Mandating Statewide Outcomes Reporting in Community Mental Health Settings: *Balancing Burden and Benefit*

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The Fountain Story
Phases of Implementation

- **Easy stuff:** Standardized outcomes with a few early adapters, circumscribed practices (ACT)

- **Harder stuff:** All CMHC’s statewide reporting on different block-grant funded programs for both adults and children within their agencies

- **Really hard stuff:** Broader statewide outcomes reporting
Outline

- Background
- Outcomes and evidence-based practice
- Implementation of block grant outcomes project
- Benefits
- Burdens
Iowa Consortium for Mental Health

- Public – Academic liaison
- Effort to bring state university resources to bear on the publicly funded mental health system of Iowa
  - Educational
  - Clinical
  - Research

www.icmentalhealth.org
Collaborators Here Today

- Jim Overland – Iowa DHS
- Jerry Mayes, PhD – Iowa Mental Health Planning Council
- Benjamin Brodey, MD, MPH, Telesage
ICMH Technical Assistance Center for Evidence-Based Practices

- Initially funded in 2003
  - via Medicaid dollars (Community reinvestment Medicaid managed care MH/SA carve-out)
- 2 arms, focusing on 2 EBP’s:
  - Assertive Community Treatment (ACT TAC)
  - Illness Management and Recovery (WMR TAC)
ACT TAC: Mission

- Expand the implementation of ACT in Iowa
- Enhance long-term stability of ACT in Iowa
- Optimize quality of ACT in Iowa
ACT Technical Assistance Center
Scope of Work

- Increase awareness and understanding of ACT in Iowa.
- Assemble a statewide advisory board.
- Propose a sustainable funding model for ACT in Iowa.
- Conduct fidelity reviews of ACT teams.
- Develop ACT program standards.
- Assess and support the educational needs of ACT teams.
- Standardize and aggregate outcome measures for ACT teams.
- Develop interest in potential ACT sites
- Bring up two new ACT teams (over a two year period)
Number of ACT teams in Iowa

![Bar chart showing the number of ACT teams in Iowa from 1996 to 2006.]
ACT Technical Assistance Center

Outcome Measures

- Standardize outcome data
  - Hospitalizations
  - Housing stability
  - Substance abuse
  - Vocational status
  - Legal problems

- Quarterly reports for each team
  - Feedback to teams
  - Process improvement
Vocational Status of ACT Clients Across Programs July-Sept '04

- Impact
- Golden Circle
- Abbe Center

- Unemployed
- Training/Vocational Program
- Sheltered Workshop
- Volunteer Job
- Self/Family Employed
- Competitive Employment
- Retired
Statewide ACT Outcomes
Cross-sectional (q2 FY07)

Percent of Clients Unemployed

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<tr>
<th>Organization</th>
<th>Percent</th>
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<tr>
<td>Abbe Center</td>
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<tr>
<td>ACTION</td>
<td>52%</td>
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<tr>
<td>Council Bluffs</td>
<td>56%</td>
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<tr>
<td>Golden Circle</td>
<td>69%</td>
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<td>IMPACT</td>
<td>33%</td>
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Statewide ACT Outcomes
Longitudinal, within Program

IMPACT
Average Number of Days Hospitalized

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<tr>
<th>Quarter</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
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ACT TAC
Costs

- Year 1-2 ~ $200K/yr
- Year 3 ~ $100K/yr
- Costs largely in professional staff
WMR TAC

- Wellness Management and Recovery
- Illness management component and activities were fairly clear
- Recovery component and activities more controversial
- Statewide advisory board
- Recovery assessments
The Mandate:

- Signed by Governor May 2004
- Effective July 2005
- Mandates 70% of Performance Partnership block grant funds to be distributed to CMHC’s (up from ~ 50%)
  - Half for adults with SMI
  - Half for children with SED
- Requirement to use 100% of these funds for “evidence-based practices”
Community Mental Health Block Grant (aka “Performance Partnership Block Grant”)

- A very small part of the overall mental health budget
  - Iowa: < $4 million/year
- From Feds – SAMSHA, CMHS
- Passed through via state’s Mental Health Authority
  - In our case, Department of Human Services
  - Overseen by Mental Health Planning Council
Funding sources for mental health programs in Iowa

Source: Torrey, 1996
Basic questions raised by legislation

- What constitutes evidence based practice?
  - Who gets to decide what is or is not EBP?
  - e.g., for children and adolescents?
  - Based on what?

- How do we determine if the practice is actually being done?
  - What prevents simply “changing the sign on the door”?  
  - Resources to monitor fidelity?
Spring 2004

- DHS issues RFP to assist DHS, providers, other stakeholders in trying to operationalize this mandate.
- DHS contracts with ICMH to enhance EBP Technical Assistance Center for these purposes, using block grant funds.
Major Tasks of Enhanced TA center

- Statewide dissemination of EBP’s
- Survey of provider readiness for EBP’s
- Identify and engage resources / consultants
- Convene and coordinate multi-stakeholder “operations” group to establish process
  - Application, review, ongoing monitoring
- Development of outcomes reporting system
- Ongoing TA to providers and DHS on all of the above
In your opinion, is your mental health center or provider agency engaged in any of the following evidence-based practices for adults with mental illness recognized by SAMHSA?

- Family Psychoeducation: 25.0%
- Supportive Employment: 25.0%
- Medication Algorithms: 4.2%
- ACT: 16.7%
- Co-Occurring Disorder Tx: 25.0%
- Illness Mgmt. and Recovery: 29.2%
- No EBPs*: 41.7%

N = 24
(55%)
“First, do no harm”

- Concerns about EBP mandates as a means to justify funding restrictions?
  - Texas?
  - Oregon?
  - Others?

Hippocrates?
Overarching Values of EBP Operations Group

- WE WANT A SYSTEM THAT LEARNS

- A system that:
  - doesn’t keep doing things that aren’t effective, out of inertia or ignorance
  - Incorporates recognized EBP’s
  - supports ongoing innovation and change
  - provides the best outcomes possible in the context of limited resources
  - information collected is information used
“Top-down” vs. “Bottom-up” Approaches to Evidence-Based Practice

- **Top down:**
  - Implementation of interventions that had been repeatedly shown to yield good outcomes in specific target populations
  - Resource kits
  - Model Fidelity

- **Bottom-up:**
  - Practicing in an “evidence-based manner”
Components of Practicing in an Evidence-Based Manner (1)

- **Who do you want to serve?**
  - The target population is clearly defined and methods are in place that allow for their identification

- **What do you want to change?**
  - Target symptoms/signs/behaviors are identified and methods are in place to assess them

- **What will you do to achieve this?**
  - The core components of the intervention are clearly defined
Components of Practicing in an Evidence-Based Manner (2)

- How will you know if it works?
  - Methods are in place that allow for an ongoing valid assessment of key outcomes

- How will you continue to improve the practice?
  - Processes are in place through which lessons learned from the outcomes can inform potential changes in the core components of the practice
The Evidence Based Practice Cycle (Continuous Quality Improvement)

Specify Core Components of Practice

Quantify Priority Outcomes Regularly

Optimize Priority Outcomes

Modify Core Components of Practice

Review Outcomes Regularly
Major Themes of Block Grant-Funded Programs

**Adult Programs (38)**
- Recovery Oriented
- Integrated MH and SA treatment
- Other/Misc: Assessment and Outcomes

**Child Programs (37)**
- School Based
- Intensive Home and Community Based
- Other/Misc: Assessment and Outcomes
Program-Specific vs. Common Outcomes?

**Program Specific**
- Most appropriate outcomes for intervention are assessed
- Inefficient
- Unrealistic

**Common**
- May not capture the outcomes program was designed to change
- Efficient
- Feasible
EBP Toolkit Outcomes

- Psych / Sub Abuse Hospitalization
- Homelessness / Living situation
- Employment / Educational status
- Substance Abuse Stage
- Criminal Justice involvement
National Outcome Measures (NOMs)

- Employment / Education
- Housing stability
- Crime / Criminal justice
- Social connectedness
- Decreased symptoms
- Perception of Care
- Access / Capacity
- Decreased hospitalization
- Cost effectiveness
- Use of EBP’s
What gets measured is what gets attended to

- Symptoms?
- Diagnosis?
- Substance Abuse?
- Employment?
- Housing?
- Contacts?
- Recovery orientation?
“Recovery – Oriented” Outcomes

“...a decent job, a place called home and a date on Saturday night…”

Charles G. Curie
## Outcome Variables Selected (Quarterly)

### Adults with SMI
- Contacts
- Employment
- Criminal justice involvement
- Psychiatric (or partial) Hospitalization
- Substance Abuse
  - Hospital/residential Tx
  - Stage
- Living Arrangement
  - Homelessness
- GAS

### Children with SED
- Contacts
  - Child, parent, school, other
- School
  - Attendance
  - Disciplinary Actions
- Juvenile Justice involvement
- Child Protection involvement
- Psychiatric Hospitalization
- Living Arrangement
- C-GAS

### Living Arrangement
- Homelessness
Intake Variables (one time entry)

- **Unique ID**
  - Birthdate + last 4 SS#

- **Demographics**
  - Age
  - gender,
  - race/ethnicity

- **Diagnosis**
  - Broad Categories

- **Agency**
  - Clinician (initials)

- **Program entry**
  - date

- **Program exit**
  - Date
  - Reason
Web-based Outcomes Reporting

- Process is important
- Can you practice in an evidence-based manner today without access to internet?
The overall mission of the Iowa Consortium for Mental Health is to enhance mutually beneficial collaboration between Iowa's universities and its public mental health system.
Welcome, admin!

Intake Information
- Add New Patient
- Edit/View Existing Patients

Quarterly Report
- New Quarterly Report
- Edit/View Existing Report
Intake Type:  Adult

Insert Into Account:  Please Select

Basic Information for Adults with SMI

(Assignment of Client Unique Identifier)

(To be completed for all adult clients receiving services from programs funded by the Performance Partnership Block Grant)

Client ID YYYY - MM - DD - SSSS  (Last 4 digits of SSN)

Birthday MM/DD/YYYY

Agency Abbe Center for Community Mental Health

When did client first begin this program?  (Approximate if necessary)

MM/YY (MM/YY)

Gender Please Select

Race/Ethnicity Please Select

Diagnostic categories:  Please check the "primary diagnosis", e.g., the diagnosis that is the major focus of treatment or causing the most functional impairment.  Then check all that apply (i.e., currently active and/or a focus of treatment).

Primary All apply

- Schizophrenia and other psychotic disorders (include schizoaffective, psychosis NOS)
**Diagnostic categories:** Please check the "primary diagnosis", e.g., the diagnosis that is the major focus of treatment or causing the most functional impairment; Then check all that apply (i.e., currently active and/or a focus of treatment).

- □ Schizophrenia and other psychotic disorders (include schizoaffective, psychosis NOS)
- □ Mood disorders (include bipolar, major depressive, dysthmic, depression NOS)
- □ Anxiety disorders (include generalized anxiety, panic, post-traumatic stress, obsessive compulsive disorders)
- □ Substance abuse disorders (specify major substance of abuse if known)
- □ Personality Disorders (specify type, if known)
- □ Mental Retardation or Borderline Intellectual Functioning
- □ Other: Please specify
- □ Unknown: If checked, please indicate reason diagnosis is unknown

**Primary Clinician 3 Initials:**  

[Buttons: Cancel | Next>>]
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**Basic Information for Children with SED**
Basic Information for Children with SED

(Assignment of Client Unique Identifier)

(To be completed for all children with SED receiving services from programs funded by the Performance Partnership Block Grant)

**Client Site:** childguidance

**Patient Status:** Person remains in the program

**Birthday:** 01 / 04 / 2000

**Agency:** Des Moines Child and Adolescent Guidance Center

**When did client first begin this program?** (Approximate if necessary)

04 / 06 (MM/YY)

**Gender:** Female

**Race / Ethnicity:** African American

**Diagnostic categories:** Please check the "primary diagnosis", e.g., the diagnosis that is the major focus of treatment or causing the most functional impairment. Then check all that apply (i.e., currently active and/or a focus of treatment).

- Disruptive Behavior Disorders (conduct disorder and/or oppositional defiant disorder)
- Attention Deficit Hyperactivity Disorders
- Pervasive Developmental Disorders (Autistic, Rett's, Aspergers, Childhood Disintegrative, NOS)
Primary  All apply

- Disruptive Behavior Disorders (conduct disorder and/or oppositional defiant disorder)
- Attention Deficit Hyperactivity Disorders
- Pervasive Developmental Disorders (Autistic, Rett's, Aspergers, Childhood Disintegrative, NOS)
- Anxiety disorders (include separation anxiety, generalized anxiety, panic disorder, obsessive compulsive disorder)
- Mood disorders (include bipolar, major depressive, dysthymic, depression NOS)
- Schizophrenia and other psychotic disorders (include schizoaffective, psychosis NOS)
- Substance abuse disorder (specify major substance of abuse if known)
- Eating disorders
- Tic disorder (include Tourette's Disorder)
- Mental Retardation or Borderline Intellectual Functioning
- Other: Please specify
- Unknown: If checked, please indicate reason diagnosis is unknown
Adding a New Quarterly Report for an Existing Client

Client Outcomes ID

0001042991
0001226005
0001260073
0001260086
0001300075
0002151425
0002240314
0003010001
0003050091
0003140080
0003140091
0003209018
0003240040
0003242811

Add new Outcomes ID

Current Quarter is: Year 2006 Quarter Oct. 1 - Dec. 31
Adult Client Outcomes --- Quarterly Report Form
(To be completed by all programs funded for adults with SMI by the Performance Partnership Block Grant)

In the past 3 months (i.e., over the quarter for which you are reporting)

☐ Report is temporarily unavailable for this quarter

1. **CONTACTS:** Approximately how many contacts have you (your program) had with this client? 4

2. **EMPLOYMENT:** How many **weeks** has the client held a competitive job? 0

3. **HOMELESSNESS:** How many days the client been homeless? 0

4. **INCARCERATION:** How many days the client been incarcerated? 0

5. **PSYCHIATRIC HOSPITALIZATION:** How many days has the client been hospitalized for psychiatric reason? 0

6. **SUBSTANCE ABUSE TREATMENT:** How many days has the client been in a substance treatment facility? 0

7. **SUBSTANCE ABUSE STAGE:** What stage of substance abuse treatment best fits for the client most of the time during the past 3 months?
   - ☐ Not applicable
   - ☐ Pre-contemplation
   - ☐ Contemplation
   - ☐ Preparation
   - ☐ Action
   - ☐ Maintenance
   - ☐ Remission
   - ☐ Unknown (no information on substance abuse history or current stage)
8. **Living Arrangements:**

- Lives alone
- Lives with others (family or non-related roommates) --- mostly independent
- Lives with others (family or non-related roommates) --- mostly dependent
- Lives in supervised housing setting (no live-in staff)
- Lives in congregate care setting, e.g., RCF, care facility
- Homeless (including any emergency shelter, without a residence)
- Other: Explain

9. **Global Assessment of Functioning (GAF) Score:**

(0-100) 65
N reported on quarterly
N reported on across sites
Child Diagnoses

- Attention Deficit Hyperactivity Disorders
- Mood disorders
- Disruptive Behavior Disorders
- Other
- Anxiety disorders

Count of ClientID

YearQuarter
- 2006 Jan-Mar 3
Child Dx (all)
Weeks Competitively Employed
Substance Abuse Stage
Sub. Abuse Stage Across 3 Programs

Count of Substance Abuse Stage

Substance Abuse Stage
- 7 Unknown
- 6 Remission
- 5 Maintenance
- 4 Action
- 3 Preparation
- 2 Contemplation
- 1 Pre-Contemplation
- 0 NA

Abbe Center
Black Hawk-Grundy MHC
Crossroads MHC

2006 Oct 1-Dec 31

Axis Title

YearQuarter ▼ ShortName ▼
Sub. Abuse Stage % over time
All Programs (excluding unknowns, NA’s)
Substance Abuse Stage within Program Over Time

IMPACT Substance Abuse Treatment Stage

- 1 Engagement
- 2 Persuasion
- 3 Active Treatment
- 4 Recovery/Remission

Count of Substance Abuse Stage Over Time
Benefits/Burdens for Stakeholders

- Client
- Family / other supports
- Advocacy Groups
- Policy makers
- Front-line provider staff
- Agency Administration
- Funder(s)
- Local Authority
- State Authority
Benefit – Front line staff, program directors

- Interest groups
  - Twice annually
  - Organized by program theme

- “Data parties”

- Allows us to step back and look at the data
  - generate questions
  - identify barriers
  - systematically change core components
Benefit – Advocacy Groups and Policy Makers

- Identifies areas of priority needs, e.g.
  - Employment
  - Parental involvement

- Allows for goal setting, tracking of progress

- Legislators love graphs
  - Especially if they are simple, and tell a simple story
Benefit

- Client?
- Family?
- CMHC administrators?
- Funders?
- Others?
CMHC Directors

- “...this is just more stupid paperwork that goes into a black hole at DHS never to be seen again”
- Lost revenue due to non-billable time for clinicians involved in data collection, entry, and training
Feedback

- Desired: Quarterly data reports to all centers
  - In a digestible form
  - Benchmarking their program compared with others
    - Statewide
    - Similar region
    - Similar program

- Actual: Annual report benchmarking their program against statewide
Consumer advocates – recovery oriented programs

- “Nothing about us without us”
- What is the consumer’s role in this?
- We are the ones who should be deciding what outcomes are important to us, not the system
- Meaningful outcomes for one person are not the same as for another
Front-line clinician

- How does this fit in with the documentation I am already required to do?
  - Treatment plans
  - Progress notes
- I have the sickest patients, so of course their outcomes aren’t going to look good.
School-based programs

- **Stigma:**
  - “Forcing us to make a diagnosis on a child is potentially stigmatizing”

- **Liability issues**
  - “…if a diagnosis is made on a child, that makes us required to do something about it”
Local (County) Authority

- “Why should we send the state our data?”
- Does this take the place of other reporting requirements to the state?
Funders

- Managed care entity
  - We like outcomes, but we want to use the same outcomes that we are using in other states and locales
Researchers

- Sampling biases
- Signal to noise issues
  - Reliability
- Missing data
Where to go from here?

- Is this worth continuing as is?
  - Tweaking?
  - Major overhaul?

- New York Model
  - Modular
  - Required outcomes (common)
  - Voluntary outcomes (program specific)
Must make it more relevant and useful to the primary stakeholders

- **Clinician**
  - Assist with treatment planning
  - Replace, rather than add to current documentation requirements

- **Client and Family**
  - Meaningful outcomes
  - Actively part of the process
Client entered vs. clinician entered information

- Not overly burdensome
  - Unwelcoming
  - Confusing
  - Impersonal
- Signal to noise ratio becomes major issue
- Questions must be appropriate to
  - Age, cognitive status, culture...etc.
Directions

- Lots of disadvantages to home-grown approaches
- Need to look beyond state level
- Maybe life isn’t like a fountain