

CLINICAL SERVICES
Outcomes Measurement Plan
FY 2006

Clinical Services provides a range of services including assessment and referral, individual, family and group therapy, psychiatric and nursing services, case management, crisis intervention and emergency services, and referral for inpatient or residential treatment. Training in specific living skills such as parenting, anger management, and children of divorce services are also offered by Clinical Services staff. An overall measure of consumer satisfaction is obtained annually.

CONSUMER SATISFACTION – CLINICAL SERVICES

Goal: Exceed statewide average on all measures

Rationale: The Consumer Satisfaction survey for Mental Health and Substance Abuse is conducted in collaboration with the Department of Mental Health, Mental Retardation and Substance Abuse Services in October of each year. This survey produces measures of access to services, appropriateness of services, and consumer satisfaction.

Method to measure: Surveys are distributed annually during a one-week sampling period to consumers seen in each office.

Organizationally Clinical Services includes programs that provide Outpatient mental health and substance abuse services, an Emergency Services program in which all clinical staff have responsibilities, and the Parent Infant Education Program which serves children birth to three years in age who have exhibited developmental delay, or are at risk of developing delay.

MENTAL HEALTH

The staff of the Outpatient program provides mental health and substance abuse services (assessment, therapy and counseling, therapeutic medications, and case management) to persons presenting with mental health problems. For adult consumers with co-morbid disorders, a measure has been developed to reflect the comprehensiveness of treatment planning which addresses both mental health and substance abuse needs. Another set of measures will track the initial effect of newly-developed procedures which allow community professionals working under the Comprehensive Services Act to make direct referrals of children and adolescents to GPCS for mental health services.

Outpatient Services – Care Planning for Mental Health and Substance Abuse Co-morbidity:

Goal: 90% of outpatient treatment plans reviewed will reflect care which addresses the consumer's need for treatment dealing with both mental health and substance abuse conditions among co-morbid consumers.

Rationale: Epidemiological studies show a high rate of co-occurring mental health and substance abuse disorders. The use of drugs or alcohol as a factor can easily be missed among the consumer's mental health symptoms, or may mask an existing mental health disorder. Research has also found poor treatment outcomes are likely if the co-morbid condition is not also treated.

Method to measure: Caseloads will be reviewed to identify currently enrolled Outpatient consumers who evidence co-morbidity. Samples of the individualized service plans developed for these consumers will be independently reviewed using an objective scoring system to determine the comprehensiveness of goals, plans and objectives in addressing mental health and substance abuse needs.

Outpatient - Children and Adolescents – Direct Referral by CSA Treatment Team Members:

Goals: Unspecified

Rationale: Youth who are not mandated for services under the Comprehensive Services Act (CSA), those with mental health or substance abuse problems or those referred by the juvenile courts, enter treatment through a routine intake process. Initial identification usually occurs when the child is in contact with schools, courts or social services, and parents or guardians are alerted that their child is in need a mental health screening. A recommendation is made verbally that the parent or guardian request services from GPCS. Once a request is received, a therapist is assigned to conduct an evaluation from which treatment goals will be developed.

This referral process can break down at a number of steps having to do with the parent's ability to follow through, the capacity of the Outpatient unit to respond quickly, or difficulties documenting the problem(s) for which the child is being referred. A system which would allow workers in programs supporting the CSA to obtain parental permission and make a direct referral for mental health screening is expected to circumvent many of these problems, making referral much more efficient and timely.

There is no way of establishing a baseline of referrals which are not completed under the existing process. Therefore goals have not been defined on this measure.

Method to measure: CSA Treatment Team members have been provided with a multipart Notification/Release form which: (1) documents the recommendation for mental health screening; (2) obtains parental or guardian permission; and (3) contains a checklist of indicators for serious emotional disturbance on the copy which is forwarded to GPCS along with contact information. If parental or guardian permission has been received, a

clinician working under the CSA Mental Health Initiative directly schedules and carries out the mental health screening.

As a proportion of number of Notification/Release forms received, Clinical Service will determine:

1. The number of children and adolescents for whom mental health screening is initiated by parents or guardians;
2. The number of children and adolescents for whom mental health screening is initiated by GPCS with parental or guardian permission;
3. The proportion of children and adolescents in (1) and (2) above with whom mental health screening is successfully completed;
4. The proportion of (3) above who are enrolled in treatment with GPCS;
5. The proportion of (3) above who are referred out for other services.

EMERGENCY SERVICES

The Emergency Services program provides crisis intervention by telephone or face-to-face 24 hours a day for persons experiencing psychiatric emergencies or at risk of needing hospitalization. Consumers without inpatient insurance coverage or resources are diverted from state facilities with funds to purchase local hospital beds, which Emergency Services administers. Emergency Services is also the gatekeeper for persons seeking outpatient or case management services from the Mental Health and Substance abuse programs.

The efficiency of Emergency Services will be measured by assessing the response time of the on-call emergency system which is in effect outside of working hours and on weekends.

Crisis Intervention – After Hours Response to Service Pages

<p>Goals: 95% of pages from answering service responded to within 10 minutes 5% or less incomplete pages from answering service</p>

Rationale: For the consumer in crisis, the time latency between placing an emergency call and actually being in telephone contact with a clinician represents the most relevant measure of the availability of emergency services. Conversely, any delay which occurs at this initial stage extends the crisis and perhaps allows the situation to escalate. The 10-minute criterion for returning service pages after hours is actually a maintenance target, which should not vary a great deal over time. Incomplete pages, when the page is not picked up for 15 minutes or more, can result from a number of factors (the on-call

worker's circumstances at the time, errors by the answering service, atmospheric conditions, etc), not all of which can be addressed by the Emergency Services program.

Method to measure: Random samples of one week's after-hours on-call activity will be drawn from answering service records and analyzed as follows: 1) For all service pages which are answered within 15 minutes (Completed Pages), weekly averages will be calculated of the elapsed time between broadcast of the page by the answering service and the recorded time that the on-call worker makes contact and picks up the message; 2) The percentage of Incomplete Pages (elapsed time is greater than 15 minutes) will be calculated for each week from the same sample data.

SUBSTANCE ABUSE

Outpatient – TRIG Participants – Successful Attendance in Treatment

Goals: Unspecified

Rationale: Incomplete episodes of care, characterized by missed appointments and dropping out of services prematurely, are common among consumers of substance abuse outpatient treatment. These forms of noncompliance are obstacles to recovery on the part of substance abusers, while successful attendance is associated with favorable outcomes. Since November, 2004 most persons requesting treatment for substance abuse from Clinical Services have been initially referred to the Treatment Readiness and Information Group (TRIG), a four-week informational and problemsolving phase, before being enrolled in Outpatient services. The intended purpose of TRIG is to work through those barriers to successful attendance which often hinder progress in later stages of treatment.

Measures have been developed based on discharge information to assess the degree to which consumers who successfully complete TRIG show better attendance and treatment compliance. Goals have not been specified because the effectiveness of TRIG can not be predicted at this point. Rather a comparison of TRIG versus Non-TRIG consumers will be carried out in order to estimate the magnitude and direction of any differences which may exist at discharge.

Method to measure: Consumer records on substance abusers which have been closed from Outpatient services since 12/1/2004 will be reviewed until the end of the collection period, and those who completed TRIG assigned to the TRIG sample. Consumers who began treatment earlier than 12/1/2004 will be assigned to the Non-TRIG sample.

Routinely collected discharge data will be entered into a worksheet to compare the TRIG and Non-TRIG samples on the following indicators of successful attendance in Outpatient treatment:

1. The number of appointments kept per week during the episode of care; and

2. The number of consumers who participated in discharge planning prior to case closing;

Comparisons will be carried out between samples on the following indicators of treatment noncompliance:

1. The number of appointments missed or cancelled per week during the episode of care;
2. Clinicians' ratings of noncompliance;
3. The proportion of consumers discharged "Against Staff Advice"; and
4. The proportion of consumers discharged due to incarceration.

PARENT INFANT EDUCATION PROGRAM

The Parent Infant Education Program serves children who are birth to three years in age and who have a developmental delay or who are at risk for developing a delay. The services offered by the program include screening, assessment, educational therapy, speech therapy, and occupational therapy, physical therapy and services coordination. Families are taught to work with their children within the context of their home lives, thereby teaching and aiding development as a routine part of their interaction with their children. At any given time, there are approximately 55 children and families in the Parent Infant Education Program.

Goal: Children served through intervention services will show an overall gain in skills in all developmental areas.

Population Measured: Children served in Intervention Status

Rationale: Children in Intervention Status with the PIEP are those children who show either a 25% or greater delay in one or more of the 7 developmental areas, atypical development or a diagnosed handicapping condition. Intervention is aimed at ameliorating those delays, helping the child catch up and aiding parents in helping their child develop. While there will be many reasons that children may not show a decrease in their documented delays, including health, family circumstances, and the underlying cause of the delay, overall gain in skills is a meaningful way to measure overall effectiveness of the interventions provided by the PIEP.

Method to Measure: All children in the population have an IFSP, which is updated every 6 months. Developmental progress is measured at these 6-month reviews, and this will be the basis for measurement.

Goal: Service provision in the PIEP will adhere 100% to Federally Mandated timelines for response to referral and multi-disciplinary assessment.

Rationale: Increasing numbers of children referred and served, increasing complexity of children and families served, and a finite resource pool from which to serve those children is creating a crisis in Early Intervention across the state in general and in the PIEP in particular. Measurement of adherence to timelines is one way to demonstrate if the program is receiving more referrals and serving more children than can be accommodated by the current staffing level.

Population Measured: Children in Intervention Status

Method to Measure: Days from Date of Referral to Contact with Family (mandated time frame - 2 days), days from date of request to date of Multi Disciplinary Team Assessment and IFSP (mandated time frame - 45 days). Data is in individual client charts.

Goal: Serve all referred consumers with appropriate staffing levels and supports.

Rationale: The population of children and families referred to the Parent Infant Education Program continues to grow and grow. The program is serving record numbers of children and those children have increasingly complex conditions and, subsequently, training and support needs. This is an issue for the entire Commonwealth, with the system needing new resources to serve an ever growing and increasingly complex consumer population. Even with resources, qualified personnel are increasingly difficult to find and hire.

Method: Access all available resources, including one-time monies, to keep staffing levels adequate to serve the population. Recruit widely to find and retain qualified personnel.