



Ohio Mental Health Consumer Outcomes System: Key Facilitators and Barriers to Implementation

Executive Summary

Why Focus on Outcomes?

- Ohio's public mental health system should enable consumers and families to build resiliency and achieve *their* life goals unimpeded by mental illness or emotional disturbances (recovery).
- Measurement of consumer outcomes at treatment start, end, and periodically throughout, lets us know if these all-important objectives are met AND supports consumer-driven treatment planning.
- Research shows that use of Outcomes in treatment for planning and feedback improves the Outcomes that are obtained.
- Research also shows that practices (EBPs or otherwise) that use evaluation methods and create and use regular reports are better implemented and more likely to be retained.
- We are more likely to retain funding if we are accountable.

For all these reasons, we are interested in what we can do to improve the collection and use of Outcomes data. In an effort to determine successful strategies and remaining barriers to full implementation of the Ohio Consumer Outcomes System, the Outcomes Support Team conducted a survey of those agencies that were collecting more than 85% of expected Outcomes data over a two-year period.

Methods:

The survey was conducted by phone and addressed five primary areas of inquiry about Outcomes implementation:

- Collection of Outcomes data
- Data flow to the local board and ODMH
- Use of Outcomes data in treatment planning
- Use of Outcomes data in quality/performance improvement
- Use of Outcomes data in fulfilling accreditation requirements.

Only agency-originated responses were included, however if an agency mentioned an area of interest, but did not cite it specifically, then probing questions concerning that area were asked.

Results:

Each section of the full report presents the facilitators and barriers as well as strategies agencies can use to improve. Some of the key findings of each section of the report are as follows:

Data collection

Key Facilitators: Agency top management support, clinical supervision and clinician buy-in.

Key Barriers: Hard-to-use technology, clinician and consumer resistance.

Data Use in Treatment

Key Facilitators: Clinical supervision buy-in, data-trained clinicians, clinician access to data, use of SOQIC forms.

Key Barriers: Clinician resistance, lack of data-trained clinicians, lack of clinician access to data.

Data Use in QI

Key Facilitators: Having data analyst on staff, easy access to aggregate data.

Key Barriers: Not having data analyst on staff, lack of access to aggregate data.

Use in Fulfilling Accreditation Requirements

Highlights the sections of accreditation requirements where people found uses for Outcomes data: 1) Performance/Quality Improvement, 2) Service Delivery/Provision of Care, 3) Outcomes Measurement 4) Individual Planning, 5) Ethics, 6) Rights & Responsibilities, 7) Governance/Leadership/Organizational Leadership, and 8) Prevention and Management. It is likely that more ways to use Outcomes data will be discovered as agencies have more experience with both Outcomes and accreditation.

Agency Resource List:

Agencies volunteered to help other agencies in a variety of ways:

- *List of technologies being used*—Find out which agency is using what technology.
- *Regional Conference Host*—Agencies with facilities that hold 100 people, and are willing to host Outcomes training events.
- *Discussion panelist or trainer in statewide event*—Agency staff who are will to be a panelist or trainer in an Outcomes training event.
- *Outcomes guide for other agency*—Agencies that are willing to support other agencies who want help implementing Outcomes; those that teach also learn!
- *References*—We cited a lot of tools that can be used within the body of the text, but there are also additional references that may prove helpful.

Conclusions:

Organizations implementing the Consumer Outcomes System face many challenges. The Outcomes System Quality Improvement Group identified five “Bigger-than-Outcomes” factors that impact an agency’s ability to implement Outcomes¹:

- 1) Financing & Reimbursement
- 2) Productivity & Quality
- 3) Information Technology
- 4) Workforce
- 5) Organizational Culture.

These important drivers for how agencies and boards manage the Outcomes requirements are not Outcomes-specific, but rather require core capacities that determine how the organization will meet the challenges facing Ohio’s public mental health system. These core capacities are not inherent traits, but rather mutable states that organizations, and staff within organizations, can manage and improve upon. In fact, due to staff turnover, changing requirements, and evolving methods, organizations must constantly refine their competencies. What is clear from this survey is that the top performers have, to a large extent, successfully tackled these “bigger than Outcomes” factors.

The full report on the Survey of Top Performers can be found here:

http://www.mh.state.oh.us/oper/outcomes/planning.training/top_performers.survey.pdf

¹ See Outcomes System Quality Improvement Group’s [OSQIG] Special Report section of its final report:

<http://www.mh.state.oh.us/oper/outcomes/osqig/osqig.rpt.1.pdf>.



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Thanks to people and agencies who responded to this survey, and the many consumers, clinicians and support staff who completed, collected and used the Outcomes data over the years—here's hoping this proves useful.

Introduction

In an effort to determine successful strategies and remaining barriers to full implementation of the Ohio Consumer Outcomes System, the Outcomes Support Team conducted a survey of those agencies that were collecting more than 85% of expected Outcomes data over a two-year period. The phone surveys were conducted with a total of 26 agencies from 11 board areas during August of 2007. The participating agencies are listed in Appendix A. The agencies ranged in caseload (the number of adults and youth served based on MACSIS billing for Fiscal Year 2007) from less than 246 to over 5,000 with a mean of 1,600 clients. Eleven agencies served both adults and youth; nine agencies served only children, while six agencies served only adults. Of the 26 agencies, five were accredited by JCAHO, 12 were accredited by COA, and 11 were accredited by CARF (two agencies were accredited by both COA and JCAHO).

Methods

Agency selection criteria

Agencies whose rates of reported data were above 85% and that had over 40 expected Outcomes for either youth or adults throughout Missing Data Reports #12-#14 were included in the first round of selection. The Instrument version of the Missing Data Report was used to assure that each agency selected was completing a substantial percentage of each required instrument.

Procedure

Agencies were contacted by e-mail to request an interview. This initial e-mail was followed by a phone call to arrange a time for the phone conference. All agencies that were selected participated in the interview. Respondents varied depending on the agency. Some agencies were represented by a single staff person, usually the Quality Improvement Coordinator. Other interviews included up to six staff. Among the other staff represented were the agency executive director, clinical director, clinical supervisors, support staff, compliance officer, information system staff, program manager, and operations director. One interview included the executive director and data programmer from the agency's ADAMHS board.

A member of the Outcomes Support Team conducted all of the interviews. Each interview began with greetings and a description of the types of questions that would be asked. There were five primary areas of inquiry:

- Outcomes data collection
- Outcomes data flow
- Outcomes data use in treatment planning
- Outcomes data use in quality/performance improvement
- Outcomes data use in supporting accrediting requirements.

For each area except the last one, agency staff was asked about facilitators and barriers. Only agency-originated responses were included, but if an agency mentioned an area of interest, but did not cite it specifically, then probing questions concerning that area were asked. For things that were seen as facilitators, the agency was asked to rate them on a scale from one to ten, where one was “A little bit helpful” and ten was “Extremely helpful.” For things that were seen as barriers, agencies were asked how great the barrier was on a scale from one to ten, where one was a “Mole hill” and ten was “Mt. Everest.”

Each agency was also asked about which accrediting standards were supported by use of Outcomes data, which data collection technology was used (and any comments about the technology), and in what ways the agency would be willing to help other agencies. During the interviews opportunities were available for the agency staff to ask questions about each area of the interview. The questions were mostly focused on the area of using data for performance improvement activities. At the end of the interview each respondent was asked if there were other areas of concern or comments about the Outcomes System they wanted to make. Most were satisfied they had ample opportunity to discuss all of their questions and concerns during the interview or took the opportunity to reinforce their responses.

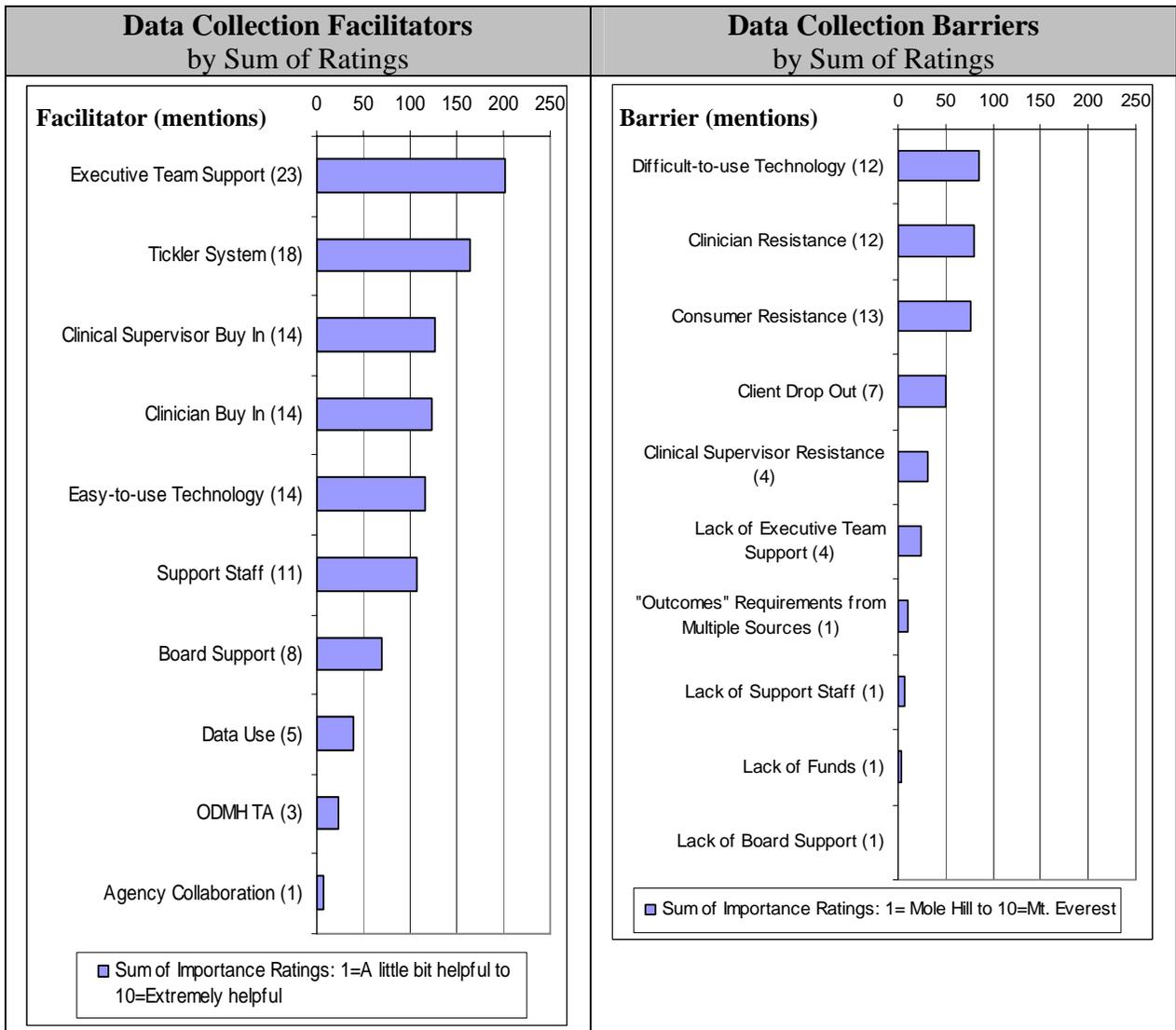
Contents

The rest of the report consists of a summary of the results and suggestions for addressing barriers for each of the areas of inquiry, and a list of resources available for use.

Results

Data Collection

Outcomes data collection is the first and most basic requirement of the Ohio Consumer Outcomes Rule. Overall, ten facilitators and ten barriers to data collection were mentioned. The mean facilitator rating was 8.84 with 111 mentions, and the mean barrier rating was 6.59 with 56 mentions. The graphs below show the sum of the ratings given to each facilitator and barrier. The representation of the sum of the ratings in the bars below includes both the strength of the ratings and the total number of mentions.



Five factors were identified as either facilitators or barriers to data collection:

- Staff Attitudes—Including executive team support or lack thereof, clinician support/resistance, clinical supervisor support/resistance, presence/absence of support staff for Outcomes data management.

- Technology—Including easy or difficult-to-use technology and presence of a tickler system.
- External—Including ADAMHS board support presence/absence, ODMH technical assistance, lack of funds, multiple outcomes requirements, and agency collaboration.
- Consumer—Only consumer resistance is noted.
- Data use—Using the Outcomes data for treatment planning or quality improvement as a facilitator in improving data collection.
- Also, see the suggestions under Data Use in Treatment Planning.

Staff Factors

Not surprisingly, the most frequently mentioned facilitator is top management support. This factor has been identified as one of the leading factors in the decision to adopt and ability to maintain Evidence-Based Practices. For information about factors affecting EBP adoption and retention see the Innovation Diffusion and Adoption Research Project (IDARP) Report: <http://www.mh.state.oh.us/oper/research/activities.idarp.index.html>. Two of the agencies reported that initially the lack of top management support was a significant impediment to successfully collecting data. Their current level of achievement was in large part due to the fact that their executive team now is very supportive and provides the resources necessary to get the job done. The lack of executive team support had four mentions as a barrier, and correlates with other clinical staff barriers such as clinical supervisor resistance (four mentions). Three of the four agencies that mentioned supervisor resistance mentioned clinical staff resistance.

While not mentioned as often as executive team support, the presence of support staff to complete Outcomes tasks (entering data, running reports, etc.) was the highest-rated facilitator, with an average score of 9.82; however, lack of support staff was only mentioned once as a barrier. The availability of support staff to manage Outcomes data not only directly affects data flow; it is often a product of executive team support. Since all of the agencies interviewed for this survey were top performers in this area, it was not surprising that this was an important facilitator and not a significantly reported barrier.

Clinical staff buy-in/resistance is an important factor, and is discussed in the section on Outcomes data use in treatment planning below.

What agencies can do address this area

- The CEO/Executive Director and the executive management team should understand the role of Outcomes in treatment, quality improvement and accountability, and regularly ask for and review Outcomes reports, primarily on the contents of the data but also on data collection rates (i.e. Missing Data Reports).
- The CEO/Executive Director should provide sufficient agency resources to support Outcomes data collection, data flow, and data management.
- Using the data in treatment planning will increase the number of clinicians who are willing to collect the data and complete the worker forms as well as the number of consumers who are willing to do the survey at subsequent administrations.

Technology Factors

The role of technology in data collection is vital. A wide variety of information system capacity exists in agencies today. Technology's role has been discussed at length as a factor elsewhere (see the Outcomes System Quality Improvement Group final report, chapter on technology, as well as the special report section:

<http://www.mh.state.oh.us/oper/outcomes/osqig/osqig.rpt.1.pdf>). The high number of mentions about "tickler" systems (to remind staff of upcoming administrations that will be due) is a telling sign about the importance of this factor.

Technology Strategies

- Start using a tickler system! This can be high tech or low tech. A high-tech example is to link expected administration with an electronic appointment book for the upcoming week. A low-tech example could be a calendar posted on the cover of each client's chart identifying dates when paperwork is due.
- Explore the available technologies to find the most cost-effective and easy-to-use solution. A number of vendors have responded to a Request For Information (RFI) about their products that can be found here: <http://www.mh.state.oh.us/oper/outcomes/data.flow.rfi.html>.
- If your agency is considering taking specifications for an information system out to bid, you should review this example RFP for behavioral health information systems: <http://www.mh.state.oh.us/oper/outcomes/planning.training/sample.information.system.r4.pdf>.
- Contact one of the Top Performers and ask them what they like and/or dislike about their information system. See Appendix B for a listing of the technologies in use at the agencies included in this survey. See Appendix C for contact information.
- Join a users' group for the technology that you employ. Contact the vendor about users' groups.
- Collaborate with other agencies to develop new technologies.
- Contact the Outcomes Support Team if you have any questions about technology.

Consumer Resistance

That consumer resistance to Outcomes is the most frequently cited (13 mentions) barrier to the collection of Outcomes data is troubling. It was, however, one of the lower-rated items with an average of 5.8, behind 7 other factors. Despite this barrier, each and every agency interviewed averaged at least 70% of consumers completing a survey (that rate was for parents at an agency whose primary function is a residential home, where parent involvement is expected to be lower).

Consumer drop-out from service is a matter of engagement and consumer readiness to change. These factors are discussed further in the section on Outcomes Data Use in Treatment Planning.

Consumer Resistance Strategies

It is noteworthy that consumer buy-in was not mentioned as a facilitator for Outcomes data collection. See more about this in Consumer Empowerment under the section about Data Use in Treatment Planning. Agencies that collect Outcomes in a transparent manner, where consumers are aware from the start that this is meaningful data that will be used in an open and responsible manner to guide treatment will have higher completion rates. Many techniques exist to enhance consumer buy-in to Outcomes at the intake administration. Lack of buy-in to Outcomes on the part of consumers past the intake must be considered part of the treatment engagement process.

- The best method would be to present the Outcomes survey to consumers separately, explain the forms, encourage them to complete it, and tell them it will be used as part of the treatment process.
- Use the Outcomes with consumers in the treatment process. If consumers observe this information being used, they will be more willing to complete the forms for re-administrations.
- For youth, the “Top Ten Ways to Use the Ohio Scales” pamphlet (available at: <http://www.mh.state.oh.us/oper/outcomes/planning.training/top.ten.uses.pdf>) can be use to explain to the consumer and their family how the data will be used.
- For adults, a similar Top Ten Ways to Use the Adult Outcomes Instrument pamphlet is under development.
- Implement the Climbing into the Driver’s Seat program. See the contents here: <http://www.mh.state.oh.us/oper/outcomes/planning.training/toolkit.handbook.adults.pdf> or contact the Ohio Advocates for Mental Health: <http://www.ohioadvocates.org/>.

External Factors

External factors play a relatively small part in the success in data collection, but are important nonetheless. Inter-agency alliances, the local ADAMHS board and ODMH technical assistance can play a meaningful role in responding to the challenges of data collection.

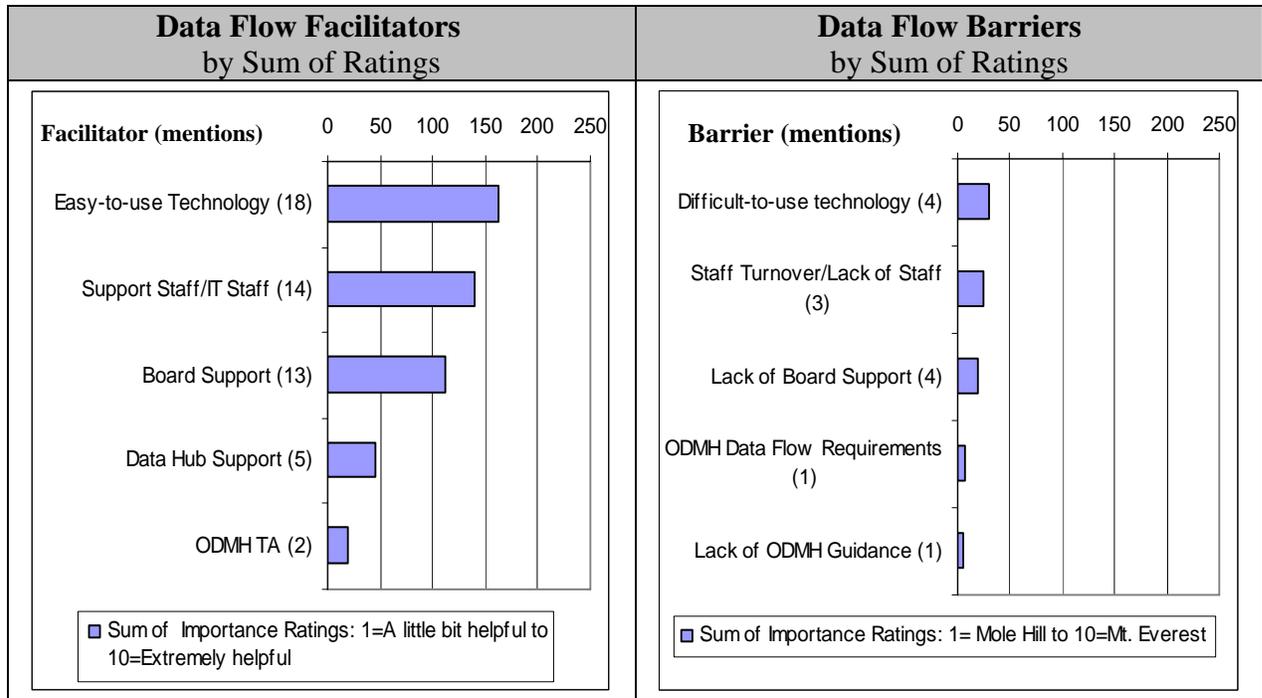
General Strategies

- Form users’ groups either within board areas or with agencies who serve similar populations to share data collection strategies and work through barriers experienced.
- Boards and agencies could consider forming a working coalition with others to benefit from economies in scale in negotiating with software and hardware vendors, or in contracting for information technology services.
- Boards and agencies could look into becoming actively involved with external sources of assistance such as CCOEs, local colleges or universities, or behavioral health trade associations.

Data Flow

Outcomes data flow covers the process of forwarding the data from the provider to the board to the state, and assuring that rejected records are corrected and resubmitted. Only five facilitators and five barriers emerged in relation to data flow, in part because of the fewer

number of staff involved in this process. The mean facilitator rating was 9.19 with 52 mentions, and the mean barrier rating was 6.5 with 13 mentions. The graphs below show the sum of the ratings given to each facilitator and barrier to data flow. The representation of the sum of the ratings in the bars below includes both the strength of the ratings and the number of mentions.



Five factors were identified as either facilitators or barriers to data collection

- Technology—The ease of use of various technologies.
- Staff—the presence or absence of staff who have an assigned role for data flow functions, and staff turnover, meaning loss of trained staff.
- Board/Hub Support—The presence or absence of local board help, or help from the designated data collection hub
- ODMH—Presence of ODMH support, and/or lack of guidance and difficulties experienced meeting the data flow requirements.

Technology Factors

The ease of use of the technology utilized for data flow is the most frequently mentioned facilitator with 18 mentions. It is interesting that difficulty of technology use for data flow was only mentioned four times as a barrier.

Strategies that agencies can use to address Technology Factors in Data Flow

- Assure that software in use at your agency has export functions that are easy to use.
 - o The format must match the file specs.

- o A conforming file-name should automatically be created
- o The software should have a method to mark records for re-export in the case that the record has been rejected.
- Use a spreadsheet to track files that are submitted along with the information about feedback files: read all about this in the section titled “Using the File Submission Tracking Form” in <http://www.mh.state.oh.us/oper/outcomes/reports/rpt.data.flow.reconciliation.pdf> .
- Contact one of the Top Performers and ask them what they like and/or dislike about their information system. See Appendix B for a listing of the technologies in use at the agencies included in this survey. See Appendix C for contact information.
- Contact the Outcomes Support Team if you have any questions about technology.

Staff Factors

The presence or absence of staff with time dedicated to assuring that files are sent and feedback reports on critical errors are processed is a major factor in facilitating or hindering smooth Outcomes data flow.

Strategies that agencies can use to address Staff Factors in Data Flow

- Assign an appropriate amount of time and staff for data entry and data flow processing.
- Keep clear procedures in place, in case of staff turnover:
 - o Be sure the procedures cover the contents of the Data Flow Guide, and have local board/hub data transmission methods that include, at least, file transmission method (board specific), handling critical errors, handling file errors that require resubmission of a whole file, and marking records for resubmission.
 - o Print a copy of the Data Flow Guide for the data flow staff: <http://www.mh.state.oh.us/oper/outcomes/data.flow/df.guide.appendices.pdf>.
 - o Make sure Outcomes data flow knowledge is “firmly entrenched in the organization” by cross-training support staff. (IDARP Bulletin #4: What resource problems has your organization encountered? <http://www.mh.state.oh.us/oper/research/activities.idarp.bulletins.html>)

Support from ADAMHS Board/Data Flow Hub

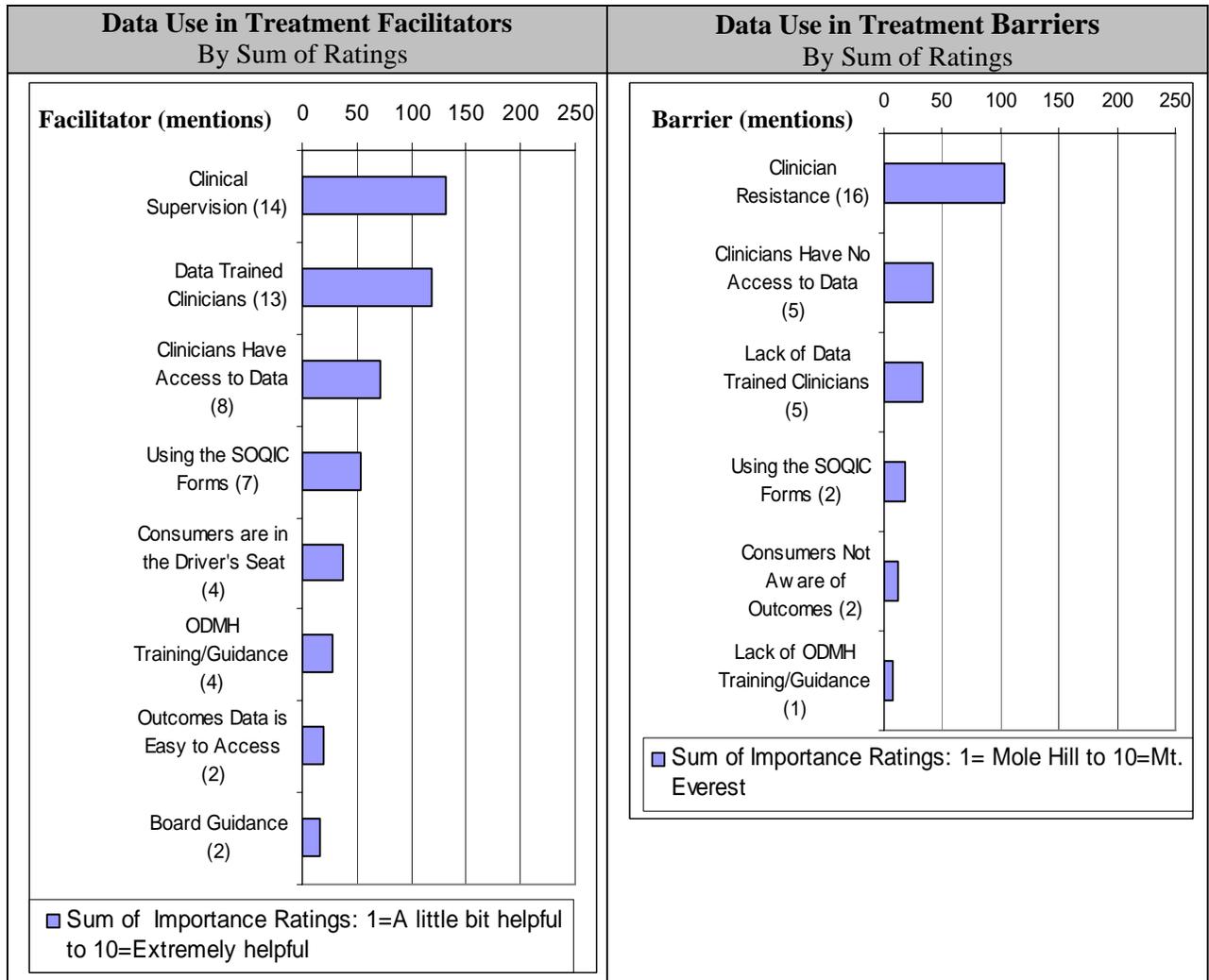
Outcomes data and MACSIS billing data flow to the state from the agencies by one of two ways, either through an ADAMHS Board or through a Data Flow Hub such as Heartland East or Ohio PPS. It is critical that there is a positive relationship between the agencies and the boards/hubs, in order for data to flow smoothly. Combined, Board support and Data Hub support were cited as a facilitator 18 times with an average importance rating level over 8.0.

Strategies to improve Data Flow through Boards/Data Hubs

- If you are experiencing issues with data flow through the board, you may use the procedures outlined in this document:
<http://www.mh.state.oh.us/oper/outcomes/reports/rpt.data.flow.reconciliation.pdf>
- Call the Outcomes Support Team for advice and support; Geoff Grove is available at 614-644-7840 or groveg@mh.state.oh.us or Marsha Zabecki at 614-466-9933 or zabeckim@mh.state.oh.us.

Data Use in Treatment Planning

The use of Outcomes data in treatment planning is required by OAC §5122-28-04 (F). Along with being a requirement, the use of Outcomes in treatment planning has been identified as an effective method for engaging consumer participation in the treatment process. The mean facilitator rating was 8.85 with 54 mentions, and the mean barrier rating was 6.96 with 31 mentions. The graphs below show the sum of the ratings given to each facilitator and barrier to using the data in treatment planning. The representation of the sum of the ratings on the bars below includes both the strength of the ratings and the number of mentions.



Four factors were identified as either facilitators or barriers to data use in treatment planning

- Staff—Including clinical supervisor’s support of data use, clinician resistance to data use, and the presence or absence of clinicians trained to use data.
- Consumer Empowerment—Including consumers actively involved in their treatment planning and consumers who are unaware of the Outcomes System.

- Technology—Clinicians’ access or lack of access to data, which is often due to the data collection technology being used.
- External—Including using the SOQIC² Forms-reported as both a facilitator and a barrier to data use, guidance or lack of guidance from ODMH, and guidance from the local board.

Staff Factors

Without staff understanding and buy-in, the data cannot be used as intended for clinical purposes. Why then is clinician resistance such a factor? Hatfield and Ogles (2007) studied the reasons why psychologists use and do not use outcomes in practice. The list of reasons for why outcomes are not used was long, but fell into three categories: Lack of perceived utility, perceived impracticality and lack of know-how to use outcomes. While there is some truth in each of these, Stewart (2007) found that use of the Ohio Scales in treatment planning is strongly positively related to the child/youth’s perception of treatment progress. Lambert (2005) lays out methods for the use of outcomes feedback as a means to improve treatment. Harmon, et al. (2005) show evidence of the positive impact of feedback on cases that are doing poorly. More generally, Outcomes data can be an effective means to give voice to consumers in the treatment process. So, it is clear to us that the instruments have utility, despite the perception of some professionals. The other factors are telling: Do they have clinical staff that are trained to use data? Does the clinical staff have access to the data? The answers to both questions could explain at least part of the resistance, as well as show two of the ways to increase data use.

What agencies can do to address this area

- To introduce the use of Outcomes data in treatment to youth, families and clinicians, the “Top Ten Ways to Use the Ohio Scales Outcomes in Treatment” pamphlet was developed :
<http://www.mh.state.oh.us/oper/outcomes/planning.training/top.ten.us.es.pdf>
- A roles-based training toolkit was developed and is available at:
<http://www.mh.state.oh.us/oper/outcomes/training.toolkit.html>
Resources are available for:
 - o Adult Clients
 - o Youth Clients
 - o Family & Caregivers
 - o Direct Service Staff
 - o Clinical Supervisors and Administrators
- When providing in-service training on clinical practices, detail how to integrate the use of Outcomes as part of that training. This integration will increase uptake of the Outcomes as a part of practice. Further, use of Outcomes should be subject matter for

² An acronym for Solutions for Ohio’s Quality Improvement and Compliance, a statewide initiative within the mental health system dedicated to improving quality, reducing costs, and ensuring compliance with federal, state and accreditation requirements.

subsequent supervision sessions, as training without follow-up is minimally if at all effective.

- Agencies and board areas could collaborate to provide trainings conducted by or created by recognized experts in the field. See Appendix C for Top Performers who can help you.

Consumer Empowerment

Consumers are empowered in treatment when they are effectively helped “in the driver’s seat” for mental health services. The first step to do that is to make sure that the consumer’s voice is heard and acted on from the very first contact at the agency to the diagnostic assessment and development of the treatment plan, to the continuous review of the treatment process. Consumers need to feel they are being treated with “mutual trust and respect” (Linhorst, 2006, p. 92). Many agencies require consumers to fill out numerous pieces of paper with many instances of duplicated information. It is important that when a consumer takes the time to complete an Outcomes instrument, a clinician subsequently takes the time to review this information with the client and /or family members and uses it in a transparent manner. The Outcomes System was developed to gather information from the perspective of the adult and adolescent consumer, direct care staff, and for children and adolescents, from their parents or guardians. This information then can be used to develop the treatment plan as well as to monitor goals and make modifications and updates to the plan while the consumer and clinician travel the road to recovery.

Why is empowerment important in these early stages of treatment? Certainly empowerment is a recovery goal, but it can also be a tool to use along the way. Linhorst (2006, p. 9) defines empowerment as “the meaningful participation of people with severe mental illness in decision making and activities that give them increased power, control, or influence over important areas of their lives.” This seems to suggest that consumers are essential partners with their mental health providers in moving treatment forward. In fact, Wampold (2003) identifies that the therapeutic alliance accounts for 60% of the observed outcomes; one of the primary determinants of a positive therapeutic alliance is the clinician’s success in empowering the consumer in treatment. Using the Outcomes as a tool to engage consumers in discussion of the treatment plan is a powerful way to build an alliance.

What agencies can do to address this area

- Empower staff so they can provide consumer-driven services. Staff empowerment can be as simple as recognizing your clinicians’ efforts to something as complex as streamlining any routine process that can relieve the burden of paperwork either through the use of increased staff support or technological solutions.
- Implement evidence-based practices that are consumer-driven and empowerment-focused.
- Monitor efforts to empower consumers using a reliable instrument
 - o Adult Consumer Form Empowerment Scale for adults (Healy, 2007).
 - o Ohio Scales Satisfaction Scale for youth and family members.
- Look into using an instrument that measures the therapeutic alliance (Duncan, 2004, p. 89-90) such as:

- o Penn Helping Alliance questionnaire (HAq)
<http://www.med.upenn.edu/cpr/instruments.html>
- o Horvath and Greenberg's Working Alliance Inventory (WAI)
<http://www.mps.mb.ca/Continuing%20Ed/Scales/WAIclient.html>
- o California Psychotherapy Alliance Scales (CALPAS)
- o Duncan and Miller's Session Rating Scale (SRS)
<http://www.talkingcure.com/index.asp?id=106>

Technology Factors

Technology can either provide ready access to data or can be an obstacle to the clinical use of data. Systems set up so that all stakeholders, from data entry specialists to clinical supervisors, can get the access to data they need allows the data to be used to optimal effect in treatment. A difficult-to-use system sets up artificial barriers and increases the workload for all staff involved, from data entry specialists to agency executives, and will build ill will toward the Outcomes system.

In many situations, clinicians have access to the forms that the client just completed, but no access to reports, such as change-over-time scores, or trends, or comparisons of view points, e.g. youth, parent and worker perspectives or adult consumer and provider perspectives. In a few situations where consumers directly enter their Outcomes responses into a computerized system, clinicians may never be able to see their clients' responses or reports based on these responses. Outcomes data cannot be used in a meaningful way in treatment planning as well as for agency wide initiatives if technology does not support this use.

Technology Strategies

The strategies suggested under Data Collection also apply here with these additions:

- Provide open access to Outcomes individual and aggregate data to clinical staff.
- Disseminate reports in a timely fashion to consumers, clinicians and supervisors.
- Set up automatic reports generators, or implement an easy-to-use technological front door so clinicians and supervisors can generate their own reports.
- Provide in-service technology training to clinicians and supervisors.
- Determine information requirements, then test potential systems, then acquire systems; don't be fooled by flash and "vaporware" (software that only exists in the salesman's promise).
- Contact one of the Top Performers and ask them what they like and/or dislike about their information system. See Appendix B for a listing of the technologies in use at the agencies included in this survey. See Appendix C for contact information.
- Contact the Outcomes Support Team if you have any questions about technology.

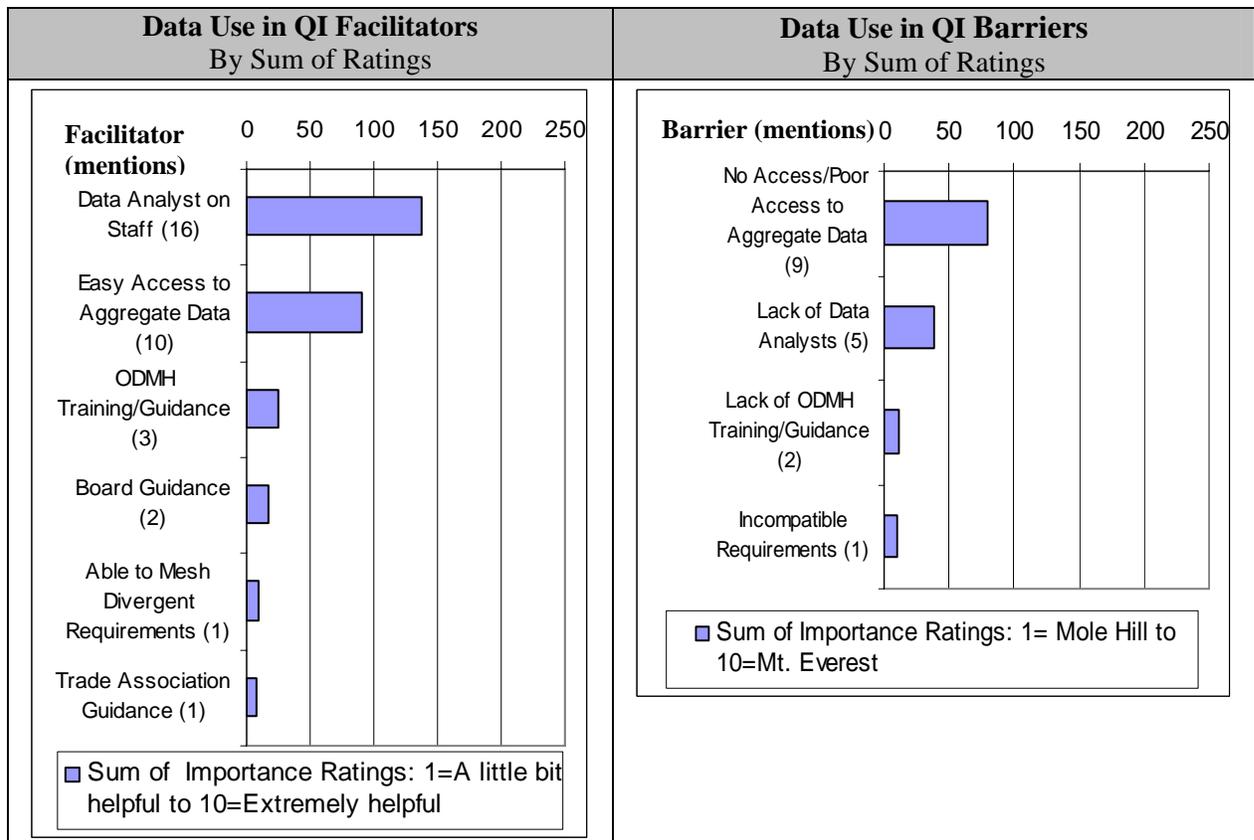
External Factors

These factors can be directly related to the concept of agency empowerment, since these issues are beyond their control. Just as a consumer may fail to thrive without empowerment, so an agency may fail to fulfill its mission to provide recovery-oriented services to their

consumers and maintain trained recovery-focused staff. Even though these factors are from outside sources, the effects can be mitigated by an agency culture that is proactive and continuously looking for ways to improve the quality of their operations and services. Guidance in implementing initiatives such as SOQIC and Outcomes is available from ODMH; nevertheless agencies should not limit themselves to these resources. If they have needs that are not being met they should “look outside the box” and determine new and different ways to get the help they need. This could include asking for strategies from not only ODMH and their ADAMHS Boards but from other appropriate sources as well.

Data Use in Quality Improvement

The use of Outcomes data in quality improvement is required by OAC §5122-28-04 (F) (the Outcomes Rule) as well as by OAC §5122-28-05 (the Performance Improvement Rule). The mean facilitator rating for this set of questions was 8.73 with 33 mentions, and the mean barrier rating was 8.81 with 17 mentions. The graphs below show the sum of the ratings given to each facilitator and barrier to using data for quality improvement (QI). The representation of the sum of the ratings in the bars below includes both the strength of the ratings and the number of mentions.



Three factors were identified as either facilitators or barriers to data use in quality improvement

- Staff—Presence or absence of trained data analysts.
- Technology—Access to aggregate data ranged from easy access to poor or no access.
- External—Including presence or absence of guidance from ODMH, guidance from local boards and/or trade associations, divergent or incompatible requirements among ODMH, accreditation organizations and funders.

Staff Factors

The presence or absence of trained data analysts is a major factor in an agency's ability to examine data for quality improvement. When funders and accreditation organizations have requirements for continuous quality improvement, agencies must ensure that they have staff available to generate the needed analytical and statistical reports in a timely and meaningful manner.

What agencies can do to address this area

- Set aside funds to hire a data/statistical analyst. Small agencies can collaborate with the board and other agencies in the board area to share a full time professional or contract for a program evaluation professional. A list of Ohio evaluators can be found here: http://pfs.osu.edu/communitytoolbox/trainings/evaluation/Ohio_Evaluator_Network_093007.xls . This is on the Center for Learning Excellence web site. They also provide a guide to selecting third party evaluators: <http://pfs.osu.edu/communitytoolbox/trainings/evaluation/Selectinga3rdPartyEvaluator.pdf> .
- Ensure that the your data analyst and/or contract evaluators as well as internal QI staff are aware of the guidelines for fulfilling the Outcomes Data Rule requirements for Outcomes data use in QI activities.
- Work with current staff to get the training needed to fulfill the responsibilities of this position.

Technology Factors

Full and easy data access is necessary for all staff in order to generate the information required for QI activities.

Technology Strategies

The strategies suggested under Data Collection also apply here with these additions:

- Provide access to Outcomes data to QI staff. Depending on the level of skills of the QI staff, this can be open-ended access (such as query-level access through SQL), or a system with easy-to-use report creator, or both.
- Disseminate reports in a timely fashion to clinicians, supervisors and top management.
- Provide in-service technology training to support staff and QI staff.
- Determine information requirements, then test potential systems, then acquire systems; don't be fooled by flash and "vaporware" (software that only exists in the salesman's promise).

External Factors

Requirements for data use and accountability from external sources are not going away. Agencies and ADAMHS boards should take the opportunity to work together to improve the system of care. Ravneberg, in his manual *Rethinking the behavioral health organization: A re-engineering source book*. (2006, pp. 6-3 to 6-4): Outlines three uses of Outcomes data:

- ***Management of Consumer Care***–Consumer outcomes data provide information for both clinical and administrative care management.
- ***Quality Improvement***–Aggregated consumer outcomes provide data for the ongoing quality improvement processes of agencies, boards and state behavioral health authorities for developing and monitoring best practices.
- ***Public Accountability***–The results obtained concerning consumer outcomes demonstrate the public mental health system’s accountability for tax dollars to the general public and to the state and federal governments.

Agencies can use the re-engineering process to minimize the efforts expended to accomplish these functions. The Re-engineering Source book can be found here:

<http://www.mh.state.oh.us/oper/outcomes/planning.training/training.re-engineering.source.book.pdf>

The Institute of Medicine recently published a Quality Chasm report specific to Behavioral Health. Its framework consists of six aims and ten rules as well as a recognition of internal and external supports that affect a health care system’s effectiveness. Several of the items could be developed into agency PI plans using analyses of Outcomes data for evaluation of progress such as:

- *Making healthcare more patient-centered*
- *Customization based on patient needs and values*
- *The patient as the source of control*
- *Shared knowledge and the free flow of information*
- *Evidence-based decision-making*
- *Anticipation of needs*

This framework can be the basis for a quality improvement plan. For example, the data from initial administrations at an agency could be used as an indicator for anticipation of needs. Client needs at intake could be reviewed over time and agency services could be modified in order to better meet those identified needs. The report can be found here:

<http://www.iom.edu/CMS/3809/19405/30836.aspx>

Data Use in Fulfilling Accreditation Requirements

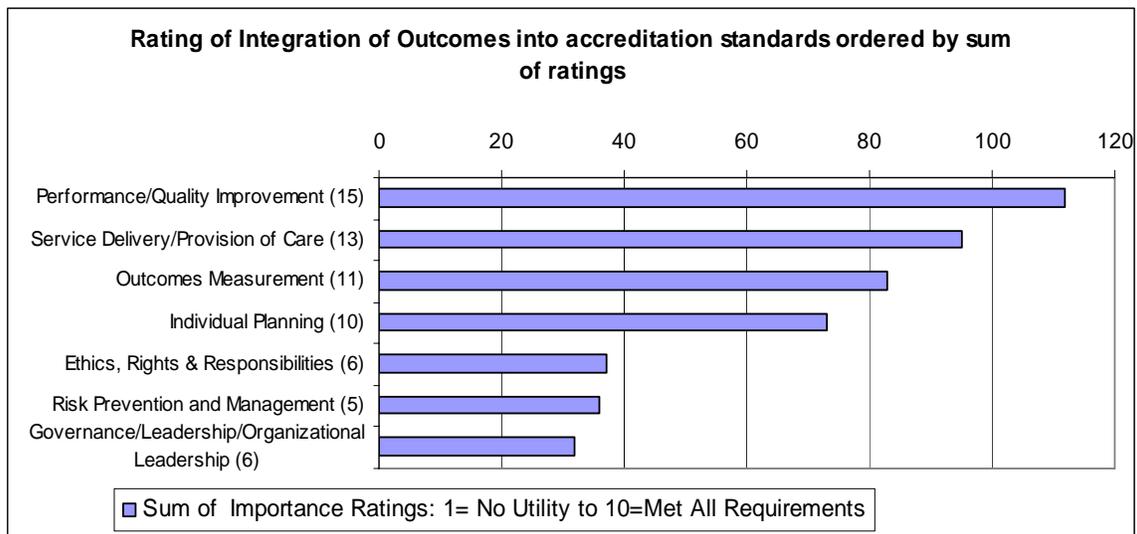
In order to improve the quality of care in the system and address regulatory burden, the Department of Mental Health revised its Community Agency Certification Rules so that accreditation by either the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or the Council on Accreditation (COA) is accepted as evidence of compliance with rules §5122-26 to §5122-29 of the Administrative Code, with the following Administrative Codes excepted from this deemed status:

- §5122-26-13—Incident Notification
- §5122-26-18—Client Rights and Abuse
- §5122-28-04—Consumer Outcomes
- Paragraph (F) of rule 5122-28-03—Performance Improvement
- §5122-26-19—Uniform Cost Reporting
- Paragraphs (C), (D), (K), (L), (M), and (O) of rule §5122-29-28 of the Administrative Code—Intensive Home Based Treatment Service
- Paragraphs (C), (D), (I), (J), (K), and (W) of rule §5122-29-29 of the Administrative Code—Assertive Community Treatment Service.

This arrangement of substituting accreditation for Certification Rules is referred to as “deemed status.” There is a varying degree of overlap with the accreditation standards and the Certification Rules excepted from the deemed status arrangement. Because the deemed status arrangement is relatively new (established in December of 2006, and effective 1/9/2006), most agencies with Certification were going through the accreditation process for the first time.

The Consumer Outcomes Rule requirements overlap with various accreditation requirements. In order to explore the extent to which the agencies have been able to use the Outcomes data to fulfill accreditation requirements, survey participants were asked which accreditation standards they have used Outcomes data to satisfy, and the extent to which Outcomes data could be integrated into the standard, where 1=*No Utility*, 10=*Complete integration of Outcomes into accreditation*. Only agency-originated responses were included, but if an agency mentioned an area of interest, but did not cite it specifically, then probing questions concerning that area were asked. It is important to note that not all of the agencies interviewed have started using Outcomes data in their accreditation review yet. Six of the agencies reported that their last accreditation visit was three years ago, and at the time they had not incorporated Outcomes into the process.

The graph below shows the sum of the ratings of the amount of integration of Outcomes into various accreditation standards with the number of agencies mentioning the standard in parentheses.



A total of 20 agencies mentioned using Outcomes data in some way to meet one or more of these standards. However, this should not be seen as a definitive or comprehensive list, as not all possible ways to use the Outcomes data in accreditation have been explored. Differences by accrediting bodies were explored, but few differences were observed.

What agencies can do to maximize the utility of Outcomes in meeting their accreditation requirements

- Work with peer organizations to develop and share policies, procedures, tools and strategies for maximizing the utility of Outcomes data
- Work with trade organizations to put on trainings around the use of the Outcomes in accreditation
- Contact one of the agencies surveyed to ask them about how they used Outcomes data in accreditation requirements. See Appendix C for contact information.
- Provide the accreditation supervisor with information about the Outcomes system and solicit advice about how to make the most of the Outcomes
- Ask the accrediting body for strategies on how to use Outcomes data.

Accreditation Web Sites

Commission on Accreditation of Rehabilitation Facilities (CARF)

<http://www.carf.org/providers.aspx?Content=Content/research/SOI.htm&ID=6>

CARF's Strategic Outcomes Initiative is a long-range plan that enhances the value of your accreditation by focusing on outcomes research and continuous quality improvement goals -- your guarantee of our dedication to maintaining the highest standards for quality and performance.

Council on Accreditation (COA)

http://www.coastandards.org/standards.php?navView=public§ion_id=28

COA's Performance and Quality Improvement (PQI) standards encourage agencies to use data to identify areas of needed improvement and implement improvement plans in support

of achieving performance targets, program goals, client satisfaction, and positive client outcomes.

The Joint Commission (JCAHO)

<http://www.jointcommission.org/>

Joint Commission standards focus on state-of-the-art performance improvement strategies that help health care organizations continuously improve the safety and quality of care, which can reduce the risk of error or low-quality care. Accreditation involves not only preparing for a survey, but maintaining a high level of quality and compliance with the latest standards. Joint Commission accreditation provides guidance to an organization's quality improvement efforts.

Discussion

Organizations implementing the Consumer Outcomes System face many challenges. This survey of top performers in reporting Outcomes data was designed to identify strategies for how to address the challenges of collecting, flowing, and using the Outcomes data in treatment planning, quality improvement and for satisfying accreditation requirements. As it turns out, many of the top facilitators and barriers are in common with those identified in research on implementation of Evidenced-Based Practices (EBP), including the Department's Innovation Diffusion and Adoption Project

(<http://www.mh.state.oh.us/oper/research/idarp/index.html>). Just as factors that are bigger than the EBP are prime determinants of implementation success, other "bigger-than-Outcomes" factors have been identified as having impacts on an agency's level of performance in implementing the Ohio Outcomes System (See Outcomes System Quality Improvement Group's [OSQIG] Special Report section of its final report:

<http://www.mh.state.oh.us/oper/outcomes/osqig/osqig.rpt.1.pdf>). In that report, five areas are outlined:

- 1) Financing & Reimbursement
- 2) Productivity & Quality
- 3) Information Technology
- 4) Workforce
- 5) Organizational Culture.

These important drivers for how agencies and boards manage the Outcomes requirements are not Outcomes-specific, but rather require core capacities that determine how the organization will meet the challenges facing Ohio's public mental health system. These core capacities are not inherent traits, but rather mutable states that organizations, and staff within organizations, can manage and improve upon. In fact, due to staff turnover, changing requirements, and evolving methods, organizations must constantly refine their competencies. What is clear from this survey is that the top performers have, to a large extent, successfully tackled these "bigger than Outcomes" factors.

The collection of suggestions included in this report does not comprise a whole strategy, or reflect the entirety of resources available to those wishing to improve their Outcomes implementation. More resources are available on the Outcomes Web site at:

<http://www.mh.state.oh.us/oper/outcomes/outcomes.index.html> Also, the Outcomes Support Team is available to answer any question about Outcomes by e-mail at outcomes@mh.state.oh.us. You can reach Marsha Zabecki at 614-466-9933 or Geoff Grove at 614-644-7840.

Appendix A: List of participating agencies

Agency Name	Location	Board Name
Applewood Community Mental Health Center	Cleveland	Cuyahoga County Community Mental Health Board
Beech Acres Parenting Center	Cincinnati	Hamilton County Mental Health and Recovery Services
Bellefaire Jewish Children's Bureau	Shaker Heights	Cuyahoga County Community Mental Health Board
Camelot Community Care	Cincinnati	Hamilton County Mental Health and Recovery Services
Central Clinic	Cincinnati	Hamilton County Mental Health and Recovery Services
Children's Advantage	Ravenna	Portage County MH&R Board
Choices for Victims of Domestic Violence	Columbus	Franklin County ADAMH Board
Christian Children's Home of Ohio, Inc.	Wooster	Wayne & Holmes Counties MH&R Board
Cincinnati Children's College Hills Campus	Cincinnati	Hamilton County Mental Health and Recovery Services
Community Counseling Services, Inc.	Bucyrus	Crawford-Marion Board of ADAMHS
Consumer Advocacy Model-Wright State Physicians, Inc.	Dayton	Montgomery County ADAMHS Board
Family Service of the Greater Cincinnati Area, Inc.	Cincinnati	Hamilton County Mental Health and Recovery Services
GLAD House	Cincinnati	Hamilton County Mental Health and Recovery Services
Greater Cincinnati Behavioral Health Services	Cincinnati	Hamilton County Mental Health and Recovery Services
Hamilton Choices, LLC	Cincinnati	Hamilton County Mental Health and Recovery Services
IKRON Rehabilitation Center	Cincinnati	Hamilton County Mental Health and Recovery Services
NECCO Center	Pedro	Adams, Lawrence, & Scioto Counties ADAMH Board
Positive Education Program	Cleveland	Cuyahoga County Community Mental Health Board
Six County, Inc.	Zanesville	Muskingum Area Board
St. Joseph Orphanage	Cincinnati	Hamilton County Mental Health and Recovery Services
The University of Toledo Medical Center	Toledo	Lucas County Mental Health and Recovery Services Board

Agency Name	Location	Board Name
The Village Network	Wooster	Wayne & Holmes Counties MH&R Board
Townhall II	Kent	Portage County MH&R Board
Trillium Family Solutions	Canton	Stark County CMH Board (Heartland East)
Twin Valley Behavioral Health New Dimensions CSN	Dayton	Montgomery County ADAMHS Board
United Methodist Children's Home	Worthington	Franklin County ADAMH Board

Appendix B: List of currently used Outcomes Technologies

ODMH Data Entry and Reports Template
Camelot Community Care
Christian Children's Home of Ohio, Inc.
GLAD House
Hamilton Choices, LLC
The University of Toledo Medical Center
The United Methodist Children's Home
Cincinnati Children's College Hills Campus

XAKTsoft
Children's Advantage
Choices for Victims of Domestic Violence
Community Counseling Services, Inc.
Townhall II

TeleForm (* in conjunction with ODMH Data Entry and Reports Template)
Beech Acres Parenting Center
Bellefaire Jewish Children's Bureau *
Consumer Advocacy Model-Wright State Physicians, Inc.*
Trillium Family Solutions*
Twin Valley Behavioral Health New Dimensions/Community Support Network
<i>*The Teleforms for the Outcomes instruments and the technology to transfer the data to the Template are available from the Outcomes Support Team</i>

TOAD
Applewood Centers
Central Clinic
Six County, Inc.

Point of View
Family Service of the Cincinnati Area, Inc.
IKRON Rehabilitation Center

Other Technology	
Greater Cincinnati Behavioral Health Services	Custom Software
NECCO Center	Defran Systems
Positive Education Program	Custom Software
St. Joseph Orphanage	Custom Software
The Village Network	CATT by ProComp

Appendix C: Resource Guide

Regional Conference Host—These agencies reported having a venue where 100 or more people could be trained and were willing to make it available for a regional training.

Agency	City	Primary Contact	Phone
Applewood Centers	Cleveland	Rochelle Murdock, Director of Quality and Evaluation	(216) 741-2241
Bellefaire Jewish Children's Bureau	Shaker Heights	Erin Williams, Evaluation Manager	(216) 320-8637
Christian Children's Home of Ohio, Inc.	Wooster	Kevin Hewett	(330) 345-7949
Community Counseling Services, Inc.	Bucyrus	Bob Moneysmith, Clinical Director	(419) 562-2000
GLAD House	Cincinnati	Adrienne Cenci, Executive Director	(513) 641-5530
Greater Cincinnati Behavioral Health Services	Cincinnati	Diane Wright, Quality Improvement Director/Client Rights Officer	(513) 354-7104
Hamilton Choices, LLC	Cincinnati	Ann Klein, Director of Outcomes and Evaluation	(513) 765-5500
Six County, Inc.	Zanesville	Nick Dubbeling, Clinical Director	(740) 588-6427
St. Joseph Orphanage	Cincinnati	Kim Whitesell, Director of Quality Improvement	(513) 231-5010
Trillium Family Solutions	Canton	Kathy Trubisky, Vice President, CQI	(330) 454-7066

Agency	City	Primary Contact	Phone
The United Methodist Children's Home	Worthington	Marti Eagleton, QI & Compliance Manager	(614) 885-5020
The University of Toledo Medical Center	Toledo	Karon Price, Executive Director	(419) 383-5419
The Village Network	Wooster	Scott Adams, Director of Continuous Quality Improvement	(330) 202-3809

Resource via e-mail or phone—These people were willing to be contacted via e-mail or phone if you have questions about the Outcomes issues discussed in this report.

Agency	Contacts
Applewood Centers	Rochelle Murdock, Director of Quality and Evaluation rmurdock@applewoodcenters.org , (216) 741-2241
Beech Acres Parenting Center	Rick Sorg, Vice President for Quality Improvement rsorg@beechacres.org , (513) 231-6630 Lynn Carlin, Program Evaluation & Planning Manager lcarlin@BeechAcres.org , (513) 231-4720 Sue Raikow, Evaluation Specialist (513) 231-6630
Bellefaire Jewish Children's Bureau	Erin Williams, Evaluation Manager williams@bellefairejcb.org , (216) 320-8637
Camelot Community Care	Megan Gooding, Clinical Director mgooding@camelotcare.com , (513) 961-5900
Central Clinic	Mary Grace, Director of Quality Improvement and Outcomes gracemc@uc.edu , (513) 558-5942 Barb Phillips, Compliance Officer Barb.Phillips@UC.edu , (513) 558-2941
Children's Advantage	Barbara Clark, CEO bclark@childrensadvantage.org , (330) 296-5552 Valerie Colvis, Project Manager vcolvis@childrensadvantage.org , (330) 296-5552 Camille Stephens, Compliance Officer (330) 296-5552 Mary McCracken, Director of Operations mmccracken@childrensadvantage.org , (330) 296-5552 Michelle Ruggiero, Manager of Fiscal Services mruggiero@childrensadvantage.org , (330) 296-5552
Choices for Victims of Domestic Violence	Gail Heller, Executive Director gheller@choicesdvc.org , (614) 224-7200
Christian Children's Home of Ohio, Inc.	Kevin Hewett hewettk@ccho.org , (330) 345-7949
Cincinnati Children's College Hills Campus	Steve Nauman, Senior Clinical Director of Psychiatric Services Steve.Nauman@cchmc.org , (513) 636-0812

Agency	Contacts
Community Counseling Services, Inc.	Bob Moneysmith, Clinical Director ccsi_bmoneysmith@rroho.com , (419) 562-2000 Robert Peare, Programmer/Analyst, Ohio PPS rpeare@ohiopps.org , (740) 654-0829
Consumer Advocacy Model-Wright State Physicians, Inc.	Kristen Dunn, Program Manager kristen.dunn@wright.edu , (937) 222-2400 Margaret Wanzo, Director Quality Improvement and Regulatory Compliance, margaret.wanzo@wright.edu , (937) 222-2400
Family Service of the Cincinnati Area, Inc.	Enid Grant, Clinical Director egrant@fsmail.org , (513) 381-6300 Anita Swift, Director of Quality Improvement & Compliance aswift@fsmail.org , (513) 354-5633 Matt Gerald, MIS Director mgerald@fsmail.org , (513) 381-6300
GLAD House	Adrienne Cenci, Executive Director gladhouse@fuse.net , (513) 641-5530
Greater Cincinnati Behavioral Health Services	Diane Wright, Quality Improvement Director/Client Rights Officer dwright@gcbhs.com , (513) 354-7104
Hamilton Choices, LLC	Ann Klein, Director of Outcomes and Evaluation aklein@hamiltonchoices.org , (513) 765-5500
IKRON Rehabilitation Center	Randy Strunk, Executive Director rstrunk@ikron.org , (513) 621-1117 David James, MIS ikron@ikron.org , (513) 621-1117
Positive Education Program	Claudia Lann Valore, Chief Program Officer (216) 361-4400 Dennis Koenig, Chief Clinical Officer (216) 361-4400 Tom Martin, Evaluation Director tmartin@pepcleve.org , (216) 361-7760
Six County, Inc.	Nick Dubbeling, Clinical Director ndubbeling@sixcounty.org , (740) 588-6427
St. Joseph Orphanage	Kim Whitesell, Director of Quality Improvement kim.whitesell@stjosephorphanage.org , (513) 231-5010
Townhall II	Mimi Domnie, Clinical Director mimi.d@townhall2.com , (330) 678-3006 Barb Deakins, Fiscal Director barbd@townhall2.com , 330) 678-3006
Trillium Family Solutions	Kathy Trubisky, Vice President, CQI ktrubisky@trilliumfs.org , (330) 454-7066

Agency	Contacts
Twin Valley BH New Dimensions/CSN	Deb Davis, Community Adjustment Training Supervisor (CATS) DavisD@mh.state.oh.us , (937) 258-0440 Ed Desmond, CSN Administration DesmondE@mh.state.oh.us , (614) 752-0333
The United Methodist Children's Home	Marti Eagleton, QI & Compliance Manager meagleton@umchohio.org , (614) 885-5020
The University of Toledo Medical Center	Karon Price, Executive Director karon.price@utoledo.edu , (419) 383-5419 Ginny York, Data Systems Coordinator/Compliance Officer Virginia.Deakin-York@utoledo.edu , (419) 383-3861
The Village Network	Scott Adams, Director of Continuous Quality Improvement SAdams@TheVillageNetwork.com , (330) 202-3809

Discussion panelist or trainer in statewide event—These people were willing to be a panelist or trainer regarding areas discussed in this report.

Agency	City	Contacts
Applewood Centers	Cleveland	Rochelle Murdock, Director of Quality and Evaluation, rmurdock@applewoodcenters.org , (216) 741-2241
Beech Acres Parenting Center	Cincinnati	Rick Sorg, Vice President for Quality Improvement, rsorg@beechacres.org , (513) 231-6630 Lynn Carlin, Program Evaluation & Planning Manager, lcarlin@BeechAcres.org , (513) 231-4720 Sue Raikow, Evaluation Specialist (513) 231-6630
Bellefaire Jewish Children's Bureau	Shaker Heights	Erin Williams, Evaluation Manager williams@bellefairejcb.org , (216) 320-8637
Choices for Victims of Domestic Violence	Columbus	Gail Heller, Executive Director gheller@choicesdvcols.org , (614) 224-7200
Christian Children's Home of Ohio, Inc.	Wooster	Kevin Hewett hewettk@ccho.org , (330) 345-7949
Cincinnati Children's College Hills Campus	Cincinnati	Steve Nauman, Senior Clinical Director of Psychiatric Services, Steve.Nauman@cchmc.org , (513) 636-0812
Consumer Advocacy Model- Wright State Physicians, Inc.	Dayton	Kristen Dunn, Program Manager kristen.dunn@wright.edu , (937) 222-2400

Agency	City	Contacts
Greater Cincinnati Behavioral Health Services	Cincinnati	Diane Wright, Quality Improvement Director/Client Rights Officer, dwright@gcbhs.com , (513) 354-7104
Hamilton Choices, LLC	Cincinnati	Ann Klein, Director of Outcomes and Evaluation aklein@hamiltonchoices.org , (513) 765-5500
IKRON Rehabilitation Center	Cincinnati	Randy Strunk, Executive Director, rstrunk@ikron.org , (513) 621-1117 David James, MIS, ikron@ikron.org , (513) 621-1117
Positive Education Program	Cleveland	Claudia Lann Valore, Chief Program Officer (216) 361-4400 Dennis Koenig, Chief Clinical Officer (216) 361-4400 Jill Koenig, Supervisor Community Services (216) 361-4400 Tom Martin, Evaluation Director tmartin@pepcleve.org , (216) 361-7760
Six County, Inc.	Zanesville	Nick Dubbeling, Clinical Director ndubbeling@sixcounty.org , (740) 588-6427
St. Joseph Orphanage	Cincinnati	Kim Whitesell, Director of Quality Improvement kim.whitesell@stjosephorphanage.org , (513) 231-5010 Joe Weisenberger, MIS, (513) 741-3100
Trillium Family Solutions	Canton	Kathy Trubisky, Vice President, CQI ktrubisky@trilliumfs.org , (330) 454-7066
Twin Valley BH New Dimensions/CSN	Dayton	Deb Davis, Community Adjustment Training Supervisor (CATS) DavisD@mh.state.oh.us , (937) 258-0440 Ed Desmond, CSN Administration DesmondE@mh.state.oh.us , (614) 752-0333
The United Methodist Children's Home	Worthington	Marti Eagleton, QI & Compliance Manager meagleton@umchohio.org , (614) 885-5020
The University of Toledo University Medical Center	Toledo	Karon Price, Executive Director karon.price@utoledo.edu , (419) 383-5419 Ginny York, Data Systems Coordinator/Compliance Officer Virginia.Deakin-York@utoledo.edu , (419) 383-3861
The Village Network	Wooster	Scott Adams, Director of Continuous Quality Improvement SAdams@TheVillageNetwork.com , (330) 202-3809

Outcomes guide for other agency— If your agency needs help in the overall Outcomes process, and would like to form a longer-term relationship than just a call or e-mail, these people and agencies were willing to serve as “guides” for the Outcomes process.

Agency	Board	Contacts
Camelot Community Care	Hamilton	Megan Gooding, Clinical Director mgooding@camelotcare.com , (513) 961-5900
Children's Advantage	Portage	Barbara Clark, CEO bclark@childrensadvantage.org , (330) 296-5552 Valerie Colvis, Project Manager vcolvis@childrensadvantage.org , (330) 296-5552 Camille Stephens, Compliance Officer (330) 296-5552 Mary McCracken, Director of Operations mmccracken@childrensadvantage.org , (330) 296-5552 Michelle Ruggiero, Manager of Fiscal Services mruggiero@childrensadvantage.org , (330) 296-5552
Christian Children's Home of Ohio, Inc.	Wayne-Holmes	Kevin Hewett hewettk@ccho.org , (330) 345-7949
Cincinnati Children's College Hills Campus	Hamilton	Steve Nauman, Senior Clinical Director of Psychiatric Services Steve.Nauman@cchmc.org , (513) 636-0812
GLAD House	Hamilton	Adrienne Cenci, Executive Director gladhouse@fuse.net , (513) 641-5530
Greater Cincinnati Behavioral Health Services	Hamilton	Diane Wright, Quality Improvement Director/Client Rights Officer dwright@gcbhs.com , (513) 354-7104
Positive Education Program	Cuyahoga	Claudia Lann Valore, Chief Program Officer (216) 361-4400 Dennis Koenig, Chief Clinical Officer (216) 361-4400 Tom Martin, Evaluation Director tmartin@pepcleve.org , (216) 361-7760
St. Joseph Orphanage	Hamilton	Kim Whitesell, Director of Quality Improvement kim.whitesell@stjosephorphanage.org , (513) 231-5010 Joe Weisenberger, MIS, (513) 741-3100
Trillium Family Solutions	Stark	Kathy Trubisky, Vice President, CQI ktrubisky@trilliumfs.org , (330) 454-7066

Agency	Board	Contacts
The University of Toledo Medical Center	Lucas	Karon Price, Executive Director karon.price@utoledo.edu , (419) 383-5419 Ginny York, Data Systems Coordinator/Compliance Officer Virginia.Deakin-York@utoledo.edu , (419) 383-3861
The Village Network	Wayne-Holmes	Scott Adams, Director of Continuous Quality Improvement SAdams@TheVillageNetwork.com , (330) 202-3809

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