monitoring Period: January 1, 2024, through December 31, 2024

Data Sources:

Numerator Source: Client & Event data, TEDS

Denominator Source: Client & Event data, TEDS

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

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**Domain: Treatment Engagement SUD4: Number of Services in the First Thirty (30) Days**

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

**Risk: 1% of SUD funding**

Rationale: Through this performance indicator, the DBHDID intends to measure engagement in treatment for clients reported in the TEDS data as part of the federal reporting requirement.

Numerator: The count of mental health and substance use outpatient services provided during the first thirty (30) days of the Treatment Episode Data Set (TEDS) episode.

Denominator: The count of outpatient Treatment Episodes Data Set (TEDS) episodes where the discharge date is during the current monitoring period

Target: At minimum, an average of three (3) outpatient services will be provided during the first thirty (30) days of a Treatment Episode Data Set (TEDS) episode.

Monitoring Period: January 1, 2024, through December 31, 2024

Data Sources:

Numerator Source: TEDS Admissions data; Client & Event data

Denominator Source: TEDS Admissions data; Client & Event data

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

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**Domain: Quality of Information SUD5: TEDS Data Fields Accuracy**

This measure focuses on Treatment Episode Data Set (TEDS) data accuracy. The SUD5 PI target is that the TEDS Client data set pass the data standards for 3 of the 4 entire quarters during the Incentive Bond Year (April 1 – March 31). The TEDS file data standard defines the threshold of missing, unknown, or invalid codes. These thresholds are

described in detail in the report “PI\_SA\_T11” which is posted to the Central Login “Block Grants” section of pre-defined reports. The bullets below outline the thresholds for new and old fields.

- New fields (fields in their first year of data collection) may have up to and no more than 20% missing, unknown, or invalid codes.
- Old fields (fields in existence for more than one year) may have up to and no more than 5% missing, unknown, or invalid codes.

**Risk: 1% of SUD funding**

Rationale: Deliverables in section 2.07.02 – SA Treatment Deliverables includes the requirement of submitting data which follows data quality standards as outlined in the guidance document “DBHDID Data Implementation Guide”. The data submitted is the source data for the Treatment Episodes Data Set (TEDS) and is related to the access and retention performance indicators described under Reporting. This performance indicator is intended to coordinate with the data quality standards expectations in this section of the contract and the expectation of federal data quality standards associated with the use of Federal Block Grant funds.

TEDS is a compilation of demographic, substance use, mental health, clinical, legal, and socioeconomic characteristics of persons who are receiving publicly funded substance use and/or mental health services. State administrative data systems, claims, and encounter data are the primary data sources. The state role in submitting TEDS to SAMHSA is critical, since TEDS is the only national data source for client-level information on persons who use substance use treatment services. This reporting framework supports SAMHSA’s initiative to build a national behavioral health data set accessible (with appropriate confidentiality protection) by the public; local, state, and federal policymakers; researchers; and many others for comparisons and trends on the characteristics of persons receiving substance use and/or mental health treatment services. TEDS provides outcomes data in support of SAMHSA’s program, performance measurement, and management goals.

Section 505 (a) of the Public Health Service Act (42 U.S.C. 290aa-4) directs the SAMHSA Administrator to collect data on the number of public and private behavioral health treatment programs and the number and characteristics of individuals seeking treatment through such programs. As specified in SAMHSA’s instructions, states should develop procedures to ensure that the data they submit to TEDS are accurate and in the correct format.

Numerator: Of the records in the denominator, the number of unknown, missing or invalid values.

Denominator: The number of CMHC submission records in the Client file during the quarter for TEDS Substance use clients.

Target:

The target is to, at the end of the monitoring period, pass compliance on the Client File as defined in the PI\_SA\_T11 report for a minimum 3 of the 4 Incentive Bond Year (IBY) quarters. The target is determined at the end of the monitoring period to ensure inclusion of data that may have been resubmitted during the year in effort to correct data errors in original file submissions.

Monitoring Period: April 1, 2024, through March 31, 2025

Data Sources:

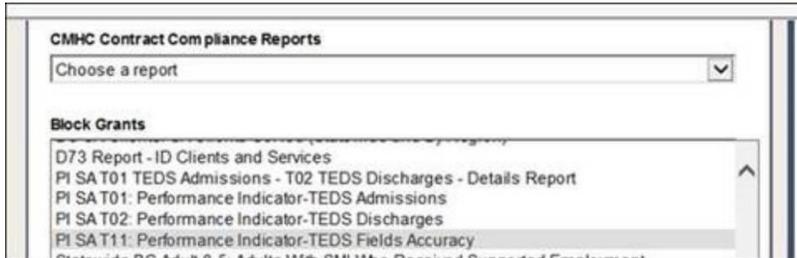
Numerator Source: Client, Event, and Discharge data sets received from CMHCs.

Denominator Source: Client, Event, and Discharge data sets received from CMHCs.

Baseline: Rates over the last 3 completed calendar years were used to determine the target.

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section “CMHC Contract Compliance Reports” as well as within the section “Block Grants”. Below is a snapshot of the Block Grant reports section showing these reports in the dropdown menu. Additional details will be summarized on monthly summary reports and discussed at the Joint Committee for Information Continuity (JCIC) committee meetings.

Location of “PI SA T11” Report



Reference: Treatment Episode Data Set (TEDS) State Instruction Manual with Data Submission System (DSS) Guide Version 4.2.1. *Prepared for:* Center for Behavioral Health Statistics and Quality Substance Abuse and Mental Health Services Administration. *Prepared by:* Eagle Technologies, Inc.

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## SECTION 2.12–DEVELOPMENTAL AND OTHER INTELLECTUAL DISABILITIES (DID)

**Domain: Quality of Information**

**I/DD3: Consistency and accuracy of client’s reported receiving SGF services.**

The DBHDID shall assess the accuracy and consistency of information reported via the Form 140 with client listing report as due through the Department Periodic Report processes. The form is due by the end of the calendar month following the end of each quarter.

Consistency and accuracy of information reported will be determined by review of form 140 with client listing to verify that number of clients reported receiving each SGF service is the same on both reports for the same period.

**Risk: 1% of I/DD funding**

Rationale: Consistency and accuracy of information reported on form 140 with client listing are essential to division monitoring and planning for services.

Numerator: The total number of complete Form 140 with client listing reports submitted during the monitoring period in which number of clients reported receiving each SGF service is the same on both reports.

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

Benchmark: The expected standard of performance is that three (3) of the four (4) quarterly submissions will be received and determined to be reporting consistent information by DBHDID by the end of the calendar month following the end of each quarter.

Target: 75% of quarterly report submissions must be complete and timely.

Monitoring Period: April 1, 2024, through March 31, 2025

Data Sources:

Numerator Source: DPR Form 140 with SGF client listing submitted to the BHDID with consistent reporting of clients receiving services.

Denominator Source: The number of required DPR Form 140s with SGF client listing reports that are due during the 12-month (4-quarter) monitoring period.

Baseline: The performance indicator monitoring process over the last three contract periods have been evaluated in order to set the target minimum of 75%.

Reports Available: Quarterly communications on successful receipt of complete quarterly reporting documents will be relayed from the Division of Developmental & Intellectual Disabilities CMHC liaison staff during scheduled meetings between the liaisons and CMHC I/DD staff. Regional reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports". References:

- Department Periodic Reporting (DPR) process <http://dbhdid.ky.gov/cmhc/dpr.aspx>
- Detailed instructions for completion of form 140 and client listing are included within the form 140.

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### **Domain: Accuracy of Information**

#### **I/DD5: Incident reporting follow up. I/DD5 applies to all CMHCs.**

The DBHDID must ensure that all reported critical incidents have follow up completed and submitted timely for individuals receiving SGF or PASRR services who are identified as having an intellectual or developmental disability. CMHCs are required to submit follow ups for all critical incident reports within 10 days of the incident/discovery of the incident report. DBHDID shall assess the rate of timely submitted follow ups for the reporting period. The expected standard of performance is that 75% of all critical incident follow ups are submitted timely.

#### **Risk: 1% of DID funds**

Rationale: The goal of I/DD incident reporting is to provide timely monitoring and follow up on critical incidents. A lack of timely follow up on critical incidents may delay identification and correction of problems that impact that health and safety of individuals receiving SGF services.

Numerator: The number of critical incident follow ups submitted by CMHC within 10 days of the incident during the monitoring period.

Denominator: The total number of critical incidents submitted by the CMHC during the monitoring period.

Benchmark: The expected standard of performance is that all critical incidents must have a follow up completed within 10 days of the critical incident.

Target: The percentage of critical incident reports with follow ups submitted within 10 days of incident must be at or above 75%.

Monitoring Period: April 1, 2024, through March 31, 2025

#### Data Sources:

Numerator Source: Redcap Incident Reporting Database. Report of number of follow ups to critical incidents submitted within 10 days of incident.

Denominator Source: Redcap Incident Reporting Database. Report of number of critical incidents submitted during the monitoring period.

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

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