

You Can't Manage What You Don't Measure
Total Clinical Outcomes Management in the child
serving system

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Challenges in the Human Service System

- ❑ Many different adults in the lives of the people we serve
 - ❑ Each has a different perspective and, therefore, different agendas, goals, and objectives
 - ❑ Honest people, honestly representing different perspectives will disagree
 - ❑ This creates the potential for conflict
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The Philosophy: Total Clinical Outcomes Management (TCOM)

- ❑ *Total* means that it is embedded in all activities with families as full partners.
 - ❑ *Clinical* means the focus is on child and family health, well-being, and functioning.
 - ❑ *Outcomes* means the measures are relevant to decisions about approach or proposed impact of interventions.
 - ❑ *Management* means that this information is used in all aspects of managing the system from individual family planning to supervision to program and system operations.
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Managing Tension is the Key to Creating an Effective System of Care

- ❑ Philosophy—always return to the shared vision. In the child serving system the shared vision is the child and family
 - ❑ Strategy—represent the shared vision and communicate it throughout the system with a standard language/assessment
 - ❑ Tactics—activities that promote the philosophy at all the levels of the system simultaneously
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The Troubles I've seen.....

- People are more honest with researchers than clinicians
- Substance abusing girls 'self esteem' plummets with treatment
- Clinical factors don't predict service utilization
- Method matters with consumer satisfaction
- Consumer & Providers use assessment for advocacy rather than accuracy
- Measures developed for research do not translate well into service delivery applications

The Strategy: CANS

Six Key Characteristics of a Communimetric Tool

- ❑ Items are included because they might impact service planning
 - ❑ Level of items translate immediately into action levels
 - ❑ It is about the child not about the service
 - ❑ Consider culture and development
 - ❑ It is agnostic as to etiology—it is about the 'what' not about the 'why'
 - ❑ The 30 day window is to remind us to keep assessments relevant and 'fresh'
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The
Child
and
Family



Behaviors
Experiences
Assets
Relationships

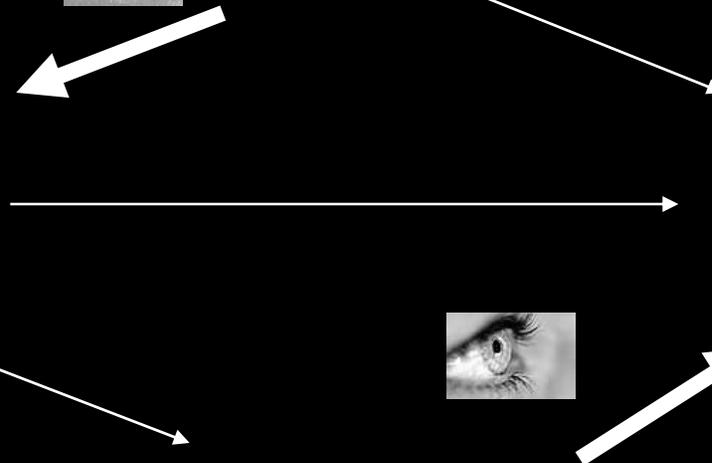


Traditional
Psychometric
Measures



Communication
Measurement

Service
Planning



Understanding our Marketplace: The Hierarchy of Offerings

- I. Commodities
- II. Products
- III. Services
- IV. Experiences
- V. Transformations

- Gilmore & Pine, 1997

TCOM Grid of Tactics

	Family & Youth	Program	System
Decision Support	Care Planning Effective practices EBP's	Eligibility Step-down	Resource Management Right-sizing
Outcome Monitoring	Service Transitions & Celebrations	Evaluation	Provider Profiles Performance/ Contracting
Quality Improvement	Case Management Integrated Care Supervision	CQI/QA Accreditation Program Redesign	Transformation Business Model Design

Services and Policy Research Perspective

- ❑ Large databases are impressive but without clinical logic can be very misleading
 - ❑ Mental health is different than health care in terms of the information used to make decisions
 - ❑ Communimetric tools can be expected to have 100% use penetration
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Figure 5.2 Survival analysis of time to placement disruption for children/youth whose placement matches CANS recommendations (Match=0), those whose placed is at a lower intensity than recommended (match=1) and those whose placement is more intensive than recommended (match=-1).

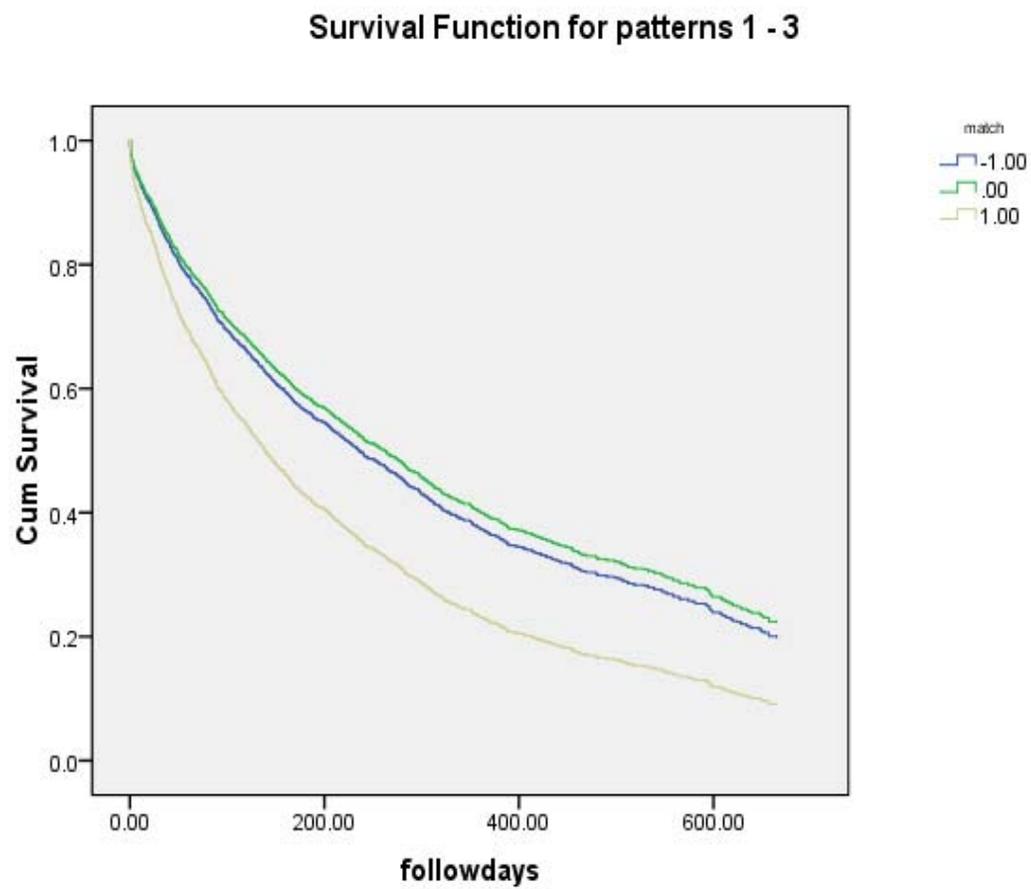


Figure 3. Comparison of Life Domain Functioning between CANS/CAYIT agreed referrals to residential treatment (Concordant) and CANS referrals to lower levels of care who were placed in residential treatment (Discordant)

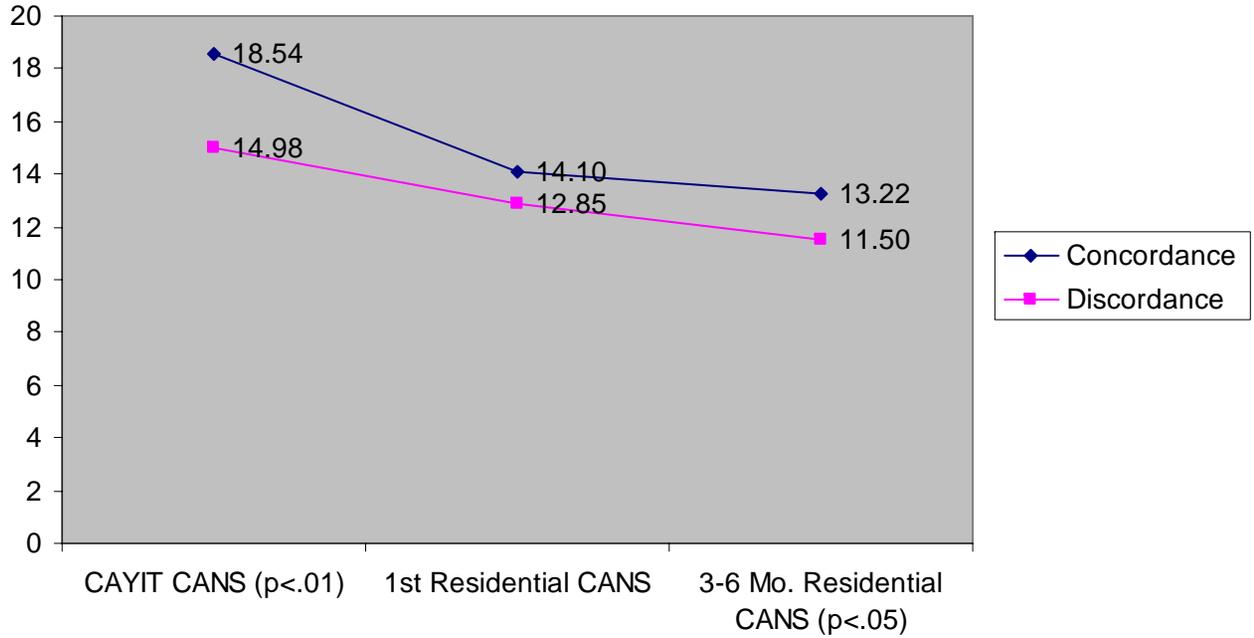


Figure 2. Trauma Symptoms comparison between CANS/CAYIT agreed referrals to residential treatment and CANS referrals to lower levels of care who were placed in residential treatment (Discordant)

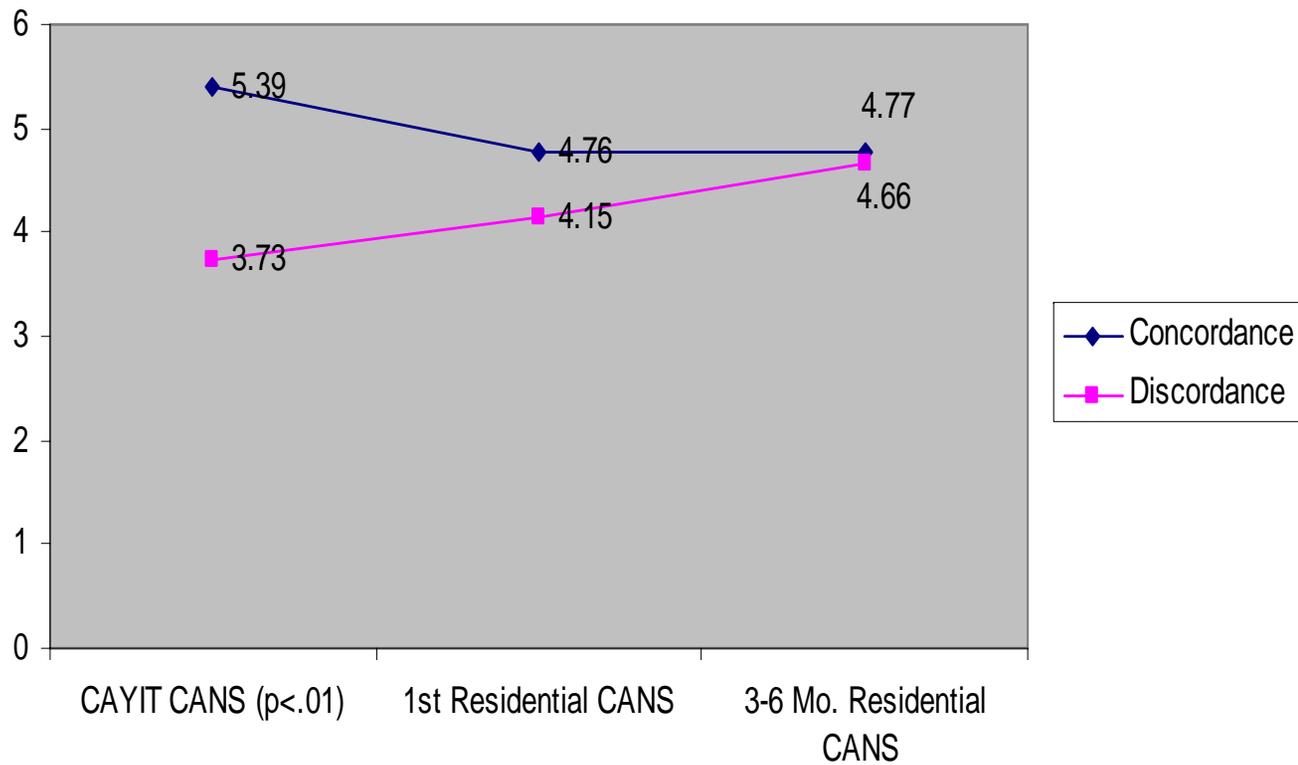


Figure 4. Comparison of Emotional/Behavioral Needs between CANS/CAYIT agreed placements in residential treatment (Concordant) and CANS referrals to lower levels of care who were placed in residential treatment (Discordant)

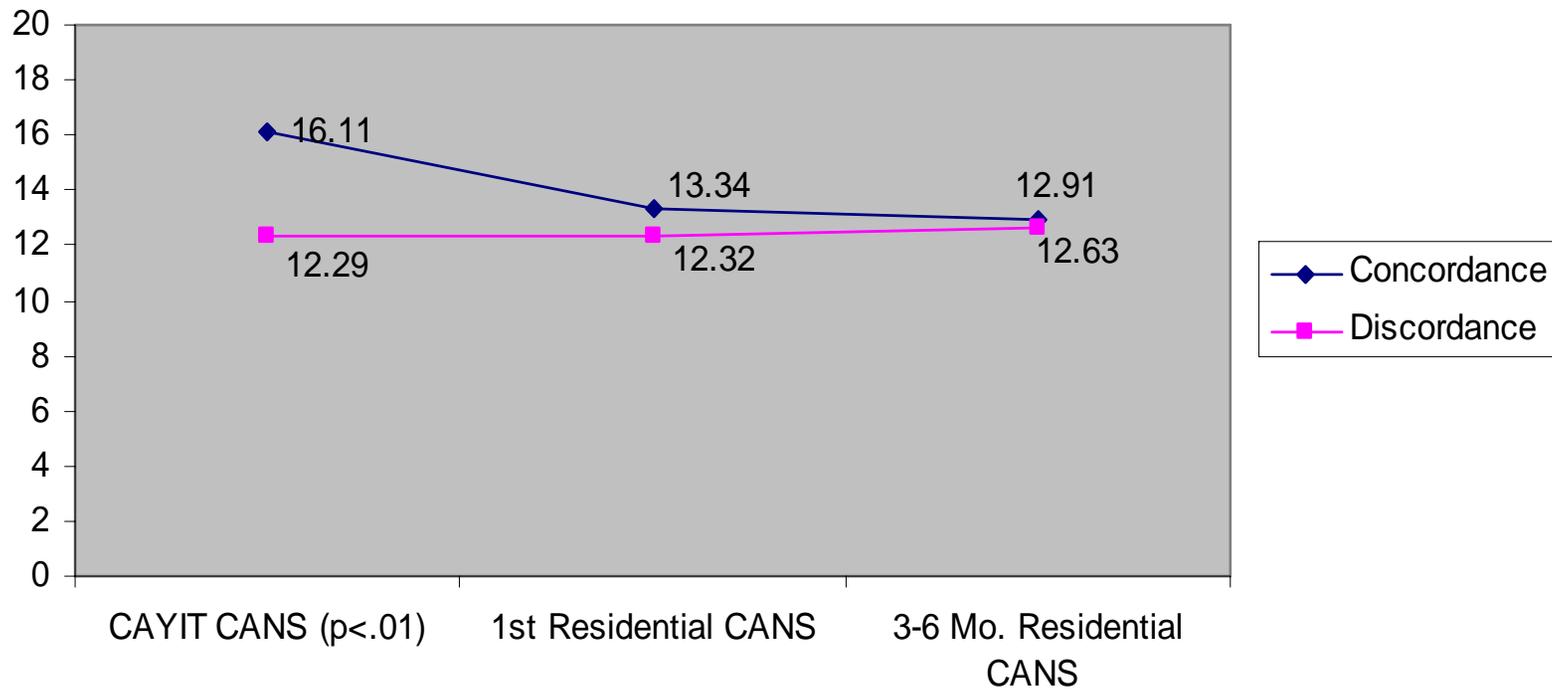
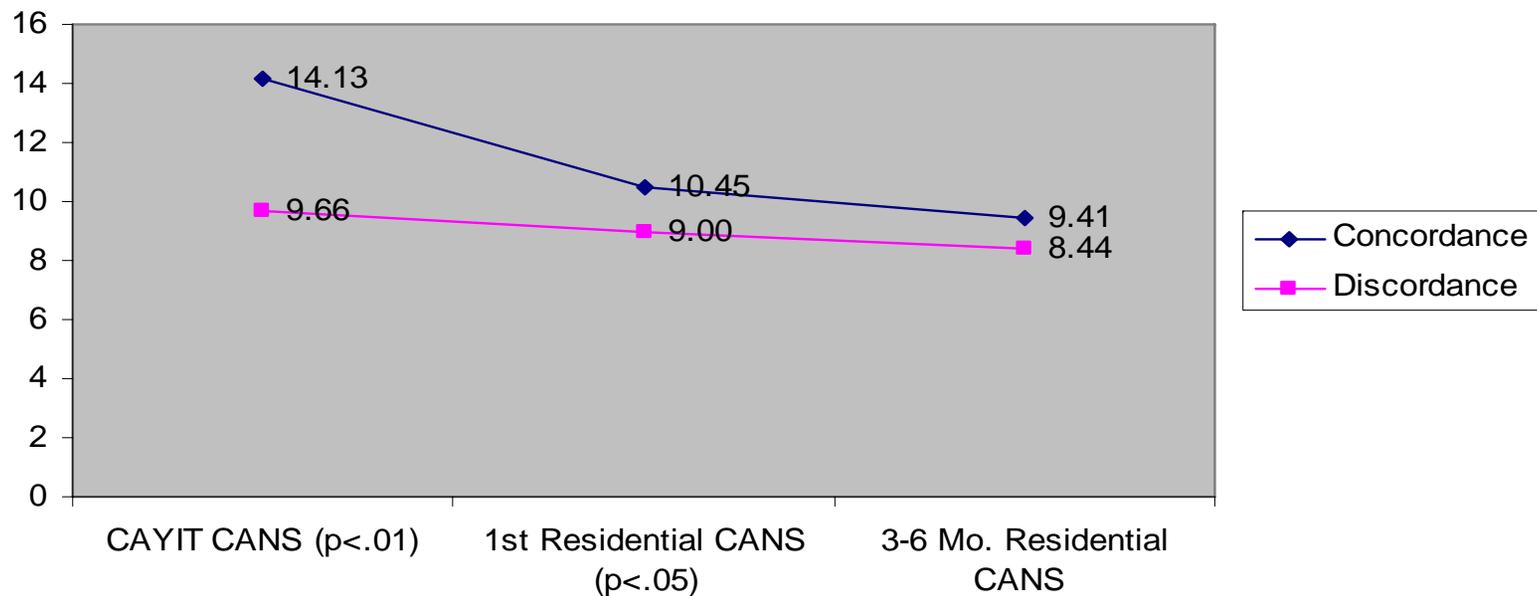


Figure 5. Comparison of high Risk Behaviors between CANS/CAYIT agreed placements in residential treatment (Concordant) and CANS referrals to lower levels of care who were placed in residential treatment (Discordant)



Prevalence of actionable needs on the Fire Setting item of the CANS by demographic characteristics.

	N	% Actionable	Confidence Interval of percentage
□ Gender			
Female	2,063	0.87	(0.52 - 1.38)
Male	2,092	1.82	(1.29 - 2.48)
□ Race/Ethnicity			
African American	2,002	1.38	(0.91 - 2.00)
Non-Hispanic White	1,900	1.21	(0.77 - 1.81)
Hispanic	233	2.15	(0.70 - 4.94)
□ Age			
0 to 3 years	1,698	0.0	(0.0 - 0.22)
4 to 6 years	565	1.06	(0.39 - 2.30)
7 to 9 years	451	1.55	(0.63 - 3.17)
10 to 13 years	554	3.43	(2.08 - 5.30)
14 to 16 years	572	3.67	(2.29 - 5.56)
17+ years	89	3.37	(0.70 - 9.54)

The relationship of trauma experiences to the likelihood of having an actionable fire setting behavior.

Number of Traumatic	n	Percent Actionable	
None	1,061	0.49	(0.16 - 1.14)
One	1,129	0.89	(0.43 - 1.62)
Two	885	0.79	(0.32 - 1.62)
Three	559	2.50	(1.38 - 4.17)
Four	296	1.35	(0.37 - 2.31)
Five	151	3.97	(1.47 - 8.45)
Six or more	119	8.40	(4.10 - 14.91)

Figure 1. Level of Need by Year for Admissions into Residential Treatment

N=2782

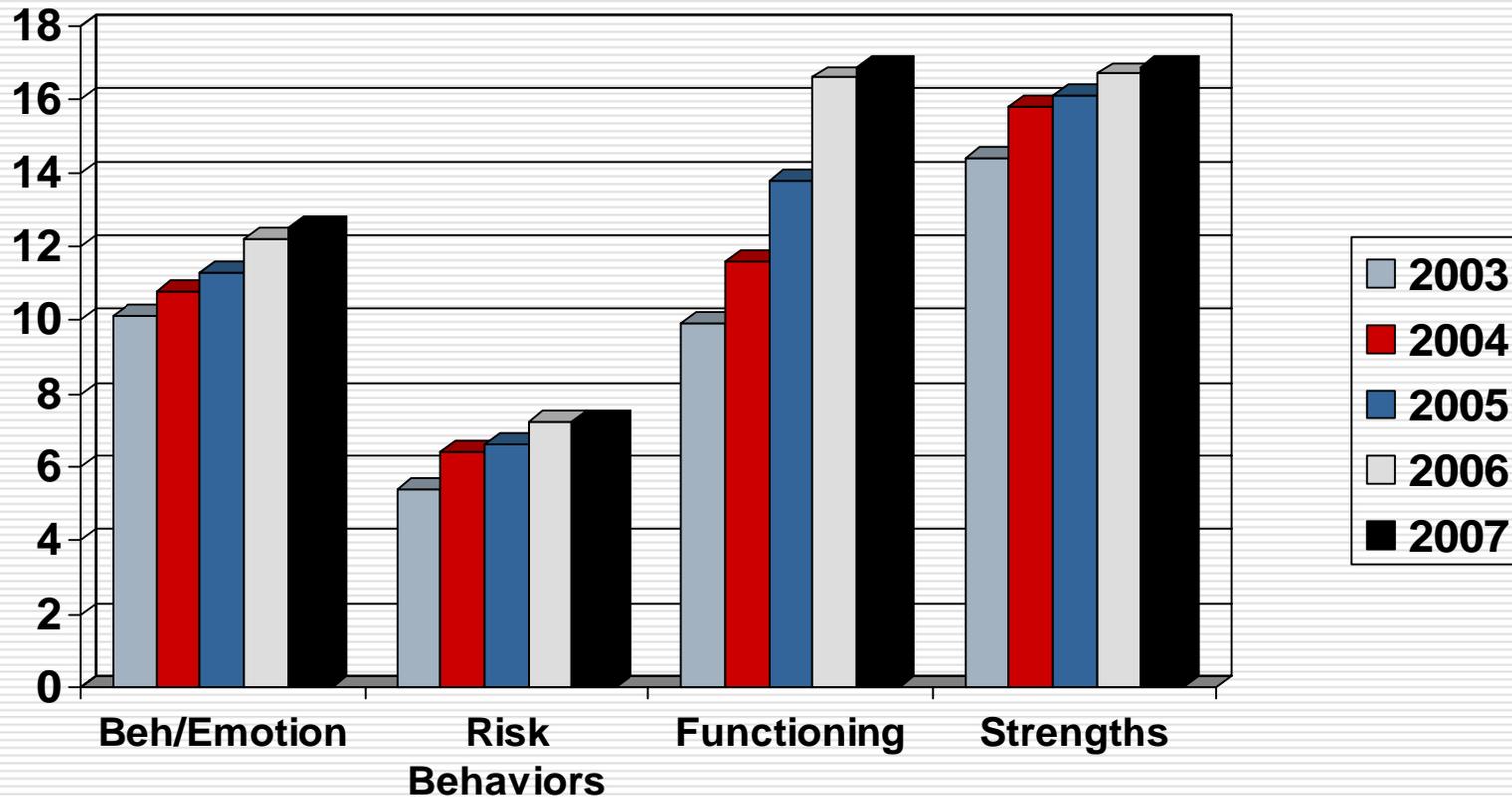


Figure 6. Comparison of total score for RTC, CMO, and YCM initial assessments by year

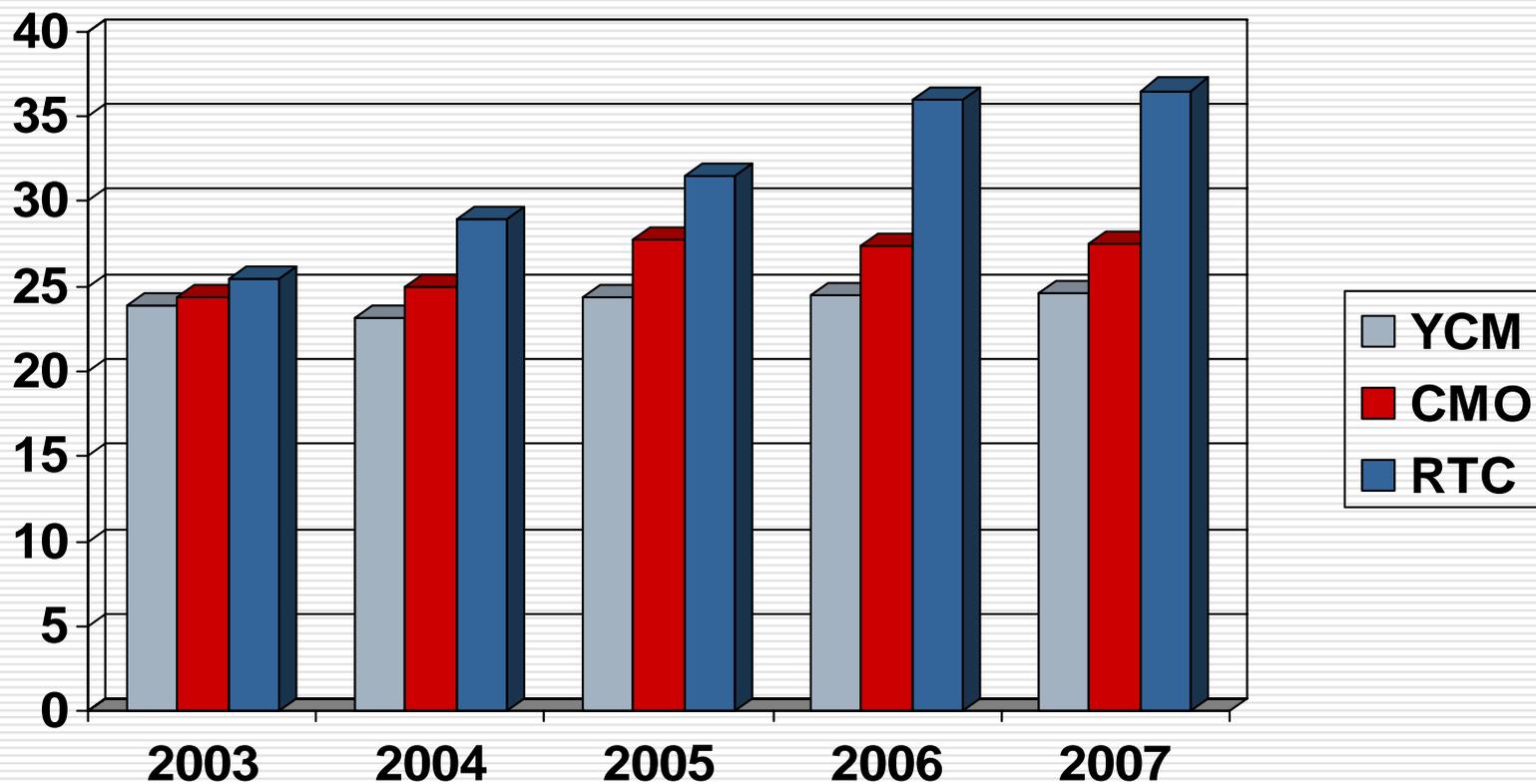
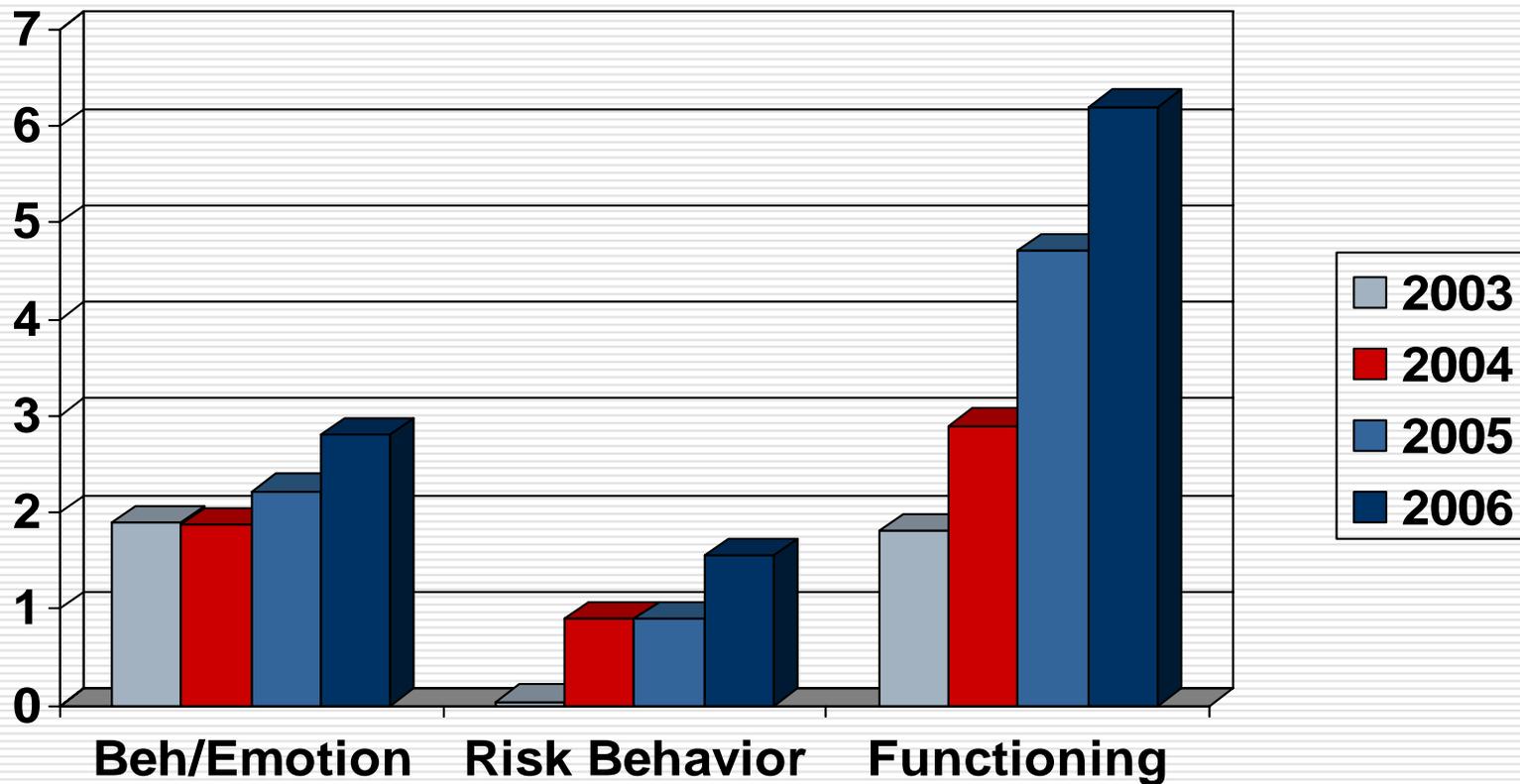
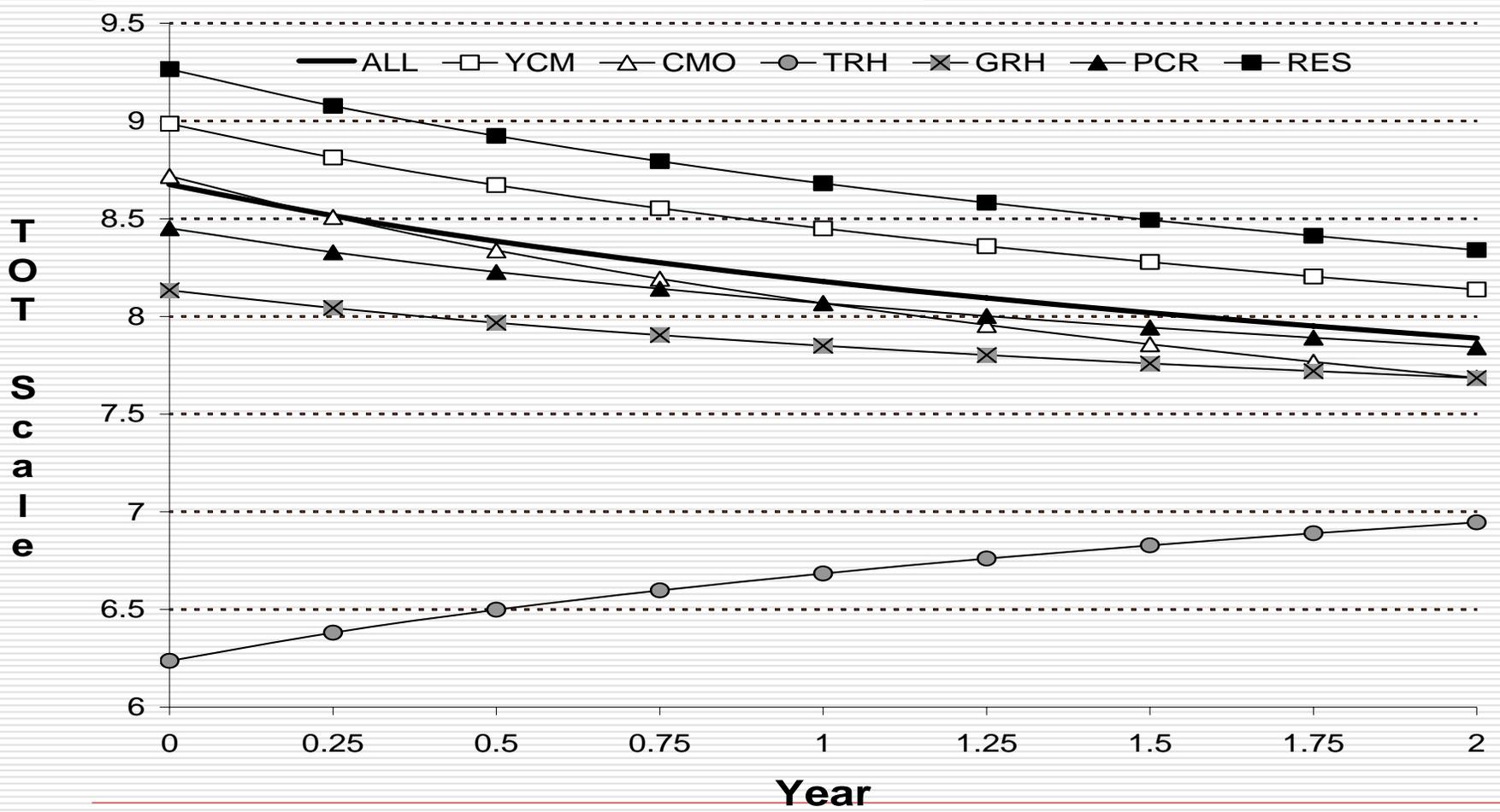


Figure 8. Average Improvement over the course of Residential Treatment by Year

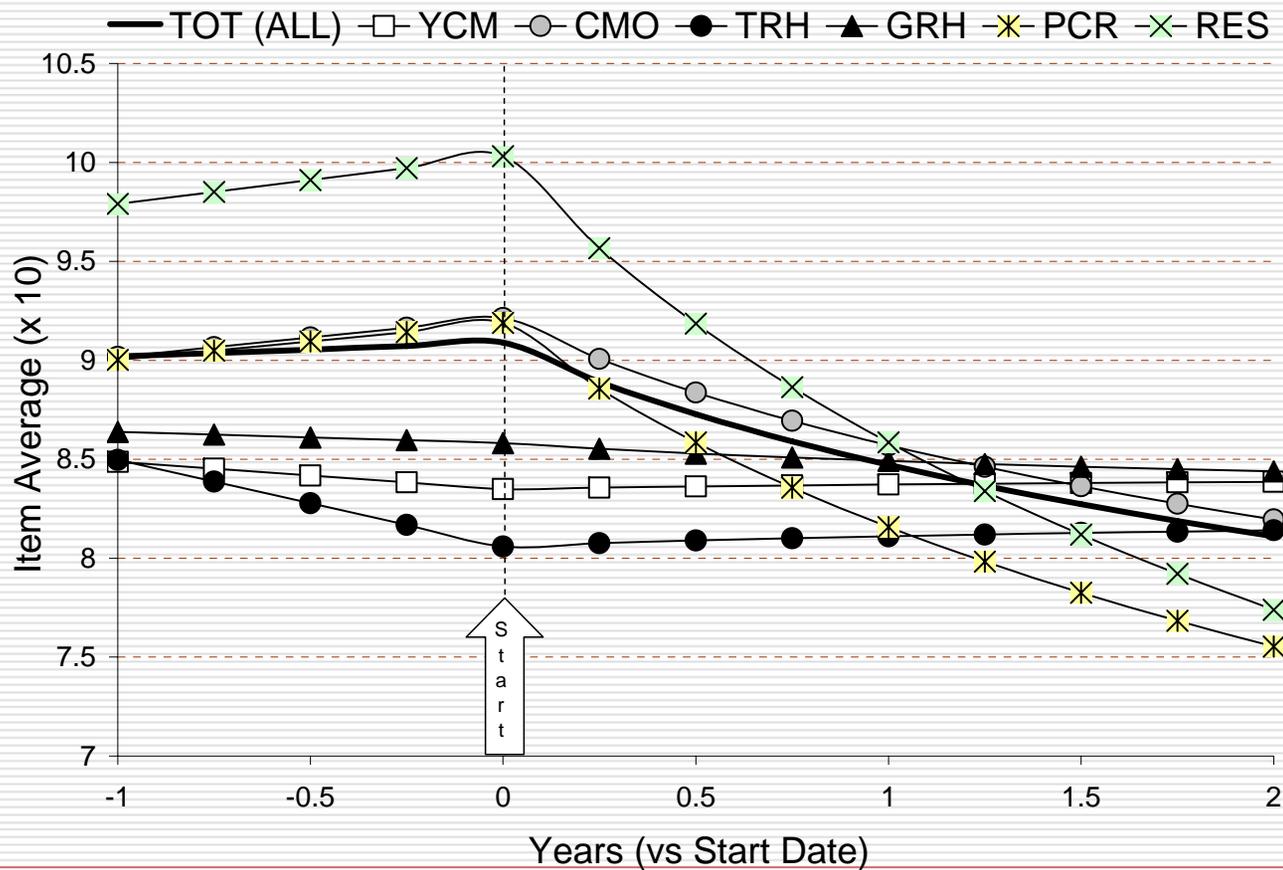
Note: higher score better improvement)



Outcome Trajectories by program type in New Jersey

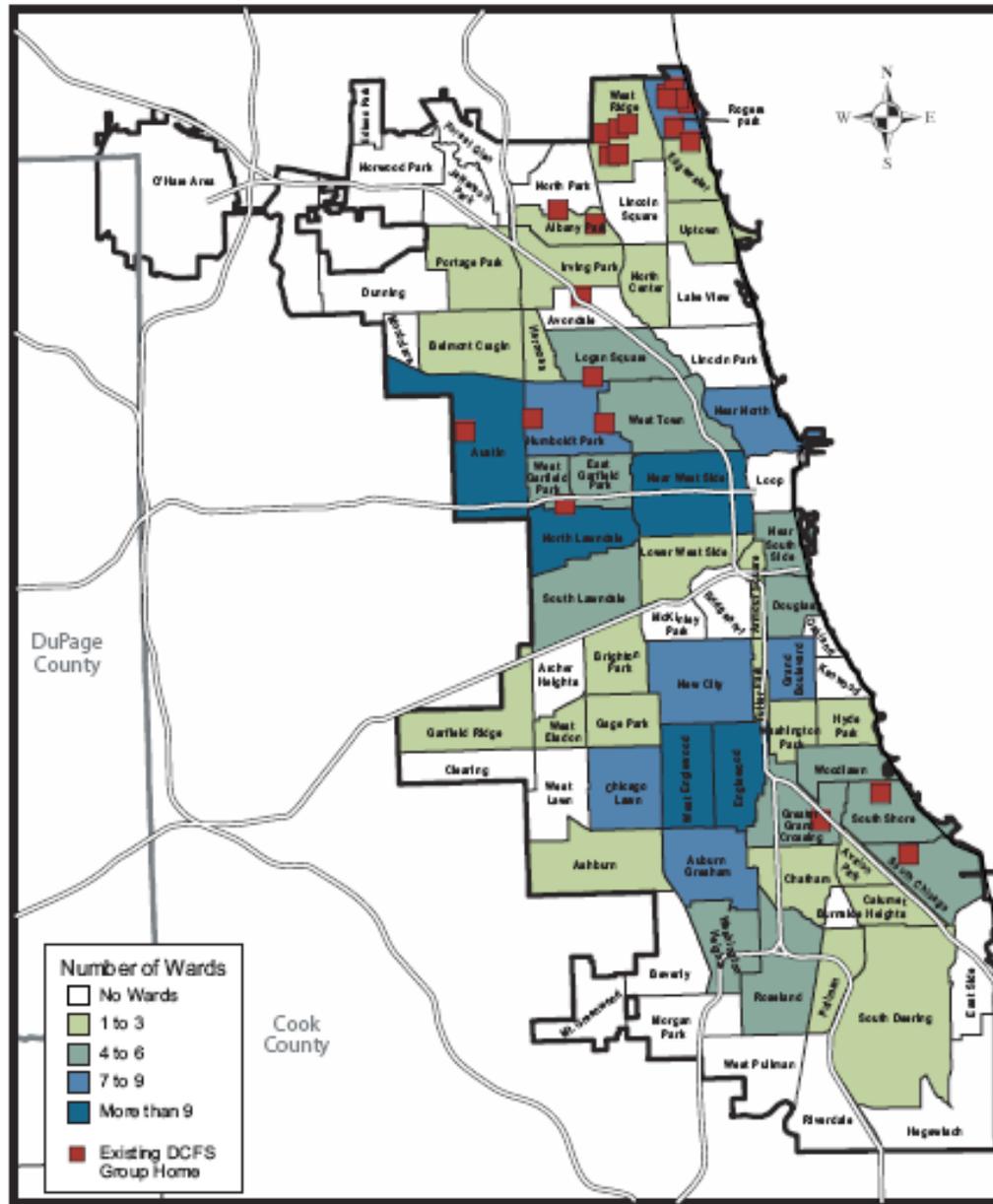


Hinge analysis of outcome trajectories prior to and after program initiation



DCFS Wards in Need of Group Homes

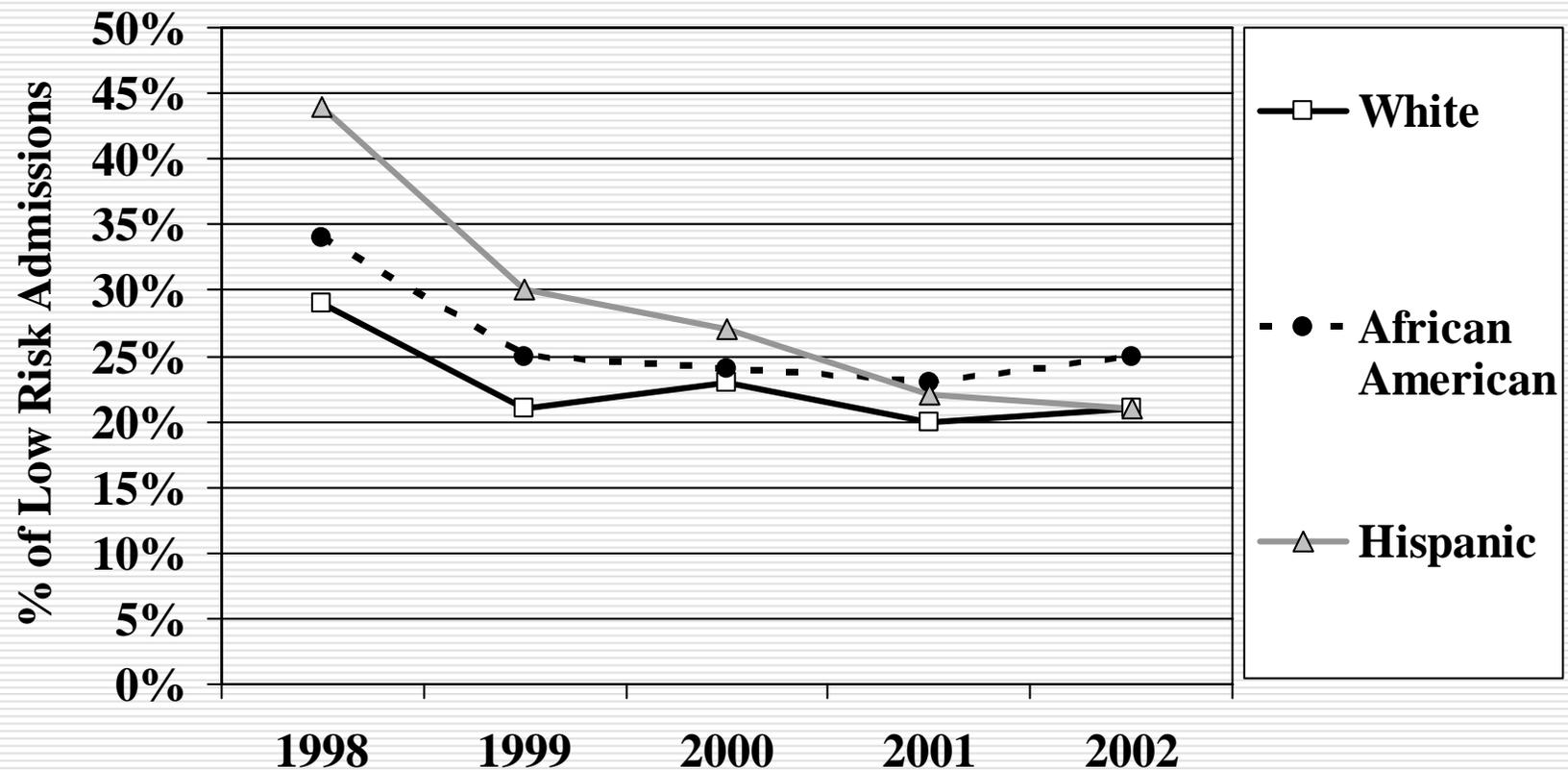
City of Chicago



Source: Illinois Department of Children & Family Services 2003

Percent of hospital admissions that were low risk by racial group

Adapted from Rawal, et al, 2003

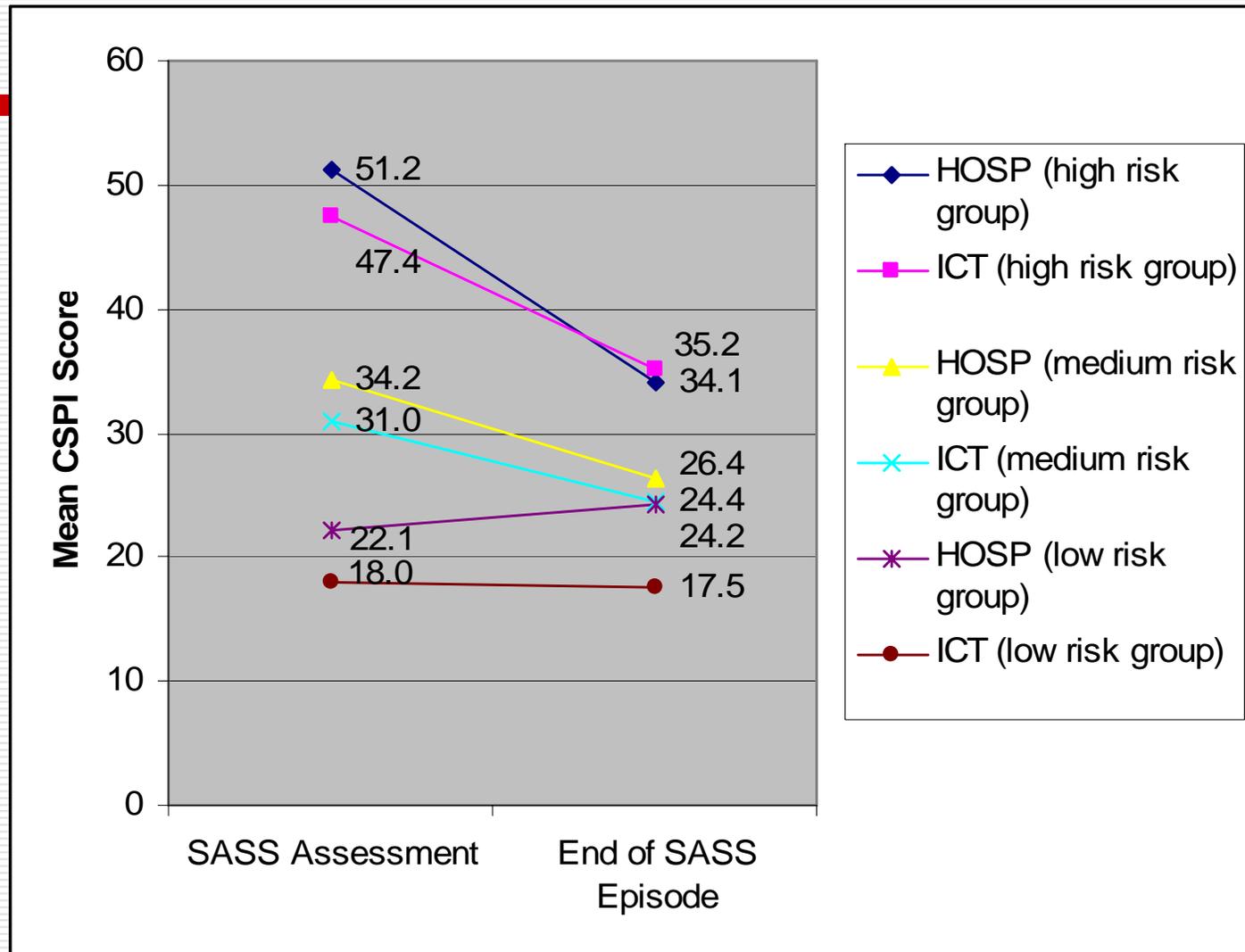


Key Decision Support CSPI Indicators Sorted by Order of Importance in Predicting Psychiatric Hospital Admission

If CSPI Item	Rated as	Start with 0 and
Suicide	2,3	Add 1
Judgment	2,3	Add 1
Danger to Others	2,3	Add 1
Depression	2,3	Add 1
Impulse/Hyperactivity	2,3	Add 1
Anger Control	3	Add 1
Psychosis	1,2,3	Add 1

Ratings of '2' and '3' are 'actionable' ratings, as compared to ratings of '0' (no evidence) and '1' (watchful waiting).

Change in Total CSPI Score by Intervention and Hospitalization Risk Level (FY06)



Integrating Total Clinical Outcome Management into Program Planning

