Chapter Three

Mental Health Services in Ohio:
Learning what works

Part I

Ohio's Mental Health Consumer Outcomes System: History and successes

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Abstract: Ohio has developed and successfully implemented a statewide system of consumer outcomes for adults and youth in the mental health system. The effort began in 1996 and continues to evolve. Providers, local administrators, other stakeholders, and the state point to its unprecedented training and communications effort as a key factor in the success of the Outcomes System.

Ohio's mental health system has rapidly evolved since passage of the Mental Health Act of 1988. This act required the Ohio Department of Mental Health (ODMH) to move from hospital-based to community-based services. By 1995, a basic level of community services was available in almost all communities in Ohio. The upcoming challenge would be to ensure quality.

The themes that emerged from the Department to shape policy activity and ensure quality are known collectively as the ODMH Quality Agenda, and include:

- Consistently applying evidence-based clinical practices;
- Moving from the use of quality assurance to continuous quality improvement techniques; and
- Measuring consumer outcomes and using these data for quality improvement.

Simultaneously, there was a focus on ensuring the protection of vulnerable consumers and shifting from state certification of service agencies to national accreditation. The following analysis focuses on the Ohio Consumer Outcomes Initiative. It highlights the continuing tension between the commitment to applying evidence-based practices and the respect for evidence generated at the practice level by consumers and families, clinicians, and administrators. The former provides a high standard against which practitioners may compare their performance. The latter provides

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a check for real-world application of concepts that may have only been tested in a research setting. The continued interplay between the two provides the material for policy initiatives as well as mid-course correction of ongoing activities. At times, such interplay can result in difficult choices. However, it is worth the effort to continue seeking resolution because the mental health system, not to mention the children and families for whom it exists, benefits in the process.

Ohio's Mental Health System

To fully appreciate the factors involved in developing and implementing Ohio's Outcomes System, it is important to understand the structure of the state's mental health system and the political context in which the Outcomes System evolved. Like North Carolina, Ohio's mental health system is highly decentralized. It consists of:

- ODMH, the state agency vested with the authority and responsibility for overall financing and regulation of the system and for operation of a network of psychiatric hospitals. *(Note: In North Carolina this responsibility is split between the Division of Medical Assistance, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.)*;
- 50 county and multi-county community mental health boards, most of which manage local alcohol and drug treatment services, in addition to mental health services;
- Nearly 400 service agencies with which the 50 health boards contract;
- A highly variable set of consumer and family advocacy organizations; and
- Statewide professional associations that represent local constituents and work at the state level to ensure effective communication of their concerns.

Local mental health boards have the authority and responsibility for financing, managing, and ensuring quality in the county-based system. They do not provide services except under certain urgent circumstances. This is also the direction of North Carolina's mental health reform efforts. Private and not-for-profit agencies contract with boards to provide publicly-funded services. Many of these agencies also have contracts with other public and non-public payers such as employer-financed employee assistance plans.

By the mid-1990s, the mental health system was influenced by the trend of devolution from the federal government to the states. In Ohio, devolution was overlaid with a long tradition of "home rule," in which county authority is vested with and exercises significant political influence. A similar context exists for North Carolina counties.

Devolution in Ohio spawned an increased emphasis on the state's consultation and collaboration with the core mental health system constituencies: consumers and families, providers of services, and county authorities. By 2000, virtually every important state-level policy activity was developed and implemented in concert with an advisory group which included a mix of these constituents. This general trend energized the state agency's predisposition to co-manage issues with constituents, to encourage system learning, and to bring more people, especially consumers and families, into the policymaking process. While this movement curtailed ODMH's ability to impose mandates on local government and private agencies, this limitation was outweighed by the advantages of partnership, collaboration, and consensus.

Other Key Contextual Factors

In partnership with the state's alcohol and drug agency, ODMH had already developed the Multi-Agency Community Service Information System (MACSIS) information system. The Outcomes System's technology environment was built on the MACSIS system and used the main MACSIS function of enrolling "members" and processing claims.

Even in the midst of an unprecedented economic boom nationally and in Ohio, mental health services financing was decreasing. The joint federal/state Medicaid program had reached its apex by the mid-1990s and was receiving public criticism for double-digit annual cost increases.[1] Limitations in the growth of Medicaid were required and efficiencies would need to be achieved. At the same time, other competing state funding priorities had emerged, particularly the priority of achieving funding parity between the hundreds of local school districts in Ohio (another similarity with North Carolina) and a growing prison system. The road ahead would require fiscal discipline, strategic thinking and documented evidence for the economic value of mental health services.[2]

There was also ambiguity about whether ODMH would mandate the use of the Outcomes System. This was unclear even to ODMH when the Outcomes Task Force (OTF) convened. Ultimately, ODMH decided to require use of the Outcomes System through the Department's regulations affecting provider agencies. (Local boards could opt to use a different system as long as it met OTF criteria.) Coincidentally, the Legislature required review of the Department's administrative rules oon after the implementation process began, meaning that consideration of a new Consumer Outcomes rule was included in the review process. The strategic approach was simple: a new, integrated package of standards would be developed that would trade reduced regulatory burden for new or additional requirements for consumer outcomes measurement, quality improvement, and core consumer protections.[3]

On the Department's second attempt, the legislature approved the standards in September 2003. The final rules required providers to demonstrate how they use data for treatment planning and performance improvement. These rules, however, were fairly permissive with regard to how providers met the requirements. One of the original administrative rules required agencies to utilize evidence-based practices. This requirement was ultimately removed from the regulatory framework and incentivized through seven Coordinating Centers of Excellence (CCOEs) based in local systems in partnership with university or other research organizations.

A Mental Health Consumer Outcomes System: Foundations of success

In September 1996, ODMH Director Michael Hogan convened the OTF and charged it with recommending an approach to measuring mental health consumer outcomes. The OTF defines consumer outcomes as "indicators of health or well-being for an individual or family, as measured by statements or characteristics of the consumer/family, not the service system."[4]

This group took the charge seriously, committing two consecutive days each month for 16 months to build consensus around a comprehensive and integrated set of recommendations. *(The recommendations are in Vital Signs, Revised- 2001, accessible at www.mh.state.oh.us/initiatives/outcomes/outcomes.html.*) Of vital importance are the preliminary sections reflecting the values and principles the group adopted. These served as the screen for every recommendation that was considered. A subsequent group guided the process of pilot testing the instruments in three local systems and produced recommendations for enhancements and changes.

While it will always face challenges, the Outcomes System has been successful and continues to add to its achievements. First, the sheer quantity of data in the system removes potential concerns about sample size and other limitations that might otherwise exist. The statewide database now includes over 1.2 million approved records, representing nearly 350,000 individual consumers, up from 161,000 and 65,000, respectively in 2003. The state produces reports that local boards and providers use for outcomes measurement, policymaking, county-to-county comparisons, and other purposes.

Leading up to implementation, ODMH and a core of local "champions" worked closely to develop the policy infrastructure that would support the vision of the OTF. The recommendations published in *Vital Signs* continue to be the marker against which the state tests new policies and procedures. Broad consensus now exists on the critical importance of using Outcomes System data:

- To inform clinical decision making;
- For program evaluation and planning at all levels of the system; and
- For administrative oversight and planning.

A Clear Vision and Shared Values

Perhaps the single most important decision of the OTF was made in the early stages. Before examining available measurement instruments, the group was guided through a series of consensus-building processes to produce statements of vision, mission, values, and assumptions. Being clear about values at the start not only helped overcome decision "gridlock" but also advanced reforming of the mental health services system for both adults and children. Hundreds of decisions followed the OTF, most of which held some element of controversy. The vision and mission statements helped subsequent workgroups stay on course by providing a credible, consensus-based framework for action. The values and assumptions provided guidance for selecting among policy options while eliminating others that were inconsistent with the recommendations of the OTF.

A good example is the value that has come to be described as "consumer-driven." It suggests that the most critical litmus test for any clinical activity is the opinion and perspective of the consumer, and in the case of children, the family. This is not to exclude clinicians but to achieve a balanced collaboration between consumer and clinician. "Consumer-driven" guided future decisions, including about which instruments and items the OTF included in the final recommendations. Other considerations guided by this value included:

- The key role of consumers and families in all subsequent workgroups - one aspect of the emerging notion of consumer "recovery";
- Surveys of consumers and families who participated in the pilot of instruments;
- Development of tailored consumer and family training packages after the pilot;
- Development of data reports for consumers that offer an opportunity to prioritize their problems and strengths; and
- Development of a clinician training program with step-by-step guidance for using Consumer Outcomes data collaboratively with consumers in treatment and recovery planning.

At the outset OTF adopted the philosophy of "recovery" for adult consumers. The initiative has continued to use this as a major filter for developing and evaluating policy options. Similarly, the philosophy that has come to be called "resiliency" for children and their families has guided decisions affecting design and implementation of outcomes measurement in the child-serving community.

Design of the Consumer Outcomes Initiative

By the time the OTF completed its work, the plan for statewide implementation had begun to take shape. The Outcomes Implementation Planning Group was a statewide taskforce that planned and developed documents for implementation of the Outcomes System. Although none of the principals could have anticipated the volume of work and the challenges ahead, it was obvious it would involve a multi-faceted, multi-year strategy. It was not enough to simply disseminate the Outcomes instruments, with or without a government mandate. A key element would be integrating the outcomes instruments into the daily operations of the provider agency, and particularly into the activity of treatment planning. This involved gaining the voluntary participation of staff at nearly 300 community agencies and 50 boards and ensuring they appreciated both the intent and the operational requirements of the Outcomes System. The overall program to accomplish this goal became known as the Outcomes Initiative.

By the conclusion of the OTF there were hints that the design of the system would need to evolve and there was commitment to continually improving and modifying the system. A good example was the decision during the pilot to abandon the package of instruments for youth in favor of a more user-friendly package that better fit the values and outcomes articulated by the OTF. This kind of flexibility and responsiveness to user concerns has characterized the Initiative and has contributed significantly to the productive collaboration with community partners.

Finally, measurement of consumer outcomes was subsequently included in the department's Quality Agenda. The notion of the Quality Agenda was developed as a way to focus attention on three critical aspects of improving the mental health system:

- Mechanisms to improve clinical quality;
- Measurement and use of consumer outcomes data; and
- Increased use of evidence-based or other demonstrated best practices.

Like the OTF recommendations, the focus on these aspects of the mental health system has shaped policies and priorities at the Department in recent years and has been used as a platform for conversations with local systems about other policies and priorities.

The Right Resources at the Right Time

Applying several kinds of resources at critical points has contributed significantly to the success of the Outcomes Initiative. These include:

- State and local staff time;
- Infusions of cash;
- Technology to ease the burden of implementation;
- Effective process facilitation;
- Political will; and
- Technical assistance and training for local systems.

Regarding technology to ease the burden of implementation, technologies to facilitate data entry and data flow have proven to be a double-edged sword: where they have worked, the data flow is voluminous and of good quality; where there have been technological problems, the volume has been

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low. Recognizing the decentralized mental health system in Ohio, local systems were allowed to choose which technology to use for collection and transport of Outcomes data. Some technologies did not function as expected, which led to problems, some of which remain. In addition, discretionary dollars to invest in technology/support have largely evaporated.

The most critical point throughout the process has been political will at all levels of the mental health system to develop an outcomes system. Not only has ODMH been willing to support the Initiative with available resources, but constituents have had to work with the Outcomes System and find ways to integrate it with their core mission. This has required significant effort, particularly from providers, and consistent support from their statewide trade association. It has required consumer and family organizations to create strategies for communicating with their constituents and encouraging the use of data in treatment planning and advocacy. It has required local boards and their statewide trade association to commit resources for contributing and using data to improve local system quality, even in an ambiguous financial and policy environment.

A critical resource was the distribution of incentive funds to local systems. A year after the mental health system moved into the implementation phase of the Outcomes System following the findings of the pilot, it became clear that implementation had reached the limits of voluntary, unfunded participation. The Initiative had achieved significant voluntary adoption by the county board representing the largest percentage of consumers, as well as some smaller areas. However, financial limitations constrained the depth and scope of implementation. Investments were required, especially in the area of data processing technology, that the chronically under-funded community mental health system was simply unable to support. In response, ODMH allocated nearly $3 million of federal block grant dollars by formula as an incentive to local systems to implement the Outcomes System, with dollars focused especially on assisting provider agencies to offset their costs. Allowable costs included data processing hardware and software, consultation, training, and communications. This infusion of cash contributed greatly to improving the level of local participation.

In addition to the formula funding, the grant dollars included a parallel marketing and training effort in response to frequent comments that local staff needed help translating the Outcomes System into action. ODMH developed and disseminated a toolkit of training and technical assistance in collaboration with local constituents. This included:

- Consumer and family training packages (manuals and training videos);
- An orientation video for consumers, families, and staff -- suitable for continuous play in waiting rooms or more specialized settings;
- An orientation pamphlet for consumers and families entitled, *Are You Getting Results?*;
- A re-engineering manual to help providers reorganize around measurement of Consumer Outcomes; and
- A set of cultural competence studies to support the introduction of the Outcomes instruments to diverse cultural groups.

These were distributed free of charge to participating local systems in hard copy and on CDs, and are available on the Outcomes web site *(www.mh.state.oh.us/oper/outcomes/training.toolkit.html)*. Subsequently, regional trainings were offered in which local clinicians tutored other direct care staff in the use of Outcomes data in treatment and recovery planning.

Process and People

Even the best idea will only take hold if it is well-understood and valued by users. Users in this context meant consumers and advocates as well as mental health professionals, state agency leaders, legislators, and other stakeholders and decision makers. This belief was at the heart of a commitment ODMH made at the outset of the Initiative: to develop and implement the Outcomes System in full partnership with local constituents. To this end, the OTF included all core constituents: consumers and families, provider and board staff, and evaluators and researchers. All subsequent work groups have included a mix of these constituents as appropriate. One effect of this decision has been the emergence of a core group of champions at each stage who work alongside the Department in developing policy and implementation procedures. This could not have occurred without the strong foundation in mutual trust and respect that was developed and nurtured from the OTF. Several factors supported the development of trust and respect, including commitment to frequent and candid communication, mutual planning, and timely responsiveness to constituent concerns.

It should be unnecessary to emphasize that these processes must be sincere and used actively to shape the processes and products of the Initiative. No significant decision about the Outcomes System has been made without consultation and partnership among constituents. In addition, all technical assistance products and communication vehicles have been designed in partnership with and focused on the needs of each constituency group with competing priorities. Continued focus on communications helps keep users focused on the Initiative.

Use of Data

Although the usefulness of the consumer outcomes database was questioned at the outset, it has proven valuable. The OTF did not start with a specific vision of data use but developed a framework on which future policy was built. With the framework, the OTF:

- Included notions that the data would need to be useful and available to all constituents, at a level of detail appropriate to the need, with protections for consumer confidentiality and privacy and with safeguards against misuse of the data;
- Advised against premature use of the data for anything other than system quality improvement, warned potential users away from any use of the data for financial purposes before the Outcomes System had an opportunity to prove itself; and
- Correctly identified fear as an implementation risk at all levels of the system, and sought to provide guidance that would prevent fear from becoming resistance.

The implementation pilot group used this data use framework to develop a matrix for each level of the system. This was distributed widely during implementation and has formed the basis for consensus around the activities needed to support responsible use of the data. Considering the cost involved in implementing a system such as Consumer Outcomes, consensus exists to ensure that the data are not left "on the shelf" for lack of insight, training, or data support resources but used to support decisions at all levels of the system. Broad consensus exists on the critical importance

of using the data to inform clinical decision making. Two years ago, the Department launched a training effort for clinicians to support this goal. It parallels the consumer-training program, *Climbing into the Driver's Seat,* which is designed to prompt and inform consumers about how they can work with providers to use the data in treatment and recovery planning and to monitor their progress. Similarly, there is broad consensus about the use of data for program evaluation and planning at all levels of the system, as well as using aggregate data at the board and Departmental levels for administrative oversight and planning.

The Outcomes System has made it possible to track and evaluate the effectiveness of other initiative, such as FAST$05, a children's mental health service provision program. Data from the system supported the FAST$05 outcomes data report by Ohio State University. *(http://medicine.osu.edu/sitetool/sites/pdfs/familyresearchpublic/outcomes05a.pdf)*

Lessons Learned

Among the most significant lessons learned was to pay attention to the education of ODMH staff and leadership. One cannot assume that all staff will automatically embrace an initiative, even one endorsed by leadership as a priority of the organization. Nor can one assume that staff will recognize the policy implications of an initiative or the imperative to think carefully about the integration of new and existing initiatives. Failure to attend to these organizational learning needs can cause confusion and frustration at best, and potential failure of the initiative at worst. It is important to maintain open channels of communication with leadership, work closely in collegial settings to integrate activities appropriately, and monitor communications and initiatives to ensure consistency and clarity.

These lessons learned concern both the importance of data use and the process of implementing an outcomes initiative:

1. Build consensus with constituents on vision, mission, values, and principles, especially from the perspective of consumers;
2. Design the implementation to include constituent representation, to be evolutionary, to support the philosophy of care ("recovery" for adults and "resiliency" for youth), to integrate with other quality activities, and to support use of data at the direct care level;
3. Apply the appropriate resources (staff time, expertise, cash) at the appropriate stage of the initiative;
4. Build partnerships among constituents based on mutual trust and respect and use these relationships to support decision making;
5. Specify a framework for the use of data early in the process in order to focus users on their expected roles and responsibilities;
6. Use data for its numerous benefits, including
    a. To inform clinical decision making;
    b. For program evaluation and planning at all levels of the system; and
    c. For administrative oversight and planning; and
7. Develop a marketing and training program for state agency staff to ensure policy integration and clear, consistent communication with the field.

Recognizing Success While Looking Ahead

Both the utility of the Outcomes System and the political will of participants have been tested since the system's inception. Its success has stemmed from ongoing investments in training, technical assistance, and technology. The closer the system gets to full integration of outcomes data in service agency operations, the more it will be able to focus on outcomes monitoring. The system has achieved more robust use of outcomes data in treatment planning with individual consumers than in the use of aggregated outcomes data in agency quality improvement. The latter has been the focus of ODMH's most recent training with related training scheduled in the future. Even with a highly-technical endeavor such as the Outcomes System, the most challenging task remains a fundamentally human activity: changing attitudes and behaviors. Ohio has found that the most effective strategies are those that are "high touch," with a healthy dose of interpersonal contact, dialogue, and personal communication. While ODMH and its partners continue to develop policies and products that demonstrate the value of the system and model best practices, there is no substitute for the personal contacts that build trust, enable learning, and reinforce important values.

ENDNOTES

[1] Shortly after implementation of the Outcomes Initiative, Ohio's budget was dramatically affected by the downturn of the U.S. economy. Revenues fell even as the cost of quality increased, and local providers, boards and ODMH faced difficult choices. While some partners appreciated the even greater need to inform policy with outcomes data, the costs involved were significant, especially to support technology solutions, and were sometimes viewed as prohibitive in light of reduced consumer access to services. While this has been addressed for the vast majority of agencies it is still a concern for the smallest providers.

[2] ODMH convened a statewide mental health commission (1999-2000) to develop an overall agenda for the mental health system, including financing, clinical quality, administrative management, services to populations with special needs, and accountability. ODMH Director Hogan was asked to chair the President's New Freedom Commission on Mental Health (2002-03), which issued its final report to the President in July, 2003.

[3] The CCOEs provide policy leadership, consultation and training to other local systems regarding particular best practices such as multi-systemic therapy for youth, Cluster Analytic Planning and Evaluation (CAPE), and the Dartmouth University model of Substance Abuse/Mental Health services.

[4] The Ohio Mental Health Consumer Outcomes System Procedural Manual, Seventh Edition (Revised), May, 2005, page 14.

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Note: Many additional references were used in shaping the work of the Ohio Mental Health Outcomes Taskforce, including a detailed list of existing mental health outcomes instruments that were reviewed by the OTF and are referenced in Vital Signs at http://www.mh.state.oh.us/oper/outcomes/history.otf.recommendations.html.

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