

TECScript 8

Representative Sample for Outcomes

Messages from 20 March 2003 – 25 March 2003



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 **TECScript** 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.

TECScripts 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 **TECScripts** 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 TECScripts 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 TECScripts. 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* 8
Representative Sample for Outcomes
20 March 2003 – 25 March 2003

Date: 20 Mar 2003 4:49PM

From: Susan Mims <susan.mims@ozarkguidance.org>

I'd appreciate some input about standard practice wisdom regarding the use of outcomes measures in only a sampling of the programs' participants, as compared to conducting outcomes on 100% of the participants. Is this commonly done? Is it acceptable as a measure of a program's effectiveness? If so, what percentage of the population should be sampled?

Thanks!

Susan Mims
Ozark Guidance
Children & Family Services
2466 S. 48th Street
Springdale, AR 72766
(470) 750-2020, ext. 450

TECScript 8
Representative Sample for Outcomes
20 March 2003 – 25 March 2003

Date: 21 Mar 2003 7:19AM
From: Dee Roth <RothD@mh.state.oh.us>

If you have a carefully drawn random sample, of a large enough percentage of participants, then it's valid for determining effectiveness. However, we've had an interesting experience with that here, with our Ohio Mental Health Outcomes System. We require that all adult SMD and child consumers be measured, but our Procedural Manual allows for a sampling of the adult general mental health population. It was a political compromise to lessen the burden on provider agencies.

But as the Outcomes System began to be implemented, we heard from more and more people who did not want to do sampling because, frankly, it can be a real pain in the neck--you have to figure out what's an adequate sample, and then you have to have ticklers on all those folks sampled so that they can be given the post measure, etc. It's less of a problem to just give the instrument to everybody, and not have all that specialized tracking.

There's another reason not to go with sampling. Outcomes instruments can be very useful clinically--for helping to design treatment plans and for ongoing monitoring of how an individual is doing. However, if you have only a certain percentage of the clients being measured, then staff don't get into the habit of using the information clinically--because not every client has it--and the measurement process becomes an exercise for somebody else, rather than for the use of those closest to the clients. The more useful the information is to staff, the more carefully measurements will get done.

Dee Roth, MA, Chief
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Ohio Department of Mental Health
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OPER site: www.mh.state.oh.us/oper.html
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Date: 21 Mar 2003 8:38AM
From: John Ward <ward@fmhi.usf.edu>

What Dee describes well has also been our experience in Florida. Florida now requires outcomes reporting on all people served...at admission, six months, annually and at discharge from care. As much of a pain that has been in helping agencies move to compliance and produce valid information, in my opinion, that process has resulted in better reporting than any earlier attempts at sampling. As Dee says, developing an adequate sample size, insuring that the sample is random (not biased, etc.) and representative of the total population of interest (not a convenience sample) requires a level of complexity most providers do not have infrastructure to manage. Florida has tried variants of cross sectional sampling (one particular point in time where all people in a selected sample and/or all people in the population of interest are evaluated) and variants of random sampling over time (e.g., all people with soc. numbers ending in an even number...or all people admitted on a certain day of the week...are evaluated for the entire year). The latter was attempted to evaluate outcomes for people in short term crises services to lessen the reporting burden on the staff who were already busy admitting and discharging large numbers of people with short stays (2 to 5 days). In my opinion, the results were not good...some staff of some agencies said it was easier to do it on everyone than try to remember who you evaluated on a certain day in order to complete a discharge assessment when they left service. However, whether you sample or not, you still want to know if characteristics of people on whom you have outcome measures reported are comparable to people on whom outcomes were not reported. However, I want to expand on what may be the most important thing Dee said...that is, no matter what you do, based on our experience in Florida and elsewhere, if your outcome measures are not simple and they do not produce clinically relevant information that is immediately available to clinicians (for client care decisions and treatment planning)and the service agency (for quality assurance monitoring), or methods of reporting are complex, compliance in using and/or reporting those outcome measures will be poor and data integrity will always be an issue.

John

John C. Ward, Jr., Ph.D.
Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Institute
and, Department of Epidemiology and Biostatistics
College of Public Health
University of South Florida
Tampa, Florida

TECScript 8
Representative Sample for Outcomes
20 March 2003 – 25 March 2003

Date: 21 Mar 2003 9:50AM

From: Richard Speiglmán <richards@PHI.ORG>

Very interesting and useful comments from John and Dee. To add one point, regarding measuring program effectiveness -- if you are thinking of evaluating program in addition to personal effects -- it is possible to have and then use too LARGE an n, which could make socially/institutionally meaningless outcomes appear statistically significant. At that point you're into a power analysis to find the appropriate n for analytical purposes, and then randomly selecting cases for analysis.

R.

Richard Speiglmán
Research Program Director
Public Health Institute
2168 Shattuck Ave., #300
Berkeley, CA 94704
phone 510. 649-1987
fax 510. 649-7894

TEC*Script* 8
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20 March 2003 – 25 March 2003

Date: 21 Mar 2003 9:59AM
From: Bill Ward <wbward@JUNO.COM >

Susan,

This is an involved question.

First, if outcome data are easily available for 100%, use them.

If you have to collect them separately, the cost is only one factor. Stretching expert resources is a more critical issue so that getting close to 100% of a well selected sample is better usually than 80% of an entire population if based on convenience of reaching the participants. I'm sure that many others will address other issues.

Bill Ward

TECScript 8
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20 March 2003 – 25 March 2003

Date: 21 Mar 2003 10:06AM

From: Scott Meier <stmeier@ACSU.BUFFALO.EDU>

In working with several large urban and suburban community mental health agencies I've reached similar conclusions about collecting data. Most people will complete surveys at intake but the follow-up is the difficult task.

The simplest and most effective approach for us to gather follow-up data has been to set "data collection months" when we provide outcome measures to everyone who walks in the door (generally 4 times a year). This approach has its problems (e.g., we tend to get the "healthiest" folks to reply; see reference below) but in agencies with few or no resources for data collection, this is the simplest way to gather sufficient quantitative data to do outcome analyses.

I'm amazed at how little recognition there is of the need for resources to do data collection and data cleaning before analysis. Does anyone know of studies or references to this issue?

FYI about our experiences with data collection:

Meier, S. T., & Letsch, E. (2000). Data collection issues in an urban community mental health center: What is necessary and sufficient information for outcome assessment? *Professional Psychology: Research and Practice*, 31, 409-411.

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Date: 21 Mar 2003 12:13PM
From: John Ward <ward@fmhi.usf.edu>

On 21 Mar 2003 9:50AM Richard Speiglmán <richards@PHI.ORG> wrote:

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R.

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Excellent point, Richard. It does seem important that clinical measures used for performance outcomes be evaluated on basis of meaningful clinical change in addition to statistical significance. That has often been pointed out as a problem with using global measures like the GAF, GAS or CGAS...i.e., easy to get clinical significance between ratings (e.g., 52 vs. 58) in large populations, but measures not often interpretable clinically...or less useful in describing characteristics of those large populations.

John

John C. Ward, Jr., Ph.D.
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and, Department of Epidemiology and Biostatistics
College of Public Health
University of South Florida
Tampa, Florida

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Date: 24 Mar 2003 10:41AM
From: Susan Mims <susan.mims@ozarkguidance.org>

On 21 Mar 2003 9:50AM Richard Speigman <richards@PHI.ORG> wrote:

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Thanks Richard.

What n size would you see as too large?

Susan Mims
Children & Family Services
Room 200
Ext. 450

TEC Script 8
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Date: 24 Mar 2003 10:45AM

From: Susan Mims <susan.mims@ozarkguidance.org>

On 21 Mar 2003 10:06AM Scott Meier <stmeier@ACSU.BUFFALO.EDU> wrote:

In working with several large urban and suburban community mental health agencies I've reached similar conclusions about collecting data. Most people will complete surveys at intake but the follow-up is the difficult task.

The simplest and most effective approach for us to gather follow-up data has been to set "data collection months" when we provide outcome measures to everyone who walks in the door (generally 4 times a year). This approach has its problems (e.g., we tend to get the "healthiest" folks to reply; see reference below) but in agencies with few or no resources for data collection, this is the simplest way to gather sufficient quantitative data to do outcome analyses.

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FYI about our experiences with data collection:

Meier, S. T., & Letsch, E. (2000). Data collection issues in an urban community mental health center: What is necessary and sufficient information for outcome assessment? Professional Psychology: Research and Practice, 31, 409-411.

Thanks for this, Scott, and for your article; I'll have to take a look at that.

You've raised an issue that we're also struggling with: who is to collect the data? Clinicians say they are too overwhelmed with paperwork to do this. With the current documentation requirements in Medicaid, our primary revenue source, this is a real factor, not just perceptual.

Susan Mims
Children & Family Services
Room 200
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Date: 24 Mar 2003 10:50AM
From: Susan Mims <susan.mims@ozarkguidance.org>

On 21 Mar 2003 9:59AM Bill Ward <wbward@JUNO.COM > wrote:

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Bill Ward

Thanks for this, Bill. Can you tell me where the figure 80% comes from—just curious.

Susan Mims
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2466 S. 48th Street
Springdale, AR 72766
(479) 750-2020, ext. 450

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Date: 24 Mar 2003 12:15PM
From: Scott Meier <stmeier@ACSU.BUFFALO.EDU>

On 24 Mar 2003 10:45AM Susan Mims <susan.mims@ozarkguidance.org> wrote:

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*Susan Mims
Children & Family Services
Room 200
Ext. 450*

I see at least two important problems in data collection, Susan, that I'd be interested in hearing others' thoughts about.

First, many funding agencies (and some agency administrators) act as if data magically appear, i.e., there's no effort required to collect it or set up systems to monitor the quality of data. Funding agencies are willing to pay for interventions, but require assessments and yet don't provide additional funding for this.

Second, many clinicians (I am the director of training for a counseling psychology program) seem data-averse. More structured forms of feedback, such as that provided in outcome assessment, just don't figure in their thinking. Some of this is vocational interests and some is lack of training, I'd guess.

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Date: 24 Mar 2003 1:04PM
From: Richard Speiglmán <richards@PHI.ORG>

On 24 Mar 2003 10:41 AM Susan Mims <susan.mims@ozarkguidance.org> wrote:

Thanks Richard.

What n size would you see as too large?

*Susan Mims
Children & Family Services
Room 200
Ext. 450*

Susan:

Alas. It depends . . . on the question you're asking and on the statistical strategy you're planning on using to get the answer. That's why people like Rex Green exist (you still on this list, Rex?), who can do the calculations for you.

Richard

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Date: 24 Mar 2003 1:08PM
From: Susan Mims <susan.mims@ozarkguidance.org>

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Scott, I'm very new at outcomes work-still spanking new!-but I have some thoughts from the front line/trenches, from whence I have recently come. Regarding clinician "data-aversion", I think there are several issues: one is that people who are drawn to practice are generally not also drawn to the more mathematical/statistical aspects of what it means to provide good practice. I see it as a kind of "right brain/left brain" split, though I realize that is a generalization. My own experience from grad school is that the instructors made a good case about why we must evaluate our own practice, but the students saw that component of our training as a hoop they had to jump through to get to the "meat", like Clinical Methods. A better way for this to be approached might be for the clinical instructors to incorporate into their training some aspect of outcomes, including tips on how to integrate this into one's daily practice. There is a disconnect in the training programs; the clinical "gurus" need to actively support measuring effectiveness; are they doing this in a meaningful way? Modeling is a powerful teaching tool; if it comes from the clinical guru too, the concept may pack more wallop.

Regarding the time factor, all I can say is that I can see what we're up against here, and I wish I could think of a simple way to do this without increasing our costs, but I don't see how. We cover a four county area and see thousands of clients a year. We are struggling to put together a package of instruments that will have clinical utility, face validity, and brevity, to get clinician buy-in, and that will also have solid good psychometric properties and be sensitive to change, with aspects that capture the concerns of our younger clients too. This is proving to be a challenge, particularly if you don't want to use four or five instruments! Tracking this, not to mention scoring and reporting, will indeed require us to invest more money into this, at a time when our revenue sources are shrinking.

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(479) 750-2020, ext. 450

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20 March 2003 – 25 March 2003

Date: 25 Mar 2003 8:15AM
From: Dee Roth <RothD@mh.state.oh.us>

On 24 Mar 2003 12:15PM Scott Meier <stmeier@ACSU.BUFFALO.EDU> wrote:

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Well, I'll probably get yelled at here, but I feel like I ought to provide some of the perspective of one of those nasty funding agencies. From where we sit, it sometimes seems like providers are only too happy to take large sums of money (huge sums, actually--in Ohio last year it was \$863,281,070) for treatment and yet we have no idea whether any of what they do is helping anybody. Almost every biennium, when it comes budget time at the Statehouse, legislators ask us "So, is all that money we are giving you making anybody better?", and we have had to find a really creative way to say something other than "We have no idea." So, we think that it is not unreasonable to ask for some accountability along with the huge sums of money, especially since they are public, taxpayer dollars.

Having said that, of course, we are very aware that data don't magically appear. When we rolled out our Ohio Mental Health Consumer Outcomes System, we gave out \$3 million in incentive grants so that local providers could purchase the technology needed to collect the data, and we've supplied a steady stream of products to help them use the data, including a Template that generates nice little client status reports for case managers and clinicians. However, we think it is now a fundamental responsibility of those provider agencies to get us information on a regular basis on how folks are doing under their care. Outcomes data collection can be about all three things--accountability, internal quality improvement and good clinical care--and that's what we are aiming for here.

Dee Roth, MA, Chief
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20 March 2003 – 25 March 2003

Date: 25 Mar 2003 8:49AM
From: John Ward <ward@fmhi.usf.edu>

On 25 Mar 2003 8:15AM Dee Roth <RothD@mb.state.oh.us> wrote:

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Nicely said...difficult to disagree. As in most areas of human behavior it probably boils down to expectations. I know that in my own private practice and as a tenured university faculty member, documentation and accountability (with accompanying paper or electronic data submission requirements) bring about moans and groans from us all...but, to be honest, I think as faculty members we often complain more about how valid the information is, how easy or difficult it is for us to report it and whether or not it is used "fairly" (certainly a loaded word and difficult concept in practice) by university administrators or policy makers. I think that is where some provider agencies of behavioral health services who are required to report outcomes to state funders often have a legitimate complaint or concern. However, I know that in Florida we have tried to address those issues...and it certainly sounds like Ohio and a few other states I know about are going the extra mile to become "user friendly". To the extent that state funders get better at addressing those more valid concerns and assure and demonstrate to providers that there is utility and validity and usefulness (fairly

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and even handedly applied) of the information they are required to submit, clinician and provider expectations will/should/could change and overall dissent will lessen...I hope!

John

John C. Ward, Jr., Ph.D.
Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Inst.
University of South Florida
Tampa, Florida
813-974-1929

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20 March 2003 – 25 March 2003

Date: 25 Mar 2003 9:37AM
From: Dick Dillon <razer@IX.NETCOM.COM>

On 25 Mar 2003 8:15AM Dee Roth <RothD@mb.state.oh.us> wrote:

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Having said that, of course, we are very aware that data don't magically appear. When we rolled out our Ohio Mental Health Consumer Outcomes System, we gave out \$3 million in incentive grants so that local providers could purchase the technology needed to collect the Data and we've supplied a steady stream of products to help them use the data, including a Template that generates nice little client status reports for case managers and clinicians. However, we think it is now a fundamental responsibility of those provider agencies to get us information on a regular basis on how folks are doing under their care. Outcomes data collection can be about all three things--accountability, internal quality improvement and good clinical care--and that's what we are aiming for here.

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Dee Roth

I couldn't agree with you more about the cavalier attitude we take towards providing hard statistics on the value of the work we do. They (whoever they are) want statistics and we tell them success stories.

On the other hand, in Missouri, our contracts with state agencies have no funding built into them to gather outcome information or process that information. With the very lean margins we run, it is a challenge to figure out how to do a good job in this regard. Is it so different in Ohio?

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I've been preaching outcomes-based payment system for over a decade here. People don't like me much for that. But we have to show that what we do actually works or soon no one will want to pay us anything.

DD

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Date: 25 Mar 2003 9:47AM
From: Dee Roth <RothD@mh.state.oh.us>

On 24 Mar 2003 1:08PM Susan Mims <susan.mims@ozarkguidance.org> wrote:

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*Susan Mims
Ozark Guidance/Children & Family Services
2466 S. 48th Street
Springdale, AR 72766
(479) 750-2020, ext. 450*

Susan is absolutely right about what needs to happen in graduate school, and also in programs that train case managers too! People need to see data collection as a tool to help them do their work, not as something on the side that they just do because someone wants them to.

Dee Roth, MA, Chief
Office of Program Evaluation & Research, Ohio Department of Mental Health
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TECScript 8
Representative Sample for Outcomes
20 March 2003 – 25 March 2003

Date: 25 Mar 2003 9:49AM
From: Bill Berman <wberman@echoman.com>

On 25 Mar 2003 9:37AM Dick Dillon <razer@IX.NETCOM.COM> wrote:

Dee Roth

I couldn't agree with you more about the cavalier attitude we take towards providing hard statistics on the value of the work we do. They (whoever they are) want statistics and we tell them success stories.

On the other hand, in Missouri, our contracts with state agencies have no funding built into them to gather outcome information or process that information. With the very lean margins we run, it is a challenge to figure out how to do a good job in this regard. Is it so different in Ohio?

I've been preaching outcomes-based payment system for over a decade here. People don't like me much for that. But we have to show that what we do actually works or soon no one will want to pay us anything.

DD

As I recall, Ohio had spent a chunk of change on creating a data warehouse/data mining tool for the agencies as well. Has that been implemented? Given that Ohio now has a huge dataset with tremendous comparison data, how is it being used both by the agencies and by the state? Are control/comparison reports or other benchmarking and QI tools being provided, or do agencies have access to these data?

Bill Berman

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20 March 2003 – 25 March 2003

Date: 25 Mar 2003 10:17AM

From: Holly Wald <HPWAssociates@AOL.COM>

I have been experiencing similar issues for years. One tactic that seems to help is to include staff in the review and development of some data collection instruments and to share the results of the analyses on a regular basis. That helps to foster their "buy-in" into the process as they begin to see that they are collecting information that is useful to them.

Holly P. Wald, Ph.D
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TEC Script 8
Representative Sample for Outcomes
20 March 2003 – 25 March 2003

Date: 25 Mar 2003 1:27PM
From: Dee Roth <RothD@mh.state.oh.us>

On 25 Mar 2003 8:49AM John Ward <ward@fmbi.usf.edu> wrote:

Nicely said...difficult to disagree. As in most areas of human behavior it probably boils down to expectations. I know that in my own private practice and as a tenured university faculty member, documentation and accountability (with accompanying paper or electronic data submission requirements) bring about moans and groans from us all...but, to be honest, I think as faculty members we often complain more about how valid the information is, how easy or difficult it is for us to report it and whether or not it is used "fairly" (certainly a loaded word and difficult concept in practice) by university administrators or policy makers. I think that is where some provider agencies of behavioral health services who are required to report outcomes to state funders often have a legitimate complaint or concern. However, I know that in Florida we have tried to address those issues...and it certainly sounds like Ohio and a few other states I know about are going the extra mile to become "user friendly". To the extent that state funders get better at addressing those more valid concerns and assure and demonstrate to providers that there is utility and validity and usefulness (fairly and even handedly applied) of the information they are required to submit, clinician and provider expectations will/ should/ could change and overall dissent will lessen...I hope!

John

*John C. Ward, Jr., Ph.D.
Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Inst.
University of South Florida
Tampa, Florida
813-974-1929*

Yes, indeed--that "how are you going to use the data?" question, with its implied "against me?" addendum is certainly an issue! Here in Ohio we have an additional layer of local mental health boards between the state and the provider agencies, and our agencies have been much more concerned about how the local boards will use the data than how we will use it at our level. To address this issue we have done a couple of things. We've issued a number of "Caveats" every time we have talked about data use at the local level, and these get repeated when we do presentations, etc. An example: data should not be used for funding decisions for a long time--enough time for the Outcomes System to get established and for norms to get established, etc.

The second thing, which is coming up on our plates very soon, is the issue of case-mix adjusting the data. We hope to eventually develop an algorithm that will do this in order for comparisons to be made between agencies, as you put it, more "fairly". But, this whole use of data area is a thorny issue and is likely to remain one for some time to come!

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From: Dee Roth <RothD@mh.state.oh.us>

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On the other hand, in Missouri, our contracts with state agencies have no funding built into them to gather outcome information or process that information. With the very lean margins we run, it is a challenge to figure out how to do a good job in this regard. Is it so different in Ohio?

I've been preaching outcomes-based payment system for over a decade here. People don't like me much for that. But we have to show that what we do actually works or soon no one will want to pay us anything.

DD

With two budget cuts to the Ohio mental health system this fiscal year, margins here are definitely lean for provider agencies and all of us. The Department of Mental Health's share of the overall state budget has been eroding for 10 years now, and at this point we have a pretty frayed safety net. However, there's been some discussion that maybe this erosion has been partly due to the fact that we have had no data to convince the legislature that our system really delivers outcomes for the money we get. Other sectors of the service system have a lot of hard data, and we go to them with a plea that helping people with serious mental illness is a social obligation. In an era where the state budget is down the drain and nobody wants to raise taxes. So, again, I guess I am still in the camp of agencies needing to provide data on outcomes back to funders in exchange for the money they get, versus "we'll only tell you how clients are doing if you pay us even more."

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TEC Script 8
Representative Sample for Outcomes
20 March 2003 – 25 March 2003

Date: 25 Mar 2003 1:46PM
From: Dee Roth <RothD@mh.state.oh.us>

On 25 Mar 2003 9:49AM Bill Berman <wberman@echoman.com> wrote:

As I recall, Ohio had spent a chunk of change on creating a data warehouse/data mining tool for the agencies as well. Has that been implemented? Given that Ohio now has a huge dataset with tremendous comparison data, how is it being used both by the agencies and by the state? Are control/comparison reports or other benchmarking and QI tools being provided, or do agencies have access to these data?

Bill Berman

Well, in all honesty, we are not quite there yet. This is one area in which the two budget cuts to the Department of Mental Health are hurting us badly. So far, a data warehouse/data mart has been instituted for the data on services/claims. We've got a statewide Outcomes Data Mart Committee working to specify what an Outcomes data mart should look like--what data elements should be included, what kinds of questions it should be able to answer, what comparisons should be provided for, etc. That information should be ready for our leadership to act on early in the next fiscal year. The leadership are very committed to making this kind of resource available for people--so they have comparison and benchmarking data--but we are all holding our breaths to see what kind of resources will be available. We're doing all this work against the backdrop of a huge, looming state deficit and a very conservative legislature.

In the meantime, my office will be putting out aggregate data reports so individual clinicians and agencies can use those for comparisons. We just issued the first one a month ago--it is on our Outcomes Web site if anyone is interested.

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TECScript 8
Representative Sample for Outcomes
20 March 2003 – 25 March 2003

Date: 25 Mar 2003 1:51PM
From: Dick Dillon <razer@IX.NETCOM.COM>

On 25 Mar 2003 1:37PM Dee Roth <RothD@mb.state.ob.us> wrote:

With two budget cuts to the Ohio mental health system this fiscal year, margins here are definitely lean for provider agencies and all of us. The Department of Mental Health's share of the overall state budget has been eroding for 10 years now, and at this point we have a pretty frayed safety net. However, there's been some discussion that maybe this erosion has been partly due to the fact that we have had no data to convince the legislature that our system really delivers outcomes for the money we get. Other sectors of the service system have a lot of hard data, and we go to them with a plea that helping people with serious mental illness is a social obligation. In an era where the state budget is down the drain and nobody wants to raise taxes. So, again, I guess I am still in the camp of agencies needing to provide data on outcomes back to funders in exchange for the money they get, versus "we'll only tell you how clients are doing if you pay us even more."

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our approach (as providers) has not been "pay us even more" but more along the lines of "let us use a small portion of our contracts -- perhaps 5% -- to evaluate how well we are using the other 95%" We don't want more money, just the ability to use some of it for this specific purpose. 5% is not much considering that CSAT is suggesting 20% for evaluation purposes in recent Grant RFAs!!

Dick