the EVALUATION CENTER @ HSRI

TECScript 7

Relationship Between Quality Improvement Activities and Outcomes Management

Messages from 19 November 2002 – 20 December 2002

An Unedited Compilation of Email Messages from the Outcomes Evaluation Topical Evaluation Network (OUTCMTEN) at outcmten@world.std.com

Human Services Research Institute
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

This **TEC*Script*** was compiled by *the Evaluation Center*@HSRI. The Center is funded through a cooperative agreement with the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. The mission of the Evaluation Center is to provide technical assistance to the evaluation of adult mental health system change.

TEC*Scripts* are one component of the **Topical Evaluations Networks (TENs) Program**. The purpose of this program is to provide mental health system stakeholders (consumers, providers, researchers and families) with the opportunity to communicate directly with each other, and with Evaluation Center associates about topics of specific interest in adult mental health system change evaluation. The Networks Program makes use of electronic mailing lists to allow subscribers who have access to the Internet to participate in ongoing discourse about the specific topics listed below.

The **TEC*Scripts*** are designed to provide interested persons with unedited compilations of email messages from the various mental health electronic mailing lists that the Evaluation Center operates. The only changes that have been made to the original messages are to correct for misspelled words. Messages are in chronological order. Time stamps are Eastern Standard Time. If the message being replied to is not the original message but is still in the same topic thread, this message is in italics and precedes the response, which is in plain text.

The Center operates four electronic mailing lists that deal with different aspects of mental health evaluation. Following are descriptions and subscribing instructions for the four lists:

- **Legal and Forensic Issues in Mental Health Topical Evaluation Network (LEGALTEN)** The purpose of the LEGALTEN list is to facilitate the implementation and use of rigorous evaluations at the interface of the mental health system, the criminal justice system, and the courts.

- **Managed Behavioral Health Care Evaluation (MBHEVAL)** The purpose of the MBHEVAL list is to discuss the evaluation of managed care as it affects the delivery, outcomes and costs of mental health care and substance abuse treatment services at the state, local, program, or consumer level.

- **Multicultural Mental Health Evaluation (MCMHEVAL)** The purpose of the MCMHEVAL list is to foster discussion of issues related to the evaluation of mental health services for diverse cultural, racial and ethnic populations. Potential issues for discussion include measuring ethnocultural identity, cultural competence, and access to mental health services for diverse groups.

- **Outcomes Evaluation Topical Evaluation Network (OUTCMTEN)** The purpose of the OUTCMTEN list is to develop a broad collective expertise with respect to problems of assessing and analyzing outcomes of interventions aimed at improving mental health systems. The list also serves to provide assistance, information, and contacts regarding (1) issues in evaluation, (2) experimental and quasi-experimental design, (3) instrument and survey development, and (4) statistical analysis for mental health.

If you would like to subscribe to LEGALTEN, MBHEVAL, MCMHEVAL or OUTCMTEN visit the list subscription page of our web site at http://tecathsri.org/lists-form.asp or send an email message to:

imailsrv@tecathsri2.org

containing only the following words (leaving the subject line blank):

subscribe list name email address

For example:

subscribe legalten jones@yahoo.com

Transcripts of on-line discussions, as well as printed copies of archived documents are made available in **TEC*Scripts*** by email or mail to interested stakeholders; especially those who do not have Internet access. Visit the publications section of our web site at http://www.tecathsri.org/pubs.asp to view available **TEC*Scripts***. For more information contact Clifton Chow at *the Evaluation Center*@HSRI by phone (617) 876-0426 x 2510 or by email chow@hsri.org.

H. Stephen Leff, Ph.D.
Director & Principal Investigator

Clifton Chow
Program Manager

TEC*Script* 7
Relationship Between Quality Improvement Activities and Outcomes Management
19 November 2002 – 20 December 2002

Date: 19 Nov 2002 3:35PM
From: Molly Brunk <mbrunk@mail2.vcu.edu>

I received the following question and thought I would ask this listserv to respond by sharing your own view on the question. Also, I would appreciate your listing any references that you would recommend on the topics.

*****
I have been trying to gain a better understanding of the concepts "continuous quality improvement", "total quality management", and "outcomes management"--how they relate, interrelate, overlap; or, how quality assessment and improvement activities relate to outcomes in terms of discrete areas of study. I have found a publication by Hermann, R.C., Leff, H.S., and Lagodmos, G. (2002) that subsumes process measures, outcome measures, fidelity measures, consumer perception of care, and cost and utilization under quality assessment. I cannot determine from the literature searching I have done so far, how generally accepted this view is.
*****

I look forward to hearing your views,

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Richmond, VA 23219
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TEC*Script* 7
Relationship Between Quality Improvement Activities and Outcomes Management
19 November 2002 – 20 December 2002

Date: 19 Nov 2002 4:54PM
From: David Colton <dcolton@ccca.state.va.us>

Molly:

The manual I developed for Virginia DMHMRSAS on QI should still be on their website (our server is down, so I can't bookmark the exact webpage – check under evaluation or POMS at www.dmhmrsas.va.state.us). You might refer the person who asked the question to that site, as the material is geared to QI in behavioral healthcare settings.

There are numerous books, journals, and articles on QI in various settings, i.e., health, behavioral health, education, social services, etc. One that I'd recommend is "Continuous Quality Improvement in Health Care" by McLaughlin and Kaluzny, Aspen Publications.

My definition of QI is "A planned and systematic approach to transform organizations by evaluating and improving systems in order to achieve better outcomes." I wrote an article that addresses many of the questions that were raised, e.g., the difference between QI, QA, and TQM, etc. Let me know if you'd like a copy. "Quality Improvement in Healthcare: Conceptual and Historical Foundations," Evaluation and the Health Professions, Sage Pub., March, 2000, 23 (1).

David Colton, Ph.D.
Commonwealth Center for Children and Adolescents
Staunton, Virginia 24401
Telephone: 540-332-2144
dcolton@ccca.state.va.us

Date: 19 Nov 2002 5:46PM
From: Rick Hermann <richard_hermann@hms.harvard.edu>

Steve Leff forwarded me the posting from the website. I haven't found the etymology of QI etc. to be very clear. One can trace some of the specific models to their authors, but in the literature these terms tend not to be used with great consistency or fidelity to their origins. I wouldn't say that all of the terms in the posting are subsumed under 'quality assessment'. One dimension of a fairly complicated matrix of concepts goes from assessment (observing or measuring) to improvement (intervening, changing). Another widely accepted dimension is Donabedian's structure-process-outcome. Each of these (s-o-p) can be assessed or improved. Some frameworks break process assessment into evaluation of technical quality (traditionally measured using claims and records data) and interpersonal issues (assessed through observation or patient surveys), but more recent work suggests that patients can also provide valuable insight into technical aspects of care. I think of fidelity measures as a subtype of technical process measurement that assesses care in comparison to its evidence base at a fairly high level of detail. Clinical outcomes can be measured independently or in conjunction with cost, e.g., in cost effectiveness analysis. An article that can be found at http://www.cqaimh.org/CHA_QM_manuscript.pdf briefly describes relationships between utilization management, quality management, and quality improvement. There is a very complex diagram to be sketched out of all of this, but that said, I'm not sure there would be broad consensus about much of it. I'd be interested to hear other thoughts.

Rick Hermann

Date: 20 Nov 2002 12:00AM
From: William Berman <wberman@echoman.com >

The literature on CQI and TQM is voluminous, just not in Psychology. W Edwards Deming is the father of the field. One of the best books in the Healthcare literature is Berwick, DM, Godfrey, AB, & Roessner, J (1990) Curing Health Care. San Francisco: Jossey Bass. There are several overview books published every year; one I liked is called The Quality Imperative, written by Business Week (McGraw Hill publishers). Statistical Process Control is an important part of this, and one of the best beginners books is Wheeler, DJ (2000). Understanding Variation: The Key to Managing Chaos. Knoxville, TN: SPC Press.

William H. Berman, Ph.D.
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Date: 20 Nov 2002 9:06AM
From: Richard Dougherty <dickd@doughertymanagement.com>

Hi Molly:

Well here's another voice - with some perhaps elementary responses to your questions.

Total Quality Management refers to an overarching strategy for management. A focus on customers, process analysis and measurement, and continuous quality improvement are some of the elements of a TQM approach.

Continuous Quality Improvement (CQI) is a set of activities designed to improve quality of a business process and product through a focus on planning, measurement, review and analysis (e.g. Plan-Do-Check-Act cycles).

Outcomes management I assume refers to the management activities required to maintain and or improve outcomes of service. In contrast CQI is a broader planning and management approach to apply to all business processes. In CQI, measures may address what Berwick and the Institute of Medicine refer to as "micro-processes" within the health care delivery system (admissions, billing, administrative processes as well as the clinical process) as well as "outcomes" of service. Proponents of outcomes management may not want to be restricted in focus to clinical outcomes either!

Quality Assessment as used by Herman et al in the article you cite seems to describe a group of methods to assess service quality. These have been expanded from a more traditional list of include, for example, evidence based practice procedures (e.g. fidelity).

Each of these are many sides of the same quality improvement focus of management. The concepts are somewhat nested. The use of different terms probably depends on your perspective and also to some degree what branch of our industry you are connected to. For instance, JCAHO, CARF, NCQA, the federal and state governments have all used different terms for the similar processes of standard setting, business processes and operations, measurement, and planning for quality improvement.

I could add performance measurement to the list of terms as well as statistical process control as suggested by Dr. Berman!

Good luck.

Date: 20 Nov 2002 12:43PM
From: Sylvia Perlman <sperlman@mhsacm.org>

Hi, Molly et al.,
I am delighted that this group has "come alive" again after a period of relative dormancy -- and that the discussion is such an interesting one. I agree with what others have said, and just wanted to add one point – I believe the use of the phrase "outcome management" in contrast to "outcome measurement" is intended to suggest that we should be doing more than just measuring outcomes (whether clinical, functional or other). We should be using the information we gather through measurement to manage care at the individual client level, the provider level and even the system level. That is how "outcome management" fits into TQM/CQI.

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http://www.mhsacm.org/

Date: 20 Nov 2002 2:37PM
From: David Colton <dcolton@ccca.state.va.us>

I think Richard Dougherty hit the nail on the head. Performance measurement, evaluation, CQI, TQM, etc. are essentially different terms for the same underlying process: to analyze processes as complex systems (which involves data collection/measurement) in order to improve outcomes. (Although it should also be pointed out that improving a process does not guarantee improved outcomes - one of the things we struggle with in health and behavioral health care.)

Although Deming was trained in statistical process control, he also realized that use of SPC and other techniques were not enough to ensure improvement. He recognized that the management culture in American organizations was a major obstacle to implementing QI. (His work was essentially ignored by American industry until it was pointed out that the Japanese have a national award for quality in his name.) Deming's "14 points" were developed to articulate the organizational change needed to support and spread the principles of QI throughout the organization. Although he was originally thinking of manufacturing industries when he developed the 14 points, they also apply to service and human service organizations.

A metaphor for QI: Think of the two gauges in a steam locomotive. One measures the level of water in the boiler and the other steam pressure. If the water level is too low, the boiler explodes. If the steam pressure is too high, the boiler explodes. That's performance measurement. What we do with the information is quality improvement.

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Date: 20 Nov 2002 2:39PM
From: Bill Berman <wberman@echoman.com>

I agree with Dr. Perlman's comments on outcomes measurement v. outcomes management. It is to my great frustration and disappointment, however, that I don't believe we will see outcomes management at the level of clinical outcomes for a patient/client/consumer at any time in the foreseeable future. Improved services based on organizational outcomes (increased revenues, increased services, decreased adverse experiences, for example) will continue to be used, but managing care by managing change is too expensive, too time consuming, and too threatening in the current economic climate.

I'd love to know if people out there disagree with me.

Bill Berman, Ph.D.
Director, Professional Services
Chief Clinical Officer
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wberman@echoman.com

Date: 20 Nov 2002 3:25PM
From: Susan Chernin <Susan.Chernin@phila.gov>

I have a question on a slightly different vein. I would like to know about research that has been done on recidivism and re admissions to Psychiatric hospitals and/or crisis response centers. Have any studies been done to predict what makes a successful out come for these consumers and do we have a consumer profile

Susan Chernin
Research Analyst
OMH/MR
1101 Market Street 7th Floor
215-685-5552
FAX (215)-685-5581

Date: 20 Nov 2002 3:35PM
From: Geoffrey Gray <ggray@oqsystems.com>

On 20 Nov 2002 2:39PM Bill Berman <wberman@echoman.com> wrote:

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Bill Berman, Ph.D.
Director, Professional Services
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Bill,

I disagree. Pacificare Behavioral Health is doing outcomes management for about 5 million covered lives using a short form of the OQ 45 and there are probably 50 or more college counseling centers and training clinics doing outcomes management routinely at this time. Clinicians send in assessments at the first, third, fifth and every fifth session thereafter and get automated certs based on recovery curve expectancies (no telephone tag, etc). PBHI aggregate data is of great interest with highly discrepant outcomes between solo practitioners and group practices (group practices do much better). The key to outcomes management is automation so that the process doesn't impose a burden on the clinician to do data gathering; use of the web enables data entry at virtually no cost; algorithms making ur decisions certify most care so that management is by exception. Also, identification early on of patients not making adequate progress increases significantly outcomes of those patients.

Date: 20 Nov 2002 4:11PM
From: William Berman <wberman@echoman.com>

On 20 Nov 2002 3:35PM Geoffrey Gray <ggray@oqsystems.com> wrote:

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That's great news! Have you written this up?

William H. Berman, Ph.D.
Director, Professional Services
Chief Clinical Officer
The Echo Group
603-447-8600 x1009
wberman@echoman.com

Date: 20 Nov 2002 5:13PM
From: Steve Beller <nhdspres@bestweb.net>

On 20 Nov 2002 3:35PM Geoffrey Gray <ggray@oqsystems.com> wrote:

Bill,

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Geoffrey,

Would you please elaborate about how your outcomes management process has had on the quality and cost of care? That is, in your organization, are patients getting better, quicker, because of improved evidenced-based decisions?

Steve Beller

Date: 21 Nov 2001 7:01AM
From: Elaine Kersten < Elaine.Kersten@MED.VA.GOV >

Also, one of the variables of vulnerability for measuring change is agency administration and internal/external politics…be very aware of these factors in a well designed Outcomes Program…and pay particular attention to whom the reports go: the data MIGHT demonstrate that problems occur in areas beyond the scope of the program e.g.: vocational services are designed to improve work outcomes; the provider for the 'back to work' program is another provider, and your data demonstrates that clients YOU serve are not working to their potential, and this is shared with the funding source, this could cause a political situation for the agency.. so be careful about where the data goes…can be VERY hot stuff…Additional issue: changing internal agency politics, leadership and funding constraints: all of these may play out in the status of an ongoing outcomes program.

These factors are actually HUGE…and can frustrate even the best designed outcomes program at the AGENCY level. Based on these issues (and i have had first hand experience here) i agree with Dr. Perlman…since the ultimate goal is to improve outcomes overall, which does mean getting to the System level…which can get pretty tricky…and risky…argh@

Elaine Kersten, EdD
Clinical Applications Coordinator
Northampton VAMC
413-584-4040 x2811

Date: 21 Nov 2002 8:31AM
From: Geoffrey Gray <ggray@oqsystems.com>

On 20 Nov 2002 5:13PM Steve Beller <nhdspres@bestweb.net> wrote:

Geoffrey,

Would you please elaborate about how your outcomes management process has had on the quality and cost of care? That is, in your organization, are patients getting better, quicker, because of improved evidenced-based decisions?

Steve Beller

The PBHI data is reported on their website and is representative of other naturalistic data sets now being collected. PBHI sample size over 37,000. Group practices achieved significantly more improvement per case than individual practitioners ($p<.00001$). Group practices achieved a 170% greater effect size than solo practitioners. Analysis controlled for case mix. Also, group practices averaged significantly fewer sessions per case ($p<.01$). Group practices averaged 5.4 sessions; solo practitioners 7.2 sessions (25%) difference.

Geof Gray
OQ Systems

Date: 21 Nov 2002 9:27AM
From: Ed Wise <Eawmhr@AOL.COM>

On 21 Nov 2001 7:01AM Elaine Kersten < Elaine.Kersten@MED.VA.GOV > wrote:

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Elaine Kersten, EdD
Clinical Applications Coordinator
Northampton VAMC
413-584-4040 x2811

This is a very interesting and important point. As a private practitioner working primarily with depressed adults on short term disability, I have seen the increase in accountability move our focus on return to work (rtw) related issues. We are looking for models and ways to increase rtw and I am interested in hearing how others are measuring and addressing this.

TIA,
Ed
Ed Wise, Ph.D.
Mental Health Resources
1027 S. Yates Rd.
Memphis, TN 38119

Date: 21 Nov 2002 9:49AM
From: Ed Wise < Eawmhr@AOL.COM>

On 20 Nov 2002 5:13PM Steve Beller <nhdspres@bestweb.net> wrote:

Geoffrey,

Would you please elaborate about how your outcomes management process has had on the quality and cost of care? That is, in your organization, are patients getting better, quicker, because of improved evidenced-based decisions?

Steve Beller

Steve,
Mike Lambert and his group in Salt Lake have been publishing some very interesting data on utilizing outcome data (OQ45) prior to the session. They have developed a proprietary signal alarm system that informs clinicians how patients are doing (e.g., green light, yellow, red) that clinicians use prior to the visit. A red light means doing something different now, pt is not responding according to their projected recovery rates based on a huge N (10,000+). I don' t have the citations handy, but you shouldn't have any trouble locating them. Also, Larry Beutler is developing something similar and they have a website. Jeb Brown is another pioneer here who has been instrumental in the PBHG study alluded to earlier, which uses the OQ30/lsq. They have made a lot of their data public at their web site. Exciting stuff.

Anyone know, after symptom reduction, how long it takes a depressed psych pt on disability to return to work? Or of any model programs addressing this?

Regards,
Ed

Date: 21 Nov 2002 1:25PM
From: Geoffrey Gray <ggray@oqsystems.com>

On 21 Nov 2002 8:31AM Geoffrey Gray <ggray@oqsystems.com> wrote:

The PBHI data is reported on their website and is representative of other naturalistic data sets now being collected. PBHI sample size over 37,000. Group practices achieved significantly more improvement per case than individual practitioners ($p<.00001$). Group practices achieved a 170% greater effect size than solo practitioners. Analysis controlled for case mix. Also, group practices averaged significantly fewer sessions per case ($p<.01$). Group practices averaged 5.4 sessions; solo practitioners 7.2 sessions (25%) difference.

Geof Gray
OQ Systems

go to www.pbhi.com
click on providers
click on alert clinical outcomes (on the right hand side of the page)
The 2001 report is several pages long.

Date: 21 Nov 2002 6:06PM
From: Janet Durbin <Janet_Durbin@CAMH.NET>

I would like to continue this dialogue, focusing on system performance monitoring

Is anyone aware of jurisdictions involved in routine outcome data collection in programs/agencies/facilities, where data are used to compare performance and for system management decisions.

I visited the PBHI website and read the Psy. Services article (July 2001) that was referenced. The article raised some key issues (such as potential bias in clinicians as a data source, and case mix adjustment) that need to be addressed in outcomes monitoring, and offered very thoughtful solutions. However the described initiative is targeted to individual providers rather than programs/facilities.

I am particularly interested in outcome monitoring for inpatient psychiatry but would also be interested in system level efforts to assess performance of community mental health agencies or programs.

The questions on the table for us:

1) Are the ratings of clinicians and consumers too prone to bias (for various reasons) to provide outcomes data that can be meaningfully used to assess performance?

2) Can a core set of measures be defined which are sufficiently relevant to the goals of all programs and services in a system that they can be used to provide meaningful evaluations of care delivery (e.g., a BASIS-32)?

3) Are we better off assessing use of evidence based practices (which have proven efficacy and effectiveness in formal research studies)? (perhaps combined with periodic outcomes assessment of a sample of patients using independent trained raters)?

We are looking for specific examples of systems that are successfully using outcomes data for system management.

Any feedback would be appreciated.

Janet Durbin, MSc
Research Scientist
Health Systems Research and Consulting Unit
Centre for Addiction and Mental Health
Assistant Professor
Department of Psychiatry, University of Toronto
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Date: 22 Nov 2002 9:48AM
From: David Colton <dcolton@ccca.state.va.us>

The following tidbit was shared earlier this week by NRI, which is the performance measurement division of the National Association of State Mental Health Program Directors:

"Per a recent JCAHO decision, effective immediately accredited long term care, home care, and behavioral health care organizations will no longer need to report ORYX data to JCAHO. HCOs must continue compliance with accreditation requirements for performance measurement. The NRI Performance Measurement System may continue to be used as a tool in providing facilities with national benchmarking numbers for use in performance improvement aiding in improving client care. HCOs also have the option of continuing to have NRI submit data to JCAHO but data submission is deferred until core measures are identified."

In regard to Jane Durbin's request to discuss system performance measures, I have several questions about the above announcement that perhaps someone on the list could answer.

1. Why is JCAHO dropping the performance measures developed by NASMHPD for their own core measures?
2. Why did 25% of the facilities participating in the NRI program drop out this past summer?
3. Are the NRI indicators truly outcome measures or are they actually output measures?

David Colton, Ph.D.
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Telephone: 540-332-2144
dcolton@ccca.state.va.us

Date: 22 Nov 2002 3:47PM
From: Stephen Beller <nhdspres@bestweb.net>

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Geof Gray
OQ Systems

Geoffrey,

You are certainly taking steps in the right direction. This is quite heartening!

I hope your efforts continue and your tool/process evolves into a system that (a) tracks longer-term outcomes and (b) effectively matches individual patients to the most suitable providers/treatments.

Keep up the good work!

And thanks, Ed Wise, for you comments.

Steve Beller

Date: 22 Nov 2002 11:56PM
From: Philip Friedman <integrativehelp@comcast.net>

To: Geof Gray
OQ Systems

I have some questions regarding the data on the PBHI website. If I read the information correctly the means scores for the PGP (groups) was 53.9 at intake and for the solos it was 54.3 at intake. Also the standard deviation from a non-treatment sample (why didn't you use the standard deviation from a treatment sample BTW) was 14 on the LSQ. So am I correct in saying that an effect size of .34 (overall effect size) was equivalent to a change of 4.76 points (14 times .34) and that an overall effect size of .87 (for the severely distressed group) was 12.18 points (.87 times 14) and that an overall effect size for the combined moderately distressed group was 5.74 points (.41 times 14).

If that is correct does it also mean that the average drop in distress level was from about 54.2 (combined PGP and Solos) to about 49.44 across all groups.

Also I didn't see any data on the changes over the 3 different time points which I believe were the first, 3rd and 5th sessions. Is that correct?

Thanks for your feedback and help.

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Blessings,

Phil

Philip H. Friedman, Ph.D
P.O. Box 627
Plymouth Meeting,
Pa. 19462
610-828-4674
integrativehelp@comcast.net

Date: 24 Nov 2002 9:17PM
From: Ruth Ross <DOCTORUTH@AOL.COM>

Forgive my ignorance: what is the working definition of "Group Practices" as it is used in this research?

Ruth Ross

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19 November 2002 – 20 December 2002

Date: 25 Nov 2002 8:09AM
From: William Berman <wberman@echoman.com>

On 21 Nov 2002 6:06PM Janet Durbin <Janet_Durbin@CAMH.NET> wrote:

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There are many institutional efforts to monitor performance. In 1999, the Joint Commission initiated the ORYX initiative, which requires all JCAHO accredited agencies to track performance using control and comparison charts on 6 indicators, and demonstrate how they are using these data for QI efforts. CARF and COA also require outcomes monitoring (technically these are organizational performance measures) by the agencies they accredit. The United Way also created an extensive set of documents providing education and training in performance measurement and outlining what they expect from their agencies in the way of performance monitoring and performance improvement.

My thoughts on your specific questions:
1) Are the ratings of clinicians and consumers too prone to bias (for various reasons) to provide outcomes data that can be meaningfully used to assess performance?
>> Bias is relative. When you ask a consumer if he/she has a problem with employment, they may say no, even though they are chronically unemployed, if this is not a domain of concern for him/her. The clinician for this consumer may have a different view. There is no TRUTH in this case, but there are multiple perspectives to pay attention to. I believe the issue is less one of bias, and more one of "What will you use the outcomes data for", and how much time/effort/energy does it take to get the data. It is much quicker and easier to measure whether we are "doing the right thing" than it is to measure whether we are getting the "right" result. Also, remember that a good outcome can be very different for a different

2) Can a core set of measures be defined which are sufficiently relevant to the goals of all programs and services in a system that they can be used to provide meaningful evaluations of care delivery (e.g., a BASIS-32)?
>> In my opinion, not likely for clinical outcomes. You could come up with "symptom improvement" for most populations, but how you measure that is very different for Adults and children, mental health v. substance abuse, acute v. chronic disorders. For many populations, a good outcome is "not deteriorating", not "improving". I'm not aware of any technology that would allow comparison across measures that are psychometrically valid without thousands of cases, which doesn't help with the comparison across programs. I think we are better off focusing on relatively homogeneous populations that can be measured on the same instrument. And of course, which instrument has significant issues related to the business of clinical measurement as well as the psychometric issues.

3) Are we better off assessing use of evidence based practices (which have proven efficacy and effectiveness in formal research studies)? (perhaps combined with periodic outcomes assessment of a sample of patients using independent trained raters)?
>> Better off than what? Evaluating the efficacy of EBP is very useful, and usually produces results superior to treatment as usual. But it's a different question than asking "are people getting good outcomes?"

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Date: 25 Nov 2002 8:58AM
From: Geoffrey Gray <ggray@oqsystems.com>

On 22 Nov 2002 11:56PM Philip Friedman <integrativehelp@comcast.net> wrote:

To: Geof Gray
OQ Systems

I have some questions regarding the data on the PBHI website. If I read the information correctly the means scores for the PGP (groups) was 53.9 at intake and for the solos it was 54.3 at intake. Also the standard deviation from a non-treatment sample (why didn't you use the standard deviation from a treatment sample BTW) was 14 on the LSQ. So am I correct in saying that an effect size of .34 (overall effect size) was equivalent to a change of 4.76 points (14 times .34) and that an overall effect size of .87 (for the severely distressed group) was 12.18 points (.87 times 14) and that an overall effect size for the combined moderately distressed group was 5.74 points (.41 times 14).

If that is correct does it also mean that the average drop in distress level was from about 54.2 (combined PGP and Solos) to about 49.44 across all groups.

Also I didn't see any data on the changes over the 3 different time points which I believe were the first, 3rd and 5th sessions. Is that correct?

Thanks for your feedback and help.

*The PBHI data is reported on their website and is representative of other naturalistic data sets now being collected. PBHI sample size over 37,000. Group practices achieved significantly more improvement per case than individual practitioners (p<.00001). Group practices achieved a 170% greater effect size than solo pra*ctitioners. Analysis controlled *for case mix. Also, group practices averaged significantly fewer sessions per case (p<.01). Group practices averaged 5.4 sessions; solo practitioners 7.2 sessions (25%) difference.*

Blessings,

Phil

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I didn't do the data analysis but I read the data the same way you do. Data on change by time point--recovery curve data--can be found at this site: www.clinical-informatics.com There is a link to a table that graphs change by intake score over time. Most change is in the first 3 to 5 sessions, with virtually no change after session 9.

Date: 25 Nov 2002 9:26AM
From: Geoffrey Gray <ggray@oqsystems.com>

Another two cents: Patient's self report of improvement in symptoms and quality of life is, I think, becoming the "gold standard" in health care generally, not just mental health care. That said, it is clear that there are a small percent of spmi patients for whom self-report is of limited utility. Self report measures aren't perfect: patients may exaggerate or deny symptoms. But clinicians do the same thing and if measures are used to evaluate clinical performance, then there is a strong incentive for them to systematically bias the assessment and this bias is hard to adjust for statistically. Furthermore, the idiosyncratic biases of patients are likely to be randomly distributed across providers making self-report measures more reliable and cheat resistant.

Date: 25 Nov 2002 11:18AM
From: David Colton < DCOLTON@ccca.state.va.us>

Last week I posted a message regarding reporting of performance data to JCAHO (for the ORYX project) through NRI. The good folks at NRI called me to respond to my questions. First, it was noted that NRI is not a division of the National Association of State Mental Health Program Directors. Second, facilities did not drop out of the program; they chose to report on different indicators. My apologies to NRI if my comments suggested any problems with their program.

However, I think that my last question about output vs. outcome measures does apply to your situation. Many of the performance indicators we collect in behavioral health care reflect outputs/processes, such as access and timeliness of treatment. It is only when we decide to act on the data (QI) that they can become outcome measures. In other words, you may want to differentiate the term "outcome measure" from "performance indicator" when thinking about and reporting this information.

Two questions you might ask of the process could be:
(1) Do the performance indicators contribute to improved client functioning (which is typically the goal of human service agencies)?

(2) What is an acceptable threshold for performance? That's a qualitative activity which could include stakeholders.

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Date: 25 Nov 2002 12:56PM
From: Philip Friedman <Integrativehelp@AOL.COM>

Geof,

In a message dated 11/25/02 9:07:03 AM, ggray@oqsystems.com writes:
<< I didn't do the data analysis but I read the data the same way you do. Data on change by time point--recovery curve data--can be found at this site: www.clinical-informatics.com There is a link to a table that graphs change by intake score over time. Most change is in the first 3 to 5 sessions, with virtually no change after session 9. >>

I have read a great deal of information on the www.clinical-informatics.com site plus the PBH cite and can't seem to locate the table that indicates change by intake over time. Can you direct me more specifically (URL) to that table/graph. Thanks.

Phil

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Date: 25 Nov 2002 8:40PM
From: Ed Wise <Eawmhr@AOL.COM>

Phil,

From

www.clinical-informatics.com

click on Decision Support Tools

There, you have a list of 4 or 5 choices and all are worth reviewing. The Trajectory of Change graph is very exciting. It requires you to enter an LSQ score (0-120) for a pt. and then plots a projected trajectory of change. As more sessions occur and more data points are entered, accuracy about projections increases. PBH now uses LSQ scores to obtain an auth for additional sessions! There are other reports, like the Change Index report, which is useful for looking at therapists in a clinic, or aggregate Outcomes, which puts it all in a report. Fascinating stuff and Jeb Brown, who owns the site, is knowledgeable and helpful. HTH,

Ed

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Date: 2 Dec 2002 2:27PM
From: Jacob Silver <jacobsilver@chartermi.net>

In my first response to the questions addressed here, which was stopped by the listpolizei, I indicated that it is the fairly usual practice of general evaluators, a species of which I may be appelled, that subjective responses, such as those derived from questionnaires, are often counterbalanced by observed client performance responses (objective data). These performance responses may be the results of performance tests, physical or mental examinations, or client behavior post treatment. To provide interpretability of post treatment behavior, it is advisable to take the very same readings prior to treatment. These are general points. But, as William says so earnestly, subjective responses are to be treated and reported as such. They refer to no reality other than the respondents' assertions, or responses, about that reality. The question of TRUTH certainly cannot and does not apply. Truth, in scientific medial or social research, in fact never pertains only to the substance of one researcher's finding until, and unless, that research has been successfully replicated, and the same finding produced. As any finding is perpetually capable of being falsified, truth in science is every only provisional. Because this jars the traditional meaning of the word, truth, is hardly every used in scientific social and medical research.

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Date: 2 Dec 2002 2:29PM
From: John Ward <ward@fmhi.usf.edu>

I feel a need to add a few cents here as well. As a practicing clinician and a mental health services researcher and an academic faculty member at a major research university and mental health research institute, it is difficult for me to continually hear (read) such strong statements about the lack of integrity of clinicians practicing in the behavioral health industry...and I assume your comments include private as well as public domains of practice. As a clinical psychologist (and the same could be said of Psychiatry and Social Work) we have published codes of ethics and national associations to review and measure acts of impropriety and misconduct. I would be interested in reading the peer reviewed articles supporting Geoff's statements that the "...strong incentive for them to systematically bias the assessment..." actually translates into "...there is strong evidence that these clinicians misrepresented the status of the patient and therefore the data is not valid". In Florida, we have done a few validity evaluations of clinician completed functional assessment data (submitted to meet state performance contract requirements) by comparing ranges of ratings on critical functional domains with other information reported in clinical records (by that same clinician and or other clinicians entering information into the clinical chart about that same consumer). The issue of "underreporting" (meaning assessments that were either not done or not found in the chart) were more of an issue than the validity of the clinician completed functional assessments that were found in the charts.

If in deed there is strong evidence that even one clinician is misrepresenting the status of patients under their care by entering data in a clinical record that is erroneous or misleading, that clinician should be reported to a board of peers for review...or to the board that licenses his or her professional activity.

Now, having said that... and running the risk of appearing self righteously high and mighty, naive and completely out of touch with reality, I think it is clear that if there is an objective body of evidence that our behavioral healthcare industry is replete with clinical staff that are willing to be that dishonest, we have a more serious problem than whether or not we use clinician or consumer completed measures to measure outcomes. There can be no substitute for integrity.

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Date: 3 Dec 2002 2:04PM
From: Geoffrey Gray <ggray@oqsystems.com>

I did not mean to imply or state that clinicians are unethical. I do mean to state that patients are better reporters of their internal states than are clinicians and the research shows a systematic divergence between clinician report and patient self report. Recent research, for instance, shows that clinicians are insensitive to patients' early change in response to treatment and that when alerted to that change better recognize patient deterioration (or rapid improvement).

Date: 3 Dec 2002 5:01PM
From: John Ward <ward@fmhi.usf.edu>

Thanks Geoff...yours is a reasonable response and reasonable summary of some studies of clinical judgment and observation...and to some extent I tend to agree. However, given the degree of power and trust we ultimately place with clinicians, it still seems a shame to say we cannot find a way to reliably utilize clinician's evaluations of consumer functional status to document status at beginning of treatment and at some periods post admission to assist us in determining whether or not people improve as a result of that care. It is, after all, the initial clinical assessment by clinical staff that is generally used to document the consumer's level of functioning and to determine need for treatment or treatment level. In reality, while the definition of what constitutes a qualified clinician may vary between agencies and programs (depending on whether you are talking about an intake counselor, a case manager, a mental health technician, a social worker, a nurse practitioner, a psychologist or a psychiatrist) private payors and much of the public mental health system require that these type of clinical assessments be done, that the results are available in the clinical record, and that they be completed by an appropriately credentialed and qualified clinician.

With regard to clinician detection of "rapid improvement" or "rapid deterioration", most large outcome monitoring systems schedule post admission evaluations to no sooner than three months (but usually about six months) from admission...and/or at discharge from treatment. In most cases, that might be a little outside the "rapid" time lines. A slightly different problem we have seen in the public mental health system is that the clinician completing the admission evaluation is often not the same clinician who ends up completing the post admission or discharge evaluations for any individual consumer. While that certainly lends fuel to the concern that without consistency in raters, clinician evaluations my not be reliable, that has not generally been the case when we have looked at interrater reliability with our measures.

However, none of this precludes use of valid and reliable consumer completed questionnaires to augment (compare, contrast and evaluate) the clinician's and consumer's perspectives where they may differ. Thus, rather than relying on only one source of data, the best choice may not be one or the other, but a combination. In fact, that would seem the optimal methodology for an outcomes monitoring system as well as a Quality Assurance model within an agency. That process might offer opportunity to monitor as well as improve outcomes by detecting those areas of disagreement for structured feedback to clinicians and consumers as a way of improving the therapeutic alliance. I only have a little data on comparison procedure of clinician and consumer completed measures on the same functional domains. However, it has been our experience that the most valid and reliable and complete clinician assessment data is found in agencies that use the data in their own QA program in addition to reporting it externally to a state level monitoring and accountability system.

John C. Ward, Jr., Ph.D.

Date: 4 Dec 2002 7:26AM
From: Dee Roth <RothD@mh.state.oh.us>

I heartily agree with John's suggestion and, in fact, that is what we are doing in the Ohio Mental Health Consumer Outcomes System. A large, blue-ribbon, multi-constituency task force helped us develop the System, and they felt strongly that consumers are better reporters on their own internal state than are clinicians. Hence, we are using the MHSIP Symptom Distress Scale as part of our adult instrument. The task force made the very important distinction between symptom distress--how much various symptoms bother the consumer--and symptom presence--something a clinician could report on. They deliberately chose the former concept for measurement because they felt it was more in line with Recovery concepts, i.e., a consumer can have symptoms but can manage them to the extent that they are less bothersome, and this is what matters.

On the other hand, the task force felt that clinicians are best able to rate community functioning, so we have a short instrument that does this for our adult consumers with serious mental illnesses. This fall we have been going around the state doing trainings for case managers and clinicians on how to use the Outcomes System data for treatment planning and progress monitoring, and we have been stressing that the two different perspectives on different areas of the consumer's life are critical for understanding the whole person and how to help him/her progress.

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Date: 20 Dec 2002 10:23AM
From: David Colton <DCOLTON@ccca.state.va.us>

Last month there was some discussion about outcomes management systems and the work being done by Pacificare Behavioral Health. I finally had some time to read the literature on PBH's ALERT system and was quite impressed with this effort. However, I have several questions about the administration of the assessment instrument that would help me understand the data collect process.

First, how often is the questionnaire administered during the course of treatment? Since the average number of sessions is limited to 5.4 sessions in group practices and 7.2 with solo practitioners, how often does the questionnaire need to be administered to ensure that the provider is alerted in a timely manner to results that need immediate attention?

How is the questionnaire administered, when during the course of treatment (e.g., after a therapy session), and approximately how long does it take for the consumer to complete?

To what if any extent does the consumer's mental health status affect the reliability of the results? For example, if the consumer is confused, anxious, or fearful, does it have any affect on how they report their mental health status?

Finally, has any "test / retest" affect been noted as a result of the consumer completing the same instrument over multiple administrations?

Thanks in advance to those working with this system who can address these questions.

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Date: 20 Dec 2002 11:28AM
From: Geoffrey Gray <ggray@oqsystems.com>

I work with the parent instrument, the OQ 45.2 and YOQ. We have deployed an outcomes management system analogous to PBHIs in a variety of settings: training clinics, counseling centers, and managed care orgs, etc. We did not look at group practitioners vs. individual practitioners--rather at overall organizational performance. We found that clinical effectiveness improved as a function of experience with the system: viz. the more a clinician used the system, the better his/her outcomes. We also found a modest decline in utilization. Both findings are consistent with Lambert's results in controlled studies.

Ideally the instrument should be administered every session. Using technology such as the Palm results in 99% acceptance. The other most common protocol is first, third, fifth, and every fifth thereafter. It is important to get a second assessment early on as that is when patients are likely to make the greatest change.

The instrument is administered BEFORE the session. The OQ 45 takes 2 minutes or less on a Palm or the internet, the OQ 30 takes even less.

Level of distress is measured by the instrument so the greater the patients distress the higher the score. Patients who are cognitively compromised, i.e. psychotic, etc are not suitable for self-report.

Test-retest effect has been noted and is discussed in the literature.

Date: 20 Dec 2002 12:48PM
From: Dave Johnson <JJbuild96@AOL.COM>

Most measurement instruments will have a difficult time in obtaining valid responses from a highly confused individual. Given that, a recent study reports findings on validity of OQ-45 in comparison to the BASIS-32 based on patients in inpatient settings, where there is a greater likelihood for psychosis and serious disturbance.

Doerfler, Addis and Moran (2002, November) Evaluating Mental Health Outcomes in an Inpatient Setting: Convergent and Divergent Validity of the OQ-45 and BASIS-32. The Journal of Behavioral Health Services and Research.

One of their concluding points states:

With regard to psychometric considerations, either measure alone will provide an acceptable outcomes measure. If outcomes assessment is restricted to inpatient psychiatric settings, the BASIS-32 may be preferable because it includes symptoms of psychosis and impulsive behaviors…If the goal of outcomes assessment is to examine the impact of treatment across various levels of care (e.g., inpatient, day treatment, outpatient), the OQ-45 may offer several advantages. The OQ-45 is already well established as a measure to assess outcomes for outpatient psychotherapy, and the present results indicate that it is an acceptable measure for inpatient settings…(pp 402-403).

Dave Johnson