The Ohio Mental Health Consumer Outcomes System

Procedural Manual

Tenth Edition

Release Date: October 15, 2008

The Ohio Department of Mental Health
30 East Broad Street
Columbus, Ohio 43215-3430

Make Sure Your

Consumer Outcomes System Procedural Manual

Stays Current!

The materials presented in this manual are correct and current as of the date of release indicated at the beginning of each chapter. However, this manual is not a static document; as new developments occur within the Ohio Mental Health Consumer Outcomes System, changes will inevitably be made in this manual.

The most recent release of this manual (and other important documents) is available from the Consumer Outcomes System Web Site, located at the following address:

www.mh.state.oh.us/oper/outcomes/outcomes.index.html

If you visit the Consumer Outcomes Web Site, you can also place yourself on an "Announcements" list and receive e-mail announcements about key activities, new products, or updates to the Ohio Mental Health Consumer Outcomes System.

Recent Revision History

Changes in the Ninth Edition: Changes from the previous Procedural Manual release include:

- General edits and updates.
- Revision of "Outcomes Use in Certification" Appendix G (Chapter 15) to reflect changes in Outcomes data use requirements.
- Correction of typographical errors.

Contents

(Release Date: October 15, 2008)

Amendments to the Outcomes Procedural Manual

(Release Date: October 15, 2008)

Effective October 15, 2008, the following amendments are made to the Outcomes Procedural Manual:

1. All requirements contained in the Outcomes Procedural Manual are voluntary for provider organizations until work is completed to develop more cost effective instruments and reporting procedures, at which time the Outcomes Procedural Manual will be further updated;

2. Provider organizations are expected to honor any existing obligations they have made or subsequently negotiated to collect and report Outcomes data for specific ODMH-funded research projects;

3. Provider organizations should accommodate consumers who wish to continue completing Outcomes instruments. Consumers may use the current methods available through the agency or may wish to explore using the tools which are now available through the Network of Care (Note: Network of Care has added the Adult Consumer, Ohio Scales Parent and Ohio Scales Youth instruments to the "My Folder" feature. Those consumers who wish to use this feature should be given the link to Network of Care (http://ohio.networkofcare.org/home_state.cfm?stateid=41), and told to select their county, where they should create a My Folder account or follow the “Use Your Outcomes Data” link. Once a consumer creates an account, they will be able to complete the instruments, have them scored, and their data will be saved. The Strengths, Red Flags and Change over Time Reports are available for their use. This information will not be transferred back to the agency, however one of the reports available to consumers can be used to carry the information back to the agency for data entry or for use in treatment planning.);

4. Provider organizations are expected to meet the requirements of accreditation related to Outcomes;

5. For provider organizations that have outstanding Plans of Correction (POC) due to the Department, continued follow up and submission of the POC is voluntary; and

6. Provider organizations that are due for certification renewal during this suspension period will not be held accountable for Outcomes submission during the time period in which ODMH is developing a more cost effective instrument and reporting procedures. If your agency decides to not respond to the Department related to your current Plan of Correction, you would still be in compliance with ODMH certification requirements. It is up to your agency to determine the next steps related to this function, and how you will comply with any other Outcomes requirement (i.e. national accreditation).

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Preface

(Release Date: October 15, 2008)

A Few Words About Consumer Outcomes

The overall intent of the Ohio Mental Health Consumer Outcomes System is to measure how people change in treatment, and determine if the services they receive have an impact. To achieve that end, the Outcomes System is designed to capture information at the beginning and the end of treatment, and if there is long enough in between, to capture information at additional intervals between the beginning and the end.

The Outcomes process is about making evidence-based, informed decisions regarding the care and treatment of people. Therefore, in order to be an effective tool for treatment planning and quality improvement, each Outcomes administration should be timely, reviewed with the consumer, integrated into the treatment planning process, and aggregated with similar administrations for other consumers for the purposes of agency quality improvement. Those administrations should then be submitted to ODMH to meet Administrative Rule and Certification requirements.

The materials in the *Consumer Outcomes System Procedural Manual* are provided to help achieve the above.

The Consumer Outcomes System Procedural Manual

> *I have served you better, if upon departing, you can follow the path rather than follow the guide.*
>
> *Unknown*

The *Consumer Outcomes System Procedural Manual* is divided into three general sections to help the reader: (1) be aware of the history and principles behind the

development of the Outcomes System; (2) learn about the individual Outcomes instruments and their administration; and (3) understand how Outcomes data are processed and what other Outcomes resources are available.

Section 1: Background Information

The first section of the manual provides a foundation for the Outcomes System, including a history of the Outcomes Initiative and a general description of the structure and content of the selected instruments and their administration.

1. **Preface** — This chapter provides a general orientation to the content of the *Consumer Outcomes System Procedural Manual*.
2. **The Ohio Mental Health Consumer Outcomes System** — This chapter describes the structure and history of the Ohio Mental Health Consumer Outcomes System.
3. **Outcomes Instruments and Administration Guidelines** — This chapter reviews the instruments selected for inclusion in the Outcomes System and provides guidelines for selecting and administering the appropriate instrument(s).
4. **Users and Uses of Consumer Outcomes Data** — This chapter describes ways various constituent groups can make use of the information provided by the Outcomes System.

Section 2: Instruments and Procedures

The second section of the manual describes the Outcomes instruments in detail and includes the following about each: (1) focus and intent; (2) scales and items; (3) cautions and qualifications; (4) respondent eligibility and characteristics; (5) minimum administration intervals; (6) administration protocol; (7) scoring; (8) analysis and interpretation; (9) how data can be used; (10) psychometric properties; (11) system fidelity checklist items; and (12) a copy of the instrument.

5. **Adult Consumer Form** — This chapter describes the Outcomes instrument that is used for all adults receiving services in the Ohio public mental health system.
6. **Provider Adult Form** — This chapter describes the Outcomes instrument that is used by provider agency workers for adult consumers.[1]

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[1] There are individuals who come to mental health agencies for resolution for short-term emotional problems who typically receive individual/group Behavioral Health Counseling & Therapy either alone or in combination with Pharmacologic Management services. For this group, almost all of the Provider Adult Form content is relevant and it is strongly encouraged that the instrument be administered. However, at this time it is not required in such situations.

7. **Ohio Youth Problem, Functioning, and Satisfaction Scales – Short Form (Ohio Scales)** — This chapter describes the Outcomes instruments that are used for child and adolescent consumers, their family members and their provider agency workers.

Chapters that relate to specific instruments are generally "stand-alone" chapters, and can be copied and used by clinical staff who wish to have a ready reference to the instruments they normally use but don't want to carry the entire *Consumer Outcomes System Procedural Manual*.

Section 3: Additional Information

The third section of the manual provides information on the flow and processing of Outcomes data and includes several appendices containing additional information.

8. **Processing Outcomes Data** — This chapter provides a general overview and quick reference for the processing of Outcomes System data.
9. **Appendix A: Outcomes at a Glance** — This appendix provides a quick tabular overview of the instruments used by the Outcomes System, the types of scales, subscales and items contained in each, and the intervals for their administration.
10. **Appendix B: System Fidelity Checklist** — This appendix provides a global checklist that includes all system fidelity items identified in instrument chapters of the *Consumer Outcomes System Procedural Manual*.
11. **Appendix C: Outcomes Data Sharing Scenarios —** This appendix provides a review of data sharing approaches when consumers are seen by more than one agency.
12. **Appendix D: Reverse Scoring Validation Scenarios —** This appendix provides a quick validity check of reverse scoring for organizations not using the Data Entry and Reports Template.
13. **Appendix E: Outcomes System Rumors** — This appendix lists a number of rumors have been encountered by the Outcomes support staff and provides the correct answers to the questions they pose.
14. **Appendix F: Outcomes Data Mart** — This appendix provides a brief overview of the Outcomes Data Mart and its design principles.
15. **Appendix G: Outcomes Use in Certification** — This appendix describes the use of the Data Use Compliance Monitoring Score Sheet and provides guidance for its use in the Certification process.
16. **Appendix H: Additional Resources** — This appendix describes additional resources that are available to individuals who are either participating or simply interested in the Ohio Mental Health Consumer Outcomes System.

17. **Appendix I: References** — This appendix provides citations for articles, publications and studies referenced elsewhere in the *Consumer Outcomes System Procedural Manual*.

The Devil is in the Details

The Consumer Outcomes System is a continually-evolving process; at the end of an initial three-year production period a formal evaluation occurred to identify ways in which the Outcomes System could be made more efficient and effective without compromising its underlying principles.

The initial set of post-evaluation changes are being implemented as of January 1, 2007, and are outlined in this manual, therefore, attention to detail is critical to the success of the Outcomes System. Specific procedures and instructions outlined in the *Consumer Outcomes System Procedural Manual* should be followed closely. While it may at times seem that there could be a shortcut or an alternative method for doing some Outcomes-related task, there are usually important reasons why the *Consumer Outcomes System Procedural Manual* dictates a particular method. Many of the details for implementing the Outcomes System were designed to minimize burden on participating individuals and organizations, and compromise might result in unanticipated consequences.[2]

Notes and Fidelity Checklist Items

Occasionally there may be particular items in the *Consumer Outcomes System Procedural Manual* that require special attention. Two ways such information shows up are through "Notes" and "Fidelity Checklist" items.

Notes — Notes appear throughout the *Consumer Outcomes System Procedural Manual*, and are designed to draw attention to particular details that enhance or expand the textual material. Notes may be simple reminders, expansion of the level of detail in surrounding paragraphs, or additional related information.

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[2] Sometimes an "obvious" shortcut turns out to offer less of a saving than appears at first glance. During the pilot phase of the Outcomes Initiative, a suggestion was made that it would impose "less burden" on organizations if they could administer the Adult Consumer Form B on a sample of eligible adults with less severe illnesses, rather than administering to all eligible consumers. Sampling was tried, but the provider organizations found that it was more difficult and time-consuming to keep track of which consumers should complete instruments than it was to administer the Adult Consumer Form B to all eligible adults. In addition, sampling significantly reduced the number of consumers for whom Outcomes information was available for care management decisions. As a result, the Outcomes Implementation Pilot Coordinating Group (OIPCG), a group comprised of consumers, family members, providers, board staff, and ODMH staff, elected to drop the sampling approach because of the additional burden it imposed.

Notes appear as boxed text preceded by exclamation points.

! ***Note:*** *Boxed text items preceded by exclamation points provide additional reminders or detail relevant to the point being discussed. If you see a note, read it carefully to make sure you don't miss an important detail or point of information.*

Fidelity Checklist Items — Fidelity Checklist items show up in chapters about specific Outcomes instruments, and are designed to assist organizations with assessing the degree to which their implementations are consistent with critical elements of the Outcomes System. Fidelity Checklist items are directed toward decisions related to overall implementation and processing of Outcomes data. If your Outcomes System implementation doesn't comply with a Fidelity Checklist item, you should reconsider how you are addressing that issue to ensure that your Outcomes data will be valid, reliable and comparable to other providers in Ohio.

Fidelity Checklist items appear as boxed text preceded by question marks.

? ***Fidelity Checklist Item –*** *Boxed text items preceded by question marks are part of a Fidelity Checklist that is included to identify particular details that might otherwise easily be overlooked. If your Outcomes System implementation doesn't comply with an item, you should reconsider how you are addressing that issue to ensure that your Outcomes data will be valid, reliable and comparable to other providers in Ohio.*

For convenience, all the checklist items that show up in a given chapter are listed together at the end of that chapter right before presentation of the instruments themselves. The *Consumer Outcomes System Procedural Manual* also contains an appendix that presents a complete listing of all Fidelity Checklist items for all instruments.

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The Ohio Mental Health Consumer Outcomes System

(Release Date: October 15, 2008)

> ***Note:*** *Much of the information in the current chapter provides background and history for the Outcomes System since its inception. Because of the period of time involved and the evolution of the Outcomes System, some references may no longer be applicable (e.g., instruments, administration intervals). Therefore, you should consult the Consumer Outcomes System Procedural Manual chapters that explain the individual instruments to obtain detailed information about the current requirements and operation of the Outcomes System.*

What is the Ohio Mental Health Consumer Outcomes System?

The Ohio Mental Health Consumer Outcomes System is an ongoing endeavor to obtain outcomes measures for consumers served by Ohio's public mental health system.

Creation of the Outcomes System

Measuring success in a large, complex mental health system requires balanced attention to data in three critical areas: quality, access, and cost. Based on the available data for Ohio's public mental health system, there have been improvements in each of these three areas. However, the most obvious systematic gap

has been in the lack of statewide data for consumer outcomes as an indicator of quality.

To resolve this issue, Michael F. Hogan, Ph.D., Director of the Ohio Department of Mental Health (ODMH), convened the Ohio Mental Health Outcomes Task Force (OTF) on September 12, 1996. The membership of the OTF consisted of a culturally diverse group of consumers, family members, providers, boards, researchers and evaluators, and staff from ODMH and Ohio Department of Alcohol and Drug Addiction Services (ODADAS). Director Hogan charged the OTF with developing an initial set of critical consumer outcomes and recommending to ODMH a standard, statewide, ongoing approach to measuring outcomes for consumers served by Ohio's public mental health system. In addition, the recommended approach was to provide useful data to all stakeholders (including consumers, families, providers, boards, ODMH staff, and the public) for planned change at the individual, agency, and human care system levels.

The OTF began its work on the Outcomes System by first establishing a values-based decision making process founded on shared vision and mission statements, eight consensual values, and five work plan assumptions documented in the *Vital Signs* final report. These vision and mission statements, values, and assumptions guided the OTF's development of (a) 24 consumer outcomes, (b) a set of instruments to measure these consumer outcomes, and (c) a recommended approach for using these instruments to measure consumer outcomes in Ohio's public mental health system.

Consumer Outcomes Defined

Recognizing that the definition of "consumer outcomes" often differed depending upon source and perspective and sometimes confused system performance or consumer satisfaction with consumer outcomes, the OTF established the following operational definitions of "consumers" and "consumer outcomes".

> *Consumers [are] persons receiving mental health services and/or supports including adults, children and adolescents and their families or significant others.*
>
> *Consumer Outcomes are indicators of health or well-being for an individual or family, as measured by statements or characteristics of the consumer/family, not the service system. Even though outcomes often are not attributable to one service or program, it is our belief that these measures provide an overall "status report" with which to better understand people's life situations.*

OTF Outcomes Model

The OTF reviewed several multidimensional models of outcomes systems and found that the models differed and sometimes presented opposing ideas with regard to the primary factors of what to measure, how to measure it, how to analyze and interpret the data, and how to report the results within and between various constituencies and stakeholder groups. The OTF adopted a three dimensional model (Rosenblatt & Attkisson, 1993) which addresses the following questions: (a) What to measure? — "domain or content area of the treatment outcome", (b) Who provides the data for the measure? — "type of respondent", and (c) Where or in which setting/situation is the measure relevant? — "social context".

The OTF's Outcomes System model includes four domains, four types of respondents who provide different perspectives, and four social contexts.

Domains of consumer outcomes measures:

- Clinical Status
- Quality of Life (Life Satisfaction, Fulfillment, and Empowerment)
- Functional Status
- Safety and Health

Types of respondents providing data for Consumer Outcomes measures:

- Consumer
- Family Member of Child/Adolescent Consumer
- Worker/Clinician
- Multi-Agency Community Services Information System (MACSIS)

Social contexts of the Consumer Outcomes measures:

- Self/Individual Receiving Mental Health Services
- Family Members or Family System
- Work or School
- Individual's Interaction with the Larger Community

Using this Outcomes model, the OTF identified 24 Outcomes to be measured for the Ohio public mental health system. For organizational clarity the OTF assigned each of these Outcomes to one of the four domains as the primary domain of the Outcome. However, the OTF also recognized that in reality many of the Outcomes involved more than one domain.

The OTF reviewed 126 proprietary and publicly available outcomes instruments in search of whole instruments, multi-item scales, or single item indicators which measured the identified 24 Outcomes. The OTF evaluated these potential instru-

ments using the following criteria listed in no particular order and adapted from the National Institute of Mental Health (NIMH) and Green and Gracely (1987):

- Direct and Indirect Cost
- Psychometric Properties
- Consistency with Principles of Consumer Recovery and Empowerment
- Cultural Sensitivity
- Consistency with OTF Outcomes
- Consistency with Principles for Child and Adolescent Service System Program (CASSP): NIMH

Based on a well documented review process, the OTF developed three instruments for measuring outcomes for adult consumers and selected three instruments for measuring outcomes for children and adolescents and their families.

OTF's Final Report

The OTF submitted its final report, *Vital Signs*, to Director Hogan on March 31, 1998 with five key recommendations for implementing the Ohio Mental Health Consumer Outcomes System. These recommendations focused on the following issues:

- Instruments and administration intervals for measuring Consumer Outcomes
- A Consumer Outcomes implementation pilot to test the process and products of gathering Consumer Outcomes data and the related issues of training, MACSIS interface, and use of data for the purposes of care management, quality improvement, and accountability
- An evaluation of the Consumer Outcomes implementation pilot while keeping in mind the need for future methodological refinements (e.g., the development of case mix adjustment formulas for case mix and statewide norms)
- Regulatory relief from existing ODMH requirements that were duplicative or did not support the OTF's recommended Outcomes approach
- Unresolved issues forwarded to the Outcomes Implementation Pilot Coordinating Group

Outcomes Implementation Pilot Coordinating Group

In March 1998 ODMH invited Community Alcohol, Drug Addiction, and Mental Health Services Boards and Community Mental Health Boards to attend the initial meeting of the Outcomes Implementation Pilot Coordinating Group (OIPCG). Eight boards, who also brought representatives from their adult and child provider agen-

cies, came to the initial meeting. The OIPCG included consumers, families, providers, board staff, OTF members, and ODMH staff.

The charge to the OIPCG was to plan and conduct a Consumer Outcomes implementation pilot that would illuminate the issues likely to be encountered in a statewide implementation. In accordance with the OTF recommendations, the OIPCG designed the pilot to evaluate (a) the process, products, and costs of gathering Consumer Outcomes data and (b) the usefulness of these data for care management, quality improvement, and accountability for the resources of the Ohio public mental health system.

Manuals, Training, and Pilot Implementation

In preparation for writing the Consumer Outcomes Implementation *Consumer Outcomes System Procedural Manual*, the OIPCG members formed five Workgroups: Purpose of Data, Instrument Documentation, Data Collection which included training, Data Flow, and Hardware/Software. Each workgroup identified implementation issues in their area and presented the issues to the OIPCG as a whole. The OIPCG discussed these issues and used a consensus process to resolve any outstanding issues. The workgroups incorporated the results of these discussions in writing their respective sections of the *Consumer Outcomes System Procedural Manual*. The Workgroups completed the *Consumer Outcomes System Procedural Manual* and the Data Entry Manual in September 1998.

Lake County, Stark County, and an adult provider in Columbiana County volunteered to be the sites for the Consumer Outcomes pilot. At the end of September 1998, the OIPCG and ODMH held a two day Outcomes implementation “train the trainers” training session for the boards and providers in the pilot sites and for a group of “next in line” local systems interested in further testing and evaluating the Consumer Outcomes approach. Each of the pilot sites selected staff to attend the training session, and these staff in turn used the training information to train the rest of the staff at the pilot sites during October 1998. The pilot boards and provider agencies began collecting Consumer Outcomes data on November 2, 1998 and continued with the time 2 data collection for the pilot throughout the spring of 1999. Although data collection for the pilot concluded with the second wave of data collection, as initially agreed the pilot boards and provider agencies have continued to maintain the Consumer Outcomes approach on an ongoing basis.

OIPCG Final Report

After the “train the trainers” training session, in the fall of 1998 the OIPCG reorganized its work groups to prepare for rolling out the Consumer Outcomes approach to other local systems and for making recommendations and writing its final report at the end of the pilot. The new OIPCG workgroups included: Evaluation of the Pilot; Data Analysis and Use; Hardware, Software and Data Flow; Marketing and Ongoing Education; and Regulatory Relief.

The OIPCG completed its work in December 1999, and made its recommendations regarding the Consumer Outcomes pilot to Director Hogan. Some of the key findings and recommendations from the Consumer Outcomes pilot were as follows:

- Changed the instruments for measuring Consumer Outcomes for children and adolescents to the three Ohio Scales (Short Form) respectively completed by youth aged 12–18 years, parents, and workers/clinicians.
- Changed the sample for non-SED children and adolescents to include all children and adolescents who utilize publicly funded mental health services.
- Changed the minimum intervals for administering the Consumer Outcomes instruments for children and adolescents to: initially during the admission process, at six months; 12 months, and annually thereafter from the date the worker/clinician completed his/her rating and/or at termination, whichever comes first.
- Retained the Adult Consumer Form A instrument, with a modification in one of the scales.
- Retained the Provider Adult Form A instrument, with some minor scoring modifications.
- Retained the Adult Consumer Form B instrument.

At the conclusion of the OIPCG's work, several boards and providers in other local systems were preparing to implement the Consumer Outcomes System in Fiscal Year 2001.

The Consumer Outcomes Incentive Grants Program

In June of 2000, the Department announced the Consumer Outcomes Incentive Grants Program. A fund of $3 million was made available to local systems to assist in beginning or implementing the Outcomes System in their areas. The majority of the grant funds went directly to agencies for a range of activities from start-up costs for data collection technology to consultation around the use of Outcomes data for clinical re-engineering. The requirements of the grants were that local systems use the Implementation Planning Checklist, a product that had been developed by the OIPCG, to develop a collaborative implementation process and begin collecting data. The grants also required that Outcomes data be flowing through local boards to the Department by September 30, 2001. Forty-two local systems, covering 192 agencies, received Incentive Grants and began implementing the Outcomes System.

At the same time, the Department developed extensive training materials to assist local systems in effectively implementing the Outcomes System. These training materials were packaged as a tool kit for each participating agency and board, and included a waiting room video and pamphlets to explain the Outcomes System to

consumers and family members, a video about how clinicians can use the Outcomes System data in Recovery planning, special materials for clinical supervisors, and a manual for managers about how to use Outcomes as a platform to re-engineer their agencies.

In the subsequent years, a number of different trainings were made available to local systems, including a series for clinicians about how to use Outcomes data in treatment planning for both adults and children/adolescents, and a "Climbing into the Driver's Seat" training for adult consumers about how Outcomes data can assist in their treatment progress and Recovery.

The Outcomes System Becomes a Mandate

The Ohio Department of Mental Health regulates provider agencies through its Certification Standards process, in which agencies are required to meet the provisions of a number of Administrative Rules. The Consumer Outcomes Rule (OAC 5122-28-04) became effective on September 4, 2003.[3]

With a few narrow exemptions, the Rule mandates that all agencies:

- must be collecting Ohio Mental Health Consumer Outcomes System data by March 4, 2004;
- must be successfully flowing data through mental health boards to the Department by September 4, 2004; and
- must provide evidence that Outcomes data are being used in both treatment planning and agency performance improvement activities by September 4, 2005.

The Consumer Outcomes Rule is one of a number of Administrative Rules which reinforce and support the Department's Quality Agenda, which is the synchronization of best practices, quality improvement and the consistent measurement of consumer outcomes.

The Outcomes System Quality Improvement Group (OSQIG)

Very early in the Outcomes Initiative, a commitment was made by ODMH to conduct a formal evaluation of Outcomes System implementation after a three-year period. The intent of the three-year period was to allow enough time for the System to be widely implemented and for local systems to gain the requisite experience upon which to conduct an evaluation. The Department began work on seating the committee that would conduct this formal evaluation in early 2005. The

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[3] The full text of the Consumer Outcomes Rule can be accessed at:
www.mh.state.oh.us/offices/odmh.certification.standards.html

committee was dubbed the Outcomes System Quality Improvement Group (OSQIG).

As with all of the Outcomes working groups in the past, OSQIG was a multi-constituency, culturally diverse, statewide group representing agencies, boards, consumers, family members, ODMH and academicians. OSQIG was convened May 31, 2005, by the Michael F. Hogan, Ph.D., Director of the Ohio Department of Mental Health. The charge to the group was to make recommendations to the Department that would improve both the operation and implementation of the Consumer Outcomes System. The group worked over a period of 18 months.[4]

OSQIG's work began with the review of a list of issues related to the operation of the Outcomes System that had been expressed by previous Outcomes committees, Outcomes Support Technical Assistance calls, and from unsolicited comments from individuals and organizations. OSQIG reviewed the list and added items as necessary, categorized the items according to the system's readiness to address them, and identified the type of issue the item represented and the groups affected. OSQIG then prioritized the items before formulating its solutions and responses.

OSQIG recommended the following simplifications, clarifications and clinical improvements to the Outcomes System, all of which were accepted by ODMH:

1. **(Simplification)** Defer any instrument changes until May 2008.

2. **(Improvement)** Add a three-month administration to the Ohio Scales schedule.

3. **(Simplification)** Drop all administration interval categories except for Termination from the Tracking Sheet.

4. **(Clarification)** Use a fixed point in time to anchor subsequent administrations.

5. **(Clarification)** Define Admission Date as the most recent agency admission.

6. **(Simplification)** Find and publicize good upcoming administrations reminder systems.

7. **(Clarification)** Auto-completion of some Outcomes instrument fields is acceptable under limited conditions.

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[4] For a detailed review of OSQIG and its products, see the OSQIG Report One, available from the Outcomes System Web Site:

www.mh.state.oh.us/oper/outcomes/outcomes.index.html

8. **(Clarification)** Use a Score Sheet to measure data use for Certification purposes.

9. **(Improvement)** Develop norms by race and other demographic variables.

10. **(Improvement, Simplification)** Use the Adult Consumer Form for all adults.

11. **(Improvement, Simplification)** Agencies are responsible for obtaining Outcomes for all consumers to whom they provide Outcomes-qualifying services.

12. **(Clarification)** Consumers should use their own understanding when answering survey questions.

13. **(Simplification, Clarification)** Upon Termination, administer a final Outcomes survey if Outcomes-qualifying services have occurred on three or more separate days since previous administration.

14. **(Clarification)** Remove the general exemption for jail and hospital settings.

The above recommendations are incorporated in the current edition of the *Consumer Outcomes System Procedural Manual*.

Why Are We Measuring Consumer Outcomes?

> *Consumer outcomes provide important information for the management of consumer care, the improvement of the service delivery system, and accountability for public resources.*

The OTF Vision states, “All participants in Ohio’s publicly supported human care system are accountable to monitor and continually improve outcomes for consumers. These outcomes, ... [based on] choice, respect, dignity, and cultural and clinical competence, embrace the values of Recovery for consumers and families. To inform this quality improvement, Ohio’s systems use a variety of compatible data sources and reporting mechanisms, including a standard, statewide approach to measuring consumer outcomes.”

Consumer outcomes have three main purposes: (a) to manage consumer care; (b) to improve the service delivery system; and (c) to account for public resources. Therefore, outcomes data are of use to consumers and their family members, workers/clinicians, agency/provider organizations, mental health boards, the Ohio Department of Mental Health, and the general public. However, to derive the

maximum benefits from the measurement of consumer outcomes, agencies, boards, and ODMH need to be "learning organizations".

Outcomes in "Learning Organizations"

The ultimate goals of outcomes measurement are a notable improvement in the health of consumers and service populations and the cost efficient utilization of mental health services. Learning organizations provide an optimal environment for measuring consumer outcomes and achieving these goals. Learning organizations, as described by Garvin, are effective at "creating, acquiring, and transferring knowledge, and at modifying [their] behavior to reflect new knowledge and insights." (Giolas, 1998, p. 27) Building a learning organization requires a cultural shift that begins at the highest levels of management and involves changes in the organizational structure, people management, process design, and technological initiatives.

Some key characteristics of a behavioral health learning organization include:

- Creates knowledge based on accurate data collection.
- Acquires knowledge through the use of computer technology and databases.
- Transfers knowledge by providing "real time" feedback.
- Maintains a structure that reflects management's belief in the importance of being a learning organization as evidenced by their establishing and empowering work groups charged with the tasks of collecting accurate data; analyzing and interpreting the results; making recommendations for change; and implementing, integrating, and monitoring these changes in the organization's daily work.
- Manages people by focusing on education and feedback.
- Designs the processes that coordinate the people and procedures involved in the collection and use of consumer outcomes data to form three interacting feedback loops. (The care management feedback loop involves the use of outcomes data for an individual consumer to inform the clinical assessment process, service/treatment planning, and service utilization management. The quality improvement feedback loop involves the use of aggregated consumer outcomes data for a service population to drive the organization's quality improvement process. The public accountability feedback loop also involves the use of aggregated consumer data, but to demonstrate the organization's accountability for public resources.)
- Implements technological initiatives that enhance the creation, acquisition, and transfer of knowledge through the use of computers for data capture

(via scanners, touch screens, etc.), databases, data warehouses, data analysis, report writing, and decision support.

Management of Consumer Care

As indicated above, the first purpose of consumer outcomes is to manage consumer care. Consumer outcomes data provide information for two types of care management involving five types of stakeholders. Both types of care management — clinical and administrative care management — involve the use of outcomes data for an individual consumer.

For clinical care management, consumer outcomes data provide additional information for individual consumers, and families of child/adolescent consumers, and workers/clinicians to use in assessment and service/treatment planning. Baseline outcomes data help the consumer and worker/clinician to identify a consumer's strengths, needs, and goals and to show areas in which the worker/clinician needs to advocate on behalf of the consumer. The comparison of a consumer's baseline outcomes data with his/her outcomes at subsequent intervals indicates where changes have occurred in the consumer's life and identifies aspects of the service/treatment plan which the consumer and worker/clinician may need to revise.

With regard to administrative care management, consumer outcomes data can facilitate a provider agency's or a board's management of consumers' use of mental health services in a cost efficient manner. In the managed care arena the authorization of a level-of-care, utilization review, and utilization management are strategies for containing consumers' service use and costs while maintaining the quality of service. Consumer outcomes, especially functional status outcomes, play a role in determining consumers' levels-of-care, and level-of-care is a prerequisite for utilization review and utilization management. Although managed care organizations use these strategies to manage their enrollees' care *prospective*ly, current laws limit the Ohio public mental health system's use of level-of-care, utilization review and utilization management to *retrospective* care management for most consumers seeking services.

Quality Improvement: Methods and the Role of Consumer Outcomes

The second purpose of consumer outcomes is to improve mental health services. Aggregated consumer outcomes provide data for the respective ongoing quality improvement processes of agencies, boards and ODMH and for developing and monitoring best practices. Using one of the documented quality improvement methods, an agency, board, or ODMH, with the active participation of consumers and families, respectively collects and analyzes its own data to make decisions about changing a program/service/treatment process that affects its consumers' outcomes.

A quality improvement method provides a structure for learning about current performance and identifying and testing changes that can improve future performance. Although the steps and specific language of the various quality improvement methods differ, the scientific method is the basis of each of the processes. All quality improvement methods address the following eight questions (Joint Commission on Accreditation of Health Care Organizations, 1998):

- What is currently known about the issue?
- What else needs to be known about this issue?
- What are the proposed changes?
- What is the expected impact of these changes?
- How are the proposed changes going to be pilot-tested?
- What are the data-based results of the tests for each of these changes?
- Which of the tested changes should the organization adopt and integrate into its daily work?
- How are the implemented changes going to be monitored and re-evaluated?

Consumer outcomes are an important source of information for quality improvement methods applied to service delivery system issues. Consumer outcomes can provide data regarding what is currently known about the issue. Furthermore, the ongoing nature of consumer outcomes measurement gives outcomes a critical role in the before and after pilot tests of proposed changes to the service delivery system. Consequently, consumer outcomes are at least a component of the test results used to decide which of the tested service delivery system changes to adopt and integrate into the daily work of the organization. Finally, the subsequent ongoing measurement of consumer outcomes provides a way to monitor and re-evaluate the implemented service delivery system changes. In this manner, consumer outcomes continue to propel an organization's never ending efforts for quality improvement.

Accountability for Public Resources

The third purpose of Consumer Outcomes is to demonstrate the Ohio public mental health system's accountability for tax dollars to the general public, the State of Ohio government, and the federal government. In Fiscal Year 2006, Ohio's publicly supported mental health system provided over 21 million units of service and support to over 200,000 adults and 100,000 children and adolescents at a cost of over $1.5 billion. These totals include a priority focus on nearly 90,000 adults diagnosed with severe mental disabilities and more than 60,000 youth with serious emotional disturbances. The Ohio Department of Mental Health provides regulatory oversight, monitoring, and a portion of the funding for these services. In addi-

tion, fifty county boards are also responsible for a portion of the funding of these services and for ensuring the availability and quality of locally managed systems of care. Boards fulfill this responsibility by contracting with a mix of over 400 mental health, substance abuse and other specialty providers.

Aggregated Consumer Outcomes data (with appropriate adjustments for case mix, if possible), can provide information for demonstrating accountability for tax dollars in several ways including:

- Support consumer and family advocacy for changes in the mental health system.
- Assist agencies with credentialing workers/clinicians to ensure competence.
- Enable agencies to meet the standards for consumer outcomes of various accrediting bodies which assure the quality of services.
- Establish benchmarking for comparing consumer outcomes across time within and between agencies, boards, and the State of Ohio in order to estimate the effectiveness of services and to plan for needed mental health services.

In summary, the issue of accountability to the public for mental health services has been central to ODMH's creation of the Consumer Outcomes System as evidenced by the following contextual concerns and issues cited in the OTF's *Vital Signs* report:

- The need for better accountability regarding the nearly $1 billion publicly funded system.
- The need for benchmarks in evaluating Ohio's mental health system.
- The need to use data, including research and evaluation findings, more effectively in improving services and supports and in applying best practices to improve the individualized care of persons with mental illness.
- The national trends toward measuring outcomes and performance, developing clinical guidelines, and standardizing and tightening business practices.
- The emergence nationally of well-tested outcomes instruments and outcomes measurement technology.
- The development of Ohio's Multi-Agency Community Services Information System (MACSIS), an encounter-level data system for both mental health and substance abuse systems.
- The demonstrated value of continuous quality improvement approaches both locally and at the state level.
- The need to tailor an outcomes approach to Ohio's unique system dynamics and characteristics.

- The potentially synergistic value of parallel activities such as the Consumer Quality Review Teams (CQRT), the Longitudinal Consumer Outcomes (LCO) Study, various program demonstration initiatives funded by the Department, and ongoing Medicaid compliance activities.

Where Do Outcomes Fit Into the ODMH Information Structure?

Consumer Outcomes data are one of three types of data that may eventually be aggregated in a potential data warehouse that would use a one-way encryption process to protect consumer confidentiality.

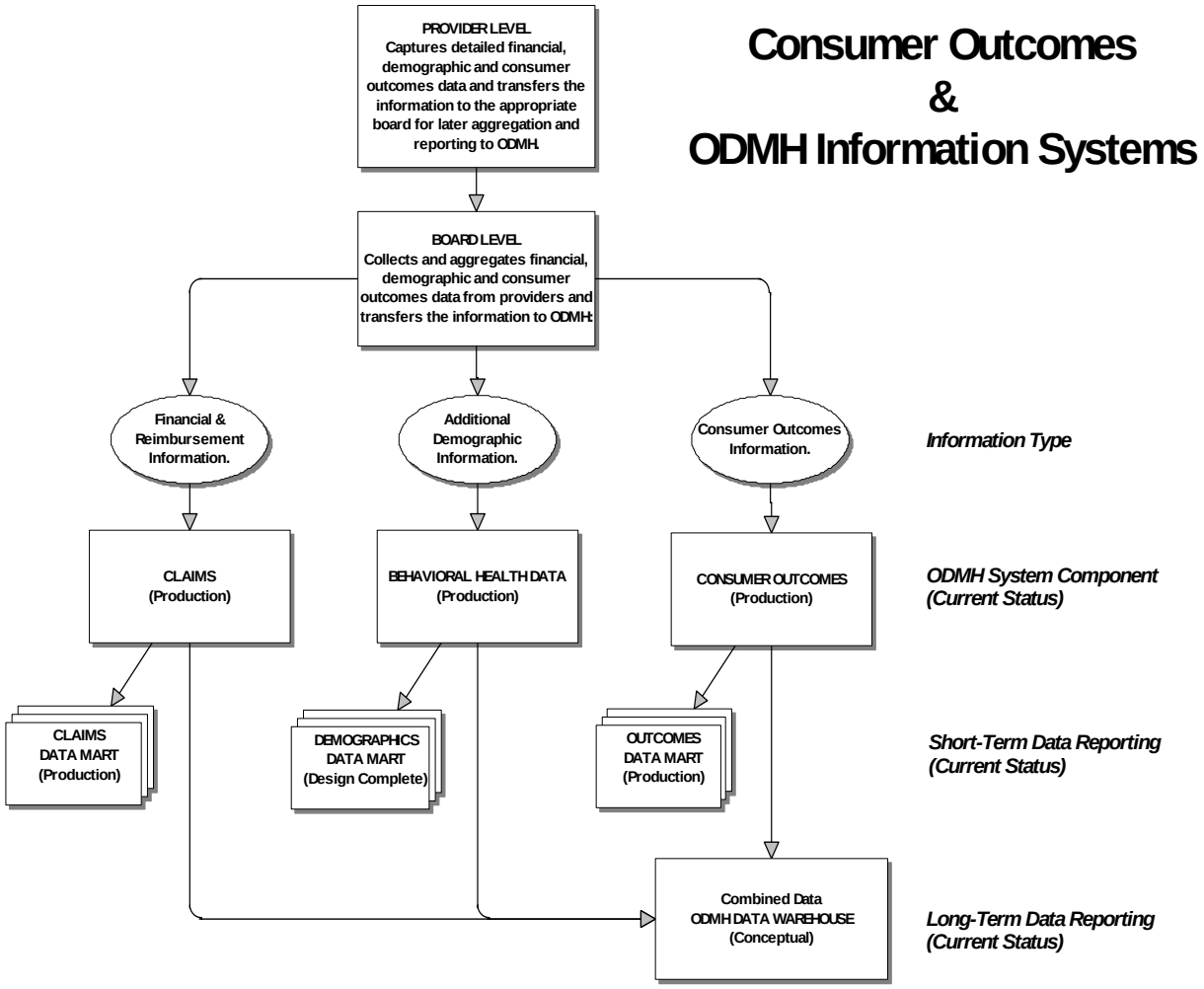
In an effort to account for services delivered to publicly-funded consumers, ODMH and ODADAS are implementing a state-wide management information system, in a multi-phased fashion as follows:

- **Financial and Reimbursement:** The first component of the information system (called MACSIS) is designed to track and reimburse services funded by public dollars, and includes only those information items required to reimburse a claim for services, including a unique consumer identifier (UCI) and consumer name.
- **Claims Data Mart:** Provider organizations submit claims information to MACSIS through their local boards. Aggregate information about claims processed by MACSIS can be accessed through a Web-based Claims Data Mart.
- **Behavioral Health Data:** If there are Business Associate Agreements in place between boards and ODADAS, additional demographic data are collected about consumers served, including admission and closure information.
- **Demographics Data Mart:** Provider organizations submit Behavioral Health data through their local boards. It is anticipated that aggregate information about consumer demographics will be available through a Web-based Demographics Data Mart that is under consideration.
- **Consumer Outcomes:** The Consumer Outcomes System contains information on the health or well-being for an individual or family, as measured by statements or characteristics of the consumer, as well as by perceptions of service providers and family members.
- **Outcomes Data Mart:** Provider organizations submit Outcomes information to the Outcomes System through their local boards. Aggregate information

about Outcomes are now accessible through a Web-based Outcomes Data Mart.

- **Future Data Warehouse:** The long-term vision includes a Data Warehouse designed to accept information from the MACSIS financial system, the Behavioral Health data and the Consumer Outcomes System and combine it for reporting purposes. At present, such a Data Warehouse is a conceptual model only; challenges related to overall cost and emerging issues of data confidentiality will have to be addressed before such a project can be undertaken.

The general structure of ODMH's outpatient information system and the functional relationships of its components are shown in the diagram below.



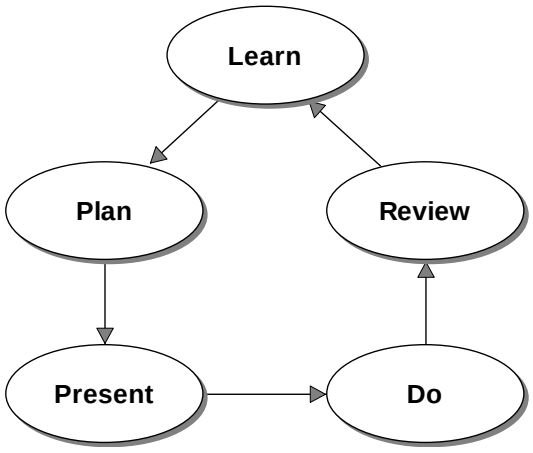
What Steps Are Necessary to Participate in the Outcomes System?

> *There is Toolkit for the Consumer Outcomes System that includes an "Outcomes Implementation Planning Checklist." The Checklist document specifies the recommended activities for participation in the initiative.*[5]

The Toolkit includes an "Outcomes Implementation Planning Checklist." This Checklist was developed out of the learnings of the OIPCG about the types of preparation necessary for a successful start-up. The Checklist spans four phases and specifies in detail the activities that need to take place within each phase in order to implement the Consumer Outcomes System. For each activity the Checklist also specifies the entities responsible for the activity and the resources available to assist in carrying out the activity.

The following is a summary of the phases of activity that local systems need to complete in order to implement the Outcomes System successfully:

Consumer Outcomes System
Phases of Implementation



[5] The Consumer Outcomes System Toolkit is available from the Outcomes System web site located at: ***http://www.mh.state.oh.us/initiatives/outcomes/outcomes.html***

Phase I: Learn About the Outcomes System

How? (Do one of the following)	• Attend an ODMH Outcomes Conference. • Attend a regional Outcomes Overview Presentation scheduled by ODMH. • Consult with other agencies who are already participating in the Outcomes System • Receive training on the Outcomes System from your local board • Learn about the Outcomes System on the Outcomes Web Site
Who?	Board and agency representatives who are interested in learning more about Ohio's Mental Health Outcomes Initiative but have not attended an ODMH Outcomes Conference. Specifically, this should include agency executive directors, clinical directors, MIS and QA staff, leadership from advocacy groups, and consumers and their family members.
Goal for Participants	To gain a general understanding of Ohio's Mental Health Outcomes Initiative and the basic steps involved in implementing the Ohio Mental Health Consumer Outcomes System locally.
General Overview Content	• Development of the Outcomes System: MACSIS, Recovery & Outcomes, Outcomes Task Force, Outcomes Domains, Selected Instruments, Minimum Administration Intervals, Data Flow • Development of Outcomes Pilot Procedures • Outcomes Pilot Implementation: Regulatory Relief, Use of Outcomes Data, Culture Change, Implementation Evaluation Methods & Results • Remaining Challenges & Future Implementation

Phase II: Plan the Local Implementation Process

How?	• Use the ODMH Outcomes Implementation Planning Checklist to begin completing the tasks necessary to develop your local implementation plan. • Contact the ODMH Outcomes staff with questions.
Who?	Board and agency representatives who will be directly involved in implementing the Outcomes System in their area, specifically potential members of the implementation teams. It is suggested that implementation teams be formed in the areas of MIS, Adult SMD population, Adult General Mental Health population, and Child/Adolescent population. Consumers and family members involved with implementation are also encouraged to attend.
Goal for Participants	To develop a detailed understanding of the tasks involved in implementing the Ohio Mental Health Consumer Outcomes System and the work involved, resources needed, suggested timeframes, and potential pitfalls of local implementation.
General Planning Content	The Implementation Planning Checklist describes the tasks involved in implementing the Outcomes System, including: • Local System Awareness • Team Building, Readiness Assessment, & Further Knowledge Development • Decision Making • Local Implementation Plan Development, Resource Acquisition, & Training • Testing, Evaluation, & Revision • Continuous Improvement/Future Development

Phase III: <u>Present</u> the Local Implementation Plan

How?	• Schedule a Local Implementation Plan meeting. • Continue completing tasks to prepare for local implementation.
Who?	Board and agency representatives who are directly involved in implementing the Outcomes System in their area, specifically members of the implementation teams. Consumers and family members involved with implementation are also encouraged to attend.
Goal for Participants	To finalize a local plan for implementing the Ohio Mental Health Consumer Outcomes System based on the Implementation Planning Checklist and to provide the opportunity for staff to ask specific questions about the plan and to offer suggestions and resources.

General Local Implementation Plan Presentation Content	Local Implementation Team members will finalize and present their local plan for implementing the Outcomes System, including decisions that have been made and work that has begun. It is expected that team members will touch upon items in each section of the Implementation Planning Checklist, including:
	• Local System Awareness
	• Team Building, Readiness Assessment, & Further Knowledge Development
	• Decision Making
	  • Decisions that have been made
	  • Questions about decisions that have not yet been made
	• Local Implementation Plan Presentation, Resource Acquisition, & Training
	• Testing, Evaluation, & Revision
	• Continuous Improvement/Future Development

Phase IV: Do and Review Local Implementation

How?	• Use Local Implementation Plan and begin to collect, use, and transfer Outcomes data. • Monitor local implementation, identify problem areas, and develop appropriate solutions. • Contact ODMH Outcomes Staff for assistance if necessary.
Who?	Local Implementation Teams
Goal for Participants	To implement successfully the Ohio Mental Health Consumer Outcomes System locally and to overcome any challenges that may arise during or as a result of local implementation. To facilitate the use of Outcomes data by developing new reports and integrating Outcomes data with existing clinical (e.g., treatment plans) and quality improvement tools.

3
Outcomes Instruments and Administration Guidelines

(Release Date: October 15, 2008)

The Ohio Mental Health Consumer Outcomes System uses a number of instruments to measure Outcomes for consumers utilizing publicly funded mental health services. This chapter gives a brief overview of the instruments and their administration. Subsequent chapters will discuss uses of the data and will describe each of the instruments and their administration in more detail.

The intent of the following descriptions is to provide a brief, concise introduction to each instrument. These instruments measure 24 Outcomes assigned to one of four conceptual domains by the Outcomes Task Force (OTF). The table presented later in this chapter identifies the four domains, the Outcomes assigned to each domain, and the specific instrument items designed to measure each Outcome.

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Note: *Outcomes instruments should be administered wherever Outcomes-qualifying services are delivered regardless of setting, including jails, prisons, hospitals, schools, nursing homes, etc. Outcomes-qualifying mental health services include: Assertive Community Treatment (ACT), Intensive Home Based Treatment (IHBT), Community Psychiatric Supportive Treatment, Behavioral Health Counseling and Therapy, Partial Hospitalization, Pharmacologic Management, Employment and Vocational, Social and Recreational, Occupational Therapy, and Adjunctive Therapy.*

The following groups are exempt from the Outcomes measurement system:

- *Individuals currently in service who are receiving only Mental Health Assessment, Crisis Intervention Mental Health or Forensic Evaluation.*
- *Persons with organic illnesses (persons who do not respond).*
- *Consumers who receive only ODADAS services.*

Instruments for Adult Consumers

The following instruments are used for adult consumers:

- Adult Consumer Form
- Provider Adult Form

Who Completes Each Instrument?

- All adult consumers should complete the Adult Consumer Form at the scheduled intervals.[6]
- All adult consumers should have Provider Adult Form completed on them at the scheduled intervals.[7]

Agencies need to determine whether they will utilize the Provider Adult Form to rate consumers who will be receiving only Behavioral Health Counseling and Therapy or Pharmacologic Management, or the circumstances under which an individual worker would make this decision.

The exact process for including the appropriate form in the "admission" paperwork packet will vary from agency to agency based on the admission policies and procedures that the agency has in place for admitting persons to agency services.

Historical Background

After reviewing the outcomes instruments available for use with adults the OTF came to the following three conclusions:

- Outcomes needed to be measured for consumers experiencing severe/persistent/chronic mental illness as well as for consumers experiencing less severe, subacute or emergent emotional or behavioral dysfunctions (defined as General Mental Health),
- None of the reviewed instruments met all of the OTF's established criteria for outcomes instruments, and
- A short form of the instrument constructed for adult consumers experiencing severe, persistent and/or chronic mental illness could be used with adult consumers experiencing subacute/emergent problems.

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[6] All adult consumers receive the Adult Consumer Form, except for those with organic illnesses (persons who do not respond).

[7] There are individuals who come to mental health agencies for resolution for short-term emotional problems who typically receive individual/group Behavioral Health Counseling & Therapy either alone or in combination with Pharmacologic Management services. For this group, almost all of the Provider Adult Form content is relevant and it is strongly encouraged that the instrument be administered. However, at this time it is not required in such situations.

Therefore, the OTF combined items and scales from several instruments and developed some items to create outcomes instruments for use with both groups of adult consumers. The following describes the components of the adult instruments.

Clinical Status: The Symptom Distress Scale ('SDS', MHSIP Task Force on Consumer-Oriented Mental Health Report Card) is a self-report instrument intended to measure the level of distress caused by severity of impact of psychiatric symptoms. The scale consists of the Symptom Checklist (SCL-10; Nguyen et. al, 1983) and five additional items from the SCL-90 "Anxiety" dimension (Derogatis & Cleary, 1977) to form a 15-item scale. Each item of the scale is scored on a five-point scale of distress ranging from "not at all" to "extremely". The total symptom distress score is obtained by summing the responses across all items.

Quality of Life: Ten items were adapted from the Quality of Life Questionnaire ('QLQ', Greenley, Greenberg & Brown, 1997) and two items were chosen from the Quality of Life Interview (Lehman, 1988) based on factor loadings. One item addressing physical health, one item addressing medication concerns, and items addressing perceived stigma in the agency and in the community were developed by the OTF and added to the instruments for both groups. The primary reasons for choosing these items were to assure that the instrument could be completed by the consumer, to limit the length of the instrument and reduce the burden on the consumer, and to assure that consumer respect and stigma were addressed.

The Making Decisions Empowerment Scale (Rogers, Chamberlin, Ellison & Crean, 1997) is designed to measure the personal construct of empowerment as defined from a consumer perspective. There are 28 items and five scales which are summed and averaged to arrive at an overall empowerment score.

Functional Status: As with quality of life, whole functioning instruments were difficult to adopt because of their length or because values and outcomes that were important to the OTF were not included. The Community Functioning Scale completed by the worker/clinician, usually the Community Support Specialist, is primarily adapted from the Multnomah Community Ability Scale (Barker & Barron, 1993) and the Basic Living Skills scale of the Adult Functioning Scales from the previously used ODMH 508 Certification/Recertification Face Sheet. This section consists of items which address social interest, social network, ability to manage money, independence in daily life, housing stability, and participation in meaningful activities.

There are also questions about overall role performance, effect of addictive or compulsive behaviors on functioning, criminal justice system involvement and aggressive behavior.

In addition, several functional status items were taken from the Hoosier Assurance Plan Instrument-Adult (HAPI-A). (Newman, 1996)

Safety and Health: The Provider Adult Form contains a series of questions that include the worker's/clinician's ratings of harm to self, victimization and harm to

others. These items collectively measure outcomes in the Safety and Health domain.

Instruments for Child and Adolescent Consumers and Family Members

The instruments for child and adolescent consumers and their family members are:

- Ohio Youth Problem, Functioning and Satisfaction Scales — Parent Rating — Short Form
- Ohio Youth Problem, Functioning and Satisfaction Scales — Youth Rating — Short Form
- Ohio Youth Problem, Functioning and Satisfaction Scales — Agency Worker Rating — Short Form

All of these instruments have demonstrated reliability and validity.

Who Completes Each Instrument?

- For each child age 5–18, a parent or caregiver (in a home-like setting) who knows the child well will complete the Ohio Scales Parent Rating Form.
- Each youth age 12–18 will complete the Ohio Scales Youth Rating Form.
- For each child age 5–18, the worker/clinician will complete the Ohio Scales Agency Worker Rating Form at the end of the diagnostic assessment process and prior to development of the Individual Service Plan.
- If the child is an older adolescent (i.e., 16 years through 18 years), the worker/clinician may choose to use the adult instruments (i.e., Adult Consumer Form and Provider Adult Form), if this choice seems more clinically appropriate.

Historical Background

Three child and adolescent instruments were originally chosen by the OTF: the Child and Adolescent Functional Assessment Scale (CAFAS), the Behavioral and Emotional Rating Scale (BERS), and the Family Empowerment Scale (FES). However, during the pilot and its evaluation phase, these instruments, particularly the BERS and FES, proved problematic for parents to complete and staff felt that they had insufficient clinical utility. In addition, the proprietary CAFAS, although deemed to be of good clinical utility, was found to be more expensive to use, in terms of both training costs and instrument usage fees.

During the same time period, another set of instruments — The Ohio Youth Problem, Functioning and Satisfaction Scales — (Ogles, Melendez, Davis & Lunnen, 1999) completed a lengthy period of psychometric testing and was found to be very sound. The OTF originally considered these instruments in its deliberations and judged them to have extremely good coverage of the list of outcomes. However, the OTF rejected them because at that point the psychometric properties were not known.

Based upon later psychometric studies (Ogles, Melendez, Davis & Lunnen, 2001), the Outcomes Implementation Pilot Coordinating Group endorsed these instruments to replace the CAFAS, BERS and FES. In addition, because the psychometric research on the Ohio Scales showed the Agency Worker form to have a high correlation with the CAFAS, the group recommended that the CAFAS continue to be an option for use in the Ohio Outcomes System to fulfill the agency worker requirement.

Ohio Youth Problem, Functioning and Satisfaction Scales — Youth, Parent and Agency Worker Ratings — Short Form: Three parallel forms (Y-form, P-form, and W-form) of the Ohio Scales were developed for completion by the Youth (self-report for ages 12 and older), the youth's Parent (or primary caretaker), and the youth's agency Worker/case manager respectively.[8]

Content Areas — After considering a large number of potential content areas, four primary areas or domains of assessment were selected: problem severity, functioning, hopefulness, and satisfaction with behavioral health services.

The parent, youth, and agency worker rate the Problem Severity and Functioning Scales. The youth and parent rate the Satisfaction Scales. Youth rate their own Hopefulness about life or overall well-being. Parents (or primary caretakers) rate their Hopefulness about caring for the identified child. In addition, the Restrictiveness of Living Environments Scales (ROLES; Hawkins, Almeida, Fabry, & Reitz, 1992) is included on the agency worker form along with data regarding several key indicators that are not used when scoring the form.

Item Descriptions — The Problem Severity Scale is comprised of 20 items covering common problems reported by youth who receive behavioral health services. A total score is calculated by summing the ratings for all 20 items. Higher scores are indicative of more problems or increased severity of problems.

The Functioning Scale is comprised of 20 items designed to rate the youth's level of functioning in a variety of areas of daily activity (e.g., interpersonal relationships,

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[8] The original version of the Ohio Scales was slightly different from the Short Form of the Ohio Scales that is described here. Through consumer feedback and empirical evaluation, the original Ohio Scales were changed to produce the Short Form which is described in the User's Manual. The detailed Technical Manual provides a description of the evolution of the Ohio Scales and the psychometric characteristics for both versions.

recreation, self-direction and motivation). Higher scores are indicative of better functioning.

In addition to the Problem Severity and Functioning Scales, two brief (four-item) scales on the Parent and Youth forms assess Satisfaction and Hopefulness. Four items assess satisfaction with and inclusion in behavioral health services on a six-point scale. The total Satisfaction score is calculated by summing the four items. Four additional items on the parent and youth forms tap levels of hopefulness and well-being either about parenting or self/future respectively. Each of these is also rated on a six-point scale. The total Hopefulness score is calculated by summing the four items.

Finally, the agency worker version of the Ohio Scales includes the Restrictiveness of Living Environments Scale (ROLES). Information regarding the initial development of the ROLES can be obtained by reviewing the original article written by Hawkins et al. (1992). The ROLES assesses the level of restrictiveness for the youth's placements during the past 90 days. A higher score means on average the youth is placed in a more restrictive setting.

How Do the Instruments Reflect the Outcomes Domains?

The previous chapter identified the four conceptual domains to be measured:

- Clinical Status
- Quality of Life (Life Satisfaction, Fulfillment and Empowerment)
- Functional Status
- Safety and Health

The OTF identified specific outcomes in each of the above four domains. The table beginning on the following page identifies the four domains, the outcomes assigned to each domain, and the specific instrument items designed to measure each outcome.

Instrumentation and the Measurement of Outcomes

The table below lists the Domains of Outcomes identified by the Outcomes Task Force, the specific Outcomes that comprise each Domain, and the items on the Adult and Children's instruments that are used as measurements of the Outcomes.

	Outcome	Related Adult Instrument Items	Related Children's Instrument Items[9]
Clinical Status	Level of symptom distress.	**Adult Consumer Form**: 17-31	**Ohio Scales:** Problems 1-20
	Number of psychiatric emergencies and emotional/behavior crises.	**MACSIS:** Utilization Data	**MACSIS:** Utilization Data
	Person/Family ability to understand, recognize and manage/seek help for symptoms, both physical and psychiatric.	**Adult Consumer Form**: 32, 33	**Ohio Scales:** Functioning 7, 20 (P) Satisfaction 2
Quality of Life	Satisfaction with areas of life including family relationships, social involvement, financial resources, physical health, control over life and choices, individual and family safety, participation in community life, living situation, productive activity, and overall satisfaction with life.	**Adult Consumer Form**: 1-12	**Ohio Scales:** (Y), (P) Hopefulness 1-4 Functioning 1-4, 7, 14
	Feeling a sense of overall fulfillment, purpose in life, hope for the future and personal or parental empowerment.	**Adult Consumer Form**: 34-61	**Ohio Scales:** (Y), (P) Hopefulness 1-4
	Attainment of personal/family goals related to culture, spirituality, sexuality, individuality, developmental stage and liberty.	**Adult Consumer Form**: 5, 6	
	Family's sense of balance between providing care and participation in other life activities.	**Adult Consumer Form**: 7 (Partly)	**Ohio Scales:** (P) Hopefulness 2, 3

[9] For the Ohio Scales, where sections and question numbers are referred to without annotation, the questions appear in all three versions of the instrument. (Y) = Youth Rating Form; (P) = Parent Rating Form; (W) = Agency Worker Rating Form.

	Outcome	Related Adult Instrument Items	Related Children's Instrument Items[10]
Functional Status	Identifying, accessing, and using community resources to fulfill needs, such as spiritual, social, cultural, recreational, etc. by participation in organizations which are not primarily mental health organizations.	**Provider Adult Form**: 1-3	**Ohio Scales:** Functioning 10, 17
	Developing and managing interpersonal relationships.	**Provider Adult Form**: 1-3	**Ohio Scales:** Functioning 1-4, 20
	Managing money.	**Provider Adult Form**: 6H	**Ohio Scales:** Functioning 17
	Managing personal hygiene and appearance, utilizing skills such as use of public transportation, phone books, grocery store, laundromat, etc. to maintain oneself independently as necessary, and maintaining a home environment in a safe, healthy and manageable fashion.	**Provider Adult Form**: 6A-G	**Ohio Scales:** Functioning 5, 6
	Advocating successfully for self with mental health professionals, landlords, families, public safety personnel, etc.		**Ohio Scales:** (Y), (P) Satisfaction 1-4
	Remaining in a home or family like environment as measured by stability and tenure.	**Behavioral Health Data** **Provider Adult Form**: 4-5	**Ohio Scales:** (W) ROLES
	Engaging in meaningful activity (e.g., work, school, volunteer activity, leisure activity).	**Adult Consumer Form:** 5 **Provider Adult Form**: 7A-F, 8	**Ohio Scales:** Functioning 9-13
	Abiding by the law sufficiently to avoid incarceration and / or justice system involvement.	**Provider Adult Form**: 9-11	**Ohio Scales:** Problems 8, Functioning 7 (W) ROLES

[10] For the Ohio Scales, where sections and question numbers are referred to without annotation, the questions appear in all three versions of the instrument. (Y) = Youth Rating Form; (P) = Parent Rating Form; (W) = Agency Worker Rating Form.

	Outcome	Related Adult Instrument Items	Related Children's Instrument Items[11]
Safety and Health	Does not want to or does not harm self.	**Provider Adult Form**: 9, 12F-G (Partly)	**Ohio Scales:** Problems 2, 7, 12, 13, 20 Functioning 6
	Does not want to or does not die from suicide.	**Provider Adult Form**: 12F (Partly)	**Ohio Scales:** Problems 12, 13
	Does not want to or does not harm others.	**Provider Adult Form**: 11	**Ohio Scales:** Problems 2, 3
	Free from physical and psychological harm or neglect in the individual's social environment to include home, school, work, and service settings.	**Adult Consumer Form**: 8, 9 **Provider Adult Form**: 12	**Ohio Scales:** Problems 15, 16
	Person is physically healthy.	**Adult Consumer Form**: 11, 13 **Provider Adult Form**: 9	**Ohio Scales:** Functioning 6 (Y) Hopefulness 2
	Treatment effects, including medication, are more positive than negative.	**Adult Consumer Form**: 14	**Ohio Scales:** (P), (Y) Satisfaction 1
	Safety and health is not threatened due to disabilities, being treated with lack of dignity, or discrimination in response to lifestyle or cultural differences.	**Adult Consumer Form**: 15,16	
	Person/family terminates services safely and planfully.		
	Person/family who receives little or no services, has secure sense that they can obtain more/additional services in a timely manner.		

[11] For the Ohio Scales, where sections and question numbers are referred to without annotation, the questions appear in all three versions of the instrument. (Y) = Youth Rating Form; (P) = Parent Rating Form; (W) = Agency Worker Rating Form.

Methodological Notes & Definitions

- **Responsible Person:** The person responsible for having the consumer complete the appropriate Outcomes instrument is the designated "primary worker" or "clinician of record" or "provider of record". The majority of persons receiving services should have at least one therapist, psychiatrist or CPST worker or a combination of these workers. If the person has all three clinicians, then the CPST worker is considered primary. If the person has a therapist and a psychiatrist, then the therapist is considered primary. If the person has only one of these (i.e., either a CPST worker, therapist or psychiatrist), then that worker is considered primary. This individual is also responsible for filling out the appropriate worker form, if the consumer is a youth or an SMD adult.
- **Crisis:** If the person is in severe crisis or in need of hospitalization at the time a survey is due, the survey should be postponed until his/her condition stabilizes.
- **Settings:** Outcomes instruments should be administered wherever Outcomes-qualifying services are delivered regardless of setting, including jails, prisons, hospitals, schools, nursing homes, etc. For adult consumers in nursing homes who are unable to complete the Adult Consumer Form, Provider Adult Form is still completed.
- **Inability to Complete:** If a problem exists with the consumer taking the survey, (e.g., refuses, is too ill) then the following pathway guides the administration of the survey:
    - Maintain the principle with all consumers of *do no harm.*
    - Use clinical judgment to determine the appropriateness of giving the survey to a particular consumer.
    - If the person refuses to complete the survey, the staff person should attempt to understand why this person refuses. If the person continues to refuse to complete the survey even after the staff person has explained the situation to the person, then the staff person should record the refusal on the Tracking Sheet.[12]
    - If the consumer refuses or is too ill to take the Adult Consumer Form, the responsible worker should still complete the Provider Adult Form.
- **Forensic Consumers:** Community forensic consumers are included in survey, unless the only service they have received is Forensic Evaluation.

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[12] The Ohio Mental Health Consumer Outcomes System Tracking Sheet records basic information related to the instrument being submitted and the agency submitting it. A copy of the Tracking Sheet must be completed and submitted with each Outcomes instrument.

Which Agency Administers the Outcomes Instrument?

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Note: *Each agency should designate one or more staff members to be responsible for ensuring that the appropriate person (adult consumer, youth consumer, family member, provider) completes the appropriate Outcomes instrument at the appropriate time.*

As was stated earlier, the overall intent of the Ohio Mental Health Consumer Outcomes System is to measure how people change in treatment, and determine if the services they receive have an impact. To achieve that end, the Outcomes System is designed to capture information at the beginning and the end of treatment, and if there is long enough in between, to capture information at additional intervals between the beginning and the end.

The Outcomes process is about making evidence-based, informed decisions regarding the care and treatment of people. Therefore, in order to be an effective tool for treatment planning and quality improvement, each Outcomes administration should be timely, reviewed with the consumer, integrated into the treatment planning process, and aggregated with similar administrations for other consumers for the purposes of agency quality improvement. Those administrations should then be submitted to ODMH to meet Administrative Rule and Certification requirements.

Although consumers are often served by more than one agency during a given period, it is unnecessary, and often inappropriate, to require completion of Outcomes instruments at more than one agency. At its most basic level, the rule of thumb is that the agency having the most intensive relationship with the consumer assumes responsibility for the completion of the Outcomes instruments.

However, agencies providing Outcomes-qualifying services are required to have and use Outcomes data for treatment planning and Quality Improvement. The Outcomes Rule mandates the following:

- **Data Collection & Submission:** Agencies are required to collect appropriate Outcomes data from consumers and staff and submit them to ODMH through their respective boards on a timely basis.
- **Individualized Data Use:** Agencies are required to use individualized Outcomes data in treatment planning.
- **Aggregate Data Use:** Agencies are required to use aggregate Outcomes data in agency performance improvement.

Therefore, agencies are responsible for obtaining Outcomes for consumers to whom they provide outcomes-qualifying services. There are three acceptable

methods for obtaining the Outcomes for consumers who have had Outcomes administered by another agency:

- **Data-Sharing Agreements:** The agency can satisfy this requirement through a data-sharing agreement with the other agency. Agencies that satisfy this requirement through data-sharing must be ready to demonstrate their methods for ensuring timely availability of data in sufficient quantity for treatment planning and conducting Quality Improvement.
- **Data-Sharing & Submission:** The agency can: (1) obtain the Outcomes information from the other agency, either electronically or as a paper submission; (2) incorporate the information into its regular Outcomes data base on a timely basis; and (3) submit the information through its local board with its next data submission batch.
- **Data Collection & Submission:** The agency can collect its own data by: (1) administering the Outcomes instruments itself to all consumers to whom it delivers Outcomes-qualifying services; (2) incorporating the information into its regular Outcomes data base; and (3) submitting the information through its local board with its next data submission batch.

Detailed requirements for each of the acceptable methods of sharing Outcomes information can be found in Appendix C.

What Are the Guidelines for Administering the Instruments?

Guidelines for the Administrator

There are several guidelines that will facilitate the administration of Outcomes System instruments:

- **Eligibility:** Ensure that the potential respondent meets the eligibility criteria for completing this instrument.
- **Site Selection:** Secure the site of the administration as you would for any assessment process. There should be adequate privacy, lighting and a minimum of background distractions.
- **Materials for Administering a "Paper and Pencil" Version:** Make sure you have the following materials at hand:
    - Several sharpened pencils with good erasers.
    - A blank survey instrument.
    - Cover Tracking Sheet.

- The card or sheet of paper describing the person's rights as a participant.
- All explanatory materials (most notably these guidelines).
- A schedule book to reschedule the administration, if necessary.

- **Respondent Willingness:** If the person is eligible, first apply the principle of *do no harm*. Experience suggests that better than 90 percent of people, whether experiencing a severe or persistent mental illness or not, are able and willing to complete such surveys if they are provided clear, courteous explanations. Infrequently, you will encounter someone who may want to cooperate, but can't. Neither you nor the respondent may initially recognize that the respondent's ability to comprehend questions, discriminate between response choices or concentrate long or well enough to do so is insufficient to guarantee valid and reliable information. However, if you observe the person to be in an emotional, physical or cognitive state that strongly suggests that he/she may not be up to the task, then ask directly if he/she thinks he/she can participate. You may want to "test" the respondent's readiness by having him/her respond to an actual survey question. If the respondent is not able to participate, thank him/her for his/her time, and reschedule the survey administration, if at all possible.

  For Parents and Youth Consumers: If the parent-completed and youth-completed instruments are integrated into the agency's admission/diagnostic process, the question of respondent willingness may be handled in a slightly different fashion. In this case, the expectation for parents or child caregivers and adolescent consumers to complete the Ohio Scales would be the same as for other admission forms.

Respondent Refusal to Complete the Survey

We strongly recommend that you rehearse these guidelines before attempting to use them. Experience with similar situations indicates that survey administrators who appear comfortable with the material and exude confidence have the lowest refusal rates, generally three to six percent. Inexperienced administrators tend to "invite" more refusals by unintentionally:

- Confusing the potential respondent.
- Contributing to the person's suspiciousness or paranoia by not acting in a forthright manner.
- Not being able to answer questions clearly and easily.
- Not conveying confidence in the importance of the survey information.
- Subtly or overtly giving the person multiple opportunities to say "no".

What the person offers as a refusal may be a screen for the real reason. An example would be an illiterate person who states he/she doesn't have time to do the survey. We suggest that your first response should be a literal one, responding directly to the issue that the person raises. Many people will reconsider and participate at this juncture. The remainder will usually either reiterate their first concern, or give you another reason for refusing. You should politely acknowledge what the respondent says, briefly and clearly state that the information will prove important to treatment, and then give him/her a chance to respond.

If the person still refuses, then you have two new objectives. The first objective is to determine if the refusal is permanent or temporary. The easiest way to determine this is to ask the person if he/she would be willing to do the survey at another time. Your second objective is to learn as much as you can about why he/she is refusing so you may be able to offer additional information to encourage participation.

The more you know about why people typically refuse to participate, the better prepared you will be to deal with the problem. Two commonly encountered reasons for refusal are:

- **Insufficient Time:** Perhaps the most common reason is insufficient time to participate. Specifically, you will hear reasons such as the person is waiting to see a provider and doesn't want to inadvertently miss the appointment, or he/she will miss a bus or someone is waiting to drive them somewhere. For this reason it's important to tell the person fairly quickly in the introduction how long it takes to complete the survey. The other preventative action you should take is one of assurance. You need to do what's necessary to allay the person's anxiety that his/her routine will not be negatively disrupted — that the appointment will not be missed, for instance, because someone will come and tell them when the clinician is ready to see him/her.
- **Fatigue:** Other common reasons for refusal have to do with the context in which the survey is presented. If the survey is introduced at the end of a long assessment session, the person may be either too fatigued to participate, or irritated and frustrated at having to answer more questions and complete yet another form.

Explaining the Purpose of the Survey

The consumer's successful completion of the Outcomes instrument depends in part on his/her understanding the purpose and importance of the endeavor. Therefore, you should explain a number of things to the consumer when introducing the instrument:

- The name of the instrument.[13]
- A brief overview of what is in the specific instrument.
- The purpose for collecting Outcomes data:
    - For adults, the opportunity to let the agency know how the consumer is doing in a number of areas, so that this information can be used for discussion with the worker around treatment planning and progress.
    - For families of child/adolescent consumers, the opportunity to let the agency know how the child is doing in a number of areas, so that the information can be used in treatment planning.
    - For youth age 12-18, the opportunity to let the agency know how the consumer is doing, so that the information can be used to help them with their problems.
- Approximately how long it will take to fill out the instrument.[14]
- How your agency protects the confidentiality of the data, in accordance with agency policies and HIPAA requirements.
- A final assurance that the information from or about the consumer is really important to the agency.
- An offer to answer questions about the instrument, if the person filing it out doesn't understand something.

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[13] **For Adult Consumers**

- Adult Consumer Form

For Child and Adolescent Consumers and Family Members

- Ohio Scales - Parent Rating Form
- Ohio Scales - Youth Rating Form

[14] **Administration Times**

- Adult Consumer Form: 10 to 40 minutes (depending upon consumer functionality)
- Ohio Scales - Parent Rating Form: 15 minutes
- Ohio Scales - Youth Rating Form: 15 minutes

Explain the Person's Rights as a Participant

Each agency should have a card or sheet of paper that contains the points outlined above, and also indicates that the individual is very much encouraged but is not required to fill out the survey, and that if he/she chooses not to fill it out, he/she will still be able to receive services.

Help the consumer understand the process and clarify any misunderstandings he/she may have. This process will give you an idea of how much assistance the person may need in completing the survey without embarrassing him/her.

Secure the respondent's cooperation. End by deliberately asking the person if he/she wants to or is ready to participate. Here's a suggested script:

> *"If you don't want to do this, or you don't feel well enough or alert enough to do it today, that's okay. If you're not sure, I'd like you to try answering a few questions before making up your mind."*

For Family Members of Child/Adolescent Consumers and Adolescent Consumers: If the Outcomes measurements are gathered as an integral part of admission information, then the rights of the participant should be reframed to correspond to how admission information is treated.

Instructions to the Respondent

Once you are as sure as you can be that the person understands his/her rights, agrees to proceed, and appears capable of participating, move on to showing him/her how to complete the survey. You should address the following points:

- **Understanding the Items:** Emphasize that the respondent should never proceed with a survey question if he/she is unsure of either its meaning or how to respond, but that it is his or her own understanding of the question that should be used in answering. If the consumer does not understand a word, let him or her know that you or some other person will provide a definition.
- **How to Select a Response:** Make sure the respondent knows how to select/choose his/her survey answers (i.e., how to use the response formats).
- **Changing Responses:** Tell the respondent that he/she can change the answers by erasing and putting a new check-mark or "X" in the better response choice.
- **Completing All Items:** Ask the respondent to please answer all the questions, unless of course there are ones that they would rather not, as explained in their rights as a participant.

Providing Assistance to the Respondent

If you apply these guidelines, you will have a fairly good idea whether or not the respondent will need assistance to complete the survey. Suggestions for assistance include:

- **Providing Limited Guidance:** Tell the consumer that his or her own understanding of the question is what counts. If the consumer does not understand a word, give them the dictionary definition of the word. Do not script or re-interpret questions for the consumer.
- **Providing Focus:** As a way of helping the respondent focus, read the question and each response choice aloud, using a pencil to focus the person's eye on each word as you read it. Use a sheet of paper to cover extraneous sections.
- **Probing:** Probing is a set of interviewing skills designed to help a respondent choose a response when they are unclear about which response best suits what they feel, think or believe. The art of probing is to lead the person to choosing what he/she ends up feeling or believing is the best-fitting choice for him/her, without unduly leading or biasing the respondent in the process.

  When a respondent isn't sure about an answer, the first principle is to break a multiple choice response format down into a series of choices between two responses (i.e., you effectively change the format from multiple choice to a dichotomous yes–no format). If the person has no idea which of multiple choices makes the most sense, start at the extremes of the response format — with the first and the last choices. Ask the respondent which end feels "more right." More typically, respondents have difficulty choosing amongst choices in the middles of scales. Rephrasing works well in many cases. Real-world examples to which the particular respondent can relate are often helpful in assisting him/her to choose a response.
- **Issues to Avoid When Probing:** Don't try to sum up the respondent's response in your own words; stick to the choices in the response format. Don't define the respondent's answer for him or her — get him/her to do it. Don't overprobe. If the respondent becomes irritated, annoyed or very frustrated, stop and go on to the next question.

Completing the Survey Process

After the person has completed the survey, thank him/her and provide assurance that the information will be very helpful in treatment. For a respondent who has low self-esteem, is timid or otherwise doesn't express much self-confidence, you may want to make him/her aware that in just a few minutes, he/she made dozens of decisions!

Ask the person to review his/her responses and make sure each is answered the way he/she intended.

Collect the survey packet and quickly review the person's response pattern. If, for instance, the person consistently selected the first response choice for every question, you need to ask the person if that's how he/she truly meant to answer. In other words, did he/she understand the questions and the response format?

Are Consumer Outcomes Activities Reimbursable?

The Outcomes System instruments represent best clinical practice in the measurement of a defined set of Consumer Outcomes. As with other clinical documentation, these Outcomes will serve as an integral part of treatment. To the degree that Consumer Outcomes instrumentation and related discussion and work with consumers occur within an otherwise billable service, their use is generally billable to payers.

More generally, clinical documentation within the ODMH certified services serves several purposes. At the agency and board level it serves as proof of treatment and as a medium through which Quality Assurance and Quality Improvement processes improve service delivery. Its primary function, however, is as a representation of critical milestones in the clinical process between a consumer and the mental health system, and as such, is integral to the therapeutic process. The completion of the relevant documentation is not treatment, and not billable. However, the process of engagement between the consumer and clinician around these integral milestones is the essence of therapeutic best practice, and is a billable intervention.

In the same manner, Consumer Outcomes serves a myriad of purposes at various levels within the system. However, its primary function is as an integral part of the assessment, treatment planning, intervention and progress monitoring of milestones in the therapeutic process. Outcomes are a design specification that brings clarity to these clinical milestones. The completion of the Outcomes instruments themselves, as with treatment planning and diagnostic assessment, is billable only to the degree that they are done in a face-to-face encounter between a consumer and eligible staff. Typically, the process of engagement around these clinical milestones as focused by Consumer Outcomes is billable.

In summary, staff time related to Consumer Outcomes must meet five criteria in order to be billable. It must:

- be face-to-face with the consumer,
- be part of an otherwise billable service (e.g., Mental Health Assessment, CPST),

- be medically necessary,
- meet provider eligibility requirements for provision of services, and
- be appropriately documented.

In addition, ODMH has standards for agency structure, staff qualifications, supervision, necessary documentation, and quality guidelines for each of the 24 certified services, of which six are Medicaid billable. [OAC 5122-23 to 5122-29 (Certification Standards) and OAC 5101-27 (Community Medicaid)].

4

Users and Uses of Consumer Outcomes Data

(Release Date: October 15, 2008)

As discussed in Chapter 2 (The Ohio Mental Health Consumer Outcomes System), the purpose of the Ohio Mental Health Consumer Outcomes System is to gather data which provide information for:

- managing consumers' care,
- improving the quality of mental health services, and
- demonstrating accountability for public resources.

These three activities involve many types of stakeholders who use Consumer Outcomes information in different ways to achieve different goals. The types of stakeholders include: consumers, family members of child and adolescent consumers, consumer and family advocacy organizations, workers/clinicians, agency/provider organizations, mental health boards, and the Ohio Department of Mental Health. These stakeholders' respective uses of Consumer Outcomes information are the focus of this chapter. (A more detailed matrix-formatted summary of the users and uses of Consumer Outcomes information is located at the end of this chapter.)

How Does a Consumer or a Family Member of a Child/Adolescent Consumer Use Consumer Outcomes?

A consumer/family member uses Outcomes information to empower him/herself in the Recovery process. He/she completes the appropriate Outcomes instrument and uses the results of this self-assessment to help develop his/her treatment plan. Consequently, the treatment plan then targets the needs and behaviors of greatest concern to the consumer/family member and specifies his/her self-determined goals.

Self-Determined Goals, Treatment Plans, and Empowerment

The primary goal of all consumers is to experience life with as much success as possible. This is best described by stating that all persons with a history of serious mental illness can be in the process of Recovery or getting better. This should be based on self-determined goals. By saying that the goals are self-determined, it does not say that there should not be collaboration with other significant stakeholders in the process of developing goals. Collaboration is encouraged.

Traditionally, the establishment of treatment plans and goals has been:

- in response to problems that are in a person's life (reactive rather than proactive, and weakness rather than strengths based), and
- generated by professional staff with little collaboration with consumers.

The Consumer Outcomes developed by the Outcomes Task Force (OTF) can provide a basis for consumers to look at an identified list of Outcomes that may help them to frame possible areas from which to work. Unfortunately, many consumers do not know what may or may not be important. The specific Outcomes could generate discussion about different objectives and goals. For example, in the Quality of Life section of the Adult Consumer Form, there is the Outcome "How do you feel about the amount of meaningful activity in your life (such as work, school, volunteer activity, leisure activity)?" A person with a history of mental illness could discuss this with family, friends, peers, and/or professionals to identify his/her dreams, set goals and "brainstorm" how to reach those goals. By creating Outcomes that have a wide range of application and teaching consumers what these Outcomes mean, it can have the effect of legitimizing their personal goals and dreams. This, in turn, will enhance movement toward a self-determined goal (empowerment). The domains and Outcomes need to be discussed and understood by consumers. This allows consumers to have a starting place in identifying their goals and dreams and potentially establishing realistic objectives. Consumers

would benefit by knowing if their management of life is better or not, by outcome and by domain.

Understanding Outcomes Data

Data acquired through the Outcomes instruments must be thoroughly explained to the person with a history of serious mental illness. This must include what it means for the individual, how it relates to others receiving information from the same provider, and system wide. Consumers should not review Outcomes data without a good interpretation provided by professional staff. In addition, consumers should be informed about the limitations of the Outcomes instruments and measurement techniques.

How Do Consumer/Family Advocacy Groups Use Consumer Outcomes?

Consumer/Family Advocacy Groups use aggregated Consumer Outcomes information to:

- *promote the development of consumer/family and worker/clinician partnerships for stronger collaborative support systems and assessment and treatment planning for care management,*
- *advocate for the improvement of mental health services, and*
- *monitor the mental health system's accountability for public resources.*

Advocates' Interest in Consumer Outcomes

Consumer and family advocates are very interested in outcomes measurement. The appropriate use of this information can be highly beneficial for them and for the mental health system. Statewide advocacy organizations want training focused on how to understand, interpret, and utilize Consumer Outcomes findings to develop policy. Advocates also have an interest in contributing to interpretations of data at the agency, board and state level. They can encourage the appropriate use of individual information gathered at the agency level to inform consumers and family/significant others in ways that would contribute to improved collaborative support systems. Outcomes data are also used to provide a basis for informed advocacy at all levels.

Aggregate data on Consumer Outcomes should be available to advocacy groups at local, regional and state levels. These data can be used to track trends, and provide a concrete basis from which to advocate for continuation of services, addi-

tion or deletion of services, improvement of services, or provision of different services and service delivery models. This information is also useful in research at local, state and national levels.

Examples of Advocates' Uses of Consumer Outcomes

Examples of how an advocacy group might use Outcomes information include the following:

- A local consumer/family advocacy organization anticipates using Outcomes data to evaluate the impact of more effective consumer-family-worker/clinician partnerships. They hope to initiate worker/clinician collaborations based on Outcomes data to stimulate provider exploration of this innovative practice. Ultimately, they would like to develop a training curriculum for workers/clinicians and a pamphlet for consumers and families that helps each party understand the benefits and challenges of such partnerships.
- An advocacy group, reviewing aggregate data from the Making Decisions Empowerment Scale, might find that it indicates a need for a greater sense of consumer empowerment. The advocacy group uses these data to encourage the implementation of consumer or consumer/family taught workshops and to develop more effective local peer support programs to address this concern.

How Do Agency/Provider Organizations Use Consumer Outcomes?

> *In agency/provider organizations there are usually four types of users of Consumer Outcomes information. They include: consumers/family members (discussed earlier), workers/clinicians, clinical supervisors, and administrators. Although each uses Consumer Outcomes information in different ways, the underlying purposes are for care management, quality improvement, or accountability for resources.*

Agency/provider organizations are where the measurement of consumer outcomes takes place. Consumers, family members of children and adolescents, and workers/clinicians provide the Outcomes data for the four domains of clinical status, quality of life, functional status, and health and safety. To make the optimal use of the information provided by these Outcomes data, agency/provider organizations need to be "learning organizations". Learning organizations are effective in creating, acquiring, and transferring knowledge and at modifying their behaviors

based on new knowledge and insights gained from the Consumer Outcomes information.[15]

In an agency culture of a learning organization, a worker/clinician collaborates with the consumer/family member to use his/her self-assessment Outcomes information to develop an individualized Recovery-focused treatment plan. Clinical supervisors and workers/clinicians use aggregated Consumer Outcomes information to support clinical supervision and program development and planning that is relevant to consumer and family needs. Agency administrators and clinical supervisors use aggregated Consumer Outcomes data to support quality improvement; to show accountability for funding in terms of the consumer outcomes produced; to meet the regulatory requirements of ODMH, accreditation bodies, and payers; and to assist with strategic planning. They also use individual consumer Outcomes data to do retrospective service utilization reviews for care management.

Worker/Clinician Uses of Outcomes with a Consumer

A worker/clinician uses Outcomes information for an individual consumer to monitor the consumer's change over time in the domains of clinical status, quality of life, functional status, and safety and health. Within some of these domains there are summative global scores for monitoring change. These are in addition to the specific items which the worker/clinician can compare over time for different administrations of the instrument. For consumers receiving long-term services, graphing the results for each administration of the Consumer Outcomes measures is helpful for seeing change or the lack of change. Now that norms and benchmarking scores are available, the worker/clinician can compare the Outcomes results for an individual consumer with those for other similar consumers statewide and in the local board area.

A worker/clinician also uses the items with highest and lowest ratings to identify strengths and needs for treatment planning and to explore trends and patterns among items with high ratings and low ratings. The worker/clinician can also look for inverse relationships, where the rating for one item goes up and the rating for the other item goes down, to check that these changes are occurring in the desired direction. The worker/clinician also identifies patterns of responses that suggest new goals not previously discussed. The Outcomes information may also suggest areas in which the worker/clinician needs to serve as an advocate for the consumer.

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[15] See Chapter 2 (The Ohio Mental Health Consumer Outcomes System) for more details about learning organizations.

Worker/Clinician Use of Outcomes with a Family Member

As appropriate, the worker/clinician uses Outcomes information for an individual consumer to inform and educate family members/significant others in order to develop more productive support systems for the consumer which lead to improved outcomes for the consumer. When dealing for the first time with a mental health crisis, “Families initially exhibit strong reliance on professionals, believing they will provide answers... When families begin to accept the limitations of what can be done, they focus more on the management of symptoms and improving the functioning of the family member with the mental illness. The professional’s response at this point is critical” (Spaniol, Zipple, and Lockwood, 1992).

By using individual and aggregated Consumer Outcomes data, a worker/clinician is better able to identify the appropriate supportive environments which enhance treatment. This is precisely the kind of information the families/significant others involved with a consumer need most in order to provide appropriate and productive support. Families/significant others often play a crucial role in the vital area of psychiatric rehabilitation and care management irrespective of whether or not the worker/clinician directly and purposively involves the family. The worker’s/clinician’s explanation of a consumer’s Outcomes, and what they mean in terms of the consumer’s support needs, helps to develop positive ongoing working relationships with a consumer’s primary caregivers.

Clinical Supervisor and Worker/Clinician Use of Consumer Outcomes for Program Planning

Using aggregated Consumer Outcomes data, clinical supervisors and workers/clinicians monitor changes in Outcomes over time for the entire agency service population or for groups of consumers. This provides information for agency needs assessment, program development, and program planning. Looking at consumers’ Outcomes in relation to their sociodemographic characteristics, service utilization patterns, and their clinicians’ characteristics leads to a better understanding of service utilization and supports the targeting of resources to support relevant programming. Now that norms and benchmarking scores are available, the clinical supervisors can also compare the Outcomes results for an individual consumer with those for other similar consumers statewide and in the local board area.

Agency Administrator and Clinical Supervisor Use of Consumer Outcomes

- **Care Management:** Now that norms and benchmarking scores are available, agency administrators can use Outcomes data to retrospectively monitor and manage consumers’ service utilization. Using statistical analyses to identify consumers, especially those with high costs and whose Out-

comes scores are outliers, administrators can compare consumers' actual scores with the expected scores and review their current level-of-care and service utilization pattern. If there is a marked discrepancy between the actual and expected Outcomes scores for a consumer, the administrator may recommend a change in the treatment plan to improve the consumer's Outcomes.

- **Quality Improvement:** One of the most important uses of Consumer Outcomes is for quality improvement of the service delivery system.[16] In one method of doing quality improvement, agency administrators use Consumer Outcomes information to determine what is currently known about a service delivery issue and to identify and prioritize issues using Pareto charts to show the most frequently occurring issues. Agency administrators then establish and charge work groups to study the selected issues. The work groups use Consumer Outcomes to provide data for before-and-after pilot tests of proposed changes to the service system and then use these findings to recommend changes for agency-wide adoption. Agency administrators use subsequent Consumer Outcomes information to monitor and re-evaluate the implemented changes in the service delivery system on an ongoing basis.
- **Accountability for Resources:** Agency administrators *cautiously* use aggregated Consumer Outcomes data as indicators in support of the effectiveness of their agency's services. However, they do this with the understanding that there are to date few empirically established causal relationships between services and consumer outcomes. Agency administrators also use Consumer Outcomes to assure that their agency is meeting the requirements of certifying, accrediting, or payer organizations. Consumer Outcomes also provide information for educating agency board members about the agency and for the agency's strategic planning. Using Consumer Outcomes to demonstrate the agency's accountability for funding to its board and other payers improves the agency's marketing, fund raising, and grant writing capabilities.

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[16] See Chapter 2 (The Ohio Mental Health Consumer Outcomes System) for more details about quality improvement methods.

How Do Mental Health Boards Use Consumer Outcomes?

Mental health boards have a number of uses for Consumer Outcomes data. In particular, there are applications for board-level care management, quality improvement that includes identifying best practices, accountability, and local system planning.

Care Management

Utilization review and utilization management are strategies for analyzing service use and costs while maintaining the quality of services for enrollees in the plan. Utilization review by boards and agency/provider organizations could facilitate consumers' use of mental health services in a cost efficient manner. In addition, Consumer Outcomes (especially functional status Outcomes) can play a role in determining the level-of-care a consumer needs.

Quality Improvement

Standardized measurement of Outcomes and the processes that lead to those Outcomes enables boards to identify what treatment works with which consumers. Linking processes to good Consumer Outcomes is the identification of "best practices." In order to develop these "best practices," Outcomes data must be used in conjunction with other sources of data such as service utilization and billing, quality assurance, grievances and appeals, CQRT, demonstration projects, research results, and others. Much of this information may eventually be available in a state-level Data Warehouse. Since large Outcomes databases are needed to identify treatment modalities that produce consistently good outcomes (Smith, Rost, Fischer, Burnam, and Burns, 1997), many mental health boards will be in an optimal position for identifying best practices because of their access to these databases.

In order to identify best practices, one must clearly understand the processes that lead to good outcomes. According to a recent publication (JCAHO, 1998), boards should attempt to continually answer the following questions in order to identify best practices:

- What are the outcomes for the individual recipient of care? What processes contribute to these outcomes?
- What are the outcomes for a particular population of consumers? What processes contribute to these outcomes?
- What are the outcomes for a group of consumers with common diagnoses? What processes contribute to these outcomes?

- What are the outcomes related to a specific therapeutic modality or approach? What processes contribute to these outcomes?

By continually seeking the answers to these questions, boards, agencies and consumers can work together to identify best practices and then implement those practices into the treatment process in order to continuously improve the system of care for consumers.

Accountability

A focus on outcomes is a key mechanism for ensuring the continued accountability of publicly funded behavioral health care in the future. Consumer Outcomes play an increasing role in helping agencies and boards demonstrate their effectiveness to all stakeholders in the system.

Organizational performance (at the individual agency level or the county-wide board level) can be evaluated systematically from two perspectives. First, an organization's performance can be compared over time. Second, an organization's performance can be compared with the performance of similar organizations. Benchmarks can be established for both of these perspectives. A benchmark is a reference point that serves as a standard for comparing or judging other things. In the case of comparing an organization's performance over time, benchmarks can be established based on the organization's past performance. In the case of comparing an organization's performance with the performance of other organizations, a benchmark could be the statewide average scale scores from the Outcomes instruments. Or, the benchmark could be the average scale scores from other board areas that are most representative of the board area. While an almost infinite number of benchmarks could be developed based on information from the Outcomes Data Mart, it is likely that time and experience will identify a few key benchmarks as the most useful. The development of adjustments for case mix may also enhance the usefulness of these benchmarks.

Now that benchmarks are established, comparisons between Consumer Outcomes from an organization and the overall benchmark will yield valuable information about that organization. Listed below are some examples of how this information could be used:

- Monitor the analysis and improvement of Outcomes of care by providers.
- Maintain performance data that will be used to continuously monitor organizational performance.
- Help organizations identify areas in need of attention.
- Identify exemplary performance.
- Document consumer improvement using a different and possibly less intensive level-of-care.

- Demonstrate improved performance.

As a cautionary note, comparisons must be conducted fairly, which means that they often must be adjusted for case mix or consider other factors that could differentiate among agencies. Case mix adjustment is a computational process that takes into consideration the severity and complexity of the consumers' conditions, age, gender, or other characteristics that are known to be related to the outcome being measured (JCAHO, 1998). Boards as well as the total system will need to address issues regarding the potential misuse of Outcomes data comparisons.

Local System Planning

Outcomes and process data will provide much of the necessary information to help boards make policy, administrative, clinical, and financial decisions. Listed below are several examples of how boards can use Outcomes data, along with other information, for local system planning:

- As mentioned in the quality improvement section above, Consumer Outcomes data can be used to help identify best practices. Once best practices are identified, boards can then make policy changes in order to help implement these practices into the treatment process for providers within the board's jurisdiction.
- Information gathered through benchmarking may highlight gaps in services. For example, a board may identify several distinct sub-populations of persons with severe mental illness based on the degree to which they experienced problems with finding a job, and making and keeping friends. The board could use these findings to identify and develop programs to meet these needs.
- Outcomes data, along with other sources of information, could be used to identify where less services are warranted.
- Boards could use Outcomes data, along with other sources of information, to project more accurately the total expense of care, both within and across various levels of service intensity. For example, boards could look at cost-benefit analyses for various service combinations and types of consumers. In addition, they could conduct cost-efficiency analyses, ascertaining whether particular timing of services is more effective.

How Does ODMH Use Consumer Outcomes?

The Ohio Department of Mental Health (ODMH) will use aggregated Consumer Outcomes data in a number of ways to support planning and policy development related to consumer needs and best practices, to monitor and improve quality and accountability in locally managed systems of care, and to develop statewide benchmarks for the improvement of mental health services.

Quality Improvement

- Status data (the initial measures and those taken at each measurement point thereafter) are being analyzed to give ODMH a sense of the most serious problem areas for consumers in the public system, and these analyses might point to areas in which new ODMH program demonstration initiatives could be funded.
- For both status and change scores data, reports are being generated by various types of populations (e.g., race, gender, age, urban vs. rural, and special groupings). These analyses highlight whether there are significant differences in outcomes for particular population groups that might require attention in a number of areas across the state.
- Benchmarking reports are being generated which compare board or regional areas and compare major agency/provider organizations with the overall group of particular types of agencies.
- After a substantial amount of status and change data have been generated, ODMH will do psychometric analyses to ascertain how the instruments perform. Norming the instruments for Ohio consumers has been done for a number of consumer characteristics, and an attempt will be made to determine which are the most crucial items in the instruments.

Accountability

When all the components of its information systems become fully operational, ODMH will have available statewide encounter-level data for use in establishing a higher threshold for accountability activities. Outcomes data would be included in the anticipated Data Warehouse (non-personally identifiable but unique files) that can be merged with fiscal, service utilization, and consumer demographic data to provide a basis for benchmarking across the state's 50 local systems. When this information is available, the following are anticipated:

- Statewide analyses to determine particular combinations of services that are most effective for particular types of consumers.

- Identification of areas of best practices.
- Analyses contrasting adult consumers with and without serious mental illness and youth with and without serious emotional disturbances on service receipt, costs and Outcomes.
- Cost-benefit analyses for various service combinations and types of consumers.
- Cost-efficiency analyses, ascertaining whether particular timing of services is more effective.
- Most of these analyses can also be done by race, gender and age, and some can be done by board area.
- Statewide benchmarking reports that would go to boards, agencies and consumer and family advocacy groups, as well as national accrediting bodies such as the JCAHO ORYX performance outcomes system.
- Development of methodology for case mix adjustment, to be applied to benchmarking data.

In addition to the uses listed above, ODMH uses Outcomes in the Certification process. Agencies seeking Certification or re-Certification must respond to Attachment 7 of the Certification application. Attachment 7 is included as an Appendix, along with some suggestions about how to provide evidence of data use in the Certification application process. Attachment 7 is subject to change; the official version can be obtained from the Office of Licensure and Certification. The copy in the Appendix is for your convenience only. As new copies of the Consumer Outcomes Procedural Manual are created, up-to-date versions of Attachment 7 will be included.

What Are the Cautions and Qualifications About Using Consumer Outcomes Data?

The Ohio Mental Health Consumer Outcomes System provides valuable information to users and purchasers of services. However, there are two key cautions and qualifications that must be taken into account before using the Consumer Outcomes information for funding and selective contracting with agencies/provider organizations.

- ***Caution/Qualification #1:*** *There are very few empirically established causal links between specific mental health system services, specific agencies, or specific workers/clinicians and consumer outcomes.*

- ***Caution/Qualification #2:*** *Comparisons of Outcomes across mental health boards, or agencies/provider organizations, or workers/clinicians should be viewed with extreme caution even though statewide benchmark scores have been developed.*

Outcomes monitoring, complemented by cost data, will provide valuable information to purchasers of mental health services that will enable them to judge the value of the services they are purchasing. Although Outcomes data could be used punitively, an Outcomes monitoring system will be more effective if data are used to stimulate discussion, to guide clinicians in tailoring consumer treatments, and to identify efficient approaches to treatment (Smith, Rost, Fischer, Burnam, and Burns, 1997). Therefore, funding organizations must take extreme caution in using data for funding and selective contracting. Both the OTF and the Outcomes Implementation Pilot Coordinating Group strongly recommend the following guidelines for users of Outcomes data:

- Outcomes findings should be used as indicators of areas requiring further exploration and subsequent treatment, program, and system planning.
- It is not appropriate to assume the cause of a given finding can be attributed only to the mental health system or to a specific provider or practitioner.
- Caution must be exercised in interpreting Outcomes data.
- Potential data users should resist the temptation to compare providers or board areas based on simple analyses that don't reflect the differences in programs and the consumers they serve.
- Data users must recognize their responsibility to monitor such inappropriate use of the data.

While funding organizations must be extremely cautious in how they make funding decisions based on comparisons between providers and a given benchmark, comparisons can and should be made. Smith, Rost, Fischer, Burnam, and Burns (1997) identified several critical components that are needed for making valid comparisons across groups:

- First, you must be able to verify that consumers in the comparison groups meet the diagnostic criteria for the condition under study.
- Second, you must have the ability to provide valid and reliable data about salient outcomes from both the consumers' and providers' perspectives.
- Third, you must be able to measure prognostic variables to permit comparisons across groups. Smith et al. define prognostic characteristics as those known to be related to choice and/or success of treatment. "These variables, sometimes referred to as case-mix variables, allow analysts to more confidently interpret relationships between treatment and observed outcomes in studies where patients are not randomly assigned to the treatment

conditions." They are particularly important when comparing outcomes across sites because they potentially allow analysts to adjust for preexisting differences in prognosis that would otherwise confound the comparisons. However, these authors assert that even with the best adjustments, caution should be taken when interpreting differences observed between consumer groups in non-experimental designs.

- Finally, you must have the ability to assess the type and extent of treatment the consumer received for the target condition across various health care delivery settings. A careful and comprehensive description and quantification of the services a consumer receives, (e.g., CPST, Pharmacologic Management, Behavioral Health Counseling and Therapy) the extent of services, (dose, frequency, duration, or number of sessions) and the settings in which the services are received, (primary care, specialty care, emergency room, day treatment, or hospital) is essential to understanding how the provision of care influences outcomes.

What Technology Aids Are Available for Agencies' Use?

A computer "template" for data entry and the production of a standard set of reports is available free of charge to the agency/provider organizations participating in the Consumer Outcomes System. It is available on CD-ROM or can be downloaded from the Outcomes Web Site. The information presented here is designed to provide a general overview of the tool and its uses. Additional information about this tool can be found in the more comprehensive Template User's Guide, available on the Outcomes Web Site.

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Note: *A new version of the Data Entry and Reports Template was issued in December of 2006. Any older version of the Template should be discarded. As of December, 2006, the Access 97 version of the Template is no longer supported.*

If your Template logon screen does look like the image to the right, you are working with an old version of the Template. You should download a new copy and transfer your data to the new version.

Data Entry and Reports Template

A data entry and reports "template" has been developed to provide an example of how technology can be used at the agency/provider level to support Outcomes data collection, storage, reporting, and transmission. This tool, a standard Microsoft® Access application, is designed to serve three basic functions:

- **Data Entry and Editing:** The Template allows provider agencies to enter and edit data contained in the Outcomes instruments. It has built-in data validation checks to reduce data entry errors and to help to ensure overall data quality. Data entered using the Template are automatically formatted to comply with the data specifications required by ODMH.
- **Outcomes Data Storage and Exporting:** The Template can be used to store Outcomes data in a database structured to meet the data specifications required by ODMH. It also includes an export function that can be used to create a properly formatted Outcomes file that, in turn, can be submitted to a board and ultimately to the statewide Outcomes database at ODMH. Agency/provider organizations that choose to collect Outcomes data using a method other than the Template (e.g., scanning, voice recognition) can "dump" their data into the tables of the Template, thereby making the export and reporting functionality available.
- **Outcomes Reporting:** The Template can also be used to produce several basic, consumer-based care management reports for all Outcomes System instruments. It extracts information from the database and prepares an individualized report of a consumer's responses to items on each instrument.

  Each of the available standard reports is described below:

  - **Change Over Time Report:** This report consists of a series of line graphs, each representing an individual's scores on particular subscales across administration periods. The report is available for the following instruments: Adult Consumer Form, Ohio Scales-Youth, Ohio Scales-Parent, and Ohio Scales-Worker.
  - **Ohio Scales Version Comparison Report:** This report consists of line graphs that compare the Youth, Parent, and Worker responses on the Ohio Scales Functioning and Problem Severity Scales across the three previous administrations.
  - **Individual Red Flags Report:** This report displays the areas that need the most attention, for a given individual and administration. The results are grouped first by areas of "most negative" vs. "negative" categories, and then by the instrument categories (e.g. "Empowerment" or "Functioning"). A message on the report indicates when there are no "negative" results for the given administration.
  - **Individual Strengths Report:** This report displays areas of strength for a given individual and administration. The results are grouped by areas of "most positive" vs. "positive" categories, and then by instrument categories (e.g. "Empowerment" or "Functioning"). A message on the report indicates when there are no "positive" results for the given administration.

- **Multiple Reports:** This report option combines and generates all four reports mentioned above, using a combined report criteria selection screen. You can mark any or all of the reports you want to create. The selection criteria depend on the selected instrument and report type(s). For example, the Ohio Scales Version Comparison report option is enabled only if one of the Ohio Scales instruments is selected.
- **Tracking Report:** The Tracking Report displays all administrations due for the selected date range. This report is the only report to display both public and private administrations.

Using the Template provides simple, direct ways to view and work with information. Microsoft® Access has powerful querying and connective capabilities that can assist in finding information quickly. In addition, queries can be changed at any time to see different layouts of data.

Finally, the Template reports also provide information for a consumer and worker/clinician to make point-in-time comparisons of a consumer's Outcomes with the Outcomes for a group of similar consumers or with established benchmarks. However, such point-in-time comparisons require great caution to assure that the consumer is truly similar to the comparison group. To develop the most meaningful point-in-time comparisons, an agency must have the management information system capability to link Consumer Outcomes data with service utilization, cost, and other sociodemographic data. An agency also needs to have the analysis capability to sort the data by relevant characteristics in order to form a comparison group that is similar to the consumer. Examples of relevant sorting variables include the following: diagnosis, voluntary/involuntary status, sociodemographic characteristics, patterns and intensity of service utilization, length of stay, cost, worker/clinician, and agency program. An agency then must also have the analysis capabilities to aggregate the Outcomes data for the comparison group and to calculate appropriate statistics for comparing the Outcomes of an individual consumer with those of the comparison group. These point-in-time analyses provide information that the consumer and worker/clinician can use to check the consumer's Outcomes in relation to those of a similar group of consumers and then to discuss revision of the treatment plan as needed.

Reports Generator

The Reports Generator is an add-on application to the Data Entry and Reports Template. The separation of the Reports Generator and the Template affords heightened protection from accidental damage to the Template and allows for more frequent changes to the Reports Generator. The Reports Generator has additional individual-level reports as well as a number of cross-sectional and longitudinal aggregate reports. Additionally, the Tickler (Upcoming Administration re-

minder) has been updated. Individual reports are run in batches, rather than one at a time.

The following reports are included in the Reports Generator:

Individual Reports

- **Adult Consumer Report:** Summarizes scores on the Adult Consumer Form over multiple administrations. This report includes records for the current episode only, not all of the records for a consumer.
- **Adult Combined Report:** Contains all of the scale scores and many individual items from the Adult Consumer measure combined with the Community Functioning Scale and a summary of information about the negative events that may have happened to the consumer from the Adult Provider instrument. This report includes records for the current episode only, not all of the records for a consumer.
- **ARROW (Achieving Recovery and Resiliency the Outcomes Way) Report:** This report is designed to be used in treatment planning, and suggests potential activities for the consumer's treatment and/or recovery plan. The ARROW is based on Maslow's hierarchy of needs and the consumer's responses to the Adult Consumer instrument.
- **Youth, Parent, Worker Combined Report:** Three-Month Schedule – Summarizes the subscale scores on all three Ohio Scales instruments over multiple administrations.
- **Youth, Parent, Worker Combined Report:** Initial/Three-Month/Six-Month/Annual Schedule – Summarizes the subscale scores on all three Ohio Scales instruments over multiple administrations. Used for reporting when data are collected according to the Ohio Outcomes System schedule.
- **Worker Treatment Planning Report:** Designed to help providers complete the initial Ohio Scales worker instrument, this reports summarizes the Youth's and Parent's initial Ohio Scales data in a report designed by Ben Ogles. Use of the report is described in detail in the "Using Youth Consumer Outcomes to Support Treatment Planning Manual", written by Dr. Ogles. The report is run only on initial administrations.

Aggregate Adult Reports

- **Adult Consumer and Provider for Agency:** Summarizes the Adult Consumer Form and Adult Provider Form subscale scores for all adult consumers in the database over multiple administrations. Cross-sectional.

- **Adult Consumer and Provider By Program:** Summarizes the Adult Consumer Form and Adult Provider Adult Form subscale scores for all adult consumers in the database over multiple administrations by program.
- **Diagnosis by Staff Adult Consumer and Provider Aggregate:** Compares average scores on the Adult Consumer and Provider reports by diagnosis and by staff member. It shows how different staff members are doing in treating consumers with different diagnoses.
- **Diagnosis Adult Consumer and Provider Aggregate:** This is a companion to the Diagnosis by Staff Adult Consumer and Provider Aggregate report, but can be used alone to compare how people with different primary diagnoses are doing on average over time. This is a cross-sectional report.
- **Adult Consumer Longitudinal Report:** Reports the mean scores on the Adult Consumer Form scales at two user-selected time points, as well as calculating the number and percentage of cases reliably improved, staying the same, and reliably deteriorating.

Aggregate Youth Reports

- **Ohio Scales Agency:** Agency-Wide Aggregate Report for Youth, Parent, and Worker forms - Summarizes the subscale scores for all three Ohio Scales instruments for all youth consumers in the database. Groups all youth by administration period. This is a cross-sectional report.
- **Ohio Scales by Program:** Program-Wide Aggregate Report for Agency Youth, Parent, and Worker forms - Summarizes the subscale scores for all three Ohio Scales instruments for all youth consumers in the database. Groups all youth by administration period and the Agency Defined Text Field, which is treated as the 'program' field. This is a cross-sectional report.
- **Ohio Scales by Diagnosis by Staff:** Compares average scores on the Ohio Scales by diagnosis and by staff member. It shows how different staff members are doing in treating consumers with different diagnoses. This is a cross-sectional report.
- **Ohio Scales by Diagnosis:** This is a companion to Ohio Scales by Diagnosis by Staff report, but can be used alone to compare how people with different primary diagnoses are doing on average over time. This is a cross-sectional report.
- **Cost of Out of Home Placements (ROLES) Restrictiveness Of Living Environment Scale:** Multiplies the days spent in each residential setting by a *per diem* rate to show how total placement cost changes. The *per diem* cost table comes from a recent review of costs in Ohio conducted by staff of the Center for Innovative Practices. This is a cross-sectional report.

Tracking Report for all Consumers

- **Tracking Report:** This report can be used to see which consumers have an upcoming administration between the start date and end date entered in the parameter field.

For more information about the Reports Generator, download the instructions from the Outcomes Web Site.

Data Use Matrix

The Data Use Matrix provides guidance about a range of uses for Outcomes data in Ohio. This guidance was developed by representatives of consumers and families, provider agencies, local ADAMH and CMH boards and staff of the Department of Mental Health. Both the Outcomes Task Force and the subsequent Pilot Coordinating Group emphasized that the most important use of these data is at the consumer and family level, in collaboration with direct care staff. In particular, this document underscores the importance of using Outcomes data within the context of a therapeutic relationship with consumers and families, and jointly deciding how and when to implement changes in treatment and Recovery plans. In addition, the matrix provides general guidance about using the data for administrative purposes at the agency, board and state levels, although these uses will vary depending on resources available and on changes in Ohio's evolving mental health system over time.

The Data Use Matrix reflects the use of basic concepts and skills, and makes only modest assumptions about knowledge, skill and resources at each level. It does assume that all system participants will have an interest in using the data responsibly and in assuring the integrity of the data. It assumes basic data processing ability at each level, yet also assumes that the data can be used effectively even without sophisticated electronic resources. The matrix also underscores the need for continuing development work, including the need to evaluate the performance of the instruments, to analyze and interpret data collaboratively at all levels and to develop case mix methodologies for ensuring that any comparisons made using Outcomes data are based on comparable samples.

Data Use Cautions

Outcomes data are best considered as a possible indicator for further focused evaluation and as one important piece of data among others (including consumer satisfaction and complaints, cost, utilization, etc.). The Outcomes System has been developed to support continuous quality improvement at all levels and is not adequately tested for more aggressive administrative functions at this time. Local systems are strongly encouraged to postpone the use of Outcomes data for funding-related decisions until the contributions of these instruments and subsequent data in enhancing quality improvement processes have been demonstrated.

There are several qualifications about these data:

- While there is likely to be some significant association between actions of a provider or clinician and a consumer's Outcomes, it is not usually possible to prove a cause-and-effect relationship between these factors. Data use should emphasize quality improvement at the clinical level at this time.
- While norms for a few population groups are available, it will take perhaps several years and a much larger data set before Ohio-specific norms can be developed for various population groups.
- These data have not been adjusted for case mix, so caution should be taken before using them to make comparisons between individuals, groups, or agencies.

Consumer Outcomes Data Use Matrix

The Data Use Matrix provides guidance about a range of uses for Outcomes data in Ohio, and provides general guidance about using the data for administrative purposes at agency, board and state levels.

Data Users	How can Outcomes help me with my job?	How do I do it?	What do I need?
Consumer and Family Level	**Goal:** ***To empower the consumer/family member by incorporating his/her self-assessment into treatment planning.*** Incorporate into treatment planning consumers' needs as indicated by the Outcomes scores; target needs and behaviors of greatest interest to consumers/families.	Use individual scores over time to identify strengths and weaknesses; may display in run charts/bar charts.	Consumer and family orientation on: purpose and structure of Outcomes measurement approach appropriate interpretation and use of data for individual advocacy use of care management templates in treatment planning use of benchmarked data to measure local system performance
Consumer and Family Level: Advocacy Organizations	**Goal:** ***To support active participation and advocacy of consumer and family organizations on behalf of persons with mental illness.*** Develop training for governmental and advocacy groups that operate as consumer and family organizations, or on behalf of persons with severe mental illness and their families; training to focus on assisting a variety of advocacy organizations how to understand and interpret Outcomes findings and utilize to influence policy; improved working relationship with related evaluative activities in the board area (e.g., CQRT); and increased involvement of consumers or other family members in planning at the agency and board level.	Use profiles based on aggregate information to identify trends in consumer strengths and challenges based on services used; assess degree to which consumer needs and expectations are being met. Conduct advocacy on behalf of and in collaboration with consumers to ensure that their needs and expectations are being met.	Orientation to assist consumers, family members and advocates in understanding the purpose, process and use of Outcomes measurements, and interpretation and use of data. Collaboration between advocates and ODMH and local systems to foster the use of Outcomes data in tracking and improving Consumer Outcomes.

Data Users	How can Outcomes help me with my job?	How do I do it?	What do I need?
Agency Level: Clinicians	**Goal:** ***To support Treatment Planning that is individualized and Recovery-focused, and to support agency Care Management activities.*** Collaborate with consumer to design appropriate actions to meet consumer's needs; jointly track consumer scores over time to monitor progress and revise treatment plans; identify consumers who might benefit from additional/alternative approaches.	Compare and contrast high and low individual Outcomes scores. May trend changes in domain scores over time. Generate a Care Management Report that includes the total scale, subscale, and single question scores for the consumer. Compare scale/item scores with normative scores or local benchmarks to help identify the consumer's strengths and weaknesses. Chart the scale/item scores at each administration and compare Outcomes scores over time to statewide data showing scores over time.	Clinicians and supervisors need training to be able to do the following: Understand and interpret data as one component of overall performance measurement. Present Outcomes data to consumers and/or family members and apply knowledge jointly. Ensure that the tool is used in conjunction with own clinical skills and consider the relation of this information to other variables. Clinical Supervisors must support and supervise the accuracy of the process and interpretations Resource needs include: Care Management Templates that graphically demonstrate scale scores over time (and eventually compared to statewide norms). Psychometrically valid norms and benchmarks for the individual consumer's scores (see state use). Clinician Training and Resource Manual for interpretation of data.
Agency Level: Clinicians and Clinical Supervisors	**Goal:** ***To support Quality Improvement, Program Development and Planning for programs relevant to consumer and family needs.*** Provide data to assess overall consumer strengths and weaknesses for agency needs assessment; support better understanding of service utilization patterns related to Outcomes; target resources to support relevant programming; help involve clinicians to identify gaps in and effectiveness of services; support the use of Outcomes data in the context of clinical supervision; identify areas with outlier scores; support level-of-care decisions.	Review aggregated subscale scores. Review percentage of consumers with high and low scores in each domain; compare domain items with normative scores and benchmarks to identify trends and patterns. Assess differential Outcomes between programs to identify trends in strengths and weaknesses; review the total number of consumers in a program or service and aggregate the scores; integrate with data on the number of service hours or the intensity of services provided. Aggregate Consumer Outcomes data over time for each clinician (or clinical team) and compare consumers' change scores to statewide benchmarks. When used with other sources of information, these results can inform clinical supervision, human resource decisions, continuing education opportunities and other clinical quality improvements.	Aggregate reports and analysis Clinician Training and Resource Manual for interpreting data Peer review of care standards related to selected variables including Outcomes scores Capacity to merge program participation data Capacity to merge Outcomes, financial and utilization data
Agency Level: Administrators and Clinical Supervisors	**Goal:** ***To support agency operation, and regulatory compliance.*** Prioritize and approve opportunities for quality improvements for the organization; meet regulatory requirements of certifying, accrediting and payer organizations, including ODMH Certification Standards Outcomes requirements; educate boards of trustees and tax payers; improve marketing, fund raising and strategic planning.	Analyze and compare aggregate Outcomes data. Submission of data to board and ODMH to demonstrate compliance with accountability requirements.	Assessment of: Capabilities of the agency, staff, consumer population in relation to use of the data Agency culture related to ability to change and to the knowledge of the change process Knowledge, competency and commitment of the agency, agency's board, and leadership to continuous improvement.

Data Users	How can Outcomes help me with my job?	How do I do it?	What do I need?
Board Level: Administration	**Goal: *To support local system evaluation and planning*.** Develop and continuously improve services to meet the MH needs of the community; identify vulnerable populations, outliers across agencies and service gaps; allocate funds to meet strategic goals; review performance of agency providers and explore possible explanations for performance differences between agencies.	Aggregate scores by significant demographic and program variables. Test for differences in the mean scores of consumers across agencies after controlling for case mix	Expertise in data analysis methodologies, data display options, case mix adjustment methodologies.
Board Level: Administration	**Goal: *To assist in identifying best practices that result in improved outcomes for consumers and families and that are cost-effective.*** Review services, Outcomes and costs to identify the most effective treatment and recovery approaches locally; encourage contract agencies to conduct continuous quality improvement and use Outcomes data.	Analyze aggregate scores and change scores at the provider level by significant demographic and program variables. Utilize Outcomes Data Mart for benchmarking across the state with similar board composition/demographics.	Expertise in data analysis methodologies, data display options, case mix adjustment methodologies.
Board Level: Administration	**Goal: *To meet public requirements for fiscal accountability, access and quality.*** Secure funding for system development and service planning; demonstrate to various stakeholders that local services are making a positive impact on consumers' lives and are cost-effective; meet MSPA Outcomes requirements; use continuous quality improvement to improve board and system performance.	Aggregate scores and change scores at the system level by significant demographic and program variables.	Expertise in data analysis methodologies, data display options, case mix adjustment methodologies.

Data Users	How can Outcomes help me with my job?	How do I do it?	What do I need?
State Level: ODMH Policy and Planning and Research Staff	**Goal:** ***To support planning and policy development related to consumer needs and best practices by developing a demographic profile of consumers served by publicly funded mental health providers.*** Develop a broad view of the consumer population profile; to support understanding of the distribution of total, scale and subscale scores across board areas, population types, and provider clusters and their relationship to specific demographic variables.	Perform frequency distribution procedures to examine demographic profiles of consumers/providers providing or utilizing mental health services in pilot board areas and all boards areas statewide. Perform frequency distribution procedures to examine subscale, scale scores, and individual question scores by board area and state. Report on scale, subscale and individual question scores by board area and state. Cross-tabulations of various demographic characteristics with various subscales, scales and scores for individual questions by board area and state. Establish confidence intervals and benchmarks by scales, subscales and individual scores in board areas and at the state level. Generate tables (frequency distributions and cross- tabulations) depicting board area and state level benchmarks by consumer/provider population characteristics and scores on instruments. Examine percentile scores for the state in relationship to various demographic variables (age, gender, race, psychiatric diagnosis) for the state (and after risk adjustment formulas for case mix are available) for board areas and agencies. Disseminate data and analyses to board areas and agencies during statewide implementation.	Expertise in data analysis methodologies, data display options, case mix adjustment methodologies.
State Level: ODMH Policy and Planning and Research Staff	**Goal:** ***To monitor and improve quality and accountability in locally managed systems of care.*** Use statewide data to establish Ohio norms needed for understanding the relative meaning of scores; use statewide data to establish a basis for statewide and sub-state benchmarking; utilize consumer profiling information to develop methodologies for evaluating health status of consumers and examining treatment effectiveness relative to cost.	Use multivariate procedures to examine population characteristics, subscale and individual question scores to examine their relationship to SMD status. Explore how information generated could be used in developing and implementing a risk adjustment methodology that could be used to understand the implications of Outcomes data. Conduct data analysis, production and presentation of findings relating to the development of a methodology to relate SMD status to Outcomes results. Re-examine data to develop a severity index methodology to predict cost and allocate resources.	Expertise in data analysis methodologies, data display options, case mix adjustment methodologies.
State Level: ODMH Research, Policy and Planning staff, Area Directors	**Goal:** ***To support monitoring of local system performance, development of funding strategies, and the systematic improvement of quality.*** Monitor agencies via Certification Standards, boards via MSPA and program development initiatives as appropriate; compare similar systems to establish a basis for judging effectiveness, planning for improvement and intervening as appropriate; examine data for implications for continuous quality improvement at the state level; communicate findings, as appropriate, to regulators, funders and constituents.	Multivariate analysis of similar local systems. Correlate with other measures, such as demographic characteristics of the community, population, etc. Explore the use of Outcomes data for monitoring local systems, developing funding strategies, and continuously improving quality.	Expertise in data analysis methodologies, data display options, case mix adjustment methodologies

Data Users	How can Outcomes help me with my job?	How do I do it?	What do I need?
State Level: ODMH Research and Evaluation Staff	**Goal:** ***To develop benchmarks, reliability and validity estimates, and confidence intervals with statewide outcomes data.*** Begin the process of conducting item analyses of questions on the adult and youth instruments for the purpose of illuminating the meaning of the data at an aggregate level.	Conduct reliability analyses including item analysis, confirmatory and exploratory factor analysis, and test for construct validity of Adult instruments. Determine critical responses that can be tagged as "red flags" or serious indicators of poor/excellent mental health functioning. Develop statewide confidence intervals for scales, subscales and individual questions and determine the interrelationships among them. Those found to be highly correlated with mental health functioning status could be used as indicators (red flags) or as predictors of Recovery.	Expertise in data analysis methodologies, data display options, case mix adjustment methodologies
State Level: ODMH Research and Policy and Planning Staff	**Goal:** ***To continuously improve the Outcomes approach by analyzing Outcomes data, gathering input from affected stakeholders regarding Outcomes data analysis and making modifications, as indicated.***	Analyze data on psychometric properties of Outcomes instruments.	Expertise in data analysis methodologies, data display options, case mix adjustment methodologies Mechanism (s) to gather input from stakeholders, collaboratively plan for modifications, and disseminate information

5
Adult Consumer Form

(Release Date: October 15, 2008)

Focus and Intent

The Adult Consumer Form gathers perceptions of quality of life, effects of health on functioning, medication concerns, symptom distress and recovery/empowerment from adult consumers.

Scales and Items

Part 1: Questions 1 through 12 are Quality of Life items. Questions 2, 3 and 4 form a subscale labeled Financial Status.

Part 2: Questions 8, 9, 11, 13, 14, 15 and 16 represent Safety and Health Outcomes. There are no subscales. The last four items were devised by the OTF.

Part 3: Questions 17 through 31 (15 items) represent the Symptom Distress Scale. There are no subscales; the responses to these items are summed to get an overall Symptom Distress score.

Questions 32 and 33, relating to symptom recognition and taking action when early warning signs of decompensation/relapse occur, were taken from the OPER-sponsored longitudinal study of consumers in the community.

Part 4: Questions 34 through 61 represent the Making Decisions empowerment instrument. There are six subscales:

- Self Esteem/Self-Efficacy (Questions **38**, **39**, **42**, **45**, **47**, **51**, **52**, **57**, and **59**),
- Power/Powerlessness (Questions 40, 41, 43, 49, 50, 54, 55 and 56),
- Community Activism and Autonomy (Questions **36**, **44**, **53**, **58**, **60** and **61**),
- Optimism and Control Over the Future (Questions **34**, **35**, **46** and **60**),
- Righteous Anger (Questions 37, 40, 43 and **48**),
- Overall Empowerment (Questions 34 through 61).

! ***Note:*** *The Data Entry and Reports Template will automatically reverse score the items in bold. If the agency is not using the Data Entry and Reports Template for data entry, items in bold must be reverse scored before computing the subscale.*

Cautions and Qualifications

Foremost, the reader is cautioned against over-interpreting responses. Nearly all of the items and subscales in the Adult Consumer Form have known validity and reliability from previous research and the full instrument has achieved high levels of reliability in large-scale testing in the pilot. However, the anticipated varying conditions of use, and the newness of the instrument to some users, should preclude the user from making summary judgments based on scores. “Best practices” for interpretation and use of the data will be identified and disseminated statewide as they surface.

In any outcomes system, scores alone are not sufficient for determining treatment needs. Scores must be considered in context with other variables when making treatment decisions or comparisons.

Threats to the Validity of Responses

These are, primarily, known or suspected respondent characteristics or motivations that result in an individual answering in a way that doesn’t really convey what he/she believes or feels. The most common are:

- Measurement error – an “inaccurate” response due to the respondent not understanding what is being asked or how to answer (how to use the response format).
- Faulty memory.

- Social response bias – wanting to be thought of well by answering in a way that is perceived as pleasing to an important other(s).
- Lying – giving deliberately inaccurate responses for shock value, attention-getting or as a way of manipulating others to take or not take some action.
- Confidentiality/privacy – not answering questions or falsifying because the person views the item as an unwarranted intrusion on privacy.
- Denial/resistance – not wanting to "admit" something to self or others.

Other Factors to Consider

- Whether the person perceives his/her treatment as voluntary or involuntary.
- Whether the person demonstrates behaviors which put him/her or others at risk, and the degree of judged risk. Included here are critical incidents and sentinel events that may strongly influence responses.
- The person's satisfaction with various aspects of treatment/services may influence responses to Outcomes questions.
- The person's awareness of his/her problems and willingness to work on them.
- The tenure, intensity and type(s) of services the person has received.
- The resources available in the family and community for managing the person's behaviors and meeting his/her needs.
- The ability of the various providers to collaboratively work in a model aimed at providing the most appropriate, medically necessary interventions in the right amount at the right time.
- Economic incentives/disincentives that affect the person's functional and treatment status and quality of life.
- Whether there exists a treatment guideline/protocol or set of best practices to guide treatment toward better outcomes, and the willingness of providers and the person served to use it.

Respondent Eligibility and Characteristics

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Note: *Outcomes instruments should be administered wherever Outcomes-qualifying services are delivered regardless of setting, including jails, prisons, hospitals, schools, nursing homes, etc. Outcomes-qualifying mental health services include: Assertive Community Treatment (ACT), Intensive Home Based Treatment (IHBT), Community Psychiatric Supportive Treatment, Behavioral Health Counseling and Therapy, Partial Hospitalization, Pharmacologic Management, Employment and Vocational, Social and Recreational, Occupational Therapy, and Adjunctive Therapy.*

The following groups are exempt from the Outcomes measurement system:

- *Individuals currently in service who are receiving only Mental Health Assessment, Crisis Intervention Mental Health or Forensic Evaluation.*
- *Persons with organic illnesses (persons who do not respond).*
- *Consumers who receive only ODADAS services.*

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Note: *If a problem exists with the consumer taking the survey, (e.g., refuses, is too ill) then the following pathway guides the administration of the survey:*

- *Maintain the principle with all consumers of do no harm.*
- *Use clinical judgment to determine the appropriateness of giving the survey to a particular consumer.*[17]
- *Community forensic consumers are included in the Outcomes System, unless the only service they have received is Forensic Evaluation.*

Population

All current and newly admitted adult consumers will have an opportunity to complete the survey.

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Population for Adult Consumer Form – *Do you administer the Adult Consumer Form to all Outcomes-eligible adult consumers? You should.*

Special Populations

All Outcomes-eligible adult consumers will be surveyed. Problems that arise in survey administration due to diversity or other situations (e.g., no interpreter available or too costly) should be documented.[18]

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[17] See Chapter 3 (Outcomes Instruments and Administration Guidelines) for helpful hints on ways to present the instrument to the consumer.

[18] Some adult instruments are also available in Japanese, Spanish-Mexican, Spanish-Puerto Rican, Russian, and Somali.

Minimum Administration Intervals

Individual Outcomes instrument administrations can be useful as "snapshots" of consumer status, but in order to achieve the goals of the Outcomes Initiative (i.e., the management of consumer care, the improvement of the service delivery system, and accountability for public resources), multiple administrations over time are required.

The administration intervals below represent minimum required administration intervals. Other factors (e.g., other funding and regulatory requirements, clinical preference, nature of the consumer-base and its service patterns) may require that individual organizations increase the frequency of administration, but in no case should actual administration intervals be less frequent than those listed below.

If an organization engages in more frequent administrations, those administrations can still be transmitted through boards to the statewide database maintained by ODMH. Those administrations will also be available for subsequent reporting in the Outcomes Data Mart.

Each agency and board should designate a data flow manager to oversee the collection and transmission of Outcomes data. The agency data flow manager is responsible for ensuring that the appropriate person completes the appropriate Outcomes instrument at the appropriate time. The guidelines below will assist the data flow manager and other agency staff in making the correct choices.

Note: *The agency data flow manager is responsible for ensuring that the appropriate person completes the appropriate Outcomes instrument at the appropriate time.*

New Consumers

At a minimum, the Adult Consumer Form should be administered at or as close as possible to the following intervals:[19]

- **First Administration:** At admission into one of the target services
- **Second Administration:** At six months after admission
- **Third Administration:** At twelve months after admission
- **Subsequent Administrations:** Annually thereafter

[19] It is important to avoid "administration creep" where late administrations can decrease the frequency with which actual administrations occur. In cases where the instruments are administered later than scheduled, follow-up administrations should be anchored to the consumer's originally scheduled initial administration date, even if this means there is a shorter time between some administrations. However, agencies have the option of shortening the time interval preceding an annual administration to coincide with some other annually-occurring event and anchor subsequent annual administrations to that event.

- **At Termination:** Administer at the time of termination if Outcomes-qualifying services have occurred on three or more separate days since previous administration.

The Provider Adult Form should also be administered at all administration times for adult consumers.[20]

> ! ***Note:*** *In order to track consumer change that occurs rapidly, some organizations may wish to administer the Outcomes instruments more frequently than the schedule outlined above. The Outcomes System will also accept administrations at intervals of 30, 60 and 90 days. The decision to administer the instruments more frequently than the ODMH minimum requirement is left to local systems.*

Current Consumers

> ! ***Note:*** *Previously Certified agencies should have already incorporated all of their current consumers into the Outcomes System.*

Any current consumers who are not yet in the Outcomes System should be incorporated immediately and the date of the first administration should be the date used to anchor all subsequent administrations.

At a minimum, the Adult Consumer Form should be administered at or as close as possible to the following intervals:[21]

- **First Administration:** Immediately
- **Second Administration:** At six months after the first administration
- **Third Administration:** At twelve months after the first administration
- **Subsequent Administrations:** Annually thereafter
- **At Termination:** Administer at the time of termination if Outcomes-qualifying services have occurred on three or more separate days since previous administration.

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[20] There are individuals who come to mental health agencies for resolution for short-term emotional problems who typically receive individual/group Behavioral Health Counseling & Therapy either alone or in combination with Pharmacologic Management services. For this group, almost all of the Provider Adult Form content is relevant and it is strongly encouraged that the instrument be administered. However, at this time it is not required in such situations.

[21] It is important to avoid "administration creep" where late administrations can decrease the frequency with which actual administrations occur. In cases where the instruments are administered later than scheduled, follow-up administrations should be anchored to the consumer's originally scheduled initial administration date, even if this means there is a shorter time between some administrations. However, agencies have the option of shortening the time interval preceding an annual administration to coincide with some other annually-occurring event and anchor subsequent annual administrations to that event.

The Provider Adult Form should also be administered at all administration times for adult consumers.[22]

Newly-Certified Agencies

Newly-Certified agencies have a period of 12 months from the date of their application for Certification to have incorporated all of their Outcomes-eligible consumers into the Outcomes System.

The agency can choose to enter consumers into the Outcomes System during this period in any manner that best fits with agency practices. For example, consumers could be started into the process based on previous ISP dates, or date of entry into the agency, by program or other factors. However, the agency should develop a "tickler" method to track when each consumer should receive his/her first Outcomes administration as well as the due dates for subsequent administrations.

At a minimum, the Adult Consumer Form should be administered at or as close as possible to the following intervals:[23]

- **First Administration:** Will occur in waves, based upon whatever method the agency adopts
- **Second Administration:** At six months after the first administration
- **Third Administration:** At twelve months after the first administration
- **Subsequent Administrations:** Annually thereafter
- **At Termination:** Administer at the time of termination if Outcomes-qualifying services have occurred on three or more separate days since previous administration.

The Provider Adult Form should also be administered at all administration times for adult consumers.[24]

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Administration Intervals for the Adult Consumer Form – *Does your system have ways to ensure that the Adult Consumer Form is administered no less frequently than at the appropriate initial point, 6 months, 12 months, annually thereafter, or at termination, whichever comes first? It should.*

Administration Protocol

Administration Time

Administration time varies as a function of the consumer's functionality, with lower-functioning consumers requiring more time to complete the instrument. The pretest done by the Outcomes Task Force and the Implementation Pilot indicated that it typically takes higher-functioning consumers between 10 and 20 minutes to complete the Adult Consumer Form and lower-functioning consumers between 30 and 40 minutes to complete the Adult Consumer Form. Some consumers, particularly those who are unable to read or those whose functioning level is low, may take longer, or may require assistance.

How Will Data Be Collected and Entered?

Data can be collected by any combination of paper and pencil, scanner or electronic input. The decision regarding which method(s) to use will be made at the agency level based on preferences and resources.[25]

In order to ensure the consistency and accuracy of Outcomes information, each agency should develop a process to allow the entry and transmission of Outcomes information in a prescribed format.[26]

The Ohio Mental Health Consumer Outcomes System has developed a Data Entry and Reports Template that can be used to enter Outcomes information into a local PC within each participating agency.[27]

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vider Adult Form content is relevant and it is strongly encouraged that the instrument be administered. However, at this time it is not required in such situations.

[25] See Chapter 9 (Processing Outcomes Data) for a more complete discussion of the transfer of information from the consumer through agencies and boards to the state and back again.

[26] Complete data specifications can be accessed at:

www.mh.state.oh.us/oper/outcomes/data.flow.specs.html

Special Topic: Reverse Scoring

Some items on the instrument are worded such that a given response (e.g., "never") represents a desirable or positive response for one question, but a less desirable response for another. In order to compare items or combine items into a numeric subscale, certain items may need to be "reverse scored" for consistency. When reverse scoring an item, the highest and lowest numerical values are substituted for each other, the next highest and next lowest values are substituted for each other, and so on.

Four-Point Scale

Original Score		Reverse Score
1	⇨	4
2	⇨	3
3	⇨	2
4	⇨	1

Five-Point Scale

Original Score		Reverse Score
1	⇨	5
2	⇨	4
3	⇨	3
4	⇨	2
5	⇨	1

Items that represent non-scaled values (e.g., missing, not-applicable) should not be included in either reverse scoring or computation of subscales.

Scoring

The Adult Consumer Form consists of four parts, which parallel the domains of Outcomes in the OTF model. The parts are: Quality of Life (Questions 1 through 12), Safety and Health (Questions 8, 9, 11, 13, 14, 15 and 16), Symptoms (Questions 17–33) and Empowerment (Questions 34–61).

! ***Note:*** *Outcomes are measured by single items/questions or by a composite score (consisting of two or more items/questions combined to create a subscale). In all cases where an outcome is represented by the average of the ratings of two or more responses, the reader should keep in mind that items that are left blank — not answered — should not be counted when averaging.*

? ***Skipped Questions –*** *Does your system allow the consumer to skip (i.e., not answer) items on the instrument? It should.*

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[27] See Chapter 4 (Users and Uses of Consumer Outcomes Data) for a more complete discussion of the Data Entry and Reports Template.

Part 1: Quality of Life (QOL)

Within the Quality of Life Part/Domain, Questions 1, 5, 6, 7, 8, 9, 10, 11, and 12 each represents a particular QOL outcome. Examples: Question 1 represents the QOL Outcome "Amount of Friendship"; Question 5 represents "Amount of Meaningful Activity". Responses to Question 1 and Questions 5 through 11 represent a five-point satisfaction continuum. The response values are as follows:

- 1 = Terrible
- 2 = Mostly Dissatisfied
- 3 = Equally Satisfied/Dissatisfied
- 4 = Mostly Satisfied
- 5 = Very Pleased
- Missing

Question 7, which is about family interaction, has an additional response value:

- Does Not Apply

Question 12 inquires about opportunity to spend time with others. The response format is frequency, with the following assigned interval values:

- 1 = Never
- 2 = Seldom/Rarely
- 3 = Sometimes
- 4 = Often
- 5 = Always
- Missing

Financial Status: Questions 2, 3, and 4 measure a single Outcome — Financial Status. Responses represent a five-point satisfaction continuum. The response intervals range from 1–5 with:

- 1 = Terrible
- 2 = Mostly Dissatisfied
- 3 = Equally Satisfied/Dissatisfied
- 4 = Mostly Satisfied
- 5 = Very Pleased
- Missing

The Financial Status subscale is an arithmetic average of the three items. To compute the subscale score, sum the responses to all items in the subscale and then divide the sum by the number of questions the consumer has answered.

! ***Note:*** *If one item out of the three is missing, this subscale score should not be calculated.*

? ***Missing Financial Status Items –*** *Does your system know that if <u>any</u> Financial Status subscale item is left blank by the consumer, the subscale is no longer valid? It should.*

Overall Quality of Life: The Overall Quality of Life Scale is an arithmetic average of the completed Quality of Life items. To compute the scale score, sum the responses to all items in the scale and then divide the sum by the number of questions the consumer has answered.

! ***Note:*** *Question 7 contains an extra response value (i.e., Does Not Apply). Although some technologies may record a numeric value for a "Does Not Apply" response, no value should be used when computing the Overall Quality of Life Scale arithmetic average. Rather, the question should be treated as if the consumer did not answer (i.e., <u>no value added in the numerator</u> to the sum of the responses and the question <u>not counted in the denominator</u> as an answered question.*

! ***Note:*** *If two or more items out of the twelve are missing, this subscale score should <u>not</u> be calculated.*

? ***Missing Quality of Life Scale Items –*** *Does your system know that if <u>two or more</u> Quality of Life Scale items are left blank by the consumer, the scale is no longer valid? It should.*

Part 2: Safety and Health

The Safety and Health section covers several Outcomes.

Questions 8 and 9 address the degree to which an individual is free from physical and psychological harm or neglect in various environments.

Questions 11 and 13 represent Physical Condition, but also have implications for level of daily functioning, as the focus is on the interference of physical condition on functioning.

Question 14, labeled Medication, assesses whether concerns about medications have been addressed.

Question 15 concerns the way an individual has been treated at the agency, and Question 16 concerns the public stigma of emotional problems.

The responses for questions 8, 9 and 11 represent a five-point satisfaction continuum with the following values.

- 1 = Terrible
- 2 = Mostly Dissatisfied
- 3 = Equally Satisfied/Dissatisfied
- 4 = Mostly Satisfied
- 5 = Very Pleased
- Missing

The responses for Questions 13, 14, 15 and 16 represent frequency categories with the following assigned interval values:

- 1 = Never
- 2 = Seldom/Rarely
- 3 = Sometimes
- 4 = Often
- 5 = Always
- Missing

!

Note: *Items 13, 14, 15 and 16 are "stand-alone" measurements of individual Outcomes related to Safety and Health; no inter-item comparisons or relationships (e.g., sums, averages) are appropriate. Even though the individual items should not be combined with each other, for consistency purposes, you should reverse score items 13 and 16 so that the most "positive" response carries the highest value. The Data Entry and Reports Template automatically reverse scores the two items.*

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Reverse Scoring – *Does your system reverse score items 13 and 16 before reporting Safety and Health responses? It should.*

Question 14 has an additional response category:

- Not Applicable/No Medications

A single response should be entered for each question.

Part 3: Symptoms

Part 3 concerns the individual's level of symptom distress. The symptoms area has three components.

Symptom Distress: Symptom Distress is a scale measured by Questions 17–31. The response format is a five-point scale representing the amount of distress. The interval values range from 1–5 with:

- 1 = Not at All
- 2 = A Little Bit
- 3 = Some
- 4 = Quite a Bit
- 5 = Extremely
- Missing

The Symptom Distress Scale score is obtained by summing the responses to Questions 17 through 31. The total possible score is 75, with a higher score indicating a greater level of symptom distress.

! ***Note:*** *If four or fewer items are missing, the individual's mean score on all the other items should be substituted for each missing item before the total score is calculated. If five or more items are missing, the total score should not be calculated.*

? ***Missing Symptom Distress Items –*** *Does your system know that if five or more Symptom Distress Scale items are left blank by the consumer, the scale is no longer valid? It should.*

Symptom Recognition: The second component is Symptom Recognition, and is measured by Question 32. The response format represents frequency categories with the following assigned interval values:

- 1 = Never
- 2 = Seldom/Rarely
- 3 = Sometimes
- 4 = Often
- 5 = Always
- Missing

A single value is entered as the score.

Symptom Prevention: The third component is Symptom Prevention and is measured by Question 33. The response format represents frequency categories with the following assigned interval values:

- 1 = Never
- 2 = Seldom/Rarely
- 3 = Sometimes
- 4 = Often
- 5 = Always
- Missing

Part 4: Empowerment

Empowerment concerns the degree to which the individual is feeling a sense of overall fulfillment, purpose in life, hope for the future and personal empowerment. This part consists of six components. The response format for all the questions is a four-point agree-disagree scale with assigned interval values of 1–4 with:

- 1 = Strongly Agree
- 2 = Agree
- 3 = Disagree
- 4 = Strongly Disagree
- Missing

Self-Esteem/Self-Efficacy: The first component of Empowerment is measured by the *Self-Esteem/Self-Efficacy Subscale.* The questions making up the subscale

are: **38**, **39**, **42**, **45**, **47**, **51**, **52**, **57**, and **59**. The Self-Esteem/Self-Efficacy subscale score is an arithmetic average. To compute the subscale score, you must first reverse score the bolded items, sum the responses to all items in the subscale and then divide the sum by the number of questions the consumer has answered.

! ***Note:*** *If more than one subscale item is left blank by the consumer, the subscale is no longer valid.*

! ***Note:*** *The Data Entry and Reports Template automatically reverse scores any appropriate items before computing the subscale score. If the agency is not using the Data Entry and Reports Template for data entry, then the methodology used must be able to reverse score appropriate items before the sum is calculated.*

? ***Missing Self-Esteem/Self-Efficacy Items –*** *Does your system know that if more than one Self-Esteem/Self-Efficacy subscale item is left blank by the consumer, the subscale is no longer valid? It should.*

Power/Powerlessness: The second component of Empowerment is measured by the *Power/Powerlessness Subscale.* The questions making up the subscale are: 40, 41, 43, 49, 50, 54, 55, and 56. The Power/Powerlessness subscale score is an arithmetic average. To compute the subscale score, sum the responses to all items in the subscale and then divide the sum by the number of questions the consumer has answered.

! ***Note:*** *If more than one subscale item is left blank by the consumer, the subscale is no longer valid.*

? ***Missing Power/Powerlessness Items –*** *Does your system know that if more than one Power/Powerlessness subscale item is left blank by the consumer, the subscale is no longer valid? It should.*

Community Activism and Autonomy: The third component of Empowerment is measured by the *Community Activism and Autonomy Subscale.* The questions making up the subscale are: **36**, **44**, **53**, **58**, **60**, and **61**. The Community Activism and Autonomy subscale score is an arithmetic average. To compute the subscale score, sum the responses to all items in the subscale and then divide the sum by the number of questions the consumer has answered.

! ***Note:*** *If more than one subscale item is left blank by the consumer, the subscale is no longer valid.*

! ***Note:*** *The Data Entry and Reports Template automatically reverse scores any appropriate items before computing the subscale score. If the agency is not using the Data Entry and Reports Template for data entry, then the methodology used must be able to reverse score appropriate items before the sum is calculated.*

? ***Missing Community Activism and Autonomy Items –*** *Does your system know that if more than one Community Activism and Autonomy subscale item is left blank by the consumer, the subscale is no longer valid? It should.*

Optimism and Control Over the Future: The fourth component of Empowerment is measured by the *Optimism and Control Over the Future Subscale.* The questions making up the subscale are: **34**, **35**, **46**, and **60**. The Optimism and Control Over the Future subscale score is an arithmetic average. To compute the subscale score, you must first reverse score the bolded items, sum the responses to all items in the subscale and then divide the sum by the number of questions the consumer has answered.

! ***Note:*** *If any subscale item is left blank by the consumer, the subscale is no longer valid.*

! ***Note:*** *The Data Entry and Reports Template automatically reverse scores any appropriate items before computing the subscale score. If the agency is not using the Data Entry and Reports Template for data entry, then the methodology used must be able to reverse score appropriate items before the sum is calculated.*

? ***Missing Optimism and Control Over the Future Items –*** *Does your system know that if any Optimism and Control Over the Future subscale item is left blank by the consumer, the subscale is no longer valid? It should.*

Righteous Anger: The fifth component of Empowerment is measured by the *Righteous Anger Subscale.* The questions making up the subscale are: 37, 40, 43, and **48**. The Righteous Anger subscale score is an arithmetic average. To compute the subscale score, you must first reverse score the bolded item, sum the responses to all items in the subscale and then divide the sum by the number of questions the consumer has answered.

! ***Note:*** *If any subscale item is left blank by the consumer, the subscale is no longer valid.*

! ***Note:*** *The Data Entry and Reports Template automatically reverse scores any appropriate items before computing the subscale score. If the agency is not using the Data Entry and Reports Template for data entry, then the methodology used must be able to reverse score appropriate items before the sum is calculated.*

? ***Missing Righteous Anger Items –*** *Does your system know that if any Righteous Anger subscale item is left blank by the consumer, the subscale is no longer valid? It should.*

Overall Empowerment: The sixth component of Empowerment is Overall Empowerment, and is measured by a composite score called the *Overall Empowerment Index*.

The Overall Empowerment score is an arithmetic average. To compute the score, sum the responses to Questions 34 through 61 (incorporating reverse scores, as appropriate) and then divide the sum by the number of questions the consumer has answered.

! ***Note:*** *If more than five Empowerment items are left blank by the consumer, the Overall Empowerment score is no longer valid.*

? ***Missing Overall Empowerment Index Items –*** *Does your system know that if more than five Empowerment items are left blank by the consumer, the Overall Empowerment score is no longer valid? It should.*

? ***Reverse Scoring –*** *Does your system reverse score the following items before computing subscale values?*

- *Self-Esteem/Self-Efficacy: 38, 39, 42, 45, 47, 51, 52, 57, and 59*
- *Community Activism and Autonomy: 36, 44, 53, 58, 60, and 61*
- *Optimism and Control Over the Future: 34, 35, 46, and 60*
- *Righteous Anger: 48*

Analysis and Interpretation

What Do the Scores Tell Me About the Individual Consumer?

Item and subscale scores provide critical perceptions of the responding consumer that, directly or through deduction or inference, can be used as a barometer of the recovery process. The scores indicate the relative strength of these perceptions, but they do NOT indicate the relative importance or priority of these perceptions to the consumer. That is why thorough discussion is required with the consumer before deriving implications or devising recommendations.

Not all consumers are equally ready to participate in discussions about Outcomes and treatment planning. For those consumers who may want or need some training about how to use the Outcomes information, a program exists called “Climbing into the Driver's Seat.” The handbook for this program is available in the training section of the Outcomes Web Site.

What Do the Aggregate Scores Tell Me?

This information represents quantifiable feedback regarding the consumer-perceived quality of the service delivery system. Trends or patterns of negative or marginal perceptions can indicate “disconnects” between consumers and provid-

ers that have implications for training, gaps in services or community resources requiring program planning, advocacy, collaboration or funding. Along with other confirmatory data sources, these trends can assist agencies in development of new programs/services or resource-shifting or elimination of services that are not effective.

How Can Data from the Instrument be Used?

Agency Level

Care management opportunities at the agency level exist 1) within the consumer/direct care provider interface, and 2) at the organizational agency level. The consumer and direct care provider would typically use the responses to individual items, subscale scores, and total scale scores on each instrument. This information could be used to develop and/or revise individual treatment plans, or discuss a specific or immediate concern and strengths of a consumer.

Aggregate data can be used by program managers within an agency to look at program effectiveness or to suggest areas in which more emphasis is needed. If aggregate subscale scores or total scale scores indicate gaps in services or community resources, then the agency could develop new programming, or encourage consumers along with advocacy organizations to develop community resources.

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***Note**: Software is available that takes responses to the Adult Consumer Form from the Data Entry and Reports Template and turns them into a Care Management Report for use by a consumer or direct care provider.*

The following are some suggestions about how data from this instrument can be used:

Quality of Life

- A clinician should closely examine items 1–12 to identify areas in a consumer's life that are particularly problematic or should be the focus of treatment planning (e.g., Meaningful Activity, Family Relationships, and Housing).

Physical Health and Medication Issues

- Items 13 and 14 should be closely monitored to ascertain whether a referral to a physical health care provider is indicated or whether the agency's medical staff needs to address the consumer's concerns about medication.

Symptom Distress

- Identification of specific symptoms with lowest ratings, as well as other areas in the questionnaire having ratings that indicate lesser levels of problems, to identify strengths.
- Comparison of symptoms with highest distress ratings with other areas in the questionnaire having high ratings to explore possible relationships between items for setting goals.
- Comparison of consumer's global symptom distress scores over time.

Making Decisions Empowerment Scale

- Comparison of items with the best empowerment ratings, as well as items in other areas having high ratings to identify strengths.
- Comparison of items with the worst empowerment ratings with items in other areas having low ratings to explore possible relationships between items for setting goals.
- Comparison of the consumer's global empowerment scores over time.
- A major use of the Making Decisions Empowerment Scale for clinicians/direct care providers is to identify areas that they need to work on with the consumer. This can be a single item or pattern of items in the instrument. Once the worker gets all the information that is in the Adult Consumer Form, the worker might be able to spot combinations of items — like a low sense of empowerment coupled with an indication that the person can't get their concerns about medication answered — that would be even more meaningful. For example, it could lead to a plan that would help the consumer in being more assertive with his/her doctor.
- Clinicians and other direct care providers could compare a person's scores over time and pick out the one or two areas where there has been the most improvement. These results could then be shared with the consumer, since it is meaningful for consumers to have feedback about areas in which they are doing well.

The Overall Instrument

- Looking carefully at the whole instrument, even without scoring into subscales, is a very valuable aid for clinicians and other direct care providers. Sometimes, individual questions have more nuance for a treatment plan than would a subscale. This is clearly critical for the Symptom Distress component. This whole section of the instrument sums to just one score, and that will be useful at all three levels of the system. However, clinicians

and other direct care providers would likely be more interested in which symptom areas were causing the most distress.

- The instrument can help clinicians and other direct care providers know where to advocate for the consumer. For example, if consumers are having housing problems, can't get medication questions answered, and/or are having physical health problems, this might point to additional services that are needed. It will also help the clinicians and other direct care providers get a better overall picture of the consumer, and may highlight areas that the provider hadn't thought about as needing attention.

Board Level

Boards can use Outcomes data from the Adult Consumer Form to make a positive impact on services for consumers, both at the individual consumer level and at the aggregate level. Listed below are some examples of how boards could use Outcomes data from this instrument:

- Depending upon the design of future managed care authority, boards may use Outcomes data from the Adult Consumer Form, along with additional data (e.g., Provider Adult Form), for level-of-care authorizations.
- Aggregate Outcomes data from the Adult Consumer Form will help boards identify service gaps for quality improvement (QI) purposes. Once these gaps are identified, boards and service providers can then partner to develop new programs for addressing consumers' unmet needs.
- Another aspect of the QI process is the identification of best practices. Boards can use the aggregate results from the Adult Consumer Form, along with the other Outcomes instruments and other critical sets of information, to help identify what treatment works best for certain groups of consumers. Once best practices are identified, boards can implement these practices system-wide and then determine if the changes made a positive impact on consumer Outcomes.
- From an accountability perspective, aggregate results from the Adult Consumer Form will become part of data that will help boards continuously monitor organizational performance. Boards can help provider organizations identify areas in need of attention, identify exemplary performance, and demonstrate improved performance.

State Level

- Statewide data have enabled the development of an overview of Consumer Outcomes profiles across the state.
- Statewide data have been used to establish Ohio norms for this instrument.
- Statewide data have been used to develop comparative reports for local systems to use in benchmarking their performance on this instrument against the rest of the state.
- Data are being used to monitor agencies through Certification Standards and local systems through the MSPA or a similar mechanism.
- Statewide data have been used for further psychometric testing of this instrument.

Psychometric Properties and Key References

Psychometric information is currently available from other sources for two components of the Adult Consumer Form — the Symptom Distress Scale and the Making Decisions Empowerment Scale.

Although full psychometric information is not yet available on the Symptom Distress Scale, the component SCL-10 has demonstrated adequate internal consistency and discriminant validity with the Beck Depression Inventory (Beck, 1967) and all but two Minnesota Multiphasic Personality Inventory (MMPI; Wiggins, 1966) scales (Brophy, Norvell & Kiluk, 1988).

The Making Decisions Empowerment Scale (Rogers, Chamberlin, Ellison & Crean, 1997) has been shown to have a high degree of internal consistency (alpha = .86, N = 261). The scale has shown some degree of construct validity as scores on the Making Decisions scale have been statistically significantly correlated with quality of life, social support, and self-esteem measures. In tests of known-groups validity (patients hospitalized at a state hospital, persons in self-help programs, and college students), the scale was able to discriminate between the groups of respondents.

Data analysis from the Outcomes Implementation Pilot yielded additional psychometric information from a group of nearly 1,500 individuals who took the Adult Consumer Form. Internal consistency information was generated for the quality of life items, the Symptom Distress Scale and the Making Decisions Empowerment Scale.

Although not initially intended to be used as a composite score of quality of life, the 12 items comprising this domain have good internal consistency (Cronbach's alpha = .86, $\underline{n}$ = 1,442). It has since been determined that the items can be used to compute an Overall Quality of Life composite score.

For the sample in this study, the Symptom Distress Scale demonstrated excellent internal consistency (Cronbach's alpha = .93, n = 1,479). In addition, for this sample, this scale has shown some degree of construct validity as scores have been statistically significantly correlated with concerns about medications, physical condition interfering with day-to-day functioning measures, and quality of life (see Table 1). The correlations with quality of life items, however, although statistically significant are not especially strong, thus the significance of these correlations may be an effect of sample size rather than something substantively meaningful.

The Making Decisions Empowerment Scale (Rogers, Chamberlin, Ellison, & Crean, 1997) exhibited good internal consistency with this sample (Cronbach's alpha = .77, n = 1376). In addition, the scale was statistically significantly correlated with Symptom Distress and Quality of Life, thus indicating construct validity (see Table 1). In other samples, tests of known-groups validity (patients hospitalized at a state hospital, persons in self-help programs, and college students) were supported as the scale was able to discriminate between the groups of respondents (Corrigan, Faber, Rashid, & Leary, 1999; Rogers, Chamberlin, Ellison, & Crean, 1997; Wowra & McCarter, 1999).

Table 1. Correlations of the Symptom Distress Scale and Making Decisions Empowerment Scale with Medication Concerns, Physical Health Interference, and Quality of Life Items
(Based on Data Analysis from the Outcomes Implementation Pilot)

	Symptom Distress Scale	Making Decisions
Symptom Distress Scale		.366** (*1,537)*[28]
Medication Concerns	.364** *(1,518)*	.364** *(1,510)*
Physical Health Interference	.609** *(1,525)*	.256** *(1,517)*
Friendship	.042 *(1,540)*	.483** *(1,535)*
Money	.143** *(1,540*)	.419** *(1,535)*
Money Comfort	.124** *(1,537)*	.459** *(1,532)*
Money Fun	.130** (1,539)	.458** *(1,534)*
Meaningful Activity	.047 *(1,541)*	.507** *(1,536)*
Freedom	.111** *(1,534)*	.487** *(1,529)*
Family Relationships	.067** *(1,522)*	.415** *(1,517)*
Personal Safety	.141** *(1,531)*	.519** *(1,526)*
Neighborhood	.186** *(1,535)*	.451** *(1,530)*
Housing	.172** *(1,536)*	.451** *(1,531)*
Health	.062* *(1,537)*	.523** *(1,532)*
Time with Friends	.215** *(1,535)*	.588** *(1,530)*

* $p \leq .05$

** $p \leq .001$

[28] Number in parentheses indicates *n*.

System Fidelity Checklist

The following checklist includes all system fidelity items identified in the current chapter. Review your procedures for implementing the Ohio Mental Health Consumer Outcomes System in your organization and compare them to the following list. Place a check ☑ next to each item with which you comply.

If your Outcomes System implementation doesn't comply with an item, you should reconsider how you are addressing that issue to ensure that your Outcomes data will be valid, reliable and comparable to other providers in Ohio.

☐ ***Population for the Adult Consumer Form –*** *Do you administer the Adult Consumer Form to all Outcomes-eligible adult consumers?*

☐ ***Administration Intervals for the Adult Consumer Form –*** *Does your system have ways to ensure that the Adult Consumer Form is administered no less frequently than at the appropriate initial point, 6 months, 12 months, annually thereafter, or at termination, whichever comes first?*

☐ ***Skipped Questions –*** *Does your system allow the consumer to skip (i.e., not answer) items on the instrument?*

☐ ***Missing Financial Status Items –*** *Does your system know that if any Financial Status subscale item is left blank by the consumer, the subscale is no longer valid?*

☐ ***Missing Quality of Life Scale Items –*** *Does your system know that if two or more Quality of Life Scale items are left blank by the consumer, the scale is no longer valid?*

☐ ***Reverse Scoring –*** *Does your system reverse score items 13 and 16 before reporting Safety and Health responses?*

☐ ***Missing Symptom Distress Items –*** *Does your system know that if five or more Symptom Distress Scale items are left blank by the consumer, the scale is no longer valid?*

☐ ***Missing Self-Esteem/Self-Efficacy Items –*** *Does your system know that if more than one Self-Esteem/Self-Efficacy subscale item is left blank by the consumer, the subscale is no longer valid?*

☐ ***Missing Power/Powerlessness Items –*** *Does your system know that if more than one Power/Powerlessness subscale item is left blank by the consumer, the subscale is no longer valid?*

☐ ***Missing Community Activism and Autonomy Items –*** *Does your system know that if more than one Community Activism and Autonomy subscale item is left blank by the consumer, the subscale is no longer valid?*

☐ ***Missing Optimism and Control Over the Future Items –*** *Does your system know that if any Optimism and Control Over the Future subscale item is left blank by the consumer, the subscale is no longer valid?*

☐ ***Missing Righteous Anger Items –*** *Does your system know that if any Righteous Anger subscale item is left blank by the consumer, the subscale is no longer valid?*

☐ ***Missing Overall Empowerment Items –*** *Does your system know that if more than five Empowerment items are left blank by the consumer, the Overall Empowerment score is no longer valid?*

☐ ***Reverse Scoring –*** *Does your system reverse score the following items before computing subscale values?*

- *Self-Esteem/Self-Efficacy: 38, 39, 42, 45, 47, 51, 52, 57, and 59*
- *Community Activism and Autonomy: 36, 44, 53, 58, 60, and 61*
- *Optimism and Control Over the Future: 34, 35, 46, and 60*
- *Righteous Anger: 48*

Adult Consumer Form Instrument

The Adult Consumer Form instrument begins on the following page.

The instrument copies in this manual are provided for reference purposes only and should not be used as photocopy or reproduction masters for instruments that will be used for collecting data. Reproduction masters of all Ohio Consumer Outcomes Systems Instruments can be obtained from the Ohio Department of Mental Health Office of Program Evaluation and Research, or downloaded directly from the Ohio Mental Health Consumer Outcomes System Web Site:

www.mh.state.oh.us/oper/outcomes/outcomes.index.html

Ohio Mental Health Consumer Outcomes System
Adult Consumer Form

Today's Date ___ ___ / ___ ___ / ___ ___ ___ ___

Name _____

Date of Birth ___ ___ / ___ ___ / ___ ___ ___ ___

Gender (check one): Male ☐ Female ☐

Agency Use Only

Client's Medical Record Number

_____

We are very interested in how you are doing, and how our services may or may not be helping you. Please answer all of the questions below, then give the questionnaire to your case manager or another staff person at the mental health agency.

Part 1

Below are some questions about how satisfied you are with various aspects of your life in ***the past 6 months***. For each question, checkmark ☑ the answer that best describes how you feel.

How do you feel about:

1. The amount of friendship in your life?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

2. The amount of money you get?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

3. How comfortable and well-off you are financially?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

4. How much money you have to spend for fun?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

5. The amount of meaningful activity in your life (such as work, school, volunteer activity, leisure activity)?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

6. The amount of freedom you have?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

7. The way you and your family act toward each other?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased
- ☐ Does not apply

Please turn to the next page ➔

8. **Your personal safety?**
   - ☐ Terrible
   - ☐ Mostly dissatisfied
   - ☐ Equally satisfied/dissatisfied
   - ☐ Mostly satisfied
   - ☐ Very pleased

9. **The neighborhood in which you live?**
   - ☐ Terrible
   - ☐ Mostly dissatisfied
   - ☐ Equally satisfied/dissatisfied
   - ☐ Mostly satisfied
   - ☐ Very pleased

10. **Your housing/living arrangements?**
   - ☐ Terrible
   - ☐ Mostly dissatisfied
   - ☐ Equally satisfied/dissatisfied
   - ☐ Mostly satisfied
   - ☐ Very pleased

11. **Your health in general?**
   - ☐ Terrible
   - ☐ Mostly dissatisfied
   - ☐ Equally satisfied/dissatisfied
   - ☐ Mostly satisfied
   - ☐ Very pleased

12. **How often do you have the opportunity to spend time with people you really like?**
   - ☐ Never
   - ☐ Seldom/rarely
   - ☐ Sometimes
   - ☐ Often
   - ☐ Always

Part 2

The next few items ask you about your health and medications ***within the past 6 months***.

13. **How often does your physical condition interfere with your day-to-day functioning?**
   - ☐ Never
   - ☐ Seldom/rarely
   - ☐ Sometimes
   - ☐ Often
   - ☐ Always

14. **Concerns about my medications (such as side effects, dosage, type of medication) are addressed:**
   - ☐ Never
   - ☐ Seldom/rarely
   - ☐ Sometimes
   - ☐ Often
   - ☐ Always
   - ☐ Not applicable/no medications

The next two items deal with how you have been treated by other people.

15. **I have been treated with dignity and respect at this agency.**
   - ☐ Never
   - ☐ Seldom/rarely
   - ☐ Sometimes
   - ☐ Often
   - ☐ Always

16. **How often do you feel threatened by people's reactions to your mental health problems?**
   - ☐ Never
   - ☐ Seldom/rarely
   - ☐ Sometimes
   - ☐ Often
   - ☐ Always

Part 3

The following questions ask you about how much you were distressed or bothered by some things ***during the last seven days***. Please mark the answer that best describes how you feel.

During the past 7 days, about how much were you distressed or bothered by:

17. **Nervousness or shakiness inside**
   - ☐ Not at all
   - ☐ A little bit
   - ☐ Some
   - ☐ Quite a bit
   - ☐ Extremely

Please turn to the next page ➔

18. Being suddenly scared for no reason

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

19. Feeling fearful

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

20. Feeling tense or keyed up

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

21. Spells of terror or panic

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

22. Feeling so restless you couldn't sit still

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

23. Heavy feelings in arms or legs

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

24. Feeling afraid to go out of your home alone

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

25. Feeling of worthlessness

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

26. Feeling lonely even when you are with people

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

27. Feeling weak in parts of your body

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

28. Feeling blue

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

29. Feeling lonely

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

30. Feeling no interest in things

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

31. Feeling afraid in open spaces or on the streets

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

Please turn to the next page →

32. How often can you tell when mental or emotional problems are about to occur?

- ☐ Never
- ☐ Seldom/rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

33. When you can tell, how often can you take care of the problems before they become worse?

- ☐ Never
- ☐ Seldom/rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Part 4

Below are several statements relating to one's view about life and having to make decisions. Please check the response that is closest to how you feel about the statement. Check the word or words that best describes how you feel now.

34. I can pretty much determine what will happen in my life.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

35. People are limited only by what they think is possible.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

36. People have more power if they join together as a group.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

37. Getting angry about something never helps.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

38. I have a positive attitude toward myself.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

39. I am usually confident about the decisions I make.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

40. People have no right to get angry just because they don't like something.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

41. Most of the misfortunes in my life were due to bad luck.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

42. I see myself as a capable person.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

43. Making waves never gets you anywhere.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

Please turn to the next page →

44. People working together can have an effect on their community.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

45. I am often able to overcome barriers.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

46. I am generally optimistic about the future.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

47. When I make plans, I am almost certain to make them work.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

48. Getting angry about something is often the first step toward changing it.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

49. Usually I feel alone.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

50. Experts are in the best position to decide what people should do or learn.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

51. I am able to do things as well as most other people.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

52. I generally accomplish what I set out to do.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

53. People should try to live their lives the way they want to.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

54. You can't fight city hall (authority).

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

55. I feel powerless most of the time.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

56. When I am unsure about something, I usually go along with the rest of the group.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

57. I feel I am a person of worth, at least on an equal basis with others.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

Please turn to the next page →

58. People have a right to make their own decisions, even if they are bad ones.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

59. I feel I have a number of good qualities.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

60. Very often a problem can be solved by taking action.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

61. Working with others in my community can help to change things for the better.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

Part 5

Please tell us some things about yourself.

62. What was the last school grade you completed?

- ☐ Less than 1st grade
- ☐ 1st grade
- ☐ 2nd grade
- ☐ 3rd grade
- ☐ 4th grade
- ☐ 5th grade
- ☐ 6th grade
- ☐ 7th grade
- ☐ 8th grade
- ☐ 9th grade
- ☐ 10th grade
- ☐ 11th grade
- ☐ High school diploma/GED
- ☐ Trade/Tech school
- ☐ Some college
- ☐ 2 yr college/Associate degree
- ☐ 4 yr college/Undergraduate degree
- ☐ Graduate school courses
- ☐ Graduate degree
- ☐ Post-graduate studies
- ☐ Further special studies

63. Race (check all that apply):

- ☐ White
- ☐ Native American/Pacific Islander
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Asian
- ☐ Other _____

64. What is your marital status?

- ☐ Never married
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Living together

65. What is your current living situation?

- ☐ Your own house/apartment
- ☐ Friend's home
- ☐ Relative's home
- ☐ Supervised group living
- ☐ Supervised apartment
- ☐ Boarding home
- ☐ Crisis residential
- ☐ Child foster care
- ☐ Adult foster care
- ☐ Intermediate care facility
- ☐ Skilled nursing facility
- ☐ Respite care
- ☐ MR intermediate care facility
- ☐ Licensed MR facility
- ☐ State MR institution
- ☐ State MH institution
- ☐ Hospital
- ☐ Correctional facility
- ☐ Homeless
- ☐ Rest home
- ☐ Other _____

66. What is your employment status?

- ☐ Employed full time
- ☐ Employed part time
- ☐ Sheltered employment
- ☐ Unemployed
- ☐ Student
- ☐ Homemaker
- ☐ Retired
- ☐ Disabled
- ☐ Inmate of institution

67. Are you in treatment because you want to be?

- ☐ Yes
- ☐ No

Please stop here. Thanks!

6
Provider Adult Form

(Release Date: October 15, 2008)

Focus and Intent

The Provider Adult Form gathers the primary worker's observations and clinical judgments about level of social and role functioning, housing status, activities of daily living, criminal justice system involvement, harmful behavior and victimization about adult consumers.

Items are worded to reflect ability level or self-management skills independently of services received.

The reference group for making ratings on this instrument should be all the adult consumers the clinician has ever known, not just the consumers on the current caseload. The clinician's observation of the consumer's behavior, self-reporting of behavior, reports from significant others and clinical judgment should all be used as sources of information on which to base the ratings.

Please note that the ratings are based on the consumer's highest level of functioning during the past six months.

Scales and Items

The Provider Adult Form measures two OTF Domains — Functional Status and Safety and Health.

Part 1: Community Functioning

- **Social Contact:** Question 1 measures a component called Social Contact. Response values represent a range of amount of contact.
- **Social Interaction:** The second component of Community Functioning is Social Interaction. Question 2 is the single item that measures this component. Response values represent a range of judgments about the quality of effectiveness of the consumer's interaction with others.
- **Social Support:** The third component of Community Functioning is Social Support. This component is measured by Question 3. The response values represent a judgment about the effectiveness of the consumer's support network in helping him/her to get needs met.
- **Housing Stability:** The fourth component of Community Functioning is measured by Question 4, labeled Housing Stability, representing Outcome 6.
- **Forced Moves:** The fifth component of Community Functioning is Forced Moves (Question 5) which also relates to Outcome 6.
- **Activities of Daily Living:** The sixth component of Community Functioning is labeled Activities of Daily Living (Questions 6A–6H). There are eight activities that will need to be scored for this component. Questions 6A through 6G represent Outcome 4 of the Functional Status Domain, relating to self-management skills. Question 6H represents Outcome 3 — managing money.
- **Meaningful Activities:** The seventh component of Community Functioning is Meaningful Activities (Questions 7A–7F), representing Outcome 7 of the same name.
- **Primary Role:** The eighth component of Community Functioning is Primary Role (Question 8). This component is also related to Outcome 7. The response format is based on a global judgment of how well the consumer performs in his/her primary role as worker, student, volunteer, parent or homemaker.
- **Addictive Behaviors:** The ninth component of Community Functioning is Addictive Behaviors (Question 9), which measures the effect of addictive or compulsive behaviors on functioning.

- **Criminal Justice:** The tenth component of Community Functioning is Criminal Justice (Question 10), which is related to Outcome 8 — "Abiding by the law sufficiently to avoid incarceration and/or justice system involvement".
- **Aggressive Behavior:** The eleventh component of Community Functioning is Aggressive Behavior (Question 11), which also relates to Outcome 8.

Part 2: Safety and Health

- **Victimization:** Questions 12a through 12e and Questions 12h and 12i deal with the extent to which the consumer has been a victim of various crimes or harassment. Questions 12f and 12g relate to Outcome 1 — "Does not want to or does not harm self," and 12f also relates to Outcome 2 — "Does not want to or does not die from suicide." Together, these items represent Safety and Health Domain Outcome 4 — "Free from physical and psychological harm or neglect... ."

Cautions and Qualifications

In any outcomes system, scores alone are not sufficient for determining treatment needs. Scores must be considered in context with other variables when making treatment decisions or comparisons.

Threats to the Validity of Responses

These are, primarily, known or suspected respondent characteristics or motivations which result in an individual answering in a way that doesn't really convey what he/she believes or feels. The most common are:

- Measurement error – an "inaccurate" response due to the respondent not understanding what is being asked or how to answer (e.g., how to use the response format),
- Faulty memory.
- Social response bias – wanting to be thought of well by answering in a way that is perceived as pleasing to an important other(s),
- Lying – giving deliberately inaccurate responses for shock value, attention-getting or as a way of manipulating others to take or not take some action.
- Confidentiality/privacy – not answering questions or falsifying because the person views the item as an unwarranted intrusion on privacy, or
- Denial/resistance – not wanting to "admit" something to self or others.

Respondent Eligibility and Characteristics

All current and newly admitted Outcomes-eligible adult consumers will have a Provider Adult Form completed on them at the scheduled intervals, even if there is not an Adult Consumer form to accompany the Provider Adult Form.

!

Note: *There are individuals who come to mental health agencies for resolution for short-term emotional problems who typically receive individual/group Behavioral Health Counseling & Therapy either alone or in combination with Pharmacologic Management services. For this group, almost all of the Provider Adult Form content is relevant and it is strongly encouraged that the instrument be administered. However, at this time it is not required in such situations. If you are unsure if the consumer is receiving only Behavioral Health Counseling & Therapy and/or Pharmacologic Management services, you should administer the instrument. After May 2008, the Provider Adult Form will be revised to make it appropriate to the entire adult population.*

!

Note: *Outcomes instruments should be administered wherever Outcomes-qualifying services are delivered regardless of setting, including jails, prisons, hospitals, schools, nursing homes, etc. Outcomes-qualifying mental health services include: Assertive Community Treatment (ACT), Intensive Home Based Treatment (IHBT), Community Psychiatric Supportive Treatment, Behavioral Health Counseling and Therapy, Partial Hospitalization, Pharmacologic Management, Employment and Vocational, Social and Recreational, Occupational Therapy, and Adjunctive Therapy.*

The following groups are exempt from the Outcomes measurement system:

- *Individuals currently in service who are receiving only Mental Health Assessment, Crisis Intervention Mental Health or Forensic Evaluation.*
- *Persons with organic illnesses (persons who do not respond).*
- *Consumers who receive only ODADAS services.*

Population

Adults 18 years of age and older who are eligible to fill out Adult Consumer Form should be rated on the Provider Adult Form.

?

Population for the Provider Adult Form – *Do you complete a Provider Adult Form for all Outcomes-eligible adult consumers, whether or not an Adult Consumer Form is administered? You should.*

Who Completes the Provider Adult Form?

The responsibility for completing the Provider Adult Form for a new consumer lies with the person completing the Mental Health Assessment process. It could be an intake worker, a therapist, a CPST worker, or anyone who is qualified to perform Mental Health Assessment under ODMH rules. For subsequent administrations, the form is completed by the primary worker, who is responsible for the consumer's treatment plan.

For current consumers, the responsibility for completing the Provider Adult Form lies with the primary worker, who is responsible for the consumer's treatment plan.

? ***Who Administers the Provider Adult Form? –*** *Does your system ensure that the Provider Adult Form is completed by the appropriate worker/clinician? It should.*

Minimum Administration Intervals

Individual Outcomes instrument administrations can be useful as "snapshots" of consumer status, but in order to achieve the goals of the Outcomes Initiative (i.e., the management of consumer care, the improvement of the service delivery system, and accountability for public resources), multiple administrations over time are required.

The administration intervals below represent minimum required administration intervals. Other factors (e.g., other funding and regulatory requirements, clinical preference, nature of the consumer-base and its service patterns) may require that individual organizations increase the frequency of administration, but in no case should actual administration intervals be less frequent than those listed below.

If an organization engages in more frequent administrations, those administrations can still be transmitted through boards to the statewide database maintained by ODMH. Those administrations will also be available for subsequent reporting in the Outcomes Data Mart.

Each agency and board should designate a data flow manager to oversee the collection and transmission of Outcomes data. The agency data flow manager is responsible for ensuring that the appropriate person completes the appropriate outcomes instrument at the appropriate time. The guidelines below will assist the data flow manager and other agency staff in making the correct choices.

! ***Note:*** *The agency data flow manager is responsible for ensuring that the appropriate person completes the appropriate outcomes instrument at the appropriate time.*

New Consumers

At a minimum, the Provider Adult Form should be administered at or as close as possible to the following intervals:[29]

[29] It is important to avoid "administration creep" where late administrations can decrease the frequency with which actual administrations occur. In cases where the instruments are administered later than scheduled, follow-up administrations should be anchored to the consumer's originally scheduled initial administration date, even if this means there is a shorter time between some administrations.

- **First Administration:** At admission into one of the target services
- **Second Administration:** At six months after admission
- **Third Administration:** At twelve months after admission
- **Subsequent Administrations:** Annually thereafter
- **At Termination:** Administer at the time of termination if Outcomes-qualifying services have occurred on three or more separate days since previous administration.

The Provider Adult Form should also be administered at all administration times for adult consumers.[30]

Current Consumers

! ***Note:*** *Previously Certified agencies should have already incorporated all of their current consumers into the Outcomes System.*

Any current consumers who are not yet in the Outcomes System should be incorporated immediately and the date of the first administration should be the date used to anchor all subsequent administrations.

At a minimum, the Provider Adult Form should be administered at or as close as possible to the following intervals:[31]

- **First Administration:** Immediately
- **Second Administration:** At six months after the first administration

---

However, agencies have the option of shortening the time interval preceding an annual administration to coincide with some other annually-occurring event and anchor subsequent annual administrations to that event.

[30] There are individuals who come to mental health agencies for resolution for short-term emotional problems who typically receive individual/group Behavioral Health Counseling & Therapy either alone or in combination with Pharmacologic Management services. For this group, almost all of the Provider Adult Form content is relevant and it is strongly encouraged that the instrument be administered. However, at this time it is not required in such situations.

[31] It is important to avoid "administration creep" where late administrations can decrease the frequency with which actual administrations occur. In cases where the instruments are administered later than scheduled, follow-up administrations should be anchored to the consumer's originally scheduled initial administration date, even if this means there is a shorter time between some administrations. However, agencies have the option of shortening the time interval preceding an annual administration to coincide with some other annually-occurring event and anchor subsequent annual administrations to that event.

- **Third Administration:** At twelve months after the first administration
- **Subsequent Administrations:** Annually thereafter
- **At Termination:** Administer at the time of termination if Outcomes-qualifying services have occurred on three or more separate days since previous administration.

The Provider Adult Form must be done at all administration times, regardless of whether the consumer filled out the Adult Consumer Form.[32]

Newly-Certified Agencies

Newly-Certified agencies have a period of 12 months from the date of their application for Certification to have incorporated all of their Outcomes-eligible consumers into the Outcomes System.

The agency can choose to enter consumers into the Outcomes System during this period in any manner that best fits with agency practices. For example, consumers could be started into the process based on previous ISP dates, or date of entry into the agency, by program or other factors. However, the agency should develop a "tickler" method to track when each consumer should receive his/her first Outcomes administration as well as the due dates for subsequent administrations.

At a minimum, the Provider Adult Form should be administered at or as close as possible to the following intervals:[33]

- **First Administration:** Will occur in waves, based upon whatever method the agency adopts
- **Second Administration:** At six months after the first administration
- **Third Administration:** At twelve months after the first administration
- **Subsequent Administrations:** Annually thereafter

---

[32] There are individuals who come to mental health agencies for resolution for short-term emotional problems who typically receive individual/group Behavioral Health Counseling & Therapy either alone or in combination with Pharmacologic Management services. For this group, almost all of the Provider Adult Form content is relevant and it is strongly encouraged that the instrument be administered. However, at this time it is not required in such situations.

[33] It is important to avoid "administration creep" where late administrations can decrease the frequency with which actual administrations occur. In cases where the instruments are administered later than scheduled, follow-up administrations should be anchored to the consumer's originally scheduled initial administration date, even if this means there is a shorter time between some administrations. However, agencies have the option of shortening the time interval preceding an annual administration to coincide with some other annually-occurring event and anchor subsequent annual administrations to that event.

- **At Termination:** Administer at the time of termination if Outcomes-qualifying services have occurred on three or more separate days since previous administration.

The Provider Adult Form must be done at all administration times, regardless of whether the consumer filled out the Adult Consumer Form.[34]

? ***Administration Intervals for the Provider Adult Form –*** *Does your system have ways to ensure that the Provider Adult Form is completed no less frequently than at the appropriate initial point, 6 months, 12 months, annually thereafter, or at termination, whichever comes first? It should.*

Administration Protocol

Administration Time

Pretests done by the Outcomes Task Force, and confirmed by the Pilot, indicated that it takes providers approximately five minutes to complete the Provider Adult Form.

Instructions to Respondent

General Instructions:

- Try to answer all questions.
- Items are worded to reflect the consumer's ability level or self-management skills independent of the services he or she receives.
- The reference group for making ratings on this instrument should be all the seriously mentally ill individuals the clinician has ever known, not the highest-functioning or lowest-functioning consumer, or the consumers on the clinician's current caseload.
- Please note that the ratings are based on the consumer's highest level of functioning during the past six months.

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[34] There are individuals who come to mental health agencies for resolution for short-term emotional problems who typically receive individual/group Behavioral Health Counseling & Therapy either alone or in combination with Pharmacologic Management services. For this group, almost all of the Provider Adult Form content is relevant and it is strongly encouraged that the instrument be administered. However, at this time it is not required in such situations.

Instructions for Specific Items or Scales:

- **Questions 1, 2 and 3:** Patterns of frequent behavior that is illegal, immoral, unacceptable by community standards, aggressive, goal-inappropriate, age-inappropriate, intrusive or ridiculous should be given lower ratings on these items.
- **Question 2:** Some clarification of response choices may prove helpful:

"Very Ineffectively"	*Destructive communication or behavior, violent or abusive interaction.*
"Ineffectively"	*Pattern of avoidant, dependent, demanding or manipulative behavior*
"Mixed or Dubious Effectiveness"	*One-sided interaction patterns, fluctuation between positive and negative communication styles.*

- **Question 3:** Clarifications:

"Very Ineffectively"	*Abuse or neglect.*

- **Questions 6 and 7:** Persons residing in a protective setting may not have the responsibility or opportunity to engage in some of these behaviors. If that is so, please use the "Unsure or not applicable" response choice. If hospital, residential or correctional staff expect the person to engage in these behaviors, however, then the numeric response choices are appropriate. An example would be a residential treatment facility resident who is expected to complete certain cleaning chores. This person should be rated using the 1 through 5 response choices on Question 6.G. ("Housekeeping").
- **Question 7A:** A consumer who is retired or has a disability that precludes him or her from working should be rated using the "Unsure or not applicable" response choice.
- **Question 7D:** A person who is a parent but does not have custody of the child or children (i.e., is not the primary caregiver) should be rated using the "Unsure or not applicable" response choice.
- **Question 8:** Homeless or "street people" represent a special consideration. Rate such a person on their overall ability to get their essential needs met.

Data Sources/Connection with Service/Treatment Planning

The clinician's observation of the consumer's behavior, self-reporting of behavior, reports from significant others and timely behavioral assessments and other available evaluation and Outcomes reports should all be used as sources of information on which to base your ratings.

What to Do if You Are Unsure About the Meaning of a Question

DO NOT ASSUME you understand what is being asked, or what the various response choices are if you are unsure. You may not interpret in the same way as another respondent would, and this will create measurement error. Please talk with your agency data flow manager or contact your designated trainer for the Outcomes System.

Who Is Responsible for Collecting Data from Providers?

The agency data flow manager is responsible for ensuring that the Provider Adult Form instrument gets completed by applicable providers at the correct data collection interval.

How Will Data Be Collected and Entered?

Data can be collected by any combination of paper and pencil, scanner or electronic input. The decision regarding which method(s) to use will be made at the agency level based on resources.[35]

In order to ensure the consistency and accuracy of Outcomes information, each agency should develop a process to allow the entry and transmission of Outcomes information in a prescribed format.[36]

The Ohio Mental Health Consumer Outcomes System has developed a Data Entry and Reports Template that can be used to enter Outcomes information into a local PC within each participating agency.[37]

Scoring

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Note: *Outcomes are measured by single items/questions or by a composite score (consisting of two or more items/questions combined to create a subscale). In all cases where an Outcome is represented by the average of the ratings of two or more responses, the reader should keep in mind that items that are left blank (not answered) or are answered "Unsure" should not be counted when averaging.*

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[35] See Chapter 9 (Processing Outcomes Data) for a more complete discussion of the transfer of information from the consumer through agencies and boards to the state and back again.

[36] Complete data specifications can be accessed at:

www.mh.state.oh.us/oper/outcomes/data.flow.specs.html

[37] See Chapter 4 (Users and Uses of Consumer Outcomes Data) for a more complete discussion of the Data Entry and Reports Template.

The Provider Adult Form measures two OTF Domains — Functional Status and Safety and Health.

Part 1: Community Functioning

Social Contact: Question 1 measures a component called Social Contact. Response values represent a range of amount of contact. The intervals range from 1–4, with:

- 1 = Withdrawn/Isolated
- 2 = Minimal Contact
- 3 = Moderate Contact
- 4 = Optimal Contact
- Unsure

A single value should be entered as the score for this component.

Social Interaction: The second component of Community Functioning is Social Interaction. Question 2 is the single item that measures this component. Response values represent a range of judgments about the quality or effectiveness of the consumer's interaction with others. The Likert-type response intervals range from 1–5, with:

- 1 = Very Ineffectively
- 2 = Ineffectively
- 3 = Mixed or Dubious Effectiveness
- 4 = Effectively
- 5 = Very Effectively
- Unsure

A single value should be entered as the score for this component.

Social Support: The third component of Community Functioning is Social Support. This component is measured by Question 3. The response values represent a judgment about the effectiveness of the consumer's support network in helping him/her to get needs met. The Likert-type response intervals range from 1–5, with:

- 1 = Very Ineffective
- 2 = Ineffective
- 3 = Mixed or Dubious Effectiveness
- 4 = Effective
- 5 = Very Effective
- Unsure

A single value should be entered as the score for this component.

Housing Stability: The fourth component of Community Functioning is measured by Question 4, labeled Housing Stability, representing Outcome 6. The response values for this component represent frequency of moving with assigned values of 1–5, with:

- 1 = Moved Very Frequently
- 2 = Moved Often
- 3 = Moved a Few Times
- 4 = Moved Once
- 5 = Did Not Move
- Unsure

A single value should be entered as the score for this component.

Forced Moves: The fifth component of Community Functioning is Forced Moves (Question 5) which also relates to Outcome 6. The response format is dichotomous, with:

- 1 = Yes
- 2 = No
- Unsure

A single value should be entered as the score for this component.

Activities of Daily Living: The sixth component of Community Functioning is labeled Activities of Daily Living (Questions 6A–6H). There are eight activities that need to be scored for this component. Questions 6A through 6G represent Outcome 4 of the Functional Status Domain, relating to self-management skills. Question 6H represents Outcome 3 — managing money. The response format is categories of accomplishment with interval values assigned to each as:

- 1 = Task is Not Completed
- 2 = Someone Other than Consumer Completes the Task
- 3 = Consumer Needs Extensive Supervision or Assistance
- 4 = Consumer Needs Some Supervision
- 5 = Consumer Acts Independently
- Unsure or Not Applicable

The Activities of Daily Living subscale score is an arithmetic average. To compute the subscale score, sum the responses to questions 6A through 6H that have values of 1, 2, 3, 4 or 5 and divide the sum by the number of questions the provider has answered. “Unsure” or “Not Applicable” responses are not used in scoring.

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Note: *If one item is missing or marked “Unsure,” the subscale score should be calculated based on the remaining seven items. If more than one item is missing or marked “Unsure,” the subscale should not be calculated.*

? ***Unknown Activities of Daily Living Items –*** *Does your system know that if one Activities of Daily Living subscale item is marked "Unsure" (and no others are left blank), the subscale should be calculated based on the remaining seven items? It should.*

? ***Missing or Unknown Activities of Daily Living Items –*** *Does your system know that if more than one Activities of Daily Living subscale item is marked "Unsure" or left blank, the subscale is no longer valid? It should.*

Meaningful Activities: The seventh component of Community Functioning is Meaningful Activities (Questions 7A–7F), representing Outcome 7 of the same name. The response format is interval, with values representing how often (frequency) various activities are performed. The range is from 1–5, with:

- 1 = Almost Never (<1x/Mo)
- 2 = Seldom (<1x/Week)
- 3 = Sometimes (1-2x/Week)
- 4 = Often (3-4x/Week)
- 5 = Almost Always (≥5x/Week)
- Unsure or Not Applicable

The Meaningful Activities subscale score is an arithmetic average. To compute the score, sum the responses to questions 7A through 7F that have values of 1, 2, 3, 4 or 5 and divide the sum by the number of questions the provider has answered.

Primary Role: The eighth component of Community Functioning is Primary Role (Question 8). This component is also related to Outcome 7. The response format is based on a global judgment of how well the consumer performs in his/her primary role as worker, student, volunteer, parent or homemaker. Response values range from 1–5, with:

- 1 = Extremely Poorly
- 2 = Poorly
- 3 = Satisfactorily
- 4 = Well
- 5 = Extremely Well
- Unsure

A single value should be entered as the score for this component.

Addictive Behaviors: The ninth component of Community Functioning is Addictive Behaviors (Question 9), which measures the effect of addictive or compulsive behaviors on functioning. The response format is a frequency interval. Values range from 1–5, with:

- 1 = Almost Always (≥5x/Week)
- 2 = Often (3-4x/Week)
- 3 = Sometimes (1-2x/Week)
- 4 = Seldom (<1x/Week)
- 5 = Almost Never (<1x/Mo)
- Unsure

A single response should be entered for this component.

Criminal Justice: The tenth component of Community Functioning is Criminal Justice (Question 10), which is related to Outcome 8 — "Abiding by the law sufficiently to avoid incarceration and/or justice system involvement". The response format is dichotomous, with:

- 1 = No
- 2 = Yes
- Unsure

A single value should be entered as the score for this component.

Aggressive Behavior: The eleventh component of Community Functioning is Aggressive Behavior (Question 11), which also relates to Outcome 8. The response format is dichotomous, with:

- 1 = Yes
- 2 = No
- Unsure

A single value should be entered as the score for this component.

Community Functioning Score

The first 11 items from the Provider Adult Form can be combined to compute the Community Functioning score for the consumer. The process has several steps, as follows:

- **Step 1. Recode "Unsure" and "Not Applicable" Responses:** All items marked either "Unsure" or "Not Applicable" should be recoded to "Missing."
- **Step 2. Recode Responses to Certain Question:** Because of the different nature of the various questions, some "standardization" is required before the responses can be combined into a single Community Functioning score.

  Item 1 (Social Contact) should be recoded as follows:

- 1 = Withdrawn/Isolated
- 2 = Minimal Contact
- 3 = Moderate Contact
- 5 = Optimal Contact

Items 5 (Forced Moves), and 11 (Aggressive Behavior) should be recoded as follows:

- 1 = Yes
- 5 = No

Item 10 (Criminal Justice) should be recoded as follows:

- 5 = Yes
- 1 = No

- **Step 3. Compute the Overall Activities of Daily Living Subscale Score:** The Activities of Daily Living subscale score is an arithmetic average. To compute the subscale score, sum the responses to questions 6A through 6H that have values of 1, 2, 3, 4 or 5 and divide the sum by the number of questions the provider has answered.

! ***Note:*** *If one item is missing or marked "Unsure," the subscale score should be calculated based on the remaining seven items. If more than one item is missing or marked "Unsure," the subscale should not be calculated.*

- **Step 4. Compute the Meaningful Activities Subscale Score:** The Meaningful Activities subscale score is an arithmetic average. To compute the score, sum the responses to questions 7A through 7F that have values of 1, 2, 3, 4 or 5 and divide the sum by the number of questions the provider has answered.

! ***Note:*** *The Meaningful Activities composite score can be computed with up to five missing items.*

- **Step 5. Compute the Community Functioning Score:** The Community Functioning score is a total. To compute the score, sum the responses to the following:

Community Functioning **=** Question 1 (Recoded) **+**
Question 2 **+**
Question 3 **+**
Question 4 **+**
Question 5 (Recoded) **+**
Overall Activities of Daily Living Subscale **+**
Meaningful Activities Composite Score **+**
Question 8 **+**
Question 9 **+**

Question 10 (Recoded) **+**
Question 11 (Recoded)

! ***Note:*** *If three or fewer items are missing, the individual's mean score on all the other items should be substituted for each missing item before the total score is calculated. If four or more items are missing, the total score should not be calculated.*

Part 2: Safety and Health

Victimization: Questions 12a through 12e and Questions 12h and 12i deal with the extent to which the consumer has been a victim of various crimes or harassment. Questions 12f and 12g relate to Outcome 1 — "Does not want to or does not harm self," and 12f also relates to Outcome 2 — "Does not want to or does not die from suicide." Together, these items represent Safety and Health Domain Outcome 4 — "Free from physical and psychological harm or neglect... ." The values for each of the nine questions range from 1–2, with:

- 1 = Yes
- 2 = No
- Unsure

Analysis and Interpretation

What Do the Scores Tell Me About the Individual Consumer?

Item and subscale scores represent the provider's critical clinical evaluative judgments primarily about the level of functioning of the consumer that, directly or through deduction or inference, can be used as a barometer of the recovery process. The scores indicate the relative strength of these perceptions, but they do NOT indicate the relative importance or priority of these perceptions to the provider or the consumer. That is why thorough discussion is required with the consumer before deriving implications or devising recommendations.

What Do the Aggregate Scores Tell Me?

Trends or patterns of low or marginal ratings can indicate "disconnects" between consumers and providers that have implications for training, gaps in services or community resources requiring program planning, advocacy, collaboration or funding. Along with other confirmatory data sources, the trends can assist agencies in

development of new programs/services or resource-shifting or elimination of services that are not effective.

How Can Data from the Instrument be Used?

Agency Level

Care management opportunities at the agency level exist 1) within the consumer/direct care provider interface, and 2) at the agency organizational level. The consumer and direct care provider would typically use the responses to individual items, subscale scores, and total scale scores on each instrument. This information could be used to develop and/or revise individual treatment plans, or to discuss a specific or immediate concern or strengths of a consumer.

Aggregate data can be used by program managers within an agency to look at program effectiveness or to suggest areas in which more emphasis is needed. If aggregate subscale scores or total scores indicate gaps in services or community resources, then the agency could develop new programming, or encourage consumers along with advocacy organizations to develop community resources.

Examples of how data from this instrument might be used are:

- Low individual functioning scores may indicate specific treatment needs. Some items may indicate more immediate needs in areas related to health and safety (e.g., housing stability, recent victimization, suicide attempt, or attempt to harm someone else).
- Particularly low scores on some questions (e.g., Question 3 regarding the consumer's social support network), will indicate that more information should be sought from the consumer, and that work needs to take place to develop more adequate resources to support the consumer in improving his/her functioning.
- Data may be able to be used by provider agencies for making level-of-care assignments.
- Aggregate data may indicate needed new areas for program expansion (e.g., housing initiatives).
- On both the individual and aggregate levels, scores from the first and the second administrations of the instrument should be compared to illuminate improvement or decreases in functioning.

Board Level

Boards can use Outcomes data from the Provider Adult Form to make a positive impact in services for consumers, both at the individual consumer level and at the aggregate level. Listed below are some examples of how boards could use Outcomes data from this instrument:

- Depending upon the design of future managed care authority, boards may use Outcomes data from the Provider Adult Form, along with additional data, for level-of-care authorizations.
- Aggregate Outcomes data from Provider Adult Form will help boards identify service gaps for quality improvement (QI) purposes. Once these gaps are identified, boards and service providers can then partner to develop new programs for addressing consumers' unmet needs.
- Another aspect of the QI process is the identification of best practices. Boards can use the aggregate results from the Provider Adult Form, along with the results from the Adult Consumer Form and other critical sets of information, to help identify what treatment works best for certain groups of consumers. Once best practices are identified, boards can implement these practices system-wide and then determine if the changes made a positive impact on consumer Outcomes.
- From an accountability perspective, aggregate results from the Provider Adult Form will help boards maintain performance data that will be used to continuously monitor organizational performance. Boards can help provider organizations identify areas in need of attention, identify exemplary performance, and demonstrate improved performance.

State Level

- Statewide data have enabled the development of an overview of Consumer Outcomes profiles across the state.
- Statewide data have been used to establish Ohio norms for this instrument.
- Statewide data have been used to develop comparative reports for local systems to use in benchmarking their performance on this instrument against the rest of the state.
- Data are being used to monitor agencies through Certification Standards and local systems through the MSPA or a similar mechanism.
- Statewide data have been used for further psychometric testing of this instrument.

Psychometric Properties

Because the Provider Adult Form has been adapted from other functioning instruments, all of the psychometric properties of this instrument are not known.

A reliability analysis for the Community Functioning Scale performed on initial Outcomes records in the statewide database as of July 6, 2004 exhibited acceptable internal consistency (Cronbach's alpha = .72, n = 23,540). This should not be considered to be a reliability measure for the entire Provider Adult Form, as the Community Functioning Scale does not contain every item on the instrument (i.e., no victimization items are included in the scale). It is anticipated that more studies will be done on the instrument after the Outcomes System is in full production.

System Fidelity Checklist

The following checklist includes all system fidelity items identified in the current chapter. Review your procedures for implementing the Ohio Mental Health Consumer Outcomes System in your organization and compare them to the following list. Place a check ☑ next to each item with which you comply.

If your Outcomes System implementation doesn't comply with an item, you should reconsider how you are addressing that issue to ensure that your Outcomes data will be valid, reliable and comparable to other providers in Ohio.

☐ ***Population for the Provider Adult Form –*** *Do you complete a Provider Adult Form for all Outcomes-eligible adult consumers, whether or not an Adult Consumer Form is administered?*

☐ ***Who Administers the Provider Adult Form? –*** *Does your system ensure that the Provider Adult Form is completed by the appropriate worker/clinician?*

☐ ***Administration Intervals for the Provider Adult Form –*** *Does your system have ways to ensure that the Provider Adult Form is completed no less frequently than at the appropriate initial point, 6 months, 12 months, annually thereafter, or at termination, whichever comes first?*

☐ ***Unknown Activities of Daily Living Items –*** *Does your system know that if one Activities of Daily Living subscale item is marked "Unsure" (and no others are left blank), the subscale should be calculated based on the remaining seven items?*

☐ ***Missing or Unknown Activities of Daily Living Items –*** *Does your system know that if more than one Activities of Daily Living subscale item is marked "Unsure" or left blank, the subscale is no longer valid?*

Provider Adult Form Instrument

The Provider Adult Form instrument begins on the following page.

The instrument copies in this manual are provided for reference purposes only and should not be used as photocopy or reproduction masters for instruments that will be used for collecting data. Reproduction masters of all Ohio Consumer Outcomes Systems Instruments can be obtained from the Ohio Department of Mental Health Office of Program Evaluation and Research, or downloaded directly from the Ohio Mental Health Consumer Outcomes System Web Site:

www.mh.state.oh.us/oper/outcomes/outcomes.index.html

Ohio Mental Health Consumer Outcomes System Provider Adult Form

Today's Date ___ ___ / ___ ___ / ___ ___ ___ ___	Consumer's Medical Record Number
Consumer's Name _____	_____

Please circle the appropriate response for each statement that corresponds with the consumer's highest level of functioning ***in the past 6 months***.

1. **Does the consumer initiate non-professional social contact or respond to others' initiation of social contact?**

Withdrawn/ Isolated	Minimal Contact	Moderate Contact	Optimal Contact	Unsure

2. **How effectively does this consumer interact with others? NOTE: "Effectively" refers to how successfully and appropriately the consumer behaves in social settings (i.e., how well she/he minimizes interpersonal friction, meets personal needs, achieves personal goals in a socially appropriate manner).**

Very Ineffectively	Ineffectively	Mixed or Dubious Effectiveness	Effectively	Very Effectively	Unsure

3. **How effective is the consumer's social support network in helping the consumer meet his/her needs? NOTE: A support network may consist of interested family, friends, acquaintances, co-workers, peers, social clubs, etc.**

Very Ineffective	Ineffective	Mixed or Dubious Effectiveness	Effective	Very Effective	Unsure

4. **Please rate the consumer's housing stability**

Moved Very Frequently	Moved Often	Moved a Few Times	Moved Once	Did Not Move	Unsure

5. **Has the consumer been forced/compelled to move from his/her living arrangements?**

Yes	No	Unsure

Please turn to the next page ➔

6. How well does the consumer perform independently in the following day-to-day living activities?

	Task is not completed	Someone other than the consumer completes task	Consumer needs extensive supervision or assistance	Consumer needs some supervision or assistance	Consumer acts independently	Unsure or not applicable
A. Personal Hygiene	1	2	3	4	5	?
B. Dressing Appropriately	1	2	3	4	5	?
C. Obtaining Regular Nutrition	1	2	3	4	5	?
D. Using Public Transportation	1	2	3	4	5	?
E. Shopping	1	2	3	4	5	?
F. Doing Laundry	1	2	3	4	5	?
G. Housekeeping	1	2	3	4	5	?
H. Managing Money	1	2	3	4	5	?

7. To what extent has the consumer engaged in the following meaningful activities?

	Almost Never (<1x/month)	Seldom (<1x/week)	Sometimes (1-2x/week)	Often (3-4x/week)	Almost Always (≥5x/week)	Unsure or not applicable
A. Work	1	2	3	4	5	?
B. School	1	2	3	4	5	?
C. Volunteer Activity	1	2	3	4	5	?
D. Parenting	1	2	3	4	5	?
E. Homemaking	1	2	3	4	5	?
F. Leisure Activity	1	2	3	4	5	?

8. Of the roles listed above, in general how well is the consumer performing in his/her primary role?

Extremely Poorly | Poorly | Satisfactorily | Well | Extremely Well | Unsure

9. How frequently is the consumer's functioning compromised by addictive or compulsive behaviors (e.g., alcohol abuse, drug abuse, gambling)?

Almost Always (≥5x/week) | Often (3-4x/week) | Sometimes (1-2x/week) | Seldom (<1x/week) | Almost Never (<1x/month) | Unsure

Please turn to the next page →

10. Has the consumer abided by the law sufficiently to avoid incarceration and/or the criminal justice system?

No Yes Unsure

11. Has the consumer attempted to or actually physically harmed someone?

Yes No Unsure

12. Has the consumer been a victim of:

A. Rape	Yes _____	No _____	Unsure _____
B. Assault	Yes _____	No _____	Unsure _____
C. Threats	Yes _____	No _____	Unsure _____
D. Exploitation	Yes _____	No _____	Unsure _____
E. Harassment	Yes _____	No _____	Unsure _____
F. Suicide Attempt	Yes _____	No _____	Unsure _____
G. Other Types of Harm to Self	Yes _____	No _____	Unsure _____
H. Hate Crimes	Yes _____	No _____	Unsure _____
I. Theft, Robbery, Vandalism	Yes _____	No _____	Unsure _____

Please stop here. Thanks!

7

Ohio Youth Problem, Functioning, and Satisfaction Scales – Short Form (Ohio Scales)

(Release Date: October 15, 2008)

Focus and Intent

The Ohio Youth Problem, Functioning, and Satisfaction Scales – Short Form (Ohio Scales) are designed to assess behavioral problems and level of functioning of youth, hopefulness, and satisfaction with services.

There are three parallel forms of the Ohio Scales completed by the youth's parent or primary caretaker (P-form), the youth (Y-form), and the youth's agency worker (W-form). This allows assessment of the consumer's strengths and weaknesses from multiple perspectives. The Youth (Y) form is designed for youth ages 12–18. The parent and agency worker versions are designed for youth ages 5–18. For children under the age of 5, the Ohio Scales Agency Worker (W) and Parent (P) forms are optional, based on the agency's judgment regarding their usefulness.

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Note: *For agencies that wish to use the Child & Adolescent Functioning Assessment Scale (CAFAS), the CAFAS may be substituted for the Agency Worker (W) form of the Ohio Scales. If this option is selected, the Parent (P) form and Youth (Y) form (if age 12–18) of the Ohio Scales must still be collected. If the child is under the age of 5, agencies may choose to use the PECFAS instrument. In these cases, the Ohio Scales Parent (P) form is not required. CAFAS and PECFAS data submitted to ODMH will not be included in statewide reports or the Outcomes Data Mart.*

Scales and Items

After considering a large number of potential content areas, four primary areas or domains of assessment were selected:

- Problem Severity
- Functioning
- Hopefulness
- Satisfaction with Behavioral Health Services

The parent, youth, and agency worker rate the Problem Severity and Functioning Scales. The youth and parent rate the Satisfaction Scales. Youth rate their own Hopefulness about life or overall well-being. Parents (or primary caretakers) rate their Hopefulness about caring for the identified child. In addition, the Restrictiveness of Living Environments Scale (ROLES; Hawkins, Almeida, Fabry, & Reitz, 1992) is included on the agency worker form along with data regarding several key indicators that are not used when scoring the form.

Item Descriptions

The Problem Severity Scale is comprised of 20 items covering common problems reported by youth who receive behavioral health services. Each item is rated for severity/frequency on a six-point scale. A total score is calculated by summing the ratings for all 20 items.

The Functioning Scale is comprised of 20 items designed to rate the youth's level of functioning in a variety of areas of daily activity (e.g., interpersonal relationships, recreation, self-direction and motivation). Each item is rated on a five-point scale. Although the Problem Severity Scale is similar to many other existing symptom rating scales that focus on the severity of behavioral problems, the Functioning Scale provides a broader range of ratings. This provides an opportunity for raters to identify areas of functional strength. A total functioning score is calculated by summing the ratings for all 20 items. Higher scores are indicative of better functioning.

In addition to the Problem Severity and Functioning Scales, two brief (four-item) scales on the parent and youth forms assess satisfaction and hopefulness. Four items assess satisfaction with and inclusion in behavioral health services on a six-point scale. The total satisfaction score is calculated by summing the four items.

Four additional items on the parent and youth forms tap levels of hopefulness and well-being either about parenting or self/future respectively. Each of these is also rated on a six-point scale. The total hopefulness score is calculated by summing the four items.

Finally, the agency worker version of the Ohio Scales includes the Restrictiveness of Living Environments Scale (ROLES). Information regarding the initial development of the ROLES can be obtained by reviewing the original article written by Hawkins et al. (1992). The ROLES assesses the level of restrictiveness for the youth's placements during the past 90 days. A higher score means on average the youth is placed in a more restrictive setting.

Ohio Scales Instruments and Scales

The Ohio Scales consist of three forms, each one page double-sided.

The parent, youth, and agency worker all complete the Problem Severity and Functioning Scales. The parent and youth complete the Hopefulness and Satisfaction Scales. In addition, the Restrictiveness of Living Environments Scale (ROLES) is included on the agency worker form, along with data on several key indicators such as school placement that are not used when scoring the form.

Parent Form (P) – Completed by Parent or Caregiver

- Problem Severity (20 items; 6 point scale)
- Hopefulness (4 items; 6 point scale)
- Satisfaction (4 items; 6 point scale)
- Functioning (20 items; 5 point scale)

Youth Form (Y) – Completed by the Youth if Age 12–18

- Problem Severity (20 items; 6 point scale)
- Hopefulness (4 items; 6 point scale)
- Satisfaction (4 items; 6 point scale)
- Functioning (20 items; 5 point scale)

Agency Worker Form (W) – Completed by Agency Worker (Provider)

- Problem Severity (20 items; 6 point scale)
- Functioning (20 items; 5 point scale)
- Restrictiveness of Living Environment Scale (ROLES)

Cautions and Qualifications

In any outcomes system, scores alone are not sufficient for determining treatment needs. Scores must be considered in context with the following other variables when making treatment decisions or comparisons:

Threats to the Validity of Responses

These are, primarily, known or suspected respondent characteristics or motivations which result in the person answering in a way that doesn't really convey what he/she believes or feels. The most common are:

- Measurement error – an "inaccurate" response due to the respondent not understanding what is being asked or how to answer (how to use the response format).
- Faulty memory.
- Social response bias – wanting to be thought of well by answering in a way that is perceived as pleasing to an important other(s).
- Lying – giving deliberately inaccurate responses for shock value, attention-getting or as a way of manipulating others to take or not take some action.
- Confidentiality/privacy – not answering questions or falsifying because the person views the item as an unwarranted intrusion on privacy.
- Denial/resistance – not wanting to "admit" something to self or others.

Other Factors to Consider

- Whether the person perceives his/her treatment as voluntary or involuntary.
- Whether the person demonstrates behaviors which put him/her or others at risk, and the degree of judged risk. Included here are critical incidents, sentinel events that may strongly influence responses.
- The person's satisfaction with various aspects of treatment/services may influence responses to outcome questions.
- The person's awareness of his/her problems and willingness to work on them.
- The tenure, intensity and type of services the person has received.
- The resources available in the family and community for managing the person's behaviors and meeting his/her needs.

- The ability of the various providers to collaboratively work in a model aimed at providing the most appropriate, medically necessary interventions in the right amount at the right time.
- Economic incentives/disincentives that affect the person's functional and treatment status and quality of life.
- Whether there exists a treatment guideline/protocol or set of best practices to guide treatment toward better outcomes, and the willingness of providers and the person served to use it.

Respondent Eligibility and Characteristics

- Parents or caregivers of child/youth age 5–18[38]
- Youth if age 12–18[39]
- Agency Worker (provider) for child/youth age 5–18

Exception: In order to rate the Problem Severity and Functioning Scales, the parent or caregiver must be knowledgeable about the child's recent behavior in the home, school, and community. Hence, caregivers of children in short-term foster homes or other short-term placements, who may not have sufficient information, are exempt.

Note: *Outcomes instruments should be administered wherever Outcomes-qualifying services are delivered regardless of setting, including jails, prisons, hospitals, schools, nursing homes, etc. Outcomes-qualifying mental health services include: Assertive Community Treatment (ACT), Intensive Home Based Treatment (IHBT), Community Psychiatric Supportive Treatment, Behavioral Health Counseling and Therapy, Partial Hospitalization, Pharmacologic Management, Employment and Vocational, Social and Recreational, Occupational Therapy, and Adjunctive Therapy.*

The following groups are exempt from the Outcomes measurement system:

- *Individuals currently in service who are receiving only Mental Health Assessment, Crisis Intervention Mental Health or Forensic Evaluation.*
- *Persons with organic illnesses (persons who do not respond).*
- *Consumers who receive only ODADAS services.*

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[38] A caregiver in this context is one who stands in the place of a parent — this could be another relative or a foster-parent. It is different from treatment staff who are in a venue such as a full-time residential treatment setting. In that case, if the parent is not involved or knowledgeable, no Parent Form should be completed, and the staff should fill out the Worker Form.

[39] Subsequent research has shown that the Problem Severity Scale of the Youth (Y) form is reliable and valid for youth as young as age 9 (the remainder of the instrument has not yet been evaluated with younger populations). While such results are only partial, organizations can optionally use the Youth (Y) form with youth as young as age 9 if it is considered clinically warranted.

! ***Note:*** *If a problem exists with the consumer taking the survey, (e.g., refuses, is too ill) then the following pathway guides the administration of the survey:*

- *Maintain the principle with all consumers of do no harm.*
- *Use clinical judgment to determine the appropriateness of giving the survey to a particular consumer.*[40]
- *Community forensic consumers are included in the Outcomes System, unless the only service they have received is Forensic Evaluation.*

Population

The Parent (P) and Agency Worker (W) forms are to be completed for all children age 5–18. The Youth (Y) form is to be completed by all youth age 12–18.

? ***Population for the Ohio Scales –*** *Are Parent (P) and Agency Worker (W) forms completed for all child and adolescent consumers age 5–18? They should be.*

? ***Population for the Ohio Scales –*** *Does your system ensure that the Youth (Y) form is completed by all child and adolescent consumers age 12–18? It should.*

? ***Who Administers Ohio Scales? –*** *Does your system ensure that the Parent (P) form is completed by the child or adolescent's parent or caregiver, that the Agency Worker (W) form is completed by the primary worker, and that the Youth (Y) form is completed by the child or adolescent age 12–18? It should.*

Special Populations

Problems that arise in the administration of the instruments due to lack of understanding of the items on the scales because of language differences or other situations should be noted, and may be a reason for exemption.[41]

While in most cases, it is desirable to have both the Parent (P) form and the Agency Worker (W) completed (and the Youth (Y) form if age 12–18), each form stands alone and should be completed even if the other form(s) are not completed.

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[40] See Chapter 3 (Outcomes Instruments and Administration Guidelines) for helpful hints on ways to present the instrument to the consumer.

[41] Selected Ohio Scales are also available in Chinese, Japanese, Korean, Spanish-Mexican, Spanish-Puerto Rican, and Russian.

Minimum Administration Intervals

Individual Outcomes instrument administrations can be useful as "snapshots" of consumer status, but in order to achieve the goals of the Outcomes Initiative (i.e., the management of consumer care, the improvement of the service delivery system, and accountability for public resources), multiple administrations over time are required.

The administration intervals below represent minimum required administration intervals. Other factors (e.g., other funding and regulatory requirements, clinical preference, nature of the consumer-base and its service patterns) may require that individual organizations increase the frequency of administration, but in no case should actual administration intervals be less frequent than those listed below.

If an organization engages in more frequent administrations, those administrations can still be transmitted through boards to the statewide database maintained by ODMH. Those administrations will also be available for subsequent reporting in the Outcomes Data Mart.

Each agency and board should designate a data flow manager to oversee the collection and transmission of Outcomes data. The agency data flow manager is responsible for ensuring that the appropriate person completes the appropriate Outcomes instrument at the appropriate time. The guidelines below will assist the data flow manager and other agency staff in making the correct choices.

Note: *The agency data flow manager is responsible for ensuring that the appropriate person completes the appropriate outcomes instrument at the appropriate time.*

New Consumers

At a minimum, the Ohio Scales should be administered at or as close as possible to the following intervals:[42]

- **First Administration:** At admission into one of the target services
- **Second Administration:** At three months after admission
- **Third Administration:** At six months after admission
- **Fourth Administration:** At twelve months after admission

[42] It is important to avoid "administration creep" where late administrations can decrease the frequency with which actual administrations occur. In cases where the instruments are administered later than scheduled, follow-up administrations should be anchored to the consumer's originally scheduled initial administration date, even if this means there is a shorter time between some administrations. However, agencies have the option of shortening the time interval preceding an annual administration to coincide with some other annually-occurring event and anchor subsequent annual administrations to that event.

- **Subsequent Administrations:** Annually thereafter
- **At Termination:** Administer at the time of termination if Outcomes-qualifying services have occurred on three or more separate days since previous administration.

! ***Note:*** *In order to track consumer change that occurs rapidly, some organizations may wish to administer the Outcomes instruments more frequently than the schedule outlined above. The Outcomes System will also accept administrations at intervals of 30, 60 and 90 days. The decision to administer the instruments more frequently for clinical purposes than the ODMH requirement is left to local systems.*

! ***Note:*** *For all youth over the age of 5, a Parent and a Worker instrument should be completed at each administration interval. Children age 12 and above are expected to complete the Youth instrument.*

Current Consumers

! ***Note:*** *Previously Certified agencies should have already incorporated all of their current consumers into the Outcomes System.*

Any current consumers who are not yet in the Outcomes System should be incorporated immediately and the date of the first administration should be the date used to anchor all subsequent administrations.

At a minimum, the Ohio Scales should be administered at or as close as possible to the following intervals:[43]

- **First Administration:** Immediately
- **Second Administration:** At three months after the first administration
- **Third Administration:** At six months after the first administration
- **Fourth Administration:** At twelve months after the first administration
- **Subsequent Administrations:** Annually thereafter

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[43] It is important to avoid "administration creep" where late administrations can decrease the frequency with which actual administrations occur. In cases where the instruments are administered later than scheduled, follow-up administrations should be anchored to the consumer's originally scheduled initial administration date, even if this means there is a shorter time between some administrations. However, agencies have the option of shortening the time interval preceding an annual administration to coincide with some other annually-occurring event and anchor subsequent annual administrations to that event.

- **At Termination:** Administer at the time of termination if Outcomes-qualifying services have occurred on three or more separate days since previous administration.

Newly-Certified Agencies

Newly-Certified agencies have a period of 12 months from the date of their application for Certification to have incorporated all of their Outcomes-eligible consumers into the Outcomes System.

The agency can choose to enter consumers into the Outcomes System during this period in any manner that best fits with agency practices. For example, consumers could be started into the process based on previous ISP dates, or date of entry into the agency, by program or other factors. However, the agency should develop a "tickler" method to track when each consumer should receive his/her first Outcomes administration as well as the due dates for subsequent administrations.

At a minimum, the Ohio Scales should be administered at or as close as possible to the following intervals:[44]

- **First Administration:** Will occur in waves, based upon whatever method the agency adopts
- **Second Administration:** At three months after the first administration
- **Third Administration:** At six months after the first administration
- **Fourth Administration:** At twelve months after the first administration
- **Subsequent Administrations:** Annually thereafter
- **At Termination:** Administer at the time of termination if Outcomes-qualifying services have occurred on three or more separate days since previous administration.

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Administration Intervals for the Ohio Scales – *Does your system have ways to ensure that the Ohio Scales are completed no less frequently than at the appropriate initial point, 3 months, 6 months, 12 months, annually thereafter, or at termination, whichever comes first? It should.*

[44] It is important to avoid "administration creep" where late administrations can decrease the frequency with which actual administrations occur. In cases where the instruments are administered later than scheduled, follow-up administrations should be anchored to the consumer's originally scheduled initial administration date, even if this means there is a shorter time between some administrations. However, agencies have the option of shortening the time interval preceding an annual administration to coincide with some other annually-occurring event and anchor subsequent annual administrations to that event.

How Will Data Be Collected and Entered?

Data can be collected by any combination of paper and pencil, scanner or electronic input. The decision regarding which method(s) to use will be made at the agency level based on resources.[45]

In order to ensure the consistency and accuracy of Outcomes information, each agency should develop a process to allow the entry and transmission of Outcomes information in a prescribed format.[46]

The Ohio Mental Health Consumer Outcomes System has developed a Data Entry and Reports Template that can be used to enter Outcomes information into a local PC within each participating agency.[47]

Scoring

The Ohio Scales were developed for quick administration, scoring and interpretation. With relatively minimal training, parents or case managers can administer, score, and interpret the meaning of scores for each of the scales.

Problem Severity

All three forms include the 20-item Problem Severity Scale. Each of these items is rated on a 6-point scale for frequency during the past 30 days:

- 0 = Not at All
- 1 = Once or Twice
- 2 = Several Times
- 3 = Often
- 4 = Most of the Time
- 5 = All of the Time
- Missing

Each column's score can then easily be added at the bottom of the page. The sum of the six columns then becomes the individual's score on the Problem Severity Scale. No items are reverse scored.

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[45] See Chapter 9 (Processing Outcomes Data) for a more complete discussion of the transfer of information from the consumer through agencies and boards to the state and back again.

[46] Complete data specifications can be accessed at:

www.mh.state.oh.us/oper/outcomes/data.flow.specs.html

[47] See Chapter 4 (Users and Uses of Consumer Outcomes Data) for a more complete discussion of the Data Entry and Reports Template.

Higher scores are indicative of more problems or increased severity of problems.

! ***Note:*** *If four or fewer items are missing, the individual's mean score on all the other items should be substituted for each missing item before the total score is calculated. If five or more items are missing, the total score should not be calculated.*

? ***Missing Problem Severity Items –*** *Does your system know that if four or fewer Problem Severity Scale items are left blank, the individual's mean score on all the other items should be substituted for each missing item before the total score is calculated? It should.*

? ***Missing Problem Severity Items –*** *Does your system know that if five or more Problem Severity Scale items are left blank, the scale is no longer valid and the total should not be calculated? It should.*

Functioning

All three forms include the 20-item Functioning Scale in the bottom half of the back page. Each of these 20 items is rated using a 5-point scale:

- 0 = Extreme Troubles
- 1 = Quite a Few Troubles
- 2 = Some Troubles
- 3 = OK
- 4 = Doing Very Well
- Missing

Because raters might have somewhat different conceptions regarding what constitutes the various levels of functioning, we use comparable ratings on the Children's Global Assessment Scale (CGAS) as a reference:

Ohio Scales	CGAS
Doing very well (4)	Superior functioning in all areas; (CGAS 90's)
OK (3)	Good functioning in all areas; (CGAS 80's)
Some Troubles (2)	Some difficulty in a single area, but generally functioning pretty well (CGAS approximately 70's)
Quite a few Troubles (1)	Moderate problems in most areas or severe impairment in one area (CGAS approximately 50's)
Extreme Troubles (0)	Major impairment in several areas and unable to function in one or more areas (CGAS 30's or below)

Note: *A common question about the Functioning Scale involves the rating of items 3 and 13. For young children, raters often wonder how to rate items concerning vocational preparation (Item 13) or developing relationships with boyfriends or girlfriends (Item 3). On these items the rater should rate "OK (3)" if they are unsure or rate the youth based on what might be expected for their developmental level. For example, developmentally appropriate vocational preparation for a 7 year old typically involves school work, chores at home, and other work-like assignments.*

Note: *If insufficient information is available to answer a specific item on the functioning scale, that item should be rated "OK (3)".*

The Functioning Scale total is calculated in the same manner used on the Problem Severity Scale. Each of the 20 items is rated on its 5-point scale.

- 0 = Extreme Troubles
- 1 = Quite a Few Troubles
- 2 = Some Troubles
- 3 = OK
- 4 = Doing Very Well
- Missing

The rating for each item is circled. The columns for each frequency are coded respectively from 0 (extreme troubles) to 4 (doing very well). Each column's score can then easily be added at the bottom of the page. The sum of the five columns then becomes the individual's score on the Functioning Scale. No items are reverse scored.

! ***Note:*** *If four or fewer items are missing, a score of 3 should be inserted for the missing items before the total score is calculated. If five or more items are missing, the total score should not be calculated.*

? ***Missing Functioning Items –*** *Does your system know that if four or fewer Functioning Scale items are left blank, a score of "3" should be substituted for each missing item before the total score is calculated? It should.*

? ***Missing Functioning Items –*** *Does your system know that if five or more Functioning Scale items are missing, the scale is no longer valid and the total should not be calculated? It should.*

As can be seen from the scoring method, a high score on the Problem Severity Scale is considered to be more problematic (more frequent problems), while a high score on the Functioning Scale is considered to be better functioning. The method of scoring is thus congruent with what one would intuitively expect given the content of each scale.

Hopefulness

On the top half of the back page of the parent and youth versions, eight questions are printed at the top of the page. The first four questions ask for ratings of hopefulness (parent) or overall well-being (youth). The specific questions vary somewhat on the two versions to fit the respondents. Each question is answered according to a 6-point scale with the specific scale items varying to fit the questions. In each question, response "1" is the most hopeful/well and response "6" is the least. The four items can then be totaled for a Hopefulness Scale score. On this scale, a lower total means more hope or wellness.

! ***Note:*** *If one or more items are missing, do not calculate the scale score.*

? ***Missing Hopefulness Items –*** *Does your system know that if any Hopefulness Scale item is missing, the scale is not valid and the total should not be calculated? It should.*

Satisfaction

The second four questions on the top half of the back page (P-form and Y-form) ask for ratings of overall satisfaction with behavioral health services received and ratings of their inclusion in treatment planning. The specific questions vary somewhat on the two versions to fit the respondents. Each question is answered according to a 6-point scale with the specific scale items varying to fit the questions. In each question, response "1" is the most satisfied/included and response "6" is

the least. The four items can then be totaled for a satisfaction scale score. On this scale, a lower total means more satisfaction.

! ***Note:*** *If one or more items are missing, do not calculate the scale score.*

? ***Missing Satisfaction Items –*** *Does your system know that if any Satisfaction Scale item is missing, the scale is not valid and the total should not be calculated? It should.*

Restrictiveness of Living Environments Scale (ROLES)

On the agency worker version of the Ohio Scales (W-form), the space in the top half of the back page is utilized quite differently since satisfaction and hopefulness ratings are only appropriate from the perspectives of the parent/caregiver and youth. The W-form includes a copy of the ROLES (Hawkins et al., 1986). The ROLES consists of a list of 23 categories of residential settings. Next to each specific setting is a blank line on which the agency worker writes the number of days (during the past 90 days) the youth was residing in that setting. (The total of all the days will therefore add to 90.) Although the authors of the Ohio Scales did not develop this scale, it was felt that tracking this information could be helpful to the agency worker, the agency, and the overall system. The worker should identify the categories that most closely resemble the settings in which the youth stayed.

Scoring for this scale is not included on the form, but it is possible to compute a score if the worker thinks it would be a meaningful measure of the child's treatment progress. Each setting is given a statistical 'weight' as listed in the table below. To get the ROLES total score, each weight is multiplied by the number of days in the blank next to the setting. The sum of these products is then calculated to get a total. The total is then divided by 90 to get the average restrictiveness for the previous 90 days. This is the ROLES score (see Hawkins et al., 1986).

Table 3. ROLES Weights

Setting	Weight
Jail	10.0
Juvenile detention/youth corrections	9.0
Inpatient psychiatric hospital	8.5
Drug/alcohol rehabilitation center	8.0
Medical hospital	7.5
Residential treatment	6.5
Group emergency shelter	6.0
Vocational center	5.5
Group home	5.5
Therapeutic foster care	5.0
Individual home emergency shelter	5.0
Specialized foster care	4.5
Foster care	4.0
Supervised independent living	3.5
Home of a family friend	2.5
Adoptive home	2.5
Home of a relative	2.5
School dormitory	2.0
Biological father	2.0
Biological mother	2.0
Two biological parents	2.0
Independent living with friend	1.5
Independent living by self	0.5

For example, if during the last 90 days a child was placed in a juvenile detention facility for two days, a group home for 12 days, and with the biological father for 76 days, the ROLES score would be calculated in this way:

Setting	Days		Weight[48]		Product
Detention Center	2	x	9.0	=	18.0
Group Home	12	x	5.5	=	66.0
With Father	76	x	2.0	=	152.0
Total	90				236.0

236 / 90 = 2.62 – The ROLES score for the past 90 days is 2.62.

The agency Worker version also includes several questions in the middle of the back side of the page. These items are 'Marker' questions and are meant to be helpful to the agency worker in tracking key information. There are blank spaces to write in information on "school placement" and "current psychoactive medications". In addition, several lines are available for recording the frequency during the past three months of arrests, suspensions from school, days in detention, days of school missed, and self-harm attempts.

Analysis and Interpretation

Clinical Use of the Ohio Scales

The Ohio Scales give the clinician a wealth of useful and easily understandable information. Perhaps most obvious is the ability to track a consumer's progress over time with repeated administrations of the instrument. Ongoing ratings of overall functioning and problem severity can be useful to clinicians and program administrators alike. Additionally, however, the initial administration of the Ohio Scales provides excellent information to aid in development of the consumer's treatment plan. It should be noted that the Ohio Scales were developed primarily to aid in the tracking of service effectiveness. As a result, they do not provide the degree of comprehensive information that might be associated with the administration of a diagnostic measure such as the Child Behavior Checklist (Achenbach & Edelbrock, 1983). Nevertheless, much useful information is available upon initial administration of the Ohio Scales.

[48] From Table 3, above.

Development of Treatment Plan

Administration of the Ohio Scales at admission provides an index of a youth's current problems and level of functioning. Answers to a standardized list of questions help ensure that the typical problems and areas of functioning encountered by youth who receive behavioral health services will be covered.

- **Critical Items:** Specific responses to critical items should be checked first. Positive responses to items such as "hurting self (cutting or scratching self, taking pills)", "talking or thinking about death", or "using drugs or alcohol" will require the immediate attention of the clinician. The youth may need to be assessed for serious risk of harm to self or others or for disturbed thinking. It may also be helpful to check whether the parent and youth give different information on these critical items.
- **Target Problems:** In developing a treatment plan, the next section to check would be the Problem Severity Scale on the front of the instrument. A quick scan will tell the clinician the problems that are endorsed as occurring most frequently. These problems are likely to be the most relevant to the treatment and can be included as target problems in the treatment plan. Again, any differences in the ratings by the parent and youth may prove helpful in dealing with both the youth and the family.
- **Functional Strengths:** The next section to check would be specific responses to the Functioning Scale on the back of the page. Any functioning items that are rated highly may be noted as strengths. A rating of "3" or "4" on a functioning item identifies specific attributes or activities that can be included in the treatment plan as personal strengths. The clinician may also take note of any specific functioning questions that might improve rapidly and then be helpful in working on problems. For example, improvement in hobby participation or appropriate recreational activities might quickly aid improvement in self-concept or relationships with peers or family.
- **Compare Total Scores:** In addition to initial use of individual item responses to aid with the specifics of a treatment plan, calculating scale total scores may also be useful. Total scores for the youth can be compared to average scores in the ODMH Data Reports series or on the Outcomes Data Mart. This gives the clinician an overall indication of how the youth's scores compare to a sample of youth who are in a different program in the agency or in the state as a whole. The Ohio Scales User's Manual gives comparative information about a sample of youth who are not receiving services.

Tracking Changes Over Time

The easy administration of the Ohio Scales allows the instrument to be used as frequently as the clinician would like. Over time, it is then possible to track any improvement in an objective manner, free from the difficulties of relying on memory.

- **Change in Total Scores:** There are several different ways to use data collected over time. Viewing scale total scores, it is possible to see the overall amount of improvement. In addition, total scale scores can be compared to a community sample. For example, the clinician can examine scale total scores at admission and after three months to see if any changes in overall Problem Severity or Functioning occurred. The Ohio Youth Problem, Functioning, and Satisfaction Scales (Short Form) User's Manual (Ogles, et al. 1999) contains forms that can be used for tracking change in Problem Severity and Functioning. Total Problem Severity and Functioning scores for all three sources (child, parent, and agency worker) can be charted on the forms.
- **Change in Items:** It may also be useful in some cases to selectively track specific problem areas that were identified for clinical work. In this case, the consumer may complete specific relevant questions (items) more frequently than the scheduled administration of the entire Ohio Scales. The Ohio Scales offer great flexibility for individual customization in order to provide the greatest usefulness possible.
- **Compare Change in Scales:** In constructing case conceptualizations, the clinician may also find it useful to use scale totals (or even specific item responses) to better understand theoretically how a consumer is improving. Specifically, the clinician may look at the improvement over time in the Problem Severity Scale versus the Functioning Scale. Does it seem with a particular youth that problems have been disrupting functioning and an improvement in the Problem Severity Scale precedes an improvement in the Functioning Scale? On the other hand, does it seem with a particular case that functioning improvement provides help with problems? The Ohio Scales provides specific information on an individual's changes to help address issues such as these.
- **Aggregate Change:** Tracking results over time also provides useful information to administrators as well as clinicians. Administrators may aggregate or average the improvement numbers for all consumers or groups of consumers to obtain information regarding specific programs. These numbers may be very useful in reporting to regulatory bodies or in attempts to gain agency funding. It should be noted that average change scores reported in this fashion do not include information regarding the causes of change. Unless control groups or some other form of control has been used in an experimental fashion, consumer improvement could be due to other factors than treatment. As a result, administrators should be careful how they make

attributions about Outcomes data collected from a single group tracked over time.

- **Satisfaction with Service:** The clinician may also examine the Satisfaction Scale to see if the consumer is satisfied with behavioral health services. In addition, the Satisfaction Scales may be aggregated to give an overall picture of consumer satisfaction with services. Reports of high consumer satisfaction with services can be helpful in communicating overall agency effectiveness. Conversely, if consumer satisfaction ratings are less favorable, this would provide important feedback to the administrator regarding specific programs.
- **Change in Hopefulness:** One key ingredient for family involvement in behavioral health services is the parent's hopefulness about being able to parent and care for their child. When families seek services, they are often physically tired and emotionally discouraged by the challenges of raising a child with serious emotional and behavioral problems. Similarly, the youth may lack hope about the future. Because of this, the Ohio Scales incorporates a four-item scale to track hopefulness over time. Clinicians may find useful information about the parent's or youth's level of hopefulness over time by tracking changes in the Hopefulness total scale score.

Clinically Significant Change

In the current behavioral health care market, consumers of outcomes data want evidence that consumers benefit from treatment. The statistical tests that researchers offer, however, do not always provide the most relevant information. Statistical tests may be difficult for many outcomes consumers to understand. In addition, statistical tests do not provide information regarding the effectiveness of treatment for any one individual. Similarly, the clinical relevance of consumer change is not considered in many research designs. Hence, methods for determining and displaying the clinical meaningfulness of consumer change may facilitate the description and dissemination of outcomes data.

Jacobson and colleagues (Jacobson, Follete, & Revenstorf, 1984; Jacobson & Revenstorf, 1988; Jacobson & Truax, 1991) proposed a standardized method for determining clinical significance. This method is based on the assumption that clinically significant change involves a return to normal functioning. Jacobson and Truax (1991) propose two criteria for assessing clinical significance.

- First, consumers receiving psychological interventions should move from a theoretical dysfunctional population to a functional population as a result of treatment. In other words, if the distributions of individuals in need of treatment and "healthy individuals" are represented graphically, the consumer who has completed treatment should be more likely to be identified as a member of the healthy population distribution. For example, a youth receiv-

ing outpatient counseling should have a Problem Severity score after treatment that is more similar to the scores for the general population than to other clinical samples.

- Second, the change for a consumer must be reliable — the pre- to post-treatment change must be large enough that differences can be attributed to "real" change and not to measurement error. Jacobson and Truax (1991) provide a method to calculate a Reliable Change Index (RCI). The change is considered reliable, or unlikely to be the product of measurement error, if the change index (RCI) is greater than 1.96. If the consumer meets both criteria, movement from one distribution to the other and an RCI greater than 1.96, then the change is considered "clinically significant".

A number of other issues must be considered when using the Jacobson method, but a thorough discussion of the difficulties and issues is beyond the scope of this manual. Similarly, the technical description of RCI calculations is beyond the scope of this manual. Interested readers can refer to the Technical Manual (Ogles, Melendez, Davis, & Lunnen, 2000) or other sources for a more detailed review (e.g., Ogles, Lambert, & Masters, 1996).

- **Consumer Meaningful Change:** Using the Jacobson method and the averages for our samples, we can identify cutoff and change scores that are necessary for calculating meaningful change. The Ohio Scales User's Manual presents examples of cutoff scores and change scores for the Problem Severity and Functioning Scales for all three raters of Outcomes. For example, if the parent ratings indicated that the total Problem Severity score decreased by 10 points and the most recent rating fell below 25, then the youth could be said to have made clinically meaningful changes. These numbers are based on the samples presented in the Technical Manual. Site specific norms may sometimes be more useful.

- **Description of Meaningful Change:** In addition to determining if the consumer made a clinically significant change or not, we could use these data to describe the child's pre- and post-treatment status. For example, "Sigmund entered treatment with a Problem Severity score of 40. This is typical of youth who receive community support services. After nine months of service, he had a Problem Severity score of 12 which is more similar to other youth living in his community (within one standard deviation of the community sample mean). The magnitude or size of change (28 points) also indicates that he made a reliable change for the better."

- **Comparing Clinical Change:** If needed we could go one step further and indicate how Sigmund's post-treatment score compared to individuals in the general population, distressed individuals, and non-distressed individuals by calculating percentile scores for each of the distributions. Of course this would require additional detailed data regarding the Ohio Scales. The point

is that clear statements regarding the clinical meaningfulness of the change may be useful adjuncts to other descriptions of outcomes.

How Can Data from the Instruments be Used?

Agency Level

Care management opportunities at the agency level exist 1) within the consumer/direct care provider interface, and 2) at the agency organizational level. As indicated in the section above, the family and direct care provider would typically use the responses to individual items, subscale scores, and total scale scores on each instrument. This information could be used to develop and/or revise individual treatment plans, or discuss a specific or immediate concern and strengths of a consumer.

Aggregate data can be used by program managers within an agency to look at program effectiveness or to suggest areas in which more emphasis is needed. If aggregate subscale scores or total scores indicate gaps in services or community resources, then the agency could develop new programming, or encourage consumers along with advocacy organizations to develop community resources.

The following are suggestions regarding uses of data from theses instruments:

- The Ohio Scales generate clinically useful information at two levels: individual item scores and levels of impairment on each of the subscales. The profile can be used as a format for organizing discussions with the youth, his or her caregivers, or other professionals.
- The three versions of the Ohio Scales can be used to give the worker/clinician a more rounded picture of the youth. Areas of disagreement in the scores among the family, worker and youth can be used as a platform for discussion and treatment planning.
- Scores within the high range on problems or the low range on functioning predict the level of resources that will likely be needed for a particular individual, and in this same context they can be an indication of whether a child will be in the SED category or will likely require longer-term services.
- Risk behaviors identified on the instrument suggest needs that must be addressed immediately in treatment.
- Data from the Ohio Scales can be used in a discussion session with the family of a child in treatment.
- Tracking change over time can identify consumers who are not progressing well, and for whom different services may be warranted.

- Data from these instruments can be compared with services data to see if services indicated by treatment plan decisions were actually received.
- Outcomes data can be used over time to evaluate treatment protocols developed for specific consumer profiles.
- Aggregate data can be valuable in the planning process, allowing agencies to examine ways to plug the gaps in their service spectrum. Program modification, enhancement, and development may all be strengthened by careful utilization of the aggregate data available through the Outcomes process.

Board Level

Boards can use Outcomes data from the Ohio Scales to make a positive impact in services for consumers, both at the individual consumer/family level and at the aggregate level. Listed below are some examples of how boards could use Outcomes data from these instruments:

- Depending upon the design of future managed care authority, boards may use data from the Ohio Scales, along with additional data, for level-of-care authorizations.
- Aggregate Outcomes data from the Ohio Scales will help boards identify service gaps for quality improvement (QI) purposes. Once these gaps are identified, boards and service providers can then partner to develop new programs for addressing consumers' unmet needs.
- Another aspect of the QI process is the identification of best practices. Boards can use the aggregate results from the Ohio Scales, along with other outcomes instruments and other critical sets of information, to help identify what treatment works best for certain groups of consumers. Once best practices are identified, boards can implement these practices systemwide and then determine if the changes made positive impact on Consumer Outcomes.
- From an accountability perspective, aggregate results from the Ohio Scales will help boards maintain performance data that will be used to continuously monitor organizational performance. Boards can help provider organizations identify areas in need of attention, identify exemplary performance, and demonstrate improved performance.

State Level

- Statewide data have enabled the development of an overview of Consumer Outcomes profiles across the state.
- Statewide data have been used to establish Ohio norms for this instrument.
- Statewide data have been used to develop comparative reports for local systems to use in benchmarking their performance on this instrument against the rest of the state.
- Data are being used to monitor agencies through Certification Standards and local systems through the MSPA or a similar mechanism.
- Statewide data have been used for further psychometric testing of this instrument.

Psychometric Properties

The Ohio Scales Short Forms are modifications of the original Ohio Youth Problem, Functioning and Satisfaction Scales. Based on a factor analysis of the parent-rated Problem Severity Scale, along with a comparison of the scores of a clinical and a non-clinical sample on the parent-rated Problem Severity items, the original 44-item Problem Severity Scale was reduced to 18 items representing the core elements of the scale. Two additional items — drug and alcohol use, and breaking rules or the law — were also selected for inclusion, as they were considered necessary for initial assessment.

In addition, the wording of items for the parent and worker versions was replaced with the simpler wording of the youth's form. Therefore, the Short Forms of the Ohio Scales consist of the 20-item Functioning Scale (reworded for parent and agency worker forms), the 4-item Hopefulness Scale (unchanged), the 4-item Satisfaction Scale (unchanged), and the 20-item Problem Severity Scale (reworded for parent and agency worker forms).

Both the Problem Severity Scale and the Functioning Scale exhibited good internal consistency, as indicated by the Cronbach's alphas in the table below.

	Community		Clinical	
	Parent (1a)	**Parent (1b)**	**Parent (2)**	**Agency Worker (4)**
Scale#	(n = 43)	(n = 33)	(n = 37)	(n = 124)
Problem Severity	.89	.90	.93	.86
Functioning	N/A	.93	N/A	.91

The primary evidence for validity of the reworded Functioning Scale and the reworded and shortened Problem Severity Scale is a high correlation with the original Ohio Scales. Data were collected for parent and agency worker versions to demonstrate consistency of the measurement between the short and original forms.

The agency worker original form and Short Form Ohio Scales ratings were highly correlated. The Problem Severity Scale was correlated at .80, and the Functioning Scale was correlated at .91.

Parent ratings of the youth's Problem Severity and Functioning on the short and original forms of the Ohio Scales were correlated using three different samples. As can be seen in the table below, the correlations were significant for all samples.

Original Ohio Scales	**Short Form**	
Sample 1a	**Problem Severity**	
Problem Severity	.95*	
Connor's	.84*	
Sample 1b	**Problem Severity**	**Functioning**
Problem Severity	.89*	—
Functioning	—	.96*
Sample 2	**Problem Severity**	
Problem Severity	.97*	
Sample 3	**Problem Severity**	**Functioning**
Problem Severity	.91*	—
Functioning	—	.86*

* $p \leq .001$

For more detailed information about the psychometric properties of both the original forms and the Short Forms of the Ohio Scales, see the Ohio Youth Problem, Functioning and Satisfaction Scales Technical Manual.

Additional Information on the Ohio Scales

Two additional references are available on the Ohio Scales:

Ogles, B.M., Melendez, G., Davis, D., & Lunnen, K.M. (1999).
The Ohio Youth Problems, Functioning and Satisfaction Scales (Short Form) User's Manual. Columbus, OH: Ohio Department of Mental Health.

Ogles, B.M., Melendez, G., Davis, D., & Lunnen, K.M. (2000).
The Ohio Youth Problem, Functioning and Satisfaction Scales Technical Manual. Columbus, OH: Ohio Department of Mental Health.

Both of the above documents can be obtained from the Ohio Department of Mental Health Office of Program Evaluation and Research, or from the Ohio Mental Health Consumer Outcomes System Web Site:

www.mh.state.oh.us/oper/outcomes/outcomes.index.html

System Fidelity Checklist

The following checklist includes all system fidelity items identified in the current chapter. Review your procedures for implementing the Ohio Mental Health Consumer Outcomes System in your organization and compare them to the following list. Place a check ☑ next to each item with which you comply.

If your Outcomes System implementation doesn't comply with an item, you should reconsider how you are addressing that issue to ensure that your Outcomes data will be valid, reliable and comparable to other providers in Ohio.

☐ ***Population for the Ohio Scales –*** *Are Parent (P) and Agency Worker (W) forms completed for all child and adolescent consumers age 5–18?*

☐ ***Population for the Ohio Scales –*** *Does your system ensure that the Youth (Y) form is completed by all child and adolescent consumers age 12–18?*

☐ ***Who Administers Ohio Scales? –*** *Does your system ensure that the Parent (P) form is completed by the child or adolescent's parent or caregiver, that the Agency Worker (W) form is completed by the primary worker, and that the Youth (Y) form is completed by the child or adolescent age 12–18?*

☐ ***Administration Intervals for the Ohio Scales –*** *Does your system have ways to ensure that the Ohio Scales are completed no less frequently than at the appropriate initial point, 3 months, 6 months, 12 months, annually thereafter, or at termination, whichever comes first?*

☐ ***Missing Problem Severity Items –*** *Does your system know that if four or fewer Problem Severity Scale items are left blank, the individual's mean score on all the other items should be substituted for each missing item before the total score is calculated? It should.*

☐ ***Missing Problem Severity Items –*** *Does your system know that if five or more Problem Severity Scale items are left blank, the scale is no longer valid and the total should not be calculated?*

☐ ***Missing Functioning Items –*** *Does your system know that if four or fewer Functioning Scale items are left blank, a score of "3" should be substituted for each missing item before the total score is calculated?*

☐ ***Missing Functioning Items –*** *Does your system know that if five or more Functioning Scale items are missing, the scale is no longer valid and the total should not be calculated?*

☐ ***Missing Hopefulness Items –*** *Does your system know that if any Hopefulness Scale item is missing, the scale is not valid and the total should not be calculated?*

☐ ***Missing Satisfaction Items –*** *Does your system know that if any Satisfaction Scale item is missing, the scale is not valid and the total should not be calculated?*

Ohio Youth Problem, Functioning, and Satisfaction Scales (Short Form) Instruments

The three Ohio Scales instruments begin on the following page.

The instrument copies in this manual are provided for reference purposes only and should not be used as photocopy or reproduction masters for instruments that will be used for collecting data. Reproduction masters of all Ohio Consumer Outcomes Systems Instruments can be obtained from the Ohio Department of Mental Health Office of Program Evaluation and Research, or downloaded directly from the Ohio Mental Health Consumer Outcomes System Web Site:

www.mh.state.oh.us/oper/outcomes/outcomes.index.html

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales
Y

Youth Rating – Short Form (Ages 12-18)

Name: _____ Date: _____ Grade: _____ ID#: _____ Completed by Agency

Date of Birth: _____ Sex: ☐ Male ☐ Female Race: _____

Instructions: Please rate the degree to which you have experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

Instructions: Please circle your response to each question.

1. Overall, how satisfied are you with your life right now?
    1. Extremely satisfied
    2. Moderately satisfied
    3. Somewhat satisfied
    4. Somewhat dissatisfied
    5. Moderately dissatisfied
    6. Extremely dissatisfied
2. How energetic and healthy do you feel right now?
    1. Extremely healthy
    2. Moderately healthy
    3. Somewhat healthy
    4. Somewhat unhealthy
    5. Moderately unhealthy
    6. Extremely unhealthy
3. How much stress or pressure is in your life right now?
    1. Very little stress
    2. Some stress
    3. Quite a bit of stress
    4. A moderate amount of stress
    5. A great deal of stress
    6. Unbearable amounts of stress
4. How optimistic are you about the future?
    1. The future looks very bright
    2. The future looks somewhat bright
    3. The future looks OK
    4. The future looks both good and bad
    5. The future looks bad
    6. The future looks very bad

Total: _____

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services you have received so far?
    1. Extremely satisfied
    2. Moderately satisfied
    3. Somewhat satisfied
    4. Somewhat dissatisfied
    5. Moderately dissatisfied
    6. Extremely dissatisfied
2. How much are you included in deciding your treatment?
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all
3. Mental health workers involved in my case listen to me and know what I want.
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all
4. I have a lot of say about what happens in my treatment.
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all

Total: _____

Instructions: Below are some ways your problems might get in the way of your ability to do everyday activities. Read each item and circle the number that best describes your current situation.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

(Add ratings together) Total _____

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales
Parent Rating – Short Form

P

Child's Name: _____ Date: _____ Child's Grade: ___ ID#: _____ (Completed by Agency)

Child's Date of Birth: _____ Child's Sex: ☐ Male ☐ Female Child's Race: _____

Form Completed By: ☐ Mother ☐ Father ☐ Step-mother ☐ Step-father ☐ Other: _____

Instructions: Please rate the degree to which your child has experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

Instructions: Please circle your response to each question.

1. Overall, how satisfied are you with your relationship with your child right now?
   1. Extremely satisfied
   2. Moderately satisfied
   3. Somewhat satisfied
   4. Somewhat dissatisfied
   5. Moderately dissatisfied
   6. Extremely dissatisfied
2. How capable of dealing with your child's problems do you feel right now?
   1. Extremely capable
   2. Moderately capable
   3. Somewhat capable
   4. Somewhat incapable
   5. Moderately incapable
   6. Extremely incapable
3. How much stress or pressure is in your life right now?
   1. Very little
   2. Some
   3. Quite a bit
   4. A moderate amount
   5. A great deal
   6. Unbearable amounts
4. How optimistic are you about your child's future right now?
   1. The future looks very bright
   2. The future looks somewhat bright
   3. The future looks OK
   4. The future looks both good and bad
   5. The future looks bad
   6. The future looks very bad

Total: _____

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services your child has received so far?
   1. Extremely satisfied
   2. Moderately satisfied
   3. Somewhat satisfied
   4. Somewhat dissatisfied
   5. Moderately dissatisfied
   6. Extremely dissatisfied
2. To what degree have you been included in the treatment planning process for your child?
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all
3. Mental health workers involved in my case listen to and value my ideas about treatment planning for my child.
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all
4. To what extent does your child's treatment plan include your ideas about your child's treatment needs?
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all

Total: _____

Instructions: Please rate the degree to which your child's problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

(Add ratings together) Total _____

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales
Agency Worker Rating – Short Form

W

Child's Name: _____ Date: _____ Child's Grade: ___ ID#: _____

Child's Date of Birth: _____ Child's Sex: ☐ Male ☐ Female Child's Race: _____

Form Completed By: _____ ☐ Case Manager ☐ Therapist ☐ Other: _____

Instructions: Please rate the degree to which the designated child has experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

Markers:

School Placement: _____

Current Psychoactive Medications: _____

Markers (Continued):	Number in Past 90 Days
Arrests *(any arrest by police or officer of the court)*	_____
Suspensions from School *(count of all instances of suspension from school by school officials)*	_____
Days in Detention *(days in a detention facility)*	_____
Days of School Missed *(all school days missed for any reason)*	_____
Self-Harm Attempts *(count of all instances of self-harm attempts that are reported or observed)*	_____

ROLES: Enter the number of days the youth was placed in each of the following settings during the past 90 days. (For example, the youth may have been in a detention center for 3 days, a group home for 7 days and with the biological mother for 80 days.)

_____	Jail	_____	Foster Care
_____	Juvenile Detention Center	_____	Supervised Independent Living
_____	Inpatient Psychiatric Hospital	_____	Home of a Family Friend
_____	Drug/Alcohol Rehabilitation Center	_____	Adoptive Home
_____	Medical Hospital	_____	Home of a Relative
_____	Residential Treatment	_____	School Dormitory
_____	Group Emergency Shelter	_____	Biological Father
_____	Residential Job Corp/Vocational Center	_____	Biological Mother
_____	Group Home	_____	Two Biological Parents
_____	Therapeutic Foster Care	_____	Independent Living with Friend
_____	Individual Home Emergency Shelter	_____	Independent Living by Self
_____	Specialized Foster Care	**90**	***(Total for the two columns should equal 90)***

Instructions: Please circle the number corresponding to the designated youth's current level of functioning in each area.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

(Add ratings together) Total _____

8
Processing Outcomes Data

(Release Date: October 15, 2008)

Much of the information contained in this chapter is taken from the much more comprehensive Outcomes Data Flow Guide, which is available on the Outcomes Web Site. The information presented here is designed to provide a general overview and quick reference to the processing of Outcomes data. Critical decisions regarding planning, software and process design should not be based upon this chapter; refer to the Outcomes Data Flow Guide.

Introduction

The Outcomes data flow process is designed to support the collection, storage, and use of Outcomes data within the mental health system. Generally, the data flow process involves collecting Outcomes data from consumers, family members and staff at the provider level at regular intervals and transmitting the data through boards to a statewide database maintained by ODMH. Throughout the Outcomes data flow process, various validation checks are performed to ensure that the data meet certain quality standards before being added to the statewide Outcomes database.

Preparing for Outcomes Data Flow

Examine Existing Products

Various products have been developed to aid local systems in their implementation efforts. These products are posted on the ODMH Outcomes Web Site located at:

www.mh.state.oh.us/oper/outcomes/outcomes.index.html

In addition to the *Consumer Outcomes System Procedural Manual*, the Implementation Planning Checklist may be particularly helpful in guiding local systems through some of the decisions that need to be considered during implementation and operation of the Ohio Mental Health Consumer Outcomes System. The Implementation Planning Checklist, available on the Outcomes Web Site, includes both board and provider activities and is based on the experiences of local areas that have already implemented the Outcomes System.

Select & Implement Technology

Some of the most important decisions that need to be made revolve around the type of technologies used by providers to capture and transmit Outcomes data. Although data may be collected using paper-and-pencil versions of the instruments, they must be transmitted electronically to ODMH. Providers, in collaboration with their boards, should research the various options and implement the technologies that best meet their needs.[49] In addition, in order to support data flow at the provider level, ODMH has developed a Data Entry and Reports Template that is available to providers free of charge.[50] The Template is a Microsoft Access application that can be used to enter and store Outcomes data in a database, generate reports for use with individual consumers, and prepare data for export to a board. Additional information regarding the Data Entry and Reports Template is available in the Data Flow & Technology section of the Outcomes Web Site.

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[49] The Outcomes Initiative released a Request for Information (RFI) designed to help Ohio's community mental health boards (and through them, individual provider organizations) in collecting information regarding how MIS vendors might be able to assist their customers with the integration of the Outcomes data and the other clinical and business content of their information systems.#Vendor responses to the RFI are posted in the Data Flow & Technology section of the Outcomes Web Site.

[50] See Chapter 4 (Users and Uses of Consumer Outcomes Data) for a more complete discussion of the Data Entry and Reports Template.

Assign Staff Responsibilities

Each agency and board should designate one or more staff members to oversee the collection and transmission of Outcomes data. Effective management of the data flow process by a local "champion" is crucial to the successful implementation of the Outcomes System. Typical duties related to managing data flow at the provider and board levels are outlined below.

Provider-Level Duties

- Oversee the process of administering the instruments, tracking administrations, and preparing the data for electronic transmission.
- Ensure that data are submitted to the board in a timely manner.
- Disseminate data flow testing and production information to all staff in order to promote quality improvement efforts.
- Provide training about Outcomes data flow to new staff and periodically retrain existing staff.
- Review and incorporate feedback from data error reports from ODMH.

Board-Level Duties

- Oversee the process of electronically transmitting Outcomes data to ODMH.
- Retrieve data flow test and production reports and distribute to providers.
- Work with providers and ODMH to resolve data flow issues.
- Provide training about Outcomes data flow to new staff and periodically retrain existing staff.
- Assure that agencies receive error reports in a timely fashion.

Each provider should already have an assigned staff person responsible for creating and transmitting claims files to a board, and each board should already have an assigned staff person responsible for receiving provider claims files and submitting them to ODMH. Because the Outcomes data transmission process is similar to the Claims process, similar types of staff are needed for transmitting Outcomes files. At the board level, the person assigned to transmit Outcomes files must be familiar with basic Unix commands and the file transfer protocol (FTP).

Integrate Outcomes Into Existing Data Flow Processes

When considering the design of your local data flow system, it is strongly suggested that the Outcomes data follow the same data flow process as Claims data.

In other words, a provider that is implementing the Outcomes System should work with the same board that is receiving that provider's Claims data. This approach should reduce the amount of confusion around the transfer of files because the procedures and relationships among the technical staffs should already be established. In addition, the same file transfer process used for Claims data should be used for Outcomes data.

The Outcomes Data Flow Process

The data flow process is set in motion immediately following the completion of an Outcomes instrument. A diagram of the general production process and the basic steps involved appears on the following page. The ultimate goal of this process is for data collected at the provider level to be transmitted through the board to the statewide Outcomes database, passing various quality checks along the way. To achieve successful data flow, providers and boards should focus their attention on three major tasks:

- **Task 1:** Creating Outcomes records and files according to ODMH data specifications
- **Task 2:** Data flow testing
- **Task 3:** Submitting production data on a regular basis

These tasks are discussed briefly in the following sections.

! ***Note:*** *For more detailed information regarding Outcomes data flow, please consult the Outcomes Data Flow Guide, available in the Data Flow & Technology section of the Outcomes Web Site.*

Diagram of Production Data Flow Process

1 *Once the Outcomes instrument is completed, it is collected and the completeness and accuracy of the data are checked. If items are incomplete or not marked legibly, the respondent is asked to clarify or complete his/her response. This is the earliest possible time that corrections can take place.*

2 *The "office use" fields included with the instrument (e.g., consumer medical record number) are completed as well as the Tracking Sheet.*

3 *Data captured on the instrument are entered into a database at the provider agency.*

4 *Data are used at the provider level to produce reports for the consumer and worker/clinician to use in treatment planning. Aggregate reports are also generated and used.*

5 *Data are transmitted from provider to board at agreed upon intervals (e.g., weekly) and according to applicable privacy regulations.*

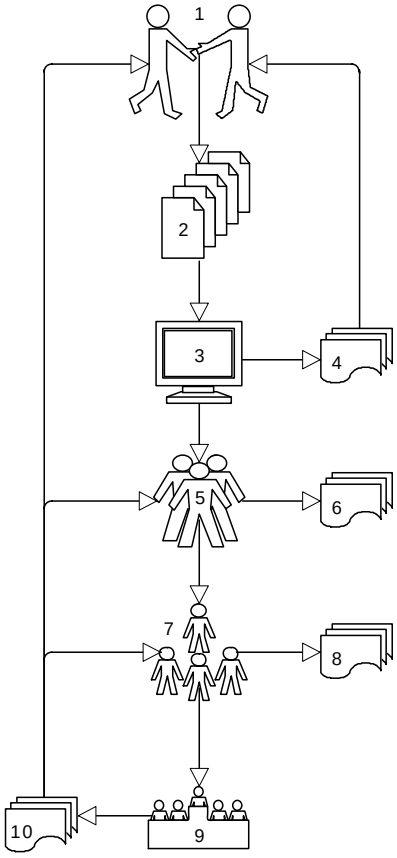
6 *Data are used at the provider level to produce aggregate reports to address care management, quality improvement, and accountability for resources.*

7 *Data received by the board are logged and checked for basic errors. Problems with data are communicated to the provider.*

8 *Data are used at the board level to produce aggregate reports to address quality improvement, accountability for resources, and local system planning.*

9 *Data are transmitted by the board via FTP to the appropriate subdirectory on the designated ODMH server. Production processing occurs every Monday. Production reports (e.g., critical errors, gap analysis) are posted to appropriate subdirectories and retrieved by boards.*

10 *ODMH produces aggregate reports and publishes the Outcomes Data Mart, allowing local areas to compare themselves with the rest of the state, and allowing the development of statewide benchmarks to address quality improvement, accountability for resources, and system planning.*



Note: The above process represents the essential business model, and is not an exact representation of the implementation model.

Task 1: Creating Outcomes Records and Files According to ODMH Data Specifications

Database Basics

With regard to the Outcomes database, a field is a container that stores one piece of information. Every question on each Outcomes instrument is represented in the database by a particular field. Fields are given names, can be different types (i.e., alphabetic, numeric, alphanumeric), can be different sizes, and are located in a certain position. A group of fields from a particular instrument is called a record, and a group of records is called a file.

Data Specifications

Each instrument in Ohio's Outcomes System has its own data specifications — its own set of instructions of how the fields in that particular type of record should be structured and organized. The data specifications for all of the Outcomes instruments are posted on the Outcomes Web Site. The data specifications provide information about each data element in an Outcomes record including the type of field, size of field, position of the field in the record, acceptable responses for the field, and how missing data should be handled. Every Outcomes record that a board includes in a file submitted to ODMH must adhere to these data specifications or the file will be rejected.

Required Fields

Certain fields in an Outcomes record, called "required" fields, are considered "mission critical" to the successful processing and storage of Outcomes data. Required fields must be complete and correct in order for records to be processed and to be allowed into the statewide Outcomes database. If the data in these fields are not complete and correct, a critical error (described below) occurs and the record is rejected. It is essential that providers get these reports, correct the errors and get the data resubmitted. A list of the required fields in an Outcomes record is provided in the Outcomes Data Flow Guide.

Key Fields

Within the group of required fields, particular fields are used to distinguish each record as being unique from all other records. Together, these fields are called a "key". If the data in these fields are not complete and correct, a critical error occurs and the record is rejected. If the data in these fields are exactly the same as the data in these fields for a record already existing in the statewide Outcomes database, the newly submitted record is considered to be a duplicate. The existing record is replaced with the duplicate record, which is assumed to contain more re-

cent data. A count of records with duplicate keys is included at the top of the production processing report that is returned to the board. A list of the key fields in an Outcomes record is provided in the Outcomes Data Flow Guide.

Warning Fields

Fields in the Outcomes record that are not required are considered "warning fields." If the data in these fields are not complete and/or correct, the record is not rejected but is entered into the statewide Outcomes database. A total count of the errors that occur in relation to warning fields is included at the top of the production processing report that is returned to boards. Boards are expected to share this information with providers in order to improve the quality of Outcomes data submitted in the future. Providers are not expected to correct and resubmit records containing errors in warning fields. This information is provided for QI purposes only. It is important to note, however, that although the data in warning fields are not "mission critical", analysis of statewide Outcomes data and reports back to boards and providers will be limited without these data.

Subscale Scores

Each instrument contains at least one group of fields that, when examined together, form a subscale. Therefore, each Outcomes record contains one or more fields in which to store subscale scores, as indicated in the data specifications for the instrument. To compute subscale scores, providers should examine the scoring rules provided in the Outcomes Data Flow Guide and build these rules into the software that they use to collect and store Outcomes data. It is the responsibility of providers to compute the correct subscale scores at the local level. When a production Outcomes record is received at ODMH, subscale scores are recomputed by ODMH and the recomputed value is stored in the database.

Batch Files

Most of the Outcomes files submitted to ODMH contain records for a particular instrument from one provider. However, some boards combine the records from different providers into one file before submitting them to ODMH. This is called a batch file. The test and production systems at ODMH are both designed to process individual or batch files, so the decision to batch is left to a board's discretion. It is important to note, however, that individual and batch files require different naming conventions. Also, if a board chooses to submit a batch file, a batch production report will be returned to the board, that is, a report containing information about records submitted by different providers. It is the board's responsibility to separate the results by provider and to give feedback to each provider included in the batch.

Naming a File

Files must be named according to the guidelines specified by the ODMH Outcomes Team in the Outcomes Data Flow Guide or they will be rejected. The naming conventions differ depending on whether a file is being submitted in test or production, whether it is an individual or batch file, and whether the file is being submitted for the first time or is being resubmitted.

Task 2: Data Flow Testing

To be approved for production, an Outcomes file must pass through a series of checks without producing critical errors (defined below). Data flow testing should occur within a month of actual production so that the testing process is accomplished just prior to actual production use of the Outcomes data. Also, Outcomes test data should be as "realistic" to production data as possible. Therefore, providers must create Outcomes test files using the technology that they will use in production and must transmit the files through the appropriate board to ODMH. Providers must submit test data for each instrument until they are notified that they have been approved for production for the instrument(s) tested. To the extent possible, a provider should test all of the instruments that it will be using at the same time.

Once a provider has been approved for production with regard to a particular instrument, it does not need to submit another test file for that instrument unless there is a technology change. Files submitted for production based on instruments that are not approved through the testing process will be rejected.

Note: *In order to be considered "live" with regard to Outcomes data flow, each provider must successfully test and achieve "approved for production" status for each instrument it will be using.*

Processing Test Files at a Board

Once a board has received an Outcomes test file from a provider, it should log and verify the file. Each board is minimally responsible for the following verification procedures:

- Verifying the file name is correct and meets the detailed data specifications as defined for each instrument
- Verifying the Outcomes file is not a duplicate by comparing against those files that have been previously logged for that particular provider
- Examining the file with an ASCII editor to ensure that it is readable, has an appropriate end of line marker, and that there are no extra carriage returns at the end of the file

Submitting Test Files to ODMH

Boards are required to send Outcomes test data to the designated server at ODMH for processing using file transfer protocol (FTP). In addition, each board should use the same established MACSIS Unix account for transferring Outcomes files that it uses for Claims processing. Each board has been assigned a unique directory structure on the ODMH server for uploading Outcomes test files. Boards may submit Outcomes test files to ODMH at any time during any day of the week.

After successfully uploading a test file to the correct directory, boards must complete a Data Flow Test Request Form and submit it to ODMH as described in the Outcomes Data Flow Guide. A separate form must be completed for each test of each provider's data. Failure to complete this form will result in that particular test file not being processed.

! ***Note:*** *Boards must submit a Data Flow Test Request Form to ODMH for each test of each provider's data in order for the test data to be processed.*

Critical Errors in Test Files

When an Outcomes test file is processed, an initial series of checks is performed to identify and report critical errors at the file level. If one or more critical errors are identified for a test file, the entire file is rejected. The ODMH Outcomes Support Team notifies the board via e-mail that the file failed the testing process and provides summary feedback as to the types of errors found. The board is expected to report test results to providers and inform them that they need to correct and resubmit the test file. A list of critical error codes for test files is included in the Outcomes Data Flow Guide.

! ***Note:*** *Boards are responsible for communicating data flow results to providers. If you are a provider and you wish to know the status of your Outcomes submissions, you should contact the board to which you submitted them for transmission to ODMH.*

Critical Errors in Test Records

Once a file successfully passes checks performed at the file level, additional checks are performed to identify and report critical errors at the record level. Each record within the file is examined to ensure that the data in required fields are complete and correct.

If the data successfully pass the test, the ODMH Outcomes Support Team notifies the board via e-mail that the provider for which the file was submitted has been approved for production for the particular instrument tested. The board is expected to report test results to providers, informing them that they have been approved to submit a particular instrument for production processing. Boards and providers can verify data flow status for a particular instrument by viewing the Data Flow Test

Status Report, which is updated weekly, on the Outcomes Web Site. Once a provider is approved for production with regard to a particular instrument, it does not need to submit another test file for that instrument unless there is a technology change.

Files submitted for production based on instruments that are not approved through the testing process will be rejected. A list of critical error codes for test records is included in the Outcomes Data Flow Guide.

Information/Verify Errors in Test Records

In addition to required fields being checked for critical errors, all of the other fields in the Outcomes record (called warning fields) are checked for incomplete and/or incorrect data. However, unlike required fields, if data in warning fields are not complete and/or correct, the record is not rejected. Instead, an information/verify error is generated and listed on the test report returned to boards. Information/verify errors inform boards of the extent to which data in warning fields are incomplete and/or incorrect. Boards are expected to share this information with providers in order to improve the quality of Outcomes data submitted in the future.

Providers are not expected to correct and resubmit records for which information/verify errors have been generated. The information is provided for quality improvement purposes only. It is important to note, however, that although the data in warning fields are not “mission critical”, analysis of statewide Outcomes data will be limited without these data.

Receiving Data Flow Test Results from ODMH

Outcomes test files are processed Monday through Friday (except for holidays). Files in the test subdirectories are deleted after they have been tested by the ODMH Outcomes Support Team. Test files are saved for a period of 30 days and then are removed from the system.

Within one week of the date that the Data Flow Test Request Form is received by the ODMH Outcomes Support Team, a summary of test results is returned via e-mail to the board staff person who submitted the test request. In addition, Outcomes test reports are placed in each board’s Outcomes subdirectories on the ODMH server. Boards are responsible for retrieving these reports and communicating data flow test results to providers.

Note: *Boards are responsible for communicating data flow results to providers. If you are a provider and you wish to know the status of your Outcomes submissions, you should contact the board to which you submitted them for transmission to ODMH.*

Task 3: Production Data Flow

Submitting Production Files to a Board

The frequency with which a provider submits Outcomes production data to a board is a local decision, although the board must submit Outcomes data to ODMH at least once a month. The method used to transfer Outcomes data between providers and boards is also left to their discretion. Keep in mind that data transmission must comply with current confidentiality statutes and HIPAA regulations.

Submitting Production Files to ODMH

Outcomes production files may be submitted at any time during any day of the week. Unlike the test process, boards are not required to notify ODMH when production files are submitted. ODMH Outcomes Production Staff retrieve submitted files each Monday (or next business day in case of a holiday). Once retrieved successfully, all production files in the board's input folder are deleted. This is necessary so that the Outcomes production files do not get reprocessed.

Boards must send Outcomes data to ODMH using file transfer protocol (FTP). In addition, each board has an established MACSIS Unix account that it uses for Claims processing. This same account should be used for transferring Outcomes files. Each board has been assigned a unique directory structure on the ODMH server for uploading Outcomes files.

Critical Errors in Production Files

When an Outcomes production file is processed, an initial series of checks is performed to identify and report critical errors at the file level. If one or more critical errors are identified for a production file, the entire file is rejected. In addition, if the number of records containing critical errors exceeds a certain threshold, the entire file is also rejected. Currently, the critical error threshold is determined by ODMH Outcomes Production Staff on a file-by-file basis after careful review of the production processing results. As the Outcomes System matures, a standard threshold based on number of records with critical errors as well as percent of records with critical errors may be established.

After critical errors are identified, the ODMH Outcomes Support Team notifies the board via e-mail that the file was rejected in production. The board is expected to retrieve production reports from their designated Outcomes subdirectories on the ODMH server and report production results to providers. Providers should be informed when they need to correct and resubmit the production file.

Files that are resubmitted by a board to ODMH after being rejected initially should be resubmitted with a different file name. If these files are submitted with the same name as the rejected files, they will be treated as duplicates and will not be ac-

cepted into production. Critical error codes for production files are listed in the Outcomes Data Flow Guide.

! ***Note:*** *If you are resubmitting a file that was previously rejected, you must resubmit it with a different file name or it will be rejected as a duplicate file.*

Critical Errors in Production Records

Once a file successfully passes checks performed at the file level, additional checks are performed to identify and report critical errors at the record level. Each record within the file is examined to ensure that the data in required fields are complete and correct. Individual records containing one or more critical errors are rejected while records without critical errors enter into the statewide Outcomes database.

Boards are expected to retrieve production reports from their designated Outcomes subdirectories on the MACSIS server and to report production results to providers. Providers should be informed that they must correct and resubmit the records with critical errors if they want these records to be included in analyses of the statewide Outcomes database. Critical error codes for production records are listed in the Outcomes Data Flow Guide.

! ***Note:*** *If critical errors are not corrected and resubmitted, the records will not appear in statewide Outcomes reports and providers will not receive credit for Outcomes administrations they have performed. This has become particularly important with the implementation of the Consumer Outcomes Rule (OAC 5122-28-04), which mandates the collection, flow and use of Outcomes data.*

Information/Verify Errors in Production Records

In addition to required fields being checked for critical errors, all of the other fields (called warning fields) are also checked for incomplete and/or incorrect data. However, unlike required fields, if data in warning fields are not complete and/or correct, the record is not rejected but is entered into the statewide Outcomes database. A total count of the errors that occur in relation to warning fields is included at the top of the production processing report that is returned to boards. Information error codes for production records are listed in the Outcomes Data Flow Guide. Boards should share information about such errors with providers in order to improve the quality of Outcomes data submitted in the future.

Providers are not expected to correct and resubmit records for which information/verify errors have been generated. The information is provided for quality improvement purposes only. It is important to note, however, that although the data in warning fields are not “mission critical”, analysis of statewide Outcomes data and reports back to boards and providers will be limited without these data.

- **Duplicate Keys:** An additional duplicate check is performed for the "key" fields in the Outcomes record. As mentioned previously, within the group of required fields, particular fields are used to distinguish each record as being unique from all other records. Together, these fields are called a "key". If the data in these fields are exactly the same for two records within the same file or for a record already existing in the statewide Outcomes database, the newly submitted record is considered to be a duplicate. The existing record is replaced with the duplicate record. A total count of the number of records with duplicate keys is included in the production processing reports that are returned to boards.
- **Other Field Checks:** In addition, the Primary Diagnosis, Age, and Refusal type fields are evaluated during production processing. Specifically, the Primary Diagnosis field must contain a valid DSM-III-R, DSM-IV, or ICD-9 diagnosis code or an information error will be generated. An information error will also be generated if provider staff enter a value other than "3 – Person Completed" or "2 – Person Unable to Complete" in the Refusal Type field on the Provider Adult Form or the Ohio Scales – Agency Worker Form. Verifying the values in these fields during production processing helps to ensure the quality of the data in the statewide database.
- **Date Logic Checks:** Several date logic checks are also part of the production processing routine. Records containing any of the following errors will still be added to the statewide Outcomes database but they will be listed in the Outcomes Information Error Report that is distributed each week to boards that have submitted production data:
    1. Administration Date before January 1, 2000
    2. Admission Date before January 1, 1950[51]
    3. Admission Date before Date of Birth
    4. Admission Date after Administration Date
    5. Consumer's age at the time of administration outside the allowable age range for the completed instrument
- **Subscale Computation Checks:** Outcomes subscale scores are also verified during production processing. It is the responsibility of providers to compute the correct subscale scores for use at the local level. When a production Outcomes record is received at ODMH, subscale scores are computed again in order to verify that they have been scored accurately. Subscale scores submitted by providers are recomputed by ODMH and the recomputed value is stored in the database.

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[51] There may be a few consumers who have been involved in the mental health system since before 1950. However, the risk of rejecting those individuals' records is much less than the risk of allowing incorrect values that would get past a more liberal criterion.#

Receiving Production Results from ODMH

Outcomes production files are processed each Monday (or next business day following a holiday) and reports are distributed no later than Tuesday morning (or next business day following a holiday). Boards are notified via e-mail when the reports are available. Boards are responsible for retrieving these reports and communicating production processing results to providers.

Problem Resolution

Boards and providers are encouraged to work together in identifying and solving data flow issues at the local level. If additional help in identifying and resolving data flow issues is needed, please contact the Outcomes Support Team.

Phone: (614) 644-7480

E-mail: outcome@mh.state.oh.us.

9
Appendix A: Outcomes at a Glance

(Release Date: October 15, 2008)

The Ohio Mental Health Consumer Outcomes System utilizes five separate instruments to capture Outcomes for both adult and youth populations from multiple perspectives. As a result, it's often difficult to remember which instrument measures which Outcomes and when they should be administered.

This appendix provides a quick tabular overview of the instruments used by the Outcomes System, the types of scales, subscales and items contained on each, and the intervals for their administration.[52]

The current section is intended to supplement the main chapters of the *Consumer Outcomes System Procedural Manual* and not to replace it.[53] If you have a detailed question, consult the appropriate section of the *Consumer Outcomes System Procedural Manual.*

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[52] The administration intervals listed represent minimum required administration intervals. Instruments should be administered at or as close as possible to the stated points. Other factors (e.g., other funding and regulatory requirements, clinical preference, nature of the consumer base and its service patterns) may require that individual organizations increase the frequency of administration, but in no case should actual administration intervals be less frequent than those listed.#

[53] For example, administration points noted in the tables are for "new" consumers who are being entered into the Outcomes System. Ongoing consumers who were added to the Outcomes System when it was first implemented or consumers from newly-Certified agencies may have their subsequent administrations anchored to their initial administration dates instead.#

Ohio Mental Health Consumer Outcomes at a Glance (Adult Consumers)

	All Adults	
Instrument	**Adult Consumer Form** (Completed by Consumer)	**Provider Adult Form** (Completed by Service Provider)
What is Measured	**Overall Quality of Life** ✱ (12-Item Scale) • **Quality of Life** (9 Independent Items) • **Financial Status** (3-Item Subscale) **Safety and Health** (7 Independent Items) **Symptom Distress** ✱ (15-Item Scale) **Overall Empowerment** ✱ (28-Item Scale) • **Self-Esteem/Self Efficacy** (9-Item Subscale) • **Power/Powerlessness** (8-Item Subscale) • **Community Activism and Autonomy** (6-Item Scale) • **Optimism and Control Over the Future** (4-Item Subscale) • **Righteous Anger** (4-Item Subscale)	**Functional Status** • **Social Contact** (1 Item) • **Social Interaction** (1 Item) • **Social Support** (1 Item) • **Housing Stability** (1 Item) • **Forced Moves** (1 Item) • **Activities of Daily Living** (8-Item Subscale) • **Meaningful Activities** (6-Item Subscale) • **Primary Role** (1 Item) • **Addictive Behaviors** (1 Item) • **Criminal Justice** (1 Item) • **Aggressive Behavior** (1 Item) **Community Functioning** ✱ (Computed Score) **Safety and Health** (9 Independent Items)
When Administered	**Initial:** At admission into one of the target services **Second:** At six months after admission **Third:** At twelve months after admission **Ongoing:** Annually thereafter **At Termination:** Administer if Outcomes-qualifying services have occurred on three or more separate days since previous administration	**Initial:** At admission into one of the target services **Second:** At six months after admission **Third:** At twelve months after admission **Ongoing:** Annually thereafter **At Termination:** Administer if Outcomes-qualifying services have occurred on three or more separate days since previous administration

✱ Outcomes followed by an asterisk are incorporated into Ohio's SOQIC Standardized Documentation Initiative forms.

Ohio Mental Health Consumer Outcomes at a Glance (Youth Consumers)

	All Youth		
Instrument	**Ohio Scales (Y-Form)** (Completed by Youth Ages 12-18)	**Ohio Scales (P-Form)** (Completed by Parent/Guardian for Youth Ages 5-18)	**Ohio Scales (W-Form)** (Completed by Service Provider for Youth Ages 5-18)
What is Measured	**Problem Severity ✱** (20-Item Scale) **Functioning ✱** (20-Item Scale) **Hopefulness About Life or Overall Well-Being** (4-Item Scale) **Satisfaction with Behavioral Health Services** (4-Item Scale)	**Problem Severity ✱** (20-Item Scale) **Functioning ✱** (20-Item Scale) **Hopefulness About Caring for the Identified Youth** (4-Item Scale) **Satisfaction with Behavioral Health Services** (4-Item Scale)	**Problem Severity ✱** (20-Item Scale) **Functioning ✱** (20-Item Scale) **Restrictiveness of Living Environment (ROLES)** (Computed Score)
When Administered	**Initial:** At admission into one of the target services **Second:** At three months after admission **Third:** At six months after admission **Fourth:** At twelve months after admission **Ongoing:** Annually thereafter **At Termination:** Administer if Outcomes-qualifying services have occurred on three or more separate days since previous administration	**Initial:** At admission into one of the target services **Second:** At three months after admission **Third:** At six months after admission **Fourth:** At twelve months after admission **Ongoing:** Annually thereafter **At Termination:** Administer if Outcomes-qualifying services have occurred on three or more separate days since previous administration	**Initial:** At admission into one of the target services **Second:** At three months after admission **Third:** At six months after admission **Fourth:** At twelve months after admission **Ongoing:** Annually thereafter **At Termination:** Administer if Outcomes-qualifying services have occurred on three or more separate days since previous administration

✱ Outcomes indicated by an asterisk are incorporated into Ohio's SOQIC Standardized Documentation Initiative forms.

10
Appendix B:
System Fidelity Checklist

(Release Date: October 15, 2008)

The global checklist on the following pages includes all system fidelity items identified in the *Consumer Outcomes System Procedural Manual*. Review your procedures for implementing the Ohio Mental Health Consumer Outcomes System in your organization and compare them to the following list. Place a check ☑ next to each item with which you comply.

If your Outcomes System implementation doesn't comply with an item, you should reconsider how you are addressing that issue to ensure that your Outcomes data will be valid, reliable and comparable to other providers in Ohio.

Adult Consumer Form

☐ ***Population for the Adult Consumer Form –*** *Do you administer the Adult Consumer Form to all Outcomes-eligible adult consumers?*

☐ ***Administration Intervals for the Adult Consumer Form –*** *Does your system have ways to ensure that the Adult Consumer Form is administered no less frequently than at the appropriate initial point, 6 months, 12 months, annually thereafter, or at termination, whichever comes first?*

☐ ***Skipped Questions –*** *Does your system allow the consumer to skip (i.e., not answer) items on the instrument?*

☐ ***Missing Financial Status Items –*** *Does your system know that if <u>any</u> Financial Status subscale item is left blank by the consumer, the subscale is no longer valid?*

☐ ***Missing Quality of Life Scale Items –*** *Does your system know that if <u>two or more</u> Quality of Life Scale items are left blank by the consumer, the scale is no longer valid?*

☐ ***Reverse Scoring –*** *Does your system reverse score items 13 and 16 before reporting Safety and Health responses?*

☐ ***Missing Symptom Distress Items –*** *Does your system know that if <u>five or more</u> Symptom Distress Scale items are left blank by the consumer, the scale is no longer valid?*

☐ ***Missing Self-Esteem/Self-Efficacy Items –*** *Does your system know that if <u>more than one</u> Self-Esteem/Self-Efficacy subscale item is left blank by the consumer, the subscale is no longer valid?*

☐ ***Missing Power/Powerlessness Items –*** *Does your system know that if <u>more than one</u> Power/Powerlessness subscale item is left blank by the consumer, the subscale is no longer valid?*

☐ ***Missing Community Activism and Autonomy Items –*** *Does your system know that if <u>more than one</u> Community Activism and Autonomy subscale item is left blank by the consumer, the subscale is no longer valid?*

☐ ***Missing Optimism and Control Over the Future Items –*** *Does your system know that if <u>any</u> Optimism and Control Over the Future subscale item is left blank by the consumer, the subscale is no longer valid?*

☐ ***Missing Righteous Anger Items –*** *Does your system know that if <u>any</u> Righteous Anger subscale item is left blank by the consumer, the subscale is no longer valid?*

☐ ***Missing Overall Empowerment Items –*** *Does your system know that if <u>more than five</u> Empowerment items are left blank by the consumer, the Overall Empowerment score is no longer valid?*

☐ ***Reverse Scoring –*** *Does your system reverse score the following items before computing subscale values?*

- *Self-Esteem/Self-Efficacy: 38, 39, 42, 45, 47, 51, 52, 57, and 59*
- *Community Activism and Autonomy: 36, 44, 53, 58, 60, and 61*
- *Optimism and Control Over the Future: 34, 35, 46, and 60*
- *Righteous Anger: 48*

Provider Adult Form

☐ ***Population for the Provider Adult Form –*** *Do you complete a Provider Adult Form for all Outcomes-eligible adult consumers, whether or not an Adult Consumer Form is administered?*

☐ ***Who Administers the Provider Adult Form? –*** *Does your system ensure that the Provider Adult Form is completed by the appropriate worker/clinician?*

☐ ***Administration Intervals for the Provider Adult Form –*** *Does your system have ways to ensure that the Provider Adult Form is completed no less frequently than at the appropriate initial point, 6 months, 12 months, annually thereafter, or at termination, whichever comes first?*

☐ ***Unknown Activities of Daily Living Items –*** *Does your system know that if one Activities of Daily Living subscale item is marked "Unsure" (and no others are left blank), the subscale should be calculated based on the remaining seven items?*

☐ ***Missing or Unknown Activities of Daily Living Items –*** *Does your system know that if more than one Activities of Daily Living subscale item is marked "Unsure" or left blank, the subscale is no longer valid?*

Ohio Scales

☐ ***Population for the Ohio Scales –*** *Are Parent (P) and Agency Worker (W) forms completed for all child and adolescent consumers age 5–18?*

☐ ***Population for the Ohio Scales –*** *Does your system ensure that the Youth (Y) form is completed by all child and adolescent consumers age 12–18?*

☐ ***Who Administers Ohio Scales? –*** *Does your system ensure that the Parent (P) form is completed by the child or adolescent's parent or caregiver, that the Agency Worker (W) form is completed by the primary worker, and that the Youth (Y) form is completed by the child or adolescent age 12–18?*

☐ ***Administration Intervals for the Ohio Scales –*** *Does your system have ways to ensure that the Ohio Scales are completed no less frequently than at the appropriate initial point, 3 months, 6 months, 12 months, annually thereafter, or at termination, whichever comes first?*

☐ ***Missing Problem Severity Items –*** *Does your system know that if four or fewer Problem Severity Scale items are left blank, the individual's mean score on all the other items should be substituted for each missing item before the total score is calculated?*

☐ ***Missing Problem Severity Items –*** *Does your system know that if five or more Problem Severity Scale items are left blank, the scale is no longer valid and the total should not be calculated?*

☐ ***Missing Functioning Items –*** *Does your system know that if four or fewer Functioning Scale items are left blank, a score of "3" should be substituted for each missing item before the total score is calculated?*

☐ ***Missing Functioning Items –*** *Does your system know that if five or more Functioning Scale items are missing, the scale is no longer valid and the total should not be calculated?*

☐ ***Missing Hopefulness Items –*** *Does your system know that if any Hopefulness Scale item is missing, the scale is not valid and the total should not be calculated?*

☐ ***Missing Satisfaction Items –*** *Does your system know that if any Satisfaction Scale item is missing, the scale is not valid and the total should not be calculated?*

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Appendix C:
Outcomes Data Sharing Scenarios

(Release Date: October 15, 2008)

Agencies providing Outcomes-qualifying services are required to have and use Outcomes data for treatment planning and Quality Improvement. The Outcomes Rule mandates the following:

- **Data Collection & Submission:** Agencies are required to collect appropriate Outcomes data from consumers and staff and submit them to ODMH through their respective boards on a timely basis.
- **Individualized Data Use:** Agencies are required to use individualized Outcomes data in treatment planning.
- **Aggregate Data Use:** Agencies are required to use aggregate Outcomes data in agency performance improvement.

Consumers sometimes move from one agency to another, or one agency may refer a consumer to a second agency to receive additional services. Often, the first agency may have already administered the appropriate Outcomes instruments. In any case, the second agency is still responsible for obtaining and using the Outcomes information as described above, and agencies have several options from which to choose regarding how to accomplish these responsibilities.

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Note: *All requirements for "normal" Outcomes administrations also apply to the "shared" Outcomes administrations referenced in the current document, including but not limited to: (1) administration intervals; (2) timeliness; (3) availability of Outcomes information for treatment planning, audits, and quality assurance reviews; and (4) compliance levels.*

For the purposes of the options below, the following definitions apply:

- **First Agency:** the agency that has collected the Outcomes data that could be shared with the second agency.
- **Second Agency:** the agency that has need of data that could be shared by the first agency.

The Outcomes information can be obtained in any of the following ways:[54]

1. **Data-Sharing Agreements:** The second agency can satisfy this requirement through a data-sharing agreement with the first agency. Agencies that satisfy this requirement through data-sharing must be ready to demonstrate their methods for ensuring timely availability of data in sufficient quantity for treatment planning and conducting Quality Improvement. Only data-sharing agreements between agency pairs will be considered. Agencies may submit data sharing agreements starting with the period beginning July 1, 2007. All data sharing agreements must be for a full year. (See Implications for the Missing Data Report below).

   OPER has developed the following criteria for establishing acceptable levels of data collection and timelines for sharing:

   - Agency data-sharing agreements must define whose data are shared with whom (e.g., all data collected at the first agency will be shared with the second agency, all data collected at the second agency will be shared with the first agency, data sharing occur in both directions).
   - Agency data-sharing agreements must explain how data will be obtained in time for treatment planning (e.g., data will be faxed to receiving agency, etc.).
   - Agency data-sharing agreements must explain how data will be obtained for Quality Improvement (e.g., a data export will be prepared on a quarterly basis; data will be appended to the agency data base, before quarterly QI reports are run).
   - Agency data-sharing agreements must be signed by both agency Executive Directors.
   - Agency data-sharing agreements must be renewed at least annually.
   - Copies of all agency data-sharing agreements should be sent to the Outcomes Manager at ODMH for review and approval.

[54] Agencies may move among any of the above options without restriction. However, there are implications for the Missing Data Report and the Outcomes Data Mart, as noted in each of the options.

The following formula will be used to compute the second agency's level of compliance in the Missing Data Report:

$$\frac{\textit{All Outcomes administrations submitted from the second agency AND All Outcomes administrations submitted from the first agency for any shared consumers for whom the second agency has: (1) provided Outcomes-qualifying service; and (2) not yet submitted an Outcomes administration}}{\textit{All cases that have received an Outcomes-qualifying service from the second agency}}$$

Implication for the Missing Data Report: Because of the complexity of the reporting requirements that would be put in place by considering mixed conditions, if an agency has a data-sharing agreement for only part of the period included in a Missing Data Report, then the Data-Sharing Agreement will be ignored, and that Missing Data Report will treat the numerator in the same manner as options 2 and 3.

Implication for Outcomes Data Mart: Only data submitted by an agency under its UPID(s) will be included in that UPID's view in the Outcomes Data Mart. Data collected at other agencies under this option will not show up in the Data Mart unless the data are resubmitted with the appropriate changes made. (See option 2.)

– or –

2. **Data-Sharing & Submission:** The second agency can: (1) obtain the Outcomes information from the first agency, either electronically or as a paper submission; (2) incorporate the information into its regular Outcomes data base on a timely basis; and (3) submit the information through its local board with its next data submission batch after having made appropriate Tracking Sheet changes (i.e., agency admission date, UPID and County codes if different). No data-sharing agreements are necessary beyond those required for normal sharing of clinical data (e.g., Ohio Administrative Rule 5122-27-08), and further documentation is not required.

   Under this option, it is expected that agencies will re-submit data that other agencies have already submitted, and this is permissible, so long as the relevant Tracking-Sheet fields have been modified to reflect the agency re-submitting the data.

   The following formula will be used to compute the second agency's level of compliance in the Missing Data Report:

$$\frac{\textit{All Outcomes administrations submitted from the second agency}}{\textit{All cases that have received an Outcomes-qualifying service from the second agency}}$$

Implication for Outcomes Data Mart: All data submitted by an agency under its UPID(s) will be included in that UPID's view in the Outcomes Data Mart. Data collected at other agencies and resubmitted under this option will show up in the Data Mart.

– or –

3. **Data Collection & Submission:** The second agency can collect its own data by: (1) administering the Outcomes instruments itself to all consumers to whom it delivers Outcomes-qualifying services; (2) incorporating the information into its regular Outcomes data base; and (3) submitting the information through its local board with its next data submission batch.

   The following formula will be used to compute the second agency's level of compliance in the Missing Data Report:

$$\frac{\textit{All Outcomes administrations submitted from the second agency}}{\textit{All cases that have received an Outcomes-qualifying service from the second agency}}$$

   Implication for Outcomes Data Mart: All data submitted by an agency under their UPID(s) will be included in that UPID's view in the Outcomes Data Mart.

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Appendix D:
Reverse Scoring Validation Scenarios

(Release Date: October 15, 2008)

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Note: *The information presented here is designed to provide a quick validity check of reverse scoring for organizations not using the Data Entry and Reports Template. System computation methods should not be based upon this document alone; for complete scoring documentation refer to the Consumer Outcomes Procedural Manual, Outcomes Data Flow Guide and other detailed documents available on the Outcomes Web Site.* ***www.mh.state.oh.us/oper/outcomes/outcomes.index.html***

Some items on the Adult Consumer Form are worded such that a given response (e.g., "never") represents a desirable or positive response for one question, but a less desirable response for another. In order to compare items or combine items into a numeric subscale, certain items need to be "reverse scored" for consistency. When reverse scoring an item, the highest and lowest numerical values are substituted for each other, the next highest and next lowest values are substituted for each other, and so on. The following table illustrates the process.

Four-Point Scale

Original Score (Checked on Form)		Reverse Score (Stored in System)
1	⇨	4
2	⇨	3
3	⇨	2
4	⇨	1

Five-Point Scale

Original Score (Checked on Form)		Reverse Score (Stored in System)
1	⇨	5
2	⇨	4
3	⇨	3
4	⇨	2
5	⇨	1

Items that represent non-scaled values (e.g., missing, not-applicable) should not be included in either reverse scoring or computation of subscales.

Reverse scored items on the Adult Consumer Form include items 13, 16, 34, 35, 36, 38, 39, 42, 44, 45, 46, 47, 48, 51, 52, 53, 57, 58, 59, 60, and 61.[55]

Testing Your Reverse Scoring Methodology

The Data Entry and Reports Template will automatically reverse score all appropriate items. If you're not using the Data Entry and Reports Template, you can check to see if your reverse scoring methodology is correct by running some sample instruments through your system and seeing if you get correct subscale scores. Two scenarios with expected values are outlined below.[56]

Scenario 1

Complete sample copies of the Adult Consumer Form with the first box checked for all questions on the instruments, as in the example below.

13. How often does your physical condition interfere with your day-to-day functioning?

- ☒ *Never*
- ☐ *Seldom/rarely*
- ☐ *Sometimes*
- ☐ *Often*
- ☐ *Always*

Now, enter the sample instrument into whatever electronic system you are using to score and store the Outcomes data. Then check to see what scores actually ended up in your system. In Scenario 1, the following values should get written into your database:

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[55] Items 13 and 16 are "stand-alone" measurements of individual outcomes related to Safety and Health; no inter-item comparisons or relationships (e.g., sums, averages) are appropriate. Even though the individual items should not be combined with each other, for consistency purposes, you should reverse score items 13 and 16 so that the most "positive" response carries the highest value.

[56] Both scenarios are based upon the traditional "paper and pencil" versions of the Adult Consumer Form printed in the Outcomes System Procedural Manual. The Procedural Manual and the individual forms can be downloaded from the Outcomes Initiative Web Site referenced above.

Item or Subscale	Form Score
13	5
16	5
Self/Esteem/Self Efficacy	4.00
Power/Powerlessness	1.00
Community Activism and Autonomy	4.00
Optimism and Control Over the Future	4.00
Righteous Anger	1.75
Overall Empowerment	3.04

Scenario 2

Complete sample copies of the Adult Consumer Form with the last box checked for all questions on the instruments, as in the example below.

13. How often does your physical condition interfere with your day-to-day functioning?

- ☐ *Never*
- ☐ *Seldom/rarely*
- ☐ *Sometimes*
- ☐ *Often*
- ☒ *Always*

Now, as before, enter the sample instrument into whatever electronic system you are using to score and store the Outcomes data. Then check to see what scores actually ended up in your system. In Scenario 2, the following values should get written into your database:

Item or Subscale	Form Score
13	1
16	1
Self/Esteem/Self Efficacy	1.00
Power/Powerlessness	4.00
Community Activism and Autonomy	1.00
Optimism and Control Over the Future	1.00
Righteous Anger	3.25
Overall Empowerment	1.96

Now What?

If your system computed the correct values involving reverse-scored items, you're finished — everything appears to be fine. However, if you ended up with values that are different than those shown in the tables (other than insignificant rounding differences on a second decimal), there appears to be a problem with the way your system computes reverse scores, and you'll need to find out what's wrong.

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Appendix E:
Outcomes System Rumors

(Release Date: October 15, 2008)

Rumors about the Outcomes Initiative abound, and like rumors everywhere, there is often a big difference between what's rumored and what is real. The following rumors have been encountered on multiple occasions by the Outcomes support staff. It's time to set the record straight.

Rumor #1

Outcomes requirements will go away.

The Reality: Not true. Collecting and using Consumer Outcomes data became an official rule as of September 4, 2003, and the Outcomes System is not going away. Two new services, ACT and IHBT, contain requirements to collect and monitor Outcomes indicators. The SOQIC forms include areas to document Outcomes scores and data use.

Rumor #2

An agency is automatically exempt from doing Outcomes if it serves only a "few" publicly funded consumers, provides only crisis or emergency services, or provides only vocational and employment services.

The Reality: Not true. There are no "automatic" exemptions or waivers. However, if a consumer receives only diagnostic assessment or crisis services, or receives only ODADAS services, an Outcomes administration for that individual is not required. Agencies must collect Outcomes data from any consumer who receives any Outcomes-qualifying mental health service.

Outcomes-qualifying mental health services include:

- Assertive Community Treatment
- Intensive Home Based Treatment
- Community Psychiatric Supportive Treatment
- Behavioral Health Counseling and Therapy
- Partial Hospitalization
- Pharmacologic Management
- Employment and Vocational
- Social and Recreational
- Occupational Therapy
- Adjunctive Therapy

Rumor #3

New agencies don't have to start collecting Outcomes data.

The Reality: Not true. All agencies that provide any Outcomes-qualifying services (see above) to publicly funded consumers must implement the Outcomes System.

Within six months of the date the agency first applies for ODMH Certification, it must begin data collection as outlined in the *Consumer Outcomes System Procedural Manual.*

Within one year of the date the agency first applies for ODMH Certification, it must be successfully sending to ODMH Outcomes data for all consumers who receive any Outcomes-qualifying services.

Within two years of the date the agency first applies for ODMH Certification, it must be able to provide evidence that it is using Outcomes data in both treatment planning and performance improvement activities.

Rumor #4

There are no penalties if Outcomes-eligible agencies do not implement the Outcomes System.

The Reality: Not true. Any agency that is substantially out of compliance will be required to file an approved Plan of Correction (POC) when it applies for ODMH Certification and demonstrate how they will put the plan into action before Certification will be granted. Implementation of the POC will be monitored by the ODMH Office of Program Evaluation and Research in coordination with the Office of Licensure and Certification.

Rumor #5

Most consumers dislike the Outcomes instruments and refuse to complete them.

The Reality: Not true. It was found from the Outcomes Pilot project and through interviews with agencies that consumers like being asked about their lives and seeing the results of their Outcomes instruments being used in discussion with staff around their treatment plans.

Rumor #6

Agencies that only see consumers a few times and are seldom able to get a second administration do not have to administer the Outcomes instruments at admission.

The Reality: Not true. Outcomes ratings are required for all consumers who get Outcomes-qualifying services, regardless of their likely time in treatment.

Rumor #7

Agencies only need to administer the Outcomes instruments to new consumers who were admitted after March 4, 2004, when the Outcomes Rule dictating data collection became effective.

The Reality: Not true. Agencies should be collecting data on <u>all</u> of their publicly funded mental health consumers.

Rumor #8

The timing of subsequent administrations can be based on the last administered Outcomes survey, even if the previous administration was late.

The Reality: Not true. It is important to avoid "administration creep" where late administrations can decrease the frequency with which actual administrations occur. In cases where the instruments are administered later than scheduled, follow-up administrations should be anchored to the consumer's originally scheduled initial administration date, even if this means there is a shorter time between some administrations. However, agencies have the option of shortening the time interval preceding an annual administration to coincide with some other annually-occurring event and anchor subsequent annual administrations to that event.

Rumor #9

The consumer's admission date for Outcomes surveys is the first time they ever received services from the agency.

The Reality: Not always true. Each time a case is opened at an agency, it is a new episode of care. Therefore the most recent admission date should be used for the Outcomes administrations.

Rumor #10

My consumers and clinicians do not understand some of the Outcomes questions. It's acceptable to use a "cheat sheet" that defines several of the questions on the Outcomes surveys and suggests possible answers.

The Reality: You cannot use a "cheat sheet" that either defines questions or suggests possible answers; consumers must be free to respond in anyway they choose to each question. Consumers should use their own understanding when answering survey questions. No one should create a script or re-interpret the questions. There is guidance on how to assist consumers in completing the surveys in Chapter 3 of the *Consumer Outcomes System Procedural Manual* under the section titled "Providing Assistance to the Respondent."

Rumor #11

The Outcomes surveys contain several questions that are just demographics, so consumers should not have to answer these questions again. It is much simpler and easier for the consumer if we pre-fill those responses from our consumer database.

The Reality: Be careful. Auto-completion of some Outcomes instrument fields is acceptable under limited conditions (i.e., demographic fields can be auto-completed; Outcomes fields cannot be auto-completed). The difference between which questions on the Outcomes surveys are true demographics and which are Outcomes is currently unclear, but will be clarified by May 2008. Until then any items that are auto-completed can be done so only under the following conditions:

- Auto-filled data are based upon the same response set as indicated on the instruments (e.g., check all that apply vs. check one);
- Data were originally obtained from the consumer/family member;
- Consumers/family members have the opportunity to review and modify, if appropriate, any auto-completed item(s) at each instrument administration; and
- Any consumer-modified response be submitted as the value for the Outcomes administration in question.

Rumor #12

I don't have to do termination administrations because most of my cases are closed before the next Outcomes administration is due.

The Reality: Termination administrations are required just as the other scheduled administrations, such as admission, six months, or annual administrations. If the case closing is planned, the consumer form should be administered at the last session, as long as Outcomes-qualifying services have been received on three or more separate days since the previous Outcomes administration. In either instance — if the consumer fills out the consumer form or if the consumer stops coming in for appointments — the Provider Adult Form should be completed for adults and the Ohio Scales Worker Form should be completed for youth.

Rumor #13

I don't have to do the Outcomes forms with my consumers if they are incarcerated or hospitalized.

The Reality: This was not a rumor; it was an earlier exemption in the Outcomes procedures. However, because many community mental health agencies are going into jails, prisons and hospitals and providing Outcomes-qualifying services, this has changed. The general exemption for jail and hospital settings no longer exists. Outcomes should be administered whenever Outcomes-qualifying services are delivered regardless of setting, including jails, prisons, hospitals, schools, nursing homes, etc.

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Appendix F: Outcomes Data Mart

(Release Date: October 15, 2008)

Putting data into a system accomplishes little if one can't get it back out. Therefore, one of the key pieces of the overall Outcomes System is a web-based Outcomes Data Mart that allows users to generate reports based upon the Outcomes data that have been collected throughout the state and submitted to ODMH.

The conceptual design of the Outcomes Data mart was developed by a Statewide Outcomes Data Mart Committee made up of individuals representing providers, local community mental health/addiction boards, ODMH, and other constituents. The Committee met for 20 months during Fiscal Years 2003 and 2004 and issued its recommendations in the form of an Outcomes Data Mart Conceptual Model, from which much of the current information is derived.

Data Mart Design Principles

The following principles were adopted by the Statewide Outcomes Data Mart Committee:

- **Non-Technical Users:** The Outcomes Data Mart should be accessible to a wide variety of individuals who have little sophistication using data analysis tools. Anticipated users include: (1) community mental health boards and agencies; (2) mental health consumers and family members; (3) ODMH Division of Program and Policy Development and others within ODMH; (4) ODMH Office of Program Evaluation Research; and (5) the general public.

- **Ease of Use:** The Outcomes Data Mart should be easy to use, and not require users to have prior knowledge of the specifics of the Consumer Outcomes Initiative or its instruments in order to make effective use of the data. The Outcomes Data Mart design shouldn't force the user to perform detailed drill-downs that often "obscure the forest for the trees" and leave the user wondering, "now what did I just do?" Users should be able to respond to a series of simple, English-language prompts and get the report they expect.
- **Decision-Support Design:** The Outcomes Data Mart should be a simple tool to provide limited basic and accurate decision-support information about reported consumer Outcomes in Ohio; it should not attempt to be "all things to all people." The primary uses of Outcomes Data Mart information should be for clinical and organizational management rather than research.
- **No Within-Consumer Design:** The Outcomes Data Mart should allow comparisons of consumer groups with given sets of characteristics to similar groups at different points in time (even though the individuals in the groups may not be the same). Difficulties inherent in programming and data integrity preclude the option of a "within-consumer" design where change measures within individuals could be measured at multiple points during treatment.
- **Confidentiality:** Best practice, Ohio statute and HIPAA requirements mandate that information contained in the Outcomes Data Mart be completely confidential; it should not be possible to use any information in the Outcomes Data Mart to identify any specific individual. Therefore: (1) no consumer identifiers should be contained in the Outcomes Data Mart; (2) the number of reporting formats and options should be limited by the design; and (3) no user downloading of raw data sets should be allowed.

Two Display Options

In keeping with the philosophy of not trying to be everything to everyone, the Outcomes Data Mart offers only two types of results displays — simple frequency distribution graphs and two-dimensional tables.

- **Bar Graphs:** Bar graphs are similar to those produced for the Initial Statewide Outcomes Report, with the X-axis representing the various reported values for the item or scale being displayed and the Y-axis representing the percentage of responses represented by each value. To the extent possible, appropriate sample measures (e.g., sample size, mean, median, standard deviation) are reported with each graph.

  Bar graphs can be prepared for an individual service board, an individual residence board, an individual provider agency, or for the entire state.

- **Tables:** The second display option is a table that lists the item or scale being requested as the column and one of the following variables as the rows:
    - Time in Treatment
    - Gender
    - Race
    - Living Situation
    - Age
    - Primary Diagnosis
    - Education
    - Marital Status (Adult Consumers Only)
    - Employment Status (Adult Consumers Only)
    - Mandated Treatment Status (Adult Consumers Only)

    Tables can be prepared for the entire state, with rows representing service boards, residence boards, provider agencies, or a selected demographic characteristic (e.g., gender, education).

A Simple Approach to Preparing Outcomes Reports

A key strength of the Outcomes Data Mart is its ability to allow a non-sophisticated user with little or no knowledge of the details of the Outcomes Initiative to frame meaningful questions and get them answered. The Data Mart accomplishes this end by guiding the user to the desired information through two sets of simple, easily understood questions supported by on-screen lists and instructions.

Selecting the Consumer Outcomes to Include: The first set of prompts identifies the particular information to be included in the desired report and includes:

- Do you want to look at Outcomes information for adult consumers or child & adolescent consumers?
- Consumer Outcomes scores come from multiple sources. Whose measurements of the consumer would you like to see?
- List any special characteristics of the consumers for whom you'd like to see Outcomes scores.
- Outcomes are measured at various points during a consumer's treatment. Indicate the approximate time in treatment (as measured by days since admission) that best describes the consumers for whom you'd like to see Outcomes scores.
- Outcomes can be examined according to the fiscal or calendar year in which they were obtained. For what period would you like to see information?

Selecting the Report to Prepare: The second set of questions identifies the particular information to be included in the desired report and includes:

- Outcomes are measured for several areas for a consumer's life. From which area would you like to see information?
- Outcomes can be displayed as bar graphs or tables. How would you like to display the Outcomes you have selected?

By selecting various possible answers to the above questions, an extensive variety of targeted Outcomes reports can be generated by users with little or no technical sophistication.

Current Status

So, where are we today? The Outcomes Data Mart is fully operational, and can be accessed through the Outcomes System Web Site:

www.mh.state.oh.us/oper/outcomes/outcomes.index.html

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Appendix G:
Outcomes Use in Certification

Amendments to the Outcomes Procedural Manual

(Release Date: October 15, 2008)

Effective October 15, 2008, the following amendments are made to the Outcomes Procedural Manual:

1. All requirements contained in the Outcomes Procedural Manual are voluntary for provider organizations until work is completed to develop more cost effective instruments and reporting procedures, at which time the Outcomes Procedural Manual will be further updated;

2. Provider organizations are expected to honor any existing obligations they have made or subsequently negotiated to collect and report Outcomes data for specific ODMH-funded research projects;

3. Provider organizations should accommodate consumers who wish to continue completing Outcomes instruments. Consumers may use the current methods available through the agency or may wish to explore using the tools which are now available through the Network of Care (Note: Network of Care has added the Adult Consumer, Ohio Scales Parent and Ohio Scales Youth instruments to the "My Folder" feature. Those consumers who wish to use this feature should be given the link to Network of Care (http://ohio.networkofcare.org/home_state.cfm?stateid=41), and told to select their

county, where they should create a My Folder account or follow the “Use Your Outcomes Data” link. Once a consumer creates an account, they will be able to complete the instruments, have them scored, and their data will be saved. The Strengths, Red Flags and Change over Time Reports are available for their use. This information will not be transferred back to the agency, however one of the reports available to consumers can be used to carry the information back to the agency for data entry or for use in treatment planning.);

4. Provider organizations are expected to meet the requirements of accreditation related to Outcomes;

5. For provider organizations that have outstanding Plans of Correction (POC) due to the Department, continued follow up and submission of the POC is voluntary; and

6. Provider organizations that are due for certification renewal during this suspension period will not be held accountable for Outcomes submission during the time period in which ODMH is developing a more cost effective instrument and reporting procedures. If your agency decides to not respond to the Department related to your current Plan of Correction, you would still be in compliance with ODMH certification requirements. It is up to your agency to determine the next steps related to this function, and how you will comply with any other Outcomes requirement (i.e. national accreditation).

Outcomes Use in Certification

> *Consumer outcomes provide important information for the management of consumer care, the improvement of the service delivery system, and accountability for public resources.*

Why collect Consumer Outcomes data? First, Outcomes data can assist in the management of consumer care. Both clinical and administrative care management involve the use of Outcomes data for an individual consumer. Second, Outcomes data can be used to improve mental health services. Aggregate data can support ongoing quality improvement processes of agencies, boards and ODMH and for developing and monitoring best practices. Third, Outcomes data can be used to help demonstrate the Ohio public mental health system's accountability for tax dollars to both the public and governmental agencies.

For these reasons, Outcomes data play an important role in the Certification process. Agencies seeking Certification or re-Certification must: (a) have an adequate Outcomes data flow to meet the Certification threshold; and (b) show evidence of its actual use in Treatment Planning and Performance Improvement.

Agency Outcomes data use is documented with a Data Use Compliance Monitoring Score Sheet (Score Sheet), and is Attachment 7 to the Certification Application, as shown on the following two pages.

Attachment 7

Consumer Outcomes Rule: Data Use Compliance Monitoring Score Sheet

Background

The Consumer Outcomes Rule (5122-28-04) requires that appropriate provider agencies: (1) plan for Outcomes implementation; (2) collect Outcomes data on eligible consumers; (3) flow those production data to ODMH; (4) provide evidence of use of Outcomes data in treatment planning; and (5) provide evidence of use of Outcomes data in agency performance improvement.

Agency compliance with the data collection and flow components of the Outcomes Rule is measured using the ODMH-produced Missing Data Report, which compares the number of Outcomes records submitted to ODMH against the number of consumers who received Outcomes-eligible services at that agency. The compliance threshold is currently 80%.

ODMH worked with feedback from agencies, consumers, and boards to develop a measure for determining compliance with the requirements to show evidence of use of Outcomes data in treatment planning and in agency performance improvement. The resulting product is the Data Use Compliance Monitoring Score Sheet.

Instructions

1. Select appropriate and manageable items from the Data Use Compliance Monitoring Score Sheet to implement. Please reference chapter 15 of the Consumer Outcomes System Procedural Manual (http://www.mh.state.oh.us/oper/outcomes/instruments/procedural.manual.pdf) for clarification.
2. Put in place efforts that will prepare the agency for completion of the items selected.
3. Conduct the necessary documentation review (records review, quality improvement project, etc.) to complete the selected items.
4. Complete column one of the Score Sheet by indicating the scores supported by the documentation. You must document at least two points in section 'A' and two points in section 'B'. If you document less than this, please indicate how your agency plans to meet the requirements. Once you have documented two points in each section, filling out the rest of that section is optional.
5. Complete column three, so that the Score Sheet reviewer correctly associates the supporting documentation with the benchmark.
6. Attach the documentation to the Score Sheet and include it with the Certification Application.
7. If there are other activities related to outcomes that you are performing, please provide these on a separate sheet. It may establish that you are achieving compliance.

Important Notes

- **Maximizing Benefit of Efforts:** A single records review can be conducted that supports the first and second Treatment Planning benchmarks. Fulfilling all the Performance Improvement benchmarks may be done by completing a PI project using Outcomes data, writing up the results, and discussing it at your board or management team meeting. See Chapter 15 of the Consumer Outcomes System Procedural Manual for details.
- **Surveys & Assessments:** If you conduct a review of potentially large populations (e.g., records, staff, consumers), it is acceptable to draw a representative sample rather than survey every item or person in those groups. Documentation of a summary of a records review with dates of review, number included, number passing, and criteria used to judge achievement of the benchmark.
- **Accreditation:** Agencies should be able to use the work completed for satisfying the requirements of this Score Sheet, particularly for Performance Improvement, to meet some of all of their consumer outcomes requirements for accreditation.

Although not required, agencies *may* consider using the Certification Planning, Preparation & Implementation Agency Self-Assessment Tool (http://www.mh.state.oh.us/oper/outcomes/planning.training/cert.checklist.pdf) to guide planning and preparation around Outcomes implementation.

Revised: 4/08

Consumer Outcomes Rule:
Data Use Compliance Monitoring Score Sheet

Ohio Department of Mental Health
Licensure and Certification, 30 E. Broad St., Columbus, Ohio 43215-3430

Agency Name: _____
Agency Certification Number: _____

0 ⇦ Under 50% **1** ⇦ 50–75% **2** ⇦ Over 75%	**(A) Treatment Planning** ***Attach supporting summary reports*** *for all items with a response of 1 or 2.*	**Attachment Number**
	In the past year, what percentage of active cases show evidence that Outcomes data were used in Diagnostic Assessments, the treatment planning process, and/or Progress Notes?	
	In the past year, what percentage of clinicians was actively using Outcomes data in treatment planning?	
	In the past year, what percentage of consumers/family members report both that they reviewed the Outcomes data with their clinicians and that the data were used actively in their treatment planning?	
	In the past year, what percentage of clinical supervisors was actively using Outcomes data in their clinical supervision activities (per clinical supervision reports)?	

0 ⇦ No **2** ⇦ Yes	**(B) Performance Improvement** ***Attach supporting reports or minutes*** *for all items with a response of 2.*	**Attachment Number**
	In the past year have you conducted any quality improvement projects that demonstrate use of aggregate Outcomes data at various stages of the project?	
	In the past year have you prepared any agency performance improvement reports that contain Outcomes data analyses and interpretation?	
	In the past year do you have any agency executive team and/or agency board of trustee's minutes that reflect discussion demonstrating use of Outcomes data?	

Total

If the total score earned for section A or B is less than two, and you can demonstrate compliance with the provisions for Outcomes data use in Treatment Planning and/or Performance Improvement in other ways than those listed above, please provide examples.

If the total score for each section is less than 2, and no other compliance documentation is provided, please indicate how your agency intends to address the actual use of Outcomes data for Treatment Planning and/or Performance Improvement.

Revised: 4/08

The Score Sheet was created with one key principle in mind – reducing burden. To minimize the impact on provider agencies, the Score Sheet records appropriate existing activities within agencies, rather than requiring completion of lengthy compliance reporting documents. Agencies that are accredited may even be able to use the work completed for accreditation to satisfy the requirements of this Score Sheet, so long as the work is based upon Consumer Outcomes data.

Demonstrating Use of Outcomes Data

The Score Sheet has two sections: (A) Treatment Planning and (B) Performance Improvement. Because agencies must submit documentation of how they met the scores reported for each item, the following information is included as a guide to what types of evidence will demonstrate compliance with the Certification requirements.

(A) Treatment Planning

The underlying intent of the Treatment Planning section is to allow agencies to demonstrate how they are using the Outcomes data collaboratively with individual mental heath consumers in treatment activities in order to facilitate management of consumer care. Such evidence can be found in a variety of possible locations, most of which are located in the consumer's record. For example:

- Within a consumer's Diagnostic Assessment, evidence of data use might be noted in areas related to the presenting problem, social information, job performance or school functioning, problem checklist, specific comments on Consumer Outcomes/Ohio scales, clinical interpretative summary-narrative section, or treatment recommendations/assessed needs.
- Within a consumer's Individual Service Plan (ISP) or Individual Recovery/Resiliency Plan (IRRP), evidence of data use might be noted in areas related to the treatment goals, strengths, objectives, or transition/level of care change/discharge.
- Within a consumer's Progress Notes, evidence of data use might be noted in relative changes in a consumer's condition, or progress toward goals and objectives.

So does this mean that an agency has to conduct a special records review to meet this Certification requirement? Not necessarily. Most agencies already conduct periodic quality assurance/peer reviews of records that already cover most of the areas noted above. By simply tracking the records that show evidence of the use of Outcomes data, the requirement could easily be satisfied.

The only supporting information that would be needed would be an explanation of the criteria that were used to determine whether a record achieved this Performance Item (including the nature of the review process), and the number of cases that were reviewed (only a sample needs to be reviewed, not all consumers). Agencies can select from the following items:

Treatment Planning Items

If You're Reporting on This Performance Item …	Then Provide This Supporting Information
In the past year, what percentage of active cases show evidence that Outcomes data were used in Diagnostic Assessments, the treatment planning process, and/or Progress Notes?	• Number of cases reviewed • Review criteria used to determine whether a record achieved this Performance Item
In the past year, what percentage of clinicians was actively using Outcomes data in treatment planning?	• Number of cases reviewed • Review criteria used to determine whether a record achieved this Performance Item
In the past year, what percentage of consumers/family members report both that they reviewed the Outcomes data with their clinicians and that the data were used actively in their treatment planning?	• Number of consumers participating in the reviews • Methodology for collecting the data (e.g., consumer satisfaction surveys, focus groups) • Criteria used to determine whether the consumer ratings achieved this Performance Item
In the past year, what percentage of clinical supervisors was actively using Outcomes data in their clinical supervision activities (per clinical supervision reports)?	• Number of clinical supervisors reviewed • Review criteria used to determine whether the clinical supervision reports achieved this Performance Item

(B) Performance Improvement

Performance Improvement (PI) is the concept of measuring a particular process or procedure, then modifying the process or procedure in order to increase its efficiency and/or effectiveness. The underlying intent of the Score Sheet's PI section is to allow agencies to demonstrate how they are using the Outcomes data in agency PI activities. Outcomes data are a primary measure of service effectiveness. However, even if the goal of PI is to improve service efficiency, Outcomes should be measured to assure that service effectiveness is not diminished by the improvement efforts. Performance Improvement activities are critical success factors for agency operations, and provide agency leadership and staff with information about the total impact of anticipated changes.

No additional PI activities would be necessary unless the agency simply wasn't doing any Outcomes-related PI activities at all. In cases where PI activities have been occurring, there are multiple ways an agency might demonstrate use of Outcomes data. In some cases, the only supporting information that would be needed would be a description of the PI change and what Outcomes data were used to support the change. In others, a copy of the referenced internal report would suffice, if it included aggregate Outcomes data and an appropriate interpretation. In another situation, copies of existing minutes from meetings of key decision makers that document discussion of aggregate Outcomes data would work. Agencies can select from the following items.

Performance Improvement Items

If You're Reporting on This Performance Item …	Then Provide This Supporting Information
In the past year have you conducted any quality improvement projects that demonstrate use of aggregate Outcomes data at various stages of the project?	• A description of the planned systemic change to the organization as a whole or to one or more selected service areas • Aggregate Outcomes data reflecting measurement at multiple time periods during the project
In the past year have you prepared any agency performance improvement reports that contain Outcomes data analyses and interpretation?	A copy of the report, if it includes: • Aggregate analysis of Outcomes survey contents • Interpretative narrative that explains the meaning of the reports
In the past year do you have any agency executive team and/or agency board of trustees' minutes that reflect discussion demonstrating use of Outcomes data?	Agency board of trustees or the executive management team* meeting minutes that reflect discussion of aggregate analyses of Outcomes survey contents * *This team must include the chief executive officer and the clinical director*

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Appendix H: Additional Resources

(Release Date: October 15, 2008)

In addition to the current manual, the Ohio Mental Health Consumer Outcomes System has a variety of additional resources available including, but not limited to, the following:

- **Outcomes Initiative Web Site:** The Outcomes Initiative maintains a comprehensive Web Site from which interested parties can obtain additional information and materials about the Ohio Mental Health Consumer Outcomes System:

  www.mh.state.oh.us/oper/outcomes/outcomes.index.html

  Items below that can be downloaded from the Outcomes Web Site are indicated with the following symbol. 💻

- **Outcomes Instruments:** 💻 Electronic copies of all instruments used in the Outcomes System are available for download from the Outcomes Web Site. All instruments can be duplicated as required by the individual provider organization. The Ohio Youth Problems, Functioning, and Satisfaction Scales are free for use within Ohio. A minimal fee will be charged for use of these copyrighted scales outside of Ohio. Foreign language versions (i.e., Chinese, Japanese, Korean, Russian, Spanish-Mexican, Spanish-Puerto Rican, Somali) of selected instruments are also available.

- **Data Entry and Reports Template:** 💻 ODMH has developed a data entry "template" that allows provider agencies to enter data contained in the in-

struments used in the Outcomes System. Information is edited for appropriateness during the data entry process. Completed records are recorded in a database structured to meet the data specifications defined by ODMH. Records are extractable for transfer to the board either via diskette or through online FTP.

The Data Entry and Reports Template can also extract information from the database and produce a variety of consumer-based care management reports for Outcomes instruments.

- **Template Reports Generator:** 💻 The Template Reports Generator was designed by a local system to augment the ODMH Data Entry and Reports Template. In particular, it was developed to save support staff time by allowing individual reports to be run in batch mode, save paper by providing brief reports (usually one page), provide reports that are unavailable in the Template (aggregate reports, initial Ohio Scales Treatment Planning Report) and to correct 'errors' in the tracking reports in the Template.
- **Data Entry and Reports Manual:** 💻 The Data Entry and Reports Manual is designed to help local systems maximize the potential of the ODMH Data Entry and Reports Template. The manual covers all aspects of the Template, including downloading the database, entering data, creating reports, exporting Outcomes data to a text file, and importing data from a previous version of the Template.
- **Outcomes Data Flow Guide** 💻 —The Outcomes Data Flow Guide addresses overall data flow processes, creation of records and files according to ODMH data specifications, data flow testing procedures, data flow production processes, and problem resolution. It also includes extensive and detailed appendices that include data specifications, codes and explanations of production reports.
- **Statewide Norms:** 💻 Norms allow us to evaluate an individual's performance on an instrument by comparing the individual's score against the distribution of scores of people similar to the individual on certain characteristics. These reports show the distribution of scores on Adult Form A, Adult Form B and the Ohio Scales based on statewide production data.
- **Statewide Quarterly Reports:** 💻 Produced every quarter, these reports alternate between "state-of-the-state" update reports and special topic reports. The reports are intended to provide all constituents in the public mental health system with statewide data that they can use to compare an individual's scores or average agency or board area scores. The special topic reports provide an in-depth look at a particular topic, based on either the adult or youth Outcomes data in the statewide database.
- **Test and Production Reports:** 💻 Several reports are regularly generated to track the test and production data that have been submitted to ODMH. In

general, these reports contain information regarding which local systems are submitting test and/or production data, the status (approved or rejected) of test and production files submitted by local systems, and the total volume of records contained in the statewide Outcomes database.

- **Missing Data Reports:** 💻 These reports compare the number of individuals who had Outcomes ratings in the statewide database to the number of individuals who received services that made them eligible to have their Outcomes reported for a specific time period. They allow agencies and boards to see how they are doing with regard to Outcomes implementation, in comparison with others both in and outside of their local area.
- **Outcomes "Toolkit":** 💻 The Outcomes Initiative has prepared a series of educational materials designed to assist the provider organization with the implementation of Outcomes. The Educational Series includes a wide variety of products, including a handbook for adult consumers, an adult training of trainers kit, a consumer brochure that describes the Outcomes process, and extensive materials for administrators, managers, clinical supervisors, families and caregivers. Also available are a detailed clinical re-engineering guide and related PowerPoint® presentation, information on cultural competency, and a series of videos directed toward youth, adults, clinical supervisors and direct service staff.
- **Implementation Planning Checklist:** 💻 The Implementation Planning Checklist specifies the recommended activities for participation in the Outcomes System. The Checklist spans four phases and specifies in detail the activities that need to take place within each phase in order to implement the Consumer Outcomes System.
- **Vendor Data Integration RFI & Vendor Responses:** 💻 The Outcomes Initiative released a Request for Information (RFI) designed to help Ohio's community mental health boards (and through them, individual provider organizations) in collecting information regarding how MIS vendors might be able to assist their customers with the integration of the Outcomes data and the other clinical and business content of their information systems.
- **Other Project Documents and Presentation Materials:** 💻 In addition to the items listed above, numerous other Outcomes-related documents are available for download from the Outcomes Initiative Web Site.

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Appendix I: References

(Release Date: October 15, 2008)

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