Training on Outcomes

Excerpt from OSQIG Report One

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Office of Program Evaluation and Research
Ohio Department of Mental Health
Outcomes Training

Introduction

The need for training to more fully implement the Ohio Consumer Outcomes System has been cited from the beginning of the OSQIG process in almost all discussions as the solution, or partial solution, to various problems. In many cases, it became evident that the problems represented a lack of knowledge about the Consumer Outcomes System, indifference or even negative attitudes toward the process, and/or significant lack of skills needed to accomplish the required tasks (e.g., integrating Outcomes with service planning at the individual consumer level). In addition, OSQIG discussion highlighted the fact that problems facing the Consumer Outcomes System implementation are rooted in structural factors that affect behavior. These factors may prevent training activities from having the desired result of helping agencies, their staff, and consumers successfully implement the Outcomes process. While recognizing these structural factors, this chapter focuses on the vital role that training must play in the successful implementation of the Ohio Consumer Outcomes System. This chapter is not intended as a comprehensive plan, rather only a framework for the issues regarding the Outcomes training needs the system faces.

Training takes the time of and effort from trainers and trainees alike. Regardless of the entity that wishes to train its staff, there is expectation and hope that the training delivers value back to the organization in the form of added capability. One important method to assure value is to obtain Continuing Education Units (CEUs) wherever possible and necessary for training. However, unless training is carefully integrated into the business, it can fail to return value to the organization. While a full discussion of the attributes of successful training is far beyond the scope of this document, some discussion of training principles is necessary.

Training can be classified as:

- Information/Knowledge building—Adding to the knowledge base of the individual by providing factual information. This would include information about Outcomes in general, Certification requirements, computer specifications, schedules, etc.
- Skills building—Adding to or improving the skills of the individual, often through participatory techniques. This would include the use of Outcomes in engaging consumers, construction and use of aggregate data reports, conducting Quality Improvement, etc.
- Attitude changing—Aimed at modifying the attitude of the individual in ways that are congruent with desired behavior changes. This would include Recovery, the utility of Outcomes, etc.

Further, training cannot be uni-modal and be successful. Various types of training are necessary for different activities. For organizations that train clinicians, the learning curve is typically ordered as follows 1) knowledge building, 2) skills training, 3) use of the method in actual practice with active supervisory feedback. The use of manuals and lectures can be appropriate for knowledge building, while the use of role play and practice exercises would be more appropriate for skills building. Attitude change training is usually combined throughout the process. The closer that the knowledge and skills match those actually used in practice, the more useful the training and the higher the return on investment. These principles apply to all staff, and to consumers as well. For example, some training programs that exist for adult consumers such as Climbing into the Driver’s Seat, BRIDGES, or WRAP are intended to be experienced in a face-to-face group setting. Fostering consumer empowerment or showing clinicians how to engage a consumer in treatment planning, will not likely be accomplished through the use of a didactic
method. Thought and care must go into the design of training programs if they are to be effective. Further, no training can have the full intended effect unless it is combined with coaching and supervision.

A wealth of training materials exists on the Outcomes Web site and in other places and it is possible to conduct a good deal of self-training. OPER has heard from more than one organization that “we got the Web site address, and that was all we needed.” At the other extreme, there are entities that have received multiple trainings and much technical assistance with little or nothing to show for it. The need for Outcomes training varies with the overall capacity of business entities. In part, this might reflect a developmental process. For those who have been routinely collecting and submitting Outcomes data and using the information in treatment, it is much more likely that their Outcomes training needs are minimal. Those new agencies that are just beginning to implement the Outcomes System probably need more training and at the most basic level. Another aspect of capacity is related to the size of organizations. Larger organizations can capitalize on efficiencies of scale to add specialized staff for Outcomes and Quality Improvement, and can devote more information system resources to implementation of the Outcomes System. Yet even small organizations can excel without efficiencies of scale.

Management style is also a determinant in the success of implementing Outcomes. Some entities take a proactive stance and determine how Outcomes (or any other business driver) can add to their business model; others treat Outcomes solely as an administrative burden without exploring what of the Outcomes activities are billable and/or how use of Outcomes data may provide a benefit to the organization.

Entities should consider that the best impact of training will occur from well-timed and well-designed training efforts. There are several key events that precipitate a need for Outcomes (and other!) training:

- An agency seeks to become a provider of an Outcomes-qualifying service,
- Staff turnover in an Outcomes role (Clinician, Supervisor, etc., defined below),
- Any change in the Outcomes System requiring different behaviors,
- Any new use of Outcomes data that is expected to be made,
- Sufficient time has passed since previous training that re-training is required to assure fidelity.

Well-designed Outcomes trainings will be those that are tailored to specific roles (discussed at length below), to specific uses of data, and to particular philosophies. It is by design that ODMH combined Outcomes, Recovery and Resiliency together in its Quality Agenda (see Context Statement above). Training should, wherever possible, make explicit the ways in which Outcomes can promote Recovery and Resiliency.

**Roles-Based Outcomes Training Model and Supporting Materials**

The processes involved in Outcomes data collection, submission and use in treatment and Quality Improvement are collectively neither simple nor especially intuitive. Further, many people do not understand the need for consumer outcomes measurement, much less the specific tools selected by the Outcomes Task Force. Even for those who accept the need, it may be difficult to be sure of what knowledge is needed to fulfill the role(s) they play. Training has been focused on the role the individual fulfills in relation to producing and/or using Outcomes data. A variety of roles have been identified. At the agency level there are identified roles for adult and youth consumers, parents of youth consumers, adult-serving and child-serving clinicians, clinical supervisors and administrators. Other agency-based Outcomes roles exist including data technician (including data entry, data verification, data transmission, etc.), family member, and Quality Improvement director. At the local system of care level, the board plays a role as Outcomes data manager and system Quality Improvement director. At the state level, there are a variety of roles that require knowledge of how to use Outcomes data: the Outcomes Support role,
the ODMH system planning role, and Coordinating Centers of Excellence. As more information is provided regarding Outcomes, it will be important to create materials on how to interpret Outcomes data to the public.

Various parts of the Outcomes system are fulfilled by people playing a variety of roles. These roles clarify and limit to some extent the content of the training that needs to occur. The content of training materials has so far been very much roles-based. ODMH's development of an Outcomes Toolkit best reflects this approach. The Toolkit was designed to aid agencies and boards in providing training to adult consumers, family members, clinicians, supervisors and administrators.

A brief walk-through of the contents is in order:

- **Getting Results Flyer**—A tri-fold brochure designed to introduce consumers to the Outcomes System and what they can do with the information.

- **Adult Consumers**—A package called Climbing Into the Driver's Seat instructs consumers on how to use Outcomes to steer the course of their treatment by both finding treatment plan content from their Outcomes Survey as well as reviewing their progress using Outcomes. The training package includes workbooks for consumers and trainers, and is designed to be taught by peers. Ohio Advocates for Mental Health directs this program. (Knowledge, Skills, Attitude)

- **Youth Consumer**—A video titled "It's About You" was designed to introduce the Ohio Scales to adolescents. It was produced by the Southern Consortium for Children under a block grant contract with ODMH. ODMH Area Directors have been distributing this video to local mental health boards and agencies. (Knowledge)

- **Family & Caregivers**—A Family & Caregiver Handbook, and a PowerPoint presentation were developed to explain the ways that Outcomes data can be used by family members and caregivers to help in treatment. (Knowledge, Attitude)

- **Direct Care Staff**—Direct Care staff implies clinicians and other individuals paid to provide care to consumers. A handbook and video were developed to explain all the ways that direct care staff should use Outcomes data in treatment. (Knowledge, Attitude)

- **Clinical Supervisors**—A handbook and video were developed to explain all the ways that clinical supervisors should use Outcomes data in the supervisory process. (Knowledge)

- **Administrators & Managers**—Two manuals were developed that help agency management focus on the role that Outcomes should play in the management of the agency and on ways that the agency should think about how to reorganize around the implementation of the Outcomes System in their agency. (Knowledge)

- **Cultural Competency**—A booklet was included in the toolkit that summarized the results of four studies of the use of Outcomes in cultural groups that exist in Ohio. This piece of the toolkit was not particularly roles-based, but would be useful to clinicians, clinical supervisors and administrators. (Knowledge, Attitude)

Additional training materials were developed for additional roles that are not a part of the formal Toolkit. For the data processing staff at agencies and boards, the Outcomes Data Flow Guide was created. Additional resources for Outcomes information system staff have been created that are too numerous to recount here.

The use of a roles-based training model allows for analysis of which roles are not supported by specific training materials. Of the roles listed above, (adult and youth consumers, family members, adult-serving and child-serving clinicians, clinical supervisors, agency administrators, data technicians, agency Quality Improvement director, board Outcomes data manager, system Quality Improvement director, ODMH system planning role, Coordinating Centers of Excellence), no specific training materials have been developed for agency Quality Improvement director, board Outcomes data manager, system Quality Improvement director, ODMH system planning role, or Coordinating Centers of Excellence.
However, some tools from other places aside from the Outcomes System proper do exist. In particular, a video aimed at instructing child-serving clinicians in how to use the Ohio Scales in treatment has been developed and is available at the Southern Consortium for Children's Behavioral Health Education website: http://www.cbed.com/catalog.html?cat=2. A set of materials has been developed by the Hamilton County Community Mental Health Board as part of its Recovery Initiative that addresses how adult-serving clinicians—and adult consumers—can use the Outcomes data in treatment and recovery planning. This material is available at: http://www.mhrecovery.com. While no materials have been developed for Quality Improvement directors, OPER in coordination with the SA/MI CCOE did a well-regarded training on the use of Outcomes in agency Quality Improvement in 2005 and repeated part of it in 2006. These gaps in training materials suggest areas where further resource development can occur. However, developing training materials for these “unexplored” roles must be weighed against the improvement to materials already developed.

In addition to the roles-based resources provided, many “general” materials have been created. The Outcomes Procedural Manual, the Frequently Asked Questions documents, and the Outcomes 101 slide show are a few examples of these types of materials available at the Outcomes Web site. These documents vary tremendously; the Frequently Asked Questions documents and the Outcomes 101 slide presentation are appropriate for use in training almost anybody involved in the Outcomes System. The Outcomes Procedural Manual is a very detailed document designed to be the definitive guide on implementing the Consumer Outcomes System. The Manual is arranged so that chapters can stand alone as references to various areas of the Outcomes System.

**Appropriate Trainers**

**Office of Program Evaluation and Research**

The role of ODMH, and particularly the Office of Program Evaluation and Research (OPER), in training is key, but not all-encompassing. By virtue of the limits of OPER’s staff, there is no way that all of the needed training could come from OPER’s Outcomes Support Team. OPER’s special role in training has been in the creation and provision of training tools (as discussed above and mostly available on the Outcomes Web site) and in providing ongoing technical assistance, which is a specialized type of training. OPER’s provision of technical support is key to implementation as a resource to new agencies and new staff coming up to full implementation of the Outcomes System, and to agencies and boards seeking to expand their use of Outcomes data. The provision of supports typically follows two primary lines: solving specific problems of implementation, and suggesting ways for improvement. Additionally, the Outcomes Support Team has actively done outreach to providers in order to head off perceived problems. When OPER has conducted training, its efforts have been focused on what critical training was needed at the time. Obviously, at the outset of the Outcomes Initiative, there was a need for all kinds of training to be done, and OPER did a large amount of training aimed directly at clinicians and clinical supervisors. However, this was part of a start-up effort and was not intended to be a model for ongoing training. In the long run, agencies, boards, and others need to conduct training on Outcomes as appropriate to fit their needs.

OSQIG suggested that several training activities be completed by OPER, which are under consideration. Some of these comprise new work, and others define ways in which OPER fulfills its Outcomes System management role. The new work activities suggested are to:

- **Produce a document that describes all training resources currently available on the Web.** Those seeking to do training would be helped by the creation of a training resource guide that would list all available training resources. While the Outcomes Web site is a rich trove of training resources, it can take time to find what is required, especially for those new to the Initiative. However, a wide variety of tools do exist, and those who need information about Outcomes, or those who need to train others about Outcomes, can usually find useful training tools. Making the document based upon the
Outcomes roles will also help. This document can list resources on the Outcomes Web site and off.

- **Develop a user-friendly document about the billability of Outcomes activities.** Which parts of the Outcomes process are billable and which parts are not is a perennial question, and one that is costly to the system. The Outcomes Procedural Manual has a section on this topic, but it is not easily found. OSQIG felt that a stand-alone product would be more accessible to those who need it. It can be an appendix to the Manual.

- **Develop a user-friendly document about the use of Outcomes in treatment.** While the use of Outcomes in treatment planning is a part of the Outcomes Rule (part F), there is limited understanding of the ways in which Outcomes information can be used in the treatment process. Although many are suggested in the Outcomes Toolkit, in chapters in the Outcomes Procedural Manual and in other documents, the need for a more accessible source of information was clearly articulated.

The suggested ways in which OPER could better fulfill its Outcomes System management role were:

- **Improve existing training tools based on feedback from the users.** So many products have been created over such a long time that many could become dated. Timely, up-to-date materials on the use of Outcomes data will have the most utility. OPER needs to periodically review the quality of its training products with its customers to assure maximum use and impact. Observing what tools are used most frequently will assist in this effort.

- **Produce additional training resources as needed that providers, boards and consumers can use to conduct training.** As pointed out in the Roles-Based Training Model section above, some roles have not been targeted with role-specific training materials. These are worth a look; but bringing often-used training materials up to date may have more of an impact.

- **Make use of technology to conduct more regional training.** Regional training is good for agencies and boards as it minimizes the cost of travel. This in turn maximizes the number of staff that can attend training.

- **Record successful training events and post them to the Outcomes Web site for others to use.** Most agencies cannot attend training on any given day when the event lasts most of a day, but all agencies can make time for training that is provided at no or minimal cost and/or are in their own offices. Various technologies can make this possible.

- **Maintain a list of experts and exemplary programs that others can use.** This is something that OPER currently does for Outcomes generalists. There are few “experts” identified that are specialists in most of the areas. However, some who have been listed no longer wish to fulfill this role due to time constraints or a felt lack of capability.

- **Report agencies and boards having success in Outcomes collection and use.** The Missing Data Report is one way to find agencies that collect Outcomes data successfully. OPER has also produced various “Best Outcomes Boards” rosters associated with the Missing Data Report, and intends to do the same with agencies.

OPER will continue to have primary responsibility to assure that Outcomes data users within ODMH are sufficiently knowledgeable about the Outcomes System so that they use the data in their various roles.

**Agencies**

Agencies already face a never-ending training challenge due to clinical and clinical-supervision staff turnover that requires each new person to get training. This kind of training is best left to the provider, as only they can know when the person starts and where Outcomes best fits into the general training package they will be providing to new staff. The Outcomes System prescribes the content and format for collection and submission of Outcomes data, as well as its use in
treatment and Quality Improvement. Various training tools are available to support these roles, but because specific data uses are not prescribed, it is important to use the available tools in ways that connect them to the specific context of the agency. This allows agency-based training that tailors Outcomes data use to a model that best fits their clinical model and philosophy. Regardless of the clinical model, agencies should include training on billability of Outcomes so that agencies can earn the maximum amount allowable from their activities. Resources for agency-based clinical role training have been made available on the Outcomes Web site and should be used to assure fidelity to the Outcomes System where necessary. Also, agencies can make consumer training on Outcomes an effective part of their treatment model. At minimum, it is recommended that agencies provide the “Getting Results?” brochure to consumers.

The training of direct care staff, and even consumers, on their role in the Outcomes process is fairly easy to envision occurring at an agency level. However, because the number of people involved is very limited, providing training for the roles of clinical supervisor, Quality Improvement director and agency administrator is more difficult. In the smallest agencies, a single person can be agency director, Quality Improvement director and clinical supervisor. However, the manualized approach to these roles taken by OPER helps to address this issue. System-level Quality Initiatives can also play a significant role in assuring that agency QI staff understand the use of Outcomes data. Agencies may want to use peer agency staff as a resource for training; “experts” from outside an organization often convey a sense of greater knowledge and offer an opportunity for exchange of ideas from “outside the box” of the agency. Additionally, agencies may request that their service organizations, such as the Ohio Council of Behavioral Health Care Providers, Family Service Council of Ohio, and Ohio Association of Child Caring Agencies, provide training in these and other areas of performance of the Outcomes System. Despite the potential difficulties outlined above in training on the use of Outcomes in Quality Improvement, the onus to retain properly trained staff at agencies is embedded in accreditation requirements and in both the Performance Improvement Rule (5122-28-03) and the Consumer Outcomes Rule (5122-28-04).

The Outcomes System’s relative newness obscures the fact that an outcomes focus is something that agencies should have already had in place. The prior version of 5122-28-04 was a directive to conduct evaluation activities using outcomes measures. Some agencies already did have an outcomes focus, using other instruments. Others have operated under models of treatment that rely on non-standardized assessments of outcomes. In either case, new agencies that have not done so are encouraged to examine their treatment processes to see how the Outcomes process can be added most effectively. In some cases, this means replacing other outcomes measures. In other cases, it means adding the Outcomes instruments to their system. Using the Outcomes instruments and data in ways that are well-integrated into their clinical processes will enhance the likelihood that the Outcomes are not treated by agencies as only an add-on. This will simplify the job of assuring data collection and use. Further, evidence suggests that feedback on the outcomes of treatment can add significantly to treatment effectiveness; thus, agencies that do integrate Outcomes into their clinical processes might well expect that their Outcomes scores will improve. Whatever changes that are made to the clinical process should be reflected in policies and procedures, including requisite training.

Boards

Community mental health boards are responsible, per ORC 340 to “Encourage the development of high quality, cost effective, and comprehensive services;...Evaluate the need for facilities and community mental health services;...(and) shall consider the cost effectiveness of services provided...and the quality and continuity of care.” It seems obvious that this broad mandate to boards requires measurement of outcomes data, and the Outcomes System provides a uniform method for boards to measure the outcomes of treatment. Thus, board staff needs to understand the Outcomes System for their own purposes, as well as understanding the meaning of Outcomes data associated with their providers. Boards have a unique capacity to observe the totality of treatment impact on Outcomes, as services to a consumer can come from potentially many providers. Additionally, the evaluation mandate in 340 gives boards broad powers to look at many kinds of data to examine the “cost-effectiveness” and “quality” of services. This sets a
high standard for data use at boards, and thus the requirement for training is high. Whoever will use Outcomes data at boards needs to understand the Outcomes System, the programs being examined, and use of the proper analytic techniques to make sense of the data. Optimal use of the Outcomes data at boards will employ additional data pertaining to program participation in the completion of program evaluation activities. Additionally, boards have specific Outcomes data-handling requirements that they must conduct.

No board-specific training materials have been developed, which is somewhat a reflection of the situation boards are in vis-à-vis Outcomes. At this time, boards are not directed to do Outcomes analysis, and Outcomes analysis by boards is a highly politicized activity. Because of the prior absence of standardized outcomes measures and the history of boards’ role in evaluation of services, the role that boards can and should play in the use of the Outcomes data is still evolving. The Ohio Association of County Behavioral Health Authorities (OACBHA) role in the development of standard expectations for board use of data will probably be large. OACBHA has a Culture of Quality initiative that is setting up standards for boards’ capacity to conduct a variety of activities. Additionally, OACBHA conducts much training for its members, and some will undoubtedly focus on the use of Outcomes data by boards.

Boards can also play a role in assisting providers in their Outcomes training by conducting and funding training on the Consumer Outcomes System. Because the use of the Outcomes data has not been pre-defined, a local system could ask its providers to use Outcomes in a specific manner and conduct training on that. As mentioned above, the board may also sponsor system-wide Outcomes or Quality Improvement Councils to give local agencies a venue to collaborate on Outcomes initiatives. Boards may wish to fund consumer education on the use of Outcomes, such as the Climbing into the Driver’s Seat program. Finally, boards may wish to develop expertise in the Outcomes System to in order to provide training and technical assistance directly to providers.

Coordinating Centers of Excellence

As part of its implementation of the Quality Agenda, ODMH has developed and funds Coordinating Centers of Excellence (CCOEs) to promote and oversee Evidence-Based Practices (EBPs) and other innovative mental health practices. Under the CCOE model, agencies seeking to provide identified EBPs should work with the CCOE on an ongoing basis to ensure adherence to the practice model of the EBP. The role of the CCOEs regarding Outcomes varies. The role of Outcomes in Assertive Community Treatment (ACT) and In-Home Behavior Therapy (IHBT) has been highly formalized, and the associated CCOEs for these services include Outcomes in their training. However, these additional specifications are related to the collection of the data for QI and accountability purposes, not the use of data in treatment. Thus, these and other CCOEs may refine the use of Outcomes and specify how the Outcomes should be used in their practice standards and the CCOE would appropriately do training on such standards. As an example, the Cluster-Based Planning Alliance conducts regular training with its member agencies on the use of the Consumer Outcomes in service planning. Given the need for outcomes to provide the evidence in EBPs, the CCOEs may have a special interest in further specifying the use of Outcomes data in the practices they oversee.

Consumer Advocacy Groups

The Climbing into the Driver’s Seat training program was developed for the purpose of showing adult consumers how to use the Outcomes data to better direct their own treatment. This program is administered by Ohio Advocates for Mental Health, and is conducted by consumers. Other advocacy groups may wish to conduct similar training events.

Institutions of Higher Learning

Turnover of critical staff trained in Outcomes management at agencies and boards limits the utility of training conducted within the system. Part of the problem identified by OSQIG regarding readiness to use Outcomes in Recovery- and Resiliency-based services is the lack of appropriate content of training received in institutions of higher learning.

Ohio Revised Code 5119.11 allows ODMH to “enter into an agreement with …one or more institutions of higher education or hospitals…to establish, manage, and conduct collaborative
training efforts for students enrolled in courses of studies for occupations or professions which may be determined by the director upon the approval of the medical director to be in occupations or professions needed to provide adequate care and treatment for persons receiving mental health services.” In fact, the Office of the Medical Director of ODMH does just that. Grants are given to about 30 programs in colleges and universities around the state. These programs follow the funding priorities of the Department as detailed on the Medical Director’s Web site (http://www.mh.state.oh.us/medicaldirdiv/clinicalbp/clinicalbp.residency.priorities.html).

One strategy is to work within the Department to revise these priorities to include those topics of concern to OSQIG:

- **The use of Outcomes in Treatment.** While tests and measurements courses do include a cursory review of outcomes measures, the uses typically promoted are for research or assessment. A stronger emphasis on treatment planning, consumer involvement and the effectiveness of feedback would serve well. Using the Ohio Mental Health Consumer Outcomes System as the exemplar of outcomes measurement would be of the most benefit to Ohio’s public mental health system, and would provide students exposure to a world-class outcomes measurement system.

- **Recovery- and Resiliency-Based Practices.** To a large extent, these are among the priorities of the Medical Director’s Office in its list of Evidence-Based Practices.

- **Outcomes in Quality Improvement.** The practice of Quality Improvement generally, and the use of Outcomes data specifically in Quality Improvement could receive stronger emphasis.

Staff of the Office of the Medical Director suggested various additional strategies for including pertinent training in institutions of higher learning.

- **Approach institutions of higher learning through their curricula development committees.** These committees sometimes include the staff of public mental health agencies, and in the past, these members have been instrumental in adding course work on topics of direct utility in the public mental health system such as paperwork requirements.

- **Be ready with well-developed curricula, and a good evidence base for the recommended additions to the curricula.**

- **Arrange to make guest lecturers available who can speak on the outcomes topics that are recommended.**

**Summary**

This chapter is intended to be a framework for efforts that must follow, and is not a comprehensive plan for Outcomes training. The proper design and development of training programs will take time to develop, and no one organization has all the answers.

The Consumer Outcomes System is an integral part of the overall public mental health system in Ohio. Just as boards and providers must have a proper understanding of the billing system, boards and providers must understand the operation of the Outcomes System. In order to prepare the workforce to conduct its various roles properly, boards, agencies and other entities in the system must be ready to conduct the training required for proper understanding. Basing training upon the roles that individuals will play in the use of the Outcomes data will minimize the training requirements and will allow the creation of training materials to be focused. Agencies, boards and others should consider how they will use the Outcomes and train for those specific uses. Training on the use of Outcomes will probably need to be repeated periodically in order to assure fidelity with the Outcomes System requirements. Perhaps most importantly, no training can have its intended effect unless it is combined with subsequent supervision and coaching.

Training does not occur in a vacuum, and its effectiveness will be mediated by the organizational and system culture and climate. These external forces can negate or minimize the positive impact even the best of training can afford. Therefore, all organizations would do well to consider how these and other factors will mitigate or augment the training employed in their organizations.