	SMI	SED	SUD-OP	SUD-Res.
How would you know a person is better as a result of treatment? *(Green highlight represents common answer)*	1. Employ. / Productive activity 2. Stable housing / Ind. living 3. Decreased: hospitalization / legal contacts 4. Safety 5. Illness self-management 6. Meet basic needs-hygiene 7. Improved Quality of Life 8. Social Connections / Improved social skills & role functioning	1. Leveling of presenting symptoms 2. Improved school beh. / attendance 3. Improved family functioning / reunification 4. Improved relationships with peers	1. Reduced recidivism 2. Decrease in use 3. Stable conditions 6mos. after-treatment	1. Evidence of gain thru ASAM criteria 2. 2nd CSR data on psychosocial & environmental factors
How would you know a person was not improving while receiving treatment?	1. Increased self-harm beh's 2. Not engaged in treatment 3. Low satisfaction on client self-report 4. Negative reports from family and collateral contacts	1. Continuing problem beh's 2. Problems with family 3. Decreased functionality 4. Increased acuity of symptoms / ref to higher level of care	1. General decrease in life conditions / domains	1. Positive UA's
What are the most important recipient characteristics that affect treatment success?	1. Self-determination / Resiliency 2. Social Supports 3. Other general resources 4. Prior level of functioning & prior treatment success 5. Physical health 6. ACE's score (past / present) 7. Relationship b/t therapist and recipient	1. Accessible transportation 2. Supportive & healthy family contact 3. Intelligence / capacity to internalize 4. Co-occurring disorders 5. Available school services & supports 6. Long history of treatment / contact with social service system	1. Motivation for treatment / those who attend after placement on a Wait-List have better treatment success.	1. Employment 2. Maintaining a meaningful activity in their life 3. Contact with family / friends that are still using
What data would you recommend to use to demonstrate treatment outcomes?	1. Evidence that basic needs are consistently met (housing, diet, safety, etc.) 2. Self & Clinician Report: Improve in Quality of Life 3. Decrease contact with hosp., law enforcement 4. Consider CCBHC Measures	1. Improved functionality 2. Decrease in symptoms 3. Increased social support contacts 4. Rely on 2nd CSR for accurate data	1. Decrease recidivism (hosp. and law enforcement)	1. Initial CSR data at 3mos and review at 6mos. 2. Overall increase in wellness. 3. Client satisfaction

	SMI	SED	SUD-OP	SUD-Res
What is the most efficient method for providers to collect and report data?	1. Use existing tools/system to collect only necessary/vital data 2. Use same data collection as primary care or FQHC's 3. Rely on Accreditation reports 4. AKAIMS & EHR's interface with HIE 5. Collect data 2x annually	1. Look at progress over longer period of time 2. Reduce double-entry to AKAIMS 3. Use existing national tools like DLA-20 4. Use Treatment Team rating 5. Use a Provider rating scale	1. 2nd CSR & Discharge CSR 2. Disconnect data reporting from funding decisions 3. Establish base-line data for each recipient 4. Link to DOC data	1. Texting survey for post-treatment follow-up 2. Use independent contractor to collect state data 3. Use grant dollars to fund post-treatment follow-up data collection
How should DBH use outcome measures?	1. Analyze data vs. just collecting & reporting 2. Use info to improve services, especially gaps in service 3. Use data to advocate for system change & growth 4. Track system progress under Medicaid Expansion 5. Share data across OCS, DJJ, SDS 6. Do not penalize outlier programs serving high acuity populations	1. Use data to identify technical asst. needs 2. Allow Providers to use their own tools to evaluate services 3. Reduce duplication of data collection / documentation	1. Evaluate effectiveness of evidence based practices 2. Determine when "recipient stability" is progress 3. Use data to educate Legislature 4. Use data to indicate need for program & service expansion / 'fill the gaps'	
What method would you use to determine that services were provided at least cost possible?	1. Control recidivism 2. Determine acceptable balance between effective and efficient (reducing cost may reduce quality) 3. Use 'cost band' for acuity vs. general cost/person	1. Examine the non-billable services delivered that are not reflected in Medicaid data 2. Look to other states that use a Managed Care model 3. Use a Payor Ratio for each Provider to cover operational costs 4. Account for savings by preventing referrals to DJJ or DOC	1. Accreditation Reports	1. Determine cost for PES services and compare to costs for community based services

	SMI	SED	SUD-OP	SUD-Res
What criteria should your community use to rate your agency?	1. Stakeholder survey 2. Customer satisfaction survey 3. Ask about: ==access to care==, fidelity to Mission, level of client safety	1. YRBS 2. Service quality 3. Level of collaboration 4. Meeting community needs / trends	1. Treating people with dignity & respect 2. How much / well recipients give back to community post-treatment 3. Impact on community problems	1. Use CSR client satisfaction questions
What is fair way for DBH to decide your agency is providing services effectively and efficiently?	1. ==Use Accreditation reports== 2. Compare with like agencies vs. against all agencies 3. Use CSR data beyond 2nd CSR 4. Agency responsiveness to need and State requests 5. Use AKAIMS data only for publicly funded services (i.e. Medicaid and GF)	1. Let community measure Providers 2. Combine site visits with DJJ, OCS and C&L 3. ==Recognize that Providers have different criteria for different funding sources== 4. Consider contextual business factors such as MMIS, multiple reporting requirements, increased costs, etc.	1. Measure staff time spent face-to-face with recipients 2. ==Maintain collaborative / TA relationship with Providers; spend time at agency before evaluating==. 3. Look at efforts to reduce 'time to [1st] service' 4. Recognize that acuity level makes treatment success more difficult	1. Use Behavioral Health Consumer Satisfaction Survey; make the BHCS available on-line 2. Examine 'public media' information about agency 3. Attempt to understand agency efforts to be flexible to recipient need

Psychiatric Emergency Services Providers	
What is the best indicators that PES services are effective?	1. No.# people served that remain in community vs. people transported to API 2. Frequency of hospitalizations annually per individual 3. Timeliness of response to request for service 4. Unduplicated number of individuals served compared to individuals seen 2 or more times 5. No.# people seen compared to percent that enroll to receive con't BH treatment
What are some of the best ways to make PES cost efficient?	1. Bill for time spent in Emergency Dept. 2. Perhaps allow Hospitals to include behavioral health crisis services in DSH formula 3. Increase tele-health capacity 4. Streamline documentation requirements 5. *Educate hospital staff and 1st responders about roles & responsibilities of professionals providing services in hospital to psychiatric emergency patients (e.g. PES is not a 'mobile unit', etc.)*
What data would recommend is used to demonstrate outcomes are achieved?	1. Track disposition of recipients following completion of PES services
What services need to be in place to maintain people in community who are experiencing psych. emergencies?	1. Speed up processing of petitions 2. Improve transition of people who need higher level of care out of community, and subsequently back into community for lower level of care 3. Arrange for medication(s) to follow recipient back to community following hospital discharge & increase amount of medication sent with recipient
What other factors might contribute to evaluating PES services?	1. Overall costs of DET, transportation, hospital services, physician time/fees 2. Educate Leg .that most PES recipients do not currently receive other behavioral health services 3. Lack of PES recipient following up with other referred services
For PES to be delivered effectively what are the most important business relationships that need to be in place?	1. Primary Care medical providers 4. Court / Public Defenders 2. Hospital Emg. Dept. & Billing Dept. 5. Community psychiatrist 3. Local police / law enforcement 6. Local gov. leadership (tribal councils, mayors, etc.)
How should PES providers measure the quality of these relationships?	1. Time spent developing relationships 2. Number of meetings / contacts; invitations to meetings 3. Number of existing MOA's 4. Documented evidence of successful collaborative care
What is a fair and meaningful way for DBH to decide PES programs are operated effectively and efficiently?	1. All responses to Question: "What are the best indicators that PES services are effective?" 2. Number of patient days per PES patient at DET and DES hospitals 3. Number of new clients seen annually for PES 4. Family member report of satisfaction with PES
What can be done to prevent the need for PES services?	1. Comprehensive community team (Mobile Crisis Team) to track frequent users of PES 2. Psychotropic medications available at local level 3. Crisis respite beds 4. Strengthen peer support programs for adults and adolescents

Tribal Organizations	
How has implementation of Tribal Encounter Rate furthered delivery of behavioral health services?	1. Basically, it covers the gap between increased costs and flat / decreased grant funding. 2. It allows for Primary Care to provide behavioral health services, and has allowed us to grow and maintain service delivery. 3. Encounter rate has demonstrated the fiscal value to Corporate of behavioral health services. 4. Allows services to be provided to under-resourced individuals
What data should T.O.'s collect that indicate successful treatment outcomes?	1. Social connections within the community; especially for Elders
How can T.O.'s demonstrate they are effectively utilizing State public funds?	1. Evidence of family preservation and successful reunification 2. Evidence that recipient is now actively participating in meaningful cultural activities such as potlatches, hunting, fishing, cutting & hauling wood, assisting with survival of the family, etc. 3. Stable housing & employment (if available) 4. Decreased suicide rates 5. Engagement in services; successful completion of services 6. Number of crisis interventions & number of recipients that engage in other behavioral health services
What are the factors that contribute to recipient's engaging in services and completing treatment?	1. Welcoming atmosphere from every staff member / Trauma informed environment / Hiring people who demonstrate compassion (regardless of credentials) 2. Immediately providing assistance when the individual presents for treatment; engaging without delay when the individual is ready for change (i.e. Same Day Access) 3. Person-centered treatment planning / Setting up ipads for consistent contact. 4. Maintaining good business relationships with other agencies to assist with [same day] access to care. 5. Sending clinician to village
How has integration with Primary Care contributed to treatment effectiveness?	1. Improves connections the recipient makes for health care / improves treatment of conditions that otherwise would have been addressed. 2. PC / BH integration and location reduces stigma for recipients accessing BH services 3. Improves collaborative care of recipient physical health conditions 4. Improves general engagement of recipients seeking SUD treatment
How can T.O.'s meet the needs of the Medicaid Expansion population?	1. Expansion will allow us to increase workforce and increase capacity to serve more people. 2. May be able to refer recipients to other organizations that have expanded capacity. 3. Perhaps increase the use of peer support.

"Common Provider Recommendations Regarding the Use of Performance Measures"

1. It is requested that the Dept. not add to the Provider's reporting burden, and wherever possible the Dept. should try to reduce that burden. *(For example, recipients tend to provide a much more honest self-report after participating in the early stages of treatment. The results of the CSR would be much more meaningful if it were conducted initially at 90 days, and then again at 6 months, and at discharge.)*

2. As much as possible, the Dept. should seek to utilize only 'high-level' measures that: A. Indicate overall system capability and effectiveness; and, B. Identify existing need for program or service expansion. Provider's should be responsible for determining and evaluating the variables for individual recipient outcomes.

3. The Dept. should not use any data punitively. Providers appreciate that the Dept. continues to strive to build a trusting, collaborative relationship with Providers that emphasizes technical assistance to mutually improve administrative processes and service delivery.

4. Whenever possible, the Dept. should coordinate all Provider requirements, including data collection and reporting, with all other relevant State agencies and Accreditation Organizations. Likewise, whenever possible, all site visits should be coordinated with other State agencies and Accreditation Organizations to reduce Provider burden and to improve exchange of information.