the EVALUATION CENTER @ HSRI

TECScript 9

Outcomes and Return on Investment (ROI)

Messages from 25 March 2003 – 11 April 2003

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

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Center for Mental Health Services
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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 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* 9
Outcomes and Return on Investment (ROI)
25 March 2003 – 11 April 2003

Date: 25 Mar 2003 3:14PM
From: Stephen Beller <nhdspres@bestweb.net>

I think one of the ways to educate organizations as to the value of outcomes data is ROI (return on investment).

The process for collecting, analyzing and reporting outcomes requires an investment of vital resources: time and money. It also requires the willingness to take a perceived risk, i.e., see how well one's organization is performing ... or at least a willingness to make changes likely to improve outcomes.

Organizations have to either (a) be forced against their will to deal with outcomes by pressure from regulators / funding sources or (b) be convinced that there is tangible ROI, that is, they will somehow receive real benefit from their investment/risk.

Option "a", I contend, is likely to give rise to data falsification as a way to avoid punitive consequences for fear that the outcomes my make one's organization "look bad."

Option "b", on the other hand, educates decision makers that by spending the time and money on good outcomes tools and practices, they will gain knowledge needed to improve performance and will show funding sources they are serious about controlling costs and delivering ever better services. The ROI includes more favorable recognition, improved operations and deliverables (service efficiency & effectiveness), and better consumer
satisfaction, all of which can give the organization a competitive advantage over those not serious about outcomes. Now if this competitive advantage results in greater funding, more clients, etc., then these returns on investment can be strong motivators for investing in outcomes work.

The question then arises: What types of outcomes data emerges the knowledge needed to improve performance and control costs? In addition to measuring client change, organizations such as case management programs, which provide a wide range of services, ought to define what they do (i.e., what specific tasks they perform for their clients) so cost and success of the various services can be measured; unfortunately, this is rarely done.

And, I believe, if programs willingly shared this information with one another -- along with lessons learned and best practices employed – openly discussing these things via virtual forums (like Outcmten or others), the greatest benefits would be gotten. This would evolve outcomes evaluation into knowledge management.

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Date: 25 Mar 2003 3:50PM
From: Susan Mims <susan.mims@ozarkguidance.org>

I agree with Steve about the need to include program evaluation along with outcomes measuring. If you don't know what you did to attain said results, you don't know how to replicate or take corrective course of action. Plus, if your outcomes are disappointing, you may be able to use this info to finally attain the program improvements you've been needing/requesting all along. Again, with the focus being on improving quality of service, poor results can result in positive change of one sort or another, as revealed in your program evaluation. Or, they may be supportive data for the need for more research on best practice with a difficult population; or indication of unrealistic expectations, even. What's important is that we recognize that any of these may be reasons for failure, and not just assume that poor results mean that practitioners are not doing good clinical work.

Susan Mims
Children & Family Services
Room 200
Ext. 450

Date: 26 Mar 2003 6:51AM
From: Elaine Kersten <Elaine.Kersten@med.va.gov>

just a word of caution: the funding source may not like some of the results of your data analysis, and this may be a problem: for instance, i worked with an agency on an outcomes project in the past several years. though the data for the residential program was interesting over time.. the data showed that, in spite of the fact that the dept of mental health funded vocational/work related programs, NONE of the 112 residential clients, including those in the younger ages (21-35) had achieved employment after looking at the data over four years. in fact, NONE had gained jobs where health insurance was offered, and NONE worked for more than 10 hours a week, (of those consumers who were in the vocational/work program outside of the residential program. this information was not well received by the local funding office.. stake holders may not like what data says about system oversight efforts at the buracracy level.. so beware of your results.. we had thought that this data would spur system improvements, but, sadly, it did not..

**must say: there WERE some consumers who had achieved employment status in the program thru residential staff efforts…which was very interesting…but that is another story altogether)

Elaine Kersten, EdD
Clinical Applications Coordinator
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Date: 26 Mar 2003 9:49AM
From: Susan Mims <susan.mims@ozarkguidance.org>

Elaine,

What was the final outcome (excuse the pun) of the funders' dissatisfaction? Were the funds or the program cut?

Susan Mims

Date: 26 Mar 2003 10:17AM
From: Elaine Kersten <Elaine.Kersten@med.va.gov>

no: the outcomes project was cut!!!!! i was the consultant…and was just about to leave the program anyway.. 'cause they were working pretty much on their own and really didn't need me anymore…the Executive Director was not as in the loop as should have been…and the Residential Program Director left, and everything came to a halt…which was too bad…it was really a sweet project for about five years…sooooo much data (i developed a pretty comprehensive Residential Clinical Assessment Tool. in addition, we did some Social Climate measurement during the evaluation period to assess the extent to which the clinical treatment environment changed in terms of attitudes by clinicians towards consumer changes within the treating climate.. the stuff from Rudolf Moos…which is really cool stuff..

anyway, it is really not a good story…the funding source got really nasty with the Executive Director, and pretty much made her stop the program!!!!! the cause of this was that we invited the DMH reps to the annual Residential outcomes symposium (we had had three other annual symposiums where we presented the year's findings and outcomes to the staffers from the residence so they would get the feedback from their efforts…). the DMH reps did NOT like the fact that we basically identified major problems with the system, and took MAJOR exception to this.. argh!!! what can i say…

good luck with your work.. if you want to call, i can give you more details…just hard to write it all out. my number is below.

Elaine Kersten, EdD
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Date: 26 Mar 2003 10:37AM
From: Susan Mims <susan.mims@ozarkguidance.org>

It's gutsy to work in evaluations and outcomes, isn't it? Some would say foolish? Maybe a little like Russian roulette, or gambling? LOL!

Susan Mims

Date: 26 Mar 2003 11:20AM
From: David Colton <dcolton@ccca.state.va.us>

On the other hand the data could have been useful in a variety of ways: (1) understanding that some clients could not benefit from the program (in which case they probably should have been moved to another level of service/alternative programs if available, and (2) identifying areas to improve within the program to make it more effective.

As an evaluator, I view unexpected or undesirable outcomes as a useful source of information to work with. Unfortunately, we live in a society that expects quick results and its difficult to convince external stakeholders in the value of working with a program over time.

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Date: 26 Mar 2003 11:59AM
From: Alan Eppel <eppela@mcmail.cis.mcmaster.ca>

Japanese CQI saying:

"Every defect is a treasure!"

Date: 27 Mar 2003 4:04PM
From: Stephen Beller <nhdspres@bestweb.net>

Susan wrote: "Again, with the focus being on improving quality of service, poor results can result in positive change of one sort or another, as revealed in your program evaluation. Or, they may be supportive data for the need for more research on best practice with a difficult population; or indication of unrealistic expectations, even. What's important is that we recognize that any of these may be reasons for failure, and not just assume that poor results mean that practitioners are not doing good clinical work."

This is a mature, rational perspective that perceives human fallibility and ignorance as opportunities for growth and development! The way we become less fallible (more competent) and less ignorant (more knowledgeable) is by learning how to make better decision and do things more effectively & efficiently. This requires receptivity, flexibility, objectivity, critical thinking (questioning existing knowledge and authority with empirical measures), selflessness, cooperation, viewing weakness and defect as potential, self-revelation (instead of self-deception), and courage. It also requires lots of valid, useful, easily accessible information and a willingness to share one's knowledge with others.

A sensible system as I just described is, imo, crucial to the successful use of outcomes data. Likewise, the outcomes data itself has to be useful to decision makers, i.e., it has to help them make better decisions and to learn from the consequence of implementing those decisions. I feel sad and frustrated when people respond to such thoughts as idealistic/unrealistic.

Elaine's caution that some funding sources may not like an organization's outcomes and, rather than using that knowledge as a source of growth/development and process improvement, they act punitively toward the provider…is also sad. It points, imo, to a broken system that, rather than managing knowledge and using it wisely to improve conditions, perpetuates mediocrity, conspiracy, and duplicity.

I read a relevant article in the March 16th NY Times written by an MD, titled: "Medicine's Progress, One Setback at a Time." Here's the opening paragraph: "A decade ago, I stood alongside my 99 fellow freshmen as we were welcomed into the ranks of medicine in a 'white coat ceremony.' Here, on our first day of med school, we were presented with the short white coats that proclaimed us part of the mystery and the discipline of medicine. During that ceremony, the dean said something that was repeated throughout my education: half of what we teach you here is wrong -- unfortunately, we don't know which half."

Among other things, it went on to discuss medical outcomes research on coronary-bypass operations and publication of surgical report cards. The outcome measure was basically mortality rates. It explained how many surgeons rebelled against such outcomes criticizing the assessment model for oversimplifying heart surgery and underestimating surgical risk for the sickest patients (i.e., poor risk adjustment measures). They complained the models did not have adequate predictive validity and did not account for such things as simple bad luck.

So the physicians fastidiously reported ever condition that could affect outcomes (to improve risk adjustment), while others "tried to 'hide' surgical deaths by transferring patient to hospice programs right before they died."

The result was a 24 percent decline in mortality and a 41 percent decline in coronary-bypass surgery. Examination of these results revealed that “there was a significant amount of 'cherry picking' in the

states with mandatory report cards," meaning that they refused to operate on the sicker patients. A conclusion was "surgical report cards led to substantial selection bias by surgeons and that patients were generally worse off for it. Mandatory reporting mechanisms inevitably give providers the incentive to decline to treat more difficult and complicated patients."

The conclusion of the article was that "scrutinizing and punishing individual doctors is not the right way to improve health care. Health care is too complex; outcomes depend on many variables. Everyone, of course, wants a system with accountability -- people want to be able to point the finger at *someone* -- but such a system often ignores the larger process at play."

What direction does this article point us?

For one thing, it says that when it comes to making healthcare decisions, ignorance is paramount. This, to me, means much more and better knowledge is needed and has to be shared and discussed widely!

It also says we should change our healthcare system into one that rewards providers for reporting valid data, for learning from their mistakes, and for having the courage to treat difficult patients.

In other words, we need a more rational system that perceives human ignorance and fallibility as opportunities for learning, growth and development. Outcome research would then be really useful.

Steve Beller

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Date: 28 Mar 2003 1:32PM
From: Bob Huber <ecsp@stargate.net>

Dear Steve

I look at ROI very simplistically Last year I invested $1500 to attend and present at a conference. I wanted to generate some business. I didn't get any business from this expenditure. My ROI was $-0-. I feel that ROI must be conceptualized in this concrete way.

Bob Huber

Date: 29 Mar 2003 6:53AM
From: William Berman <wberman@echoman.com>

I want to echo that sentiment.

On a slight tangent, I have been unable to find any concrete data on ROI for electronic medical records. It's clear everyone things they are cool, and state-of-the-art, but I have not been able to find any data that suggests that there is a real cost-savings in using electronics v. paper charting.

ROI from this viewpoint would come from
1) decreased charting time (e.g., more time to treat patients)
2) decreased staffing (in medical records, transcription)
3) decreased overhead costs (e.g., lower liability insurance for prescribing physicians)
4) decreased A/R days (better documentation leads to better, more timely payment)

I'm curious whether anyone has seen any data on this, or has identified other ROI dependent variables.

Bill Berman, Ph.D.
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Date: 29 Mar 2003 8:56AM
From: Ed Wise <Eawmhr@aol.com>

On 29 Mar 2003 6:53AM William Berman <wberman@echoman.com> wrote:

…ROI from this viewpoint would come from
1) decreased charting time (e.g., more time to treat patients)
2) decreased staffing (in medical records, transcription)
3) decreased overhead costs (e.g., lower liability insurance for prescribing physicians)
4) decreased A/R days (better documentation leads to better, more timely payment)…

5) decreased time between request for old paper chart and new electronic chart to hit the floor (inpt.) => quicker tx => fewer days/hrs of care

Ed

Ed Wise, Ph.D.
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Date: 29 Mar 2003 9:43AM
From: Tom Trabin <tom@trabin.com>

Bill,

The Computer Based Patient Record Institute gives a Malcolm Baldridge-style award every year to organizations that have done the best job of full implementing an electronic health record system. The Davies Award, as it is called, has been in place now for over ten years in the general health informatics field, and for four years in behavioral health. The awardee in behavioral health uses software from your company, so I'm sure you're familiar with the award. One of the qualifying criteria is that the organization must do an evaluation. Often, although not always, that evaluation includes an ROI. You can find out more about the Award at www.himss.org. I think you might have to make a couple calls to get back copies of awardee reports, but they're definitely available. Many of them have also published. Sorry I can't be more precise with actual references, but that should give you a start.

Regards,
Tom Trabin
(parenthetically, Davies Award committee member)

Date: 31 Mar 2003 10:01AM
From: Susan Mims <susan.mims@ozarkguidance.org>

Also, electronic records = increased availability of info between sites; we span a four county area and clients sometimes move between these sites, or present emergently to a site that does not see them regularly. EMR improves accuracy and responsiveness to the client; such quality improvements are harder to quantify in $$$ but are just as important, particularly in the mental health sector.

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Date: 31 Mar 2003 10:35AM
From: William Berman <wberman@echoman.com>

Susan,

I agree wholeheartedly. Unfortunately, what I'm hearing from both clinical and fiscal people during this time of budget shortfalls is that if they can't see realtime cost savings, EMR/ECR/EPRs won't be an immediate priority.

Bill Berman, Ph.D.
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Date: 31 Mar 2003 10:48AM
From: Marvin Chaffin <mchaffin@bhcpns.org>

Dr. Berman's opinion is certainly valid though there are more than a few outliers in the EMR process. The organization that I belong to has been using an EMR system for the past four years. We are now piloting a move to a more advanced system. We have been able to see a modest return on investment mainly due to the fact that we have service providers scattered over a four county area in the Florida panhandle.

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Date: 31 Mar 2003 11:30AM
From: William Berman <wberman@echoman.com>

I agree there are early adopters and agencies/facilities who adopt for reasons other than financial. How are you seeing a return?

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Date: 31 Mar 2003 12:03PM
From: David Colton <dcolton@ccca.state.va.us>

One electronic medical record system I had the opportunity to observe generated reports and treatment plans, so it did produce some time savings. However, like any system, there is a learning curve. A psychiatrist who was using the system noted he was trained to write comprehensive, "elegant" evaluations. The reports generated by the system were not so elegant, but met stakeholder (i.e., licensing, reimbursement, etc.) requirements. He acknowledged it took some getting used to and that it took a while for clinicians to become comfortable with the system.

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Date: 2 Apr 2003 5:46PM
From: Stephen Beller <nhdspres@bestweb.net>

After the learning curve, EMR systems may save record keeping, reporting, and information retrieval time, which may enable providers to see more patients (additional revenue) and/or reduce support staff (cost savings). This is one form of financial ROI, though I don't know how meaningful/ significant it really is. And use of EMR systems doesn't necessarily mean better outcomes tracking or quality improvement.

Another form of ROI, which can be difficult to measure, involves the use of knowledge management (KM) tools and practices. KM focuses on:

- Knowledge creation and innovation
- Changing the organizational culture to foster sharing/exchange of ideas, lessons learned, best practices
- Establishing processes concentrating on continuous learning and awareness
- Optimizing the synergy between people, process and technology
- Helping organizations leverage their competitive advantage via agility (i.e., taking quick, intelligent action to changing circumstances).

ROI measures related to KM come in different forms, including (a) outcomes depicting greater client improvement and fewer clinical errors via improved decision support (e.g., evidenced-based guidelines) and (b) cost reductions via implementation of better (more efficient) work practices.

Here's a link about KM in medicine; there's not much on mental health and KM.
http://www.evidence-based-medicine.org/clinical-knowledge-information-mangement.htm

My hypothesis is this: Organizations establishing formalized KM systems to improve ROI (via use of KM tools and processes), and marketing themselves as such, will be viewed more favorably by consumers and payers than those who don't.

It's the difference between saying:

"We give our clients the Basis-32, which shows good results overall."

and

"We focus on obtaining and using sound knowledge to improve the quality and control the costs of our services. For example, we use evidenced-based clinical guidelines, which we regularly evaluate and update; our clinicians support each other by openly sharing lessons learned and innovative ideas on a regular basis; we evaluate both outcomes of the services we provide and the cost of delivering those services; we are a learning organization; we use best of class technologies and techniques; instead of being rigid in our ways, we stay flexible and are willing to change how we do things if it improves the quality and economy of our services."

Date: 5 Apr 2003 11:13AM
From: Ruth Ross <doctoruth@aol.com>

On 26 Mar 2003 11:59AM Alan Eppel <eppela@mcmail.cis.mcmaster.ca> wrote:

Japanese CQI saying:

"Every defect is a treasure!"

And, regarding the Japanese saying about defects, I was always taught in my methodology classes that much can be learned from 'no results' and so-called, 'negative' results. Ruth Ross

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Date: 5 Apr 2003 11:43AM
From: Ruth Ross <doctoruth@aol.com >

One of the first things I learned in my Ph.D. program about evaluation - of anything and anybody - that, if you blame or accuse or suggest or hint or imply (etc., etc.) that the practitioner is at fault or to be criticized, etc. anything other than a complete plan with everybody involved to develop, change and adjust programs so that they reflect desired results. Ruth Ross

Date: 8 Apr 2003 1:58PM
From: Elaine Kersten <Elaine.Kersten@med.va.gov >

just a word of caution with respect to computerized patient records: do NOT think about electronic records simply as 'time savers'…since i do believe that it takes MORE time to enter comprehensive clinical documentation…the major purpose of the EMR (electronic medical record) is comprehensive documentation that supports a thorough chart to review and also provides practice tools for better care. so, when evaluating 'ROI' or return on investment.. there are some other factors that need to be considered: reduction of death because of bar code medication systems that have the potential to reduce to almost ZERO medication errors, use of clinical reminders that 'prompt' providers about health maintenance/preventive care activities (e.g. 'reminders' about labs for clozaril patients; prompts for AIMS testing for patients on anti-psychotic medications; Lithium lab reminders, annual diabetic foot exams, smoking cessation reminders; etc, etc, etc), and use of standard templates in notes that will assure minimum standard documentation. add to this the power of voice recognition, and you are really talking about a totally new leg to the journey…i attach an article that gives a pretty good overview (and some potential variables) of the VA's CPRS…and includes some of the benefits/"ROI" of such a record, and some references at the end for further inquiry.

Elaine Kersten, EdD
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413-584-4040 x2811

Date: 11 Apr 2003 2:53PM
From: Stephen Beller <sbeller@nhds.com>

WOW, Elaine, this is what I've been saying for past 20 years: We need comprehensive documentation and decision-support tools so we can measure outcomes AND learn how improve them (i.e., provide better care). It is important to obtain information from clinicians AND (as Susan indicated) from consumers regarding clinical and financial data (e.g., diagnostic, process, and clinical outcomes and cost data). Only then can you begin to know which services rendered to which consumers get the best results, and how much it costs to achieve those results, and where there are opportunities for improvement. This also enables you to risk-adjust the outcomes data for more valid assessments and more valid knowledge creation. Adding workflow management capabilities to such a comprehensive documentation tool (i.e., reminders, documentation templates, voice recognition, etc.) would make the system even better. And providing an efficient way for stakeholders to share/discuss ideas, lessons learned, and establish best practices would help increase the usefulness of knowledge gained (e.g., a virtual "community of practice").

I have to tell you, however, that this has not been a popular point of view in the past!

Nevertheless, we've stuck to the vision for many years as we focused on developing a next-generation information and knowledge management system with the capabilities described above. Enough of my ideas, I'd like to ask this group several questions so I can better understand your thoughts and needs:

1. What would a tool have to do for you to say, "I've got to have it for my organization!" That is, what would be on your wish list?

2. Would it be important that the tool help your organization demonstrate a commitment to continuous quality improvement (CQI) and a focus on delivering good return on investment (ROI)?

3. Do you think the CQI/ROI focus would help your organization vie for funding/clients? Do you think this path would actually help improve the quality and cost-effectiveness of your organization's services?

4. Would there be the need for some sort of change in your organization's culture for such a tool and focus to be adopted? That is, changes in people's mind sets, work processes, relationships, etc.

5. Would it be beneficial to have an efficient way to share ideas, lessons learned, group-think, collaborative decision making via a virtual forum where all authorized people can at any time read what others have to say, reply to them, and even start their own topics?

6. Is it important to have better (more efficient, effective) ways of discovering, creating, sharing, accessing, and using knowledge about;
a. Clients (e.g., comprehensive documentation)
b. Services rendered (e.g., outcomes)
c. Clinical issues (e.g., offering decision-support, best practice guidelines)?

Steve Beller