



CMH BENCHMARKING



WHAT'S IN IT FOR STATES ?
WHAT'S IN IT FOR "THE FIELD" ?

BENCHMARKING FROM THE STATE'S PERSPECTIVE

- IMPORTANCE
- DATA USES (Also Data Requirements)
- CHALLENGES

IMPORTANCE OF DATA PROGRAM EVALUATION

■ WHY?

- Court public support for programs
- Maintain funding levels
- ? general knowledge of what works
- Pro-active approach – CQI

■ “UNITS OF GOOD”

- Or (versus)

■ ACCOUNTABILITY

-ACCOUNTABILITY – (FOR PUBLIC PROGRAMS)

- **ACCOUNTABILITY EQUATION (Two Parts):**

- **ACCOUNTABILITY = COST ÷ OUTCOMES
(VALUE)**
 - **OUTCOMES =**
 - RESULTS
 - BENEFITS
 - EFFECTIVENESS
 - “WHAT YOU WANT TO HAPPEN”

BASIC INFORMATION NEEDS

- INFORMATION REQUIREMENTS
FALL WITHIN TWO DOMAINS

1.UTILIZATION DATA

2.OUTCOMES DATA

DATA/INFORMATION NEEDS AND REQUIREMENTS

1. WHAT IT IS WE DO?

- SERVICES ARRAY
- UTILIZATION
 - Access
 - How Much/Many (Clients)
 - What Kinds (And Quantity Of Each Service Utilized))

2. HOW WELL WE DO IT?

- OUTCOMES
 - Client Adaptive Functioning
 - Client Clinical Functioning (Symptom ?)
 - Client Satisfaction

3. HOW MUCH DOES IT COST?

- TOTAL
 - By Client
 - By Service Type

FURTHER USES OF CMH BENCHMARKS (STATE'S PERSPECTIVE)

- SYSTEM PERFORMANCE MEASURES AND INDICATORS
 - STATES “WANT” (NEED) TO KNOW HOW THEY ARE DOING
 - In Comparison To What ???
 - STATES NEED TO BE ABLE TO EVALUATE THEIR PUBLIC MENTAL HEALTH SERVICE SYSTEMS
 - Standards Provided By CMHS (Block Grant Performance Measures)
 - Benchmarks
 - Internally Developed Measures And Standards (Community Report Cards)

CHILD WELFARE'S EXPERIENCE WITH "BENCHMARKING"

- CHILD AND FAMILY SERVICE REVIEWS (CFSRs):
 1. Establish Key Outcome And Performance Indicators
 - Define and Operationalize
 2. Decide How These Shall Be Measured
 - Implement Data Collection/Recording System
 3. Collect Measures And Data On The Same Indicators
 4. Establish Standards (Benchmarks)
 5. Comparisons/Evaluations (as compared to standards on outcomes)

CHALLENGES FACING STATES

- STATE PUBLIC MENTAL HEALTH SYSTEMS NEED TO KNOW HOW THEY ARE DOING
 - Need Benchmarks And Standards To Answer Basic Questions
 - Need Data Systems Which Support Obtaining Of The Necessary Data
 - Often times data system is the billing system by default (good for utilization data lousy way to collect outcomes data)
 - Multiple Data Systems ? Duplication Of Data (unknown degrees)
 - e.g. Medicaid vs. Mental Health Authority
 - If you rely on another entity to get your data their priority(s) may not be your priority(s)
 - Structural/Organizational issues
 - Resources, shifting priorities, leadership changes

USES OF BENCHMARKING DATA STATE PERSPECTIVE

- PROGRAM EVALUATION
 - DESCRIPTIVE
 - COMPARISON

- CONTINUOUS QUALITY IMPROVEMENT
 - IDENTIFIES POTENTIAL ISSUES AND PROBLEM AREAS
 - DATA PROMPTS QUESTIONS
 - IN TURN ? FURTHER ANALYSIS AND ACTION

BENCHMARKING – APPLIED IDAHO GENERAL COMPARISONS

- As compared to other reporting states, Medicaid probably plays a more important role (proportionally) as a provider of CMH services than the MHA program (access = 3/1). {figure 3}
- Idaho has “favorable” Medicaid penetration rate. {figure 4}
- Idaho as compared to other reporting states spends fewer total dollars per child for mental health services. {figures 5 and 6}
- Over-all Idaho’s mental Health Authority data reporting system is lacking (e.g. missing data)

BENCHMARKING – APPLIED STATE PERSPECTIVE

- Initial Experience With Year 2 Data
 - ? Questions

- Eg. #1: Medicaid expenditures/child (\$2,000) higher than Mental Health Authority expenditures/child (\$1,600). {Figures 5 and 6}
 - Provided the discrepancy in the universe of the 2 populations, with the MHA population being narrower and with greater treatment needs (S.E.D), this should be reversed?
 - Not inconsistent with other reporting states?

BENCHMARKING – APPLIED STATE PERSPECTIVE

- Eg. # 2: Mental Health Authority inpatient expenditures as %-age of total mental health expenditures (31/69%) > than Medicaid inpatient/total mental health expenditure ratio (23/77%).
 - Provided the difference in the two populations (severity) this might be predicted.
 - However, Idaho's MHA's 31% , is higher than the 22% average across all reporting states (inpatient/total expenditures). Whereas the Medicaid % ratio is at the mean? (Figures 7 and 8).
 - Need for continued/greater emphasis on community –based service system using MHA funds???

CURRENT CAVEATS

STATE'S PERSPECTIVES

- POOR DATA
 - i.e. unknown duplicate data counts
 - Reliability of data

- COMPARABILITY OF DATA ACCROSS STATES
 - States are not necessarily counting the same things in the same ways (e.g. definitional variances).
Problematic for both:
 - Comparing services (varying definitions)
 - Comparing expenditures

- OVER-INTERPRETATION OF THE EARLY DATA
 - There Are No Standards or “Benchmarks”, yet