Managing the business of personal change:

TCOM and the myths of outcomes management
1. We are running a service delivery system
2. Outcomes management is a form of program evaluation and program evaluation is a form of applied research
3. Objective is better than subjective
4. You have to triangulate your outcomes by measuring different perspectives
5. Status at discharge represents an outcome
6. Changes in means represents meaningful changes in people
7. Discharge status is an outcome
Understanding the Business of Residential Treatment: The Hierarchy of Offerings

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

- Gilmore & Pine, 1997
Problems with Managing Services

- Find people and get them to show up
- Assessment exists to justify service receipt
- Manage staff productivity (case loads)
- Incentives support treating the least challenging individuals.
- Supervision as the compliance enforcement
- An hour is an hour. A day is a day
- System management is about doing the same thing as cheaply as possible.
How Transformation Management is Different

- Find people you can help, help them and then find some one else
- Accuracy is advocacy. Assessment communicate important information about the people we serve
- Impact (workload) more important that productivity
- Incentives to treat the most challenging individuals.
- Supervision as teaching
- Time early in a treatment episodes is more valuable than time later.
- System management is about maximizing effectiveness of the overall system
Myth 2: Outcome Management is not program evaluation and program evaluation is not research. Therefore, Outcomes Management is not research

It is engineering......
**Inputs** are the resources used by the program.

Examples: program staff, funding, time, external partners, volunteers, materials, equipment, technology

**Activities** are what the program does with its inputs to fulfill its mission.

Examples: events, informational materials, products, workshops, trainings, conferences, exhibits, curricula

**Audience** refers to the participants, clients, or customers reached by the program.

Examples: number of people attending an event, workshop, and/or training; type of participants (grade levels, ages, ethnicities, etc. of participants)

**Outcomes** are the results of your program. They are the changes that take place during or after the program for individuals, groups, communities, or organizations. These changes can take place over the short, intermediate, or long-term. Long-term outcomes are sometimes referred to as **Impacts**.

Examples of short/intermediate-term **Outcomes**: knowledge, attitudes, awareness, opinions, skills, behavior

Examples of **Impacts**: educational, environmental quality, or human health improvements

**Satisfaction** refers to participants’ satisfaction with their experience in the program and how it was implemented
The creative application of scientific principles to design or develop structures, machines, apparatus, or manufacturing processes, or works utilizing them singly or in combination; or to construct or operate the same with full cognizance of their design; or to forecast their behavior under specific operating conditions; all as respects an intended function, economics of operation or safety to life and property (American Engineer’s Council, 1947).
This belief leads us to focus on measuring things that are ‘objective’ rather than things that are relevant to a transformational enterprise.

There is substantial body research that demonstrates that global, subjective ratings are often more reliable and valid than very specific ratings.

Subjective does not mean unreliable. It means that judgment is involved. How can you be clinically, culturally or developmentally sensitive without exercising judgment.
Myth 5: You must triangulate by measuring multiple perspectives

- Youth self report, Parent report, therapist report, teacher report and so forth represent the standard of triangulation in research and program evaluation.
- We have been trying for more than 50 years to statistically create a consensus outcome—it is impossible.
- You have to triangulate first and then measure.
Scenario 1: Youth is distressed and the parent is minimizing the situation. With treatment the youth feels better and the parents come to realize the youth’s mental health needs.
Scenario 2. Parent is catastrophizing and youth is minimizing. With treatment the youth understand his her mental health needs better and the parent sees progress.
The problem with means of single perspectives—the average of two clinically successful treatment episodes equates to no effect
What is post-triangulation measurement?

- 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 inevitable conflict.
- This reality has created a significant amount of distrust
Different perspectives cause inevitable conflict. Resolving those perspectives requires conflict resolution strategies.

There are two key principles to effective conflict resolution:

- There must be a shared vision
- There must be a strategy for creating and communicating that shared vision
Let’s say you effectively help 75% of the youth you serve.

But the other 25% escalate and require something more intensive.

How does the mean change reflect your success rate?
Mean Outcomes of a Program that is successful 75% of the time
Myth 8: Discharge Status is an outcome

- The people with the best discharge status are generally those with the best admission status.
- This reality has led us to conclude that the people who have the best outcomes are the ones with the lowest needs.
- When you shift to understanding an outcome as personal change, the people with the best outcomes are the ones with the greatest need.
Core Concepts of Transformation Management

- We need to create and communicate a shared vision that is about wellbeing of our children and families. This shared vision has to involve the participation of all key partners in order to restore trust.
- We need to use that information to make good decisions about having an impact (rather than spending time and space with youth). This information must be used simultaneously at all levels of the system to ensure that we are all working towards the same goals.
- This is not going to be easy.
The Philosophy: Transformational Collaborative Outcomes Management (TCOM)

- **Transformation** means that it is focused on the personal change that is the reason for intervention.
- **Collaborative** means that a shared visioning approach is used—not one person’s perspective.
- **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.
Managing Tension is the Key to Creating an Effective System of Care

- Philosophy—always return to the shared vision. In the mental health system the shared vision are people with mental health challenges.
- 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.
Most measures are developed from a research tradition. Researchers want to know a lot about a little. Agents of change need to know a little about a lot. Lots of questions to measure one thing.

Traditional measurement is arbitrary. You don’t really know what the number means even if you norm your measures.

Traditional measurement confounds interventions, culture and development and become irrelevant or biases. You have to contextualize the understanding of a person in their environment to have meaningful information.

Triangulation occurs post measurement which is likely impossible.
The Strategy: CANS and FAST

Six Key Characteristics of a Communimetric Tool

- Items are included because they might impact care planning
- Level of items translate immediately into action levels
- It is about the individual not about the individual in care
- 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’
Action Levels of a Communimetric Measure

- **Needs**
  - 0 indicates no evidence, no need for action
  - 1 indicates watchful waiting/prevention
  - 2 indicates action
  - 3 indicates immediate/intensive action

- **Strengths**
  - 0 indicates a centerpiece strength
  - 1 indicates a useful strength
  - 2 indicates an identified (potential) strength
  - 3 indicates no strength yet identified
# TCOM Grid of Tactics

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Program</th>
<th>System</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decision Support</strong></td>
<td>Care Planning</td>
<td>Eligibility Step-down</td>
<td>Resource Management Right-sizing</td>
</tr>
<tr>
<td></td>
<td>Effective practices EBP’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Monitoring</strong></td>
<td>Service Transitions &amp; Celebrations</td>
<td>Evaluation</td>
<td>Provider Profiles Performance/Contracting</td>
</tr>
<tr>
<td><strong>Quality Improvement</strong></td>
<td>Case Management Integrated Care Supervision</td>
<td>CQI/QA Accreditation Program Redesign</td>
<td>Transformation Business Model Design</td>
</tr>
</tbody>
</table>
Strategies for Engagement and Shared Visioning

- A conversation
- About the what, not about the why—no shame or blame
- Time spent in understanding pays off in impact
- Output of an assessment process
- It is not an event
- Once one CANS/ANSA is completed you don’t ‘redo’ it, you check in on it.
Strategies Used For Treatment Planning

- Matching (with prioritization)
- Transformational Care Planning (CIMH)
- Clustering (Northwestern)
- Cross Cutting Needs (San Francisco)
- Treatment and Recovery Planning (TARP)
Responsibilities in Supervision

- Ensure compliance with policies and procedures
- Help manage schedules and workloads
- Improve quality of care provided by supervisees
- Facilitate professional development
- Problem solve challenges as they arise
Opportunities in Supervision

- Developing marketable skill sets including basic management skills
- Broadening clinical expertise through vicarious treatment experiences
- Mentoring bright young workers
- Helping improve the lives of a larger group of children and families
Strategies Used by Supervisors

- Review and sign off on any CANS/ANSA before submitted
- Discuss any case by first reviewing the CANS/ANSA so that it serves as Cliff/Coles Notes on the case
- Shadow a supervisee doing a CANS/ANSA with a family or individual
- Have a supervisee shadow supervisor doing a CANS/ANSA with a family or individual
- Use CANS/ANSA at the start of any discussion in case presentations or team supervisions
- Review family service plans using the SPANS or another approach to ensure that planning is guided by how the family or individual is understood using CANS/ANSA
- Monitor supervisee level reports on the status of their cases and outcomes from episodes of care and review performance with supervisees
Strategies for Decision Support

- Define Choices/Options
  - Treatment or placement type
  - Intensity of care
  - Level of Care
- Define Child/Family Level inputs into good decision making
- Create version of the tool that reflects that information
- Model and test algorithm
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

<table>
<thead>
<tr>
<th>If CSPI Item</th>
<th>Rated as</th>
<th>Start with 0 and</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide</td>
<td>2,3</td>
<td>Add 1</td>
</tr>
<tr>
<td>Judgment</td>
<td>2,3</td>
<td>Add 1</td>
</tr>
<tr>
<td>Danger to Others</td>
<td>2,3</td>
<td>Add 1</td>
</tr>
<tr>
<td>Depression</td>
<td>2,3</td>
<td>Add 1</td>
</tr>
<tr>
<td>Impulse/Hyperactivity</td>
<td>2,3</td>
<td>Add 1</td>
</tr>
<tr>
<td>Anger Control</td>
<td>3</td>
<td>Add 1</td>
</tr>
<tr>
<td>Psychosis</td>
<td>1,2,3</td>
<td>Add 1</td>
</tr>
</tbody>
</table>

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)

Mean CSPI Score

HOSP (high risk group)
ICT (high risk group)
HOSP (medium risk group)
ICT (medium risk group)
HOSP (low risk group)
ICT (low risk group)

SASS Assessment | End of SASS Episode
Strategies to Define Outcomes

- **Item Level**
  - Actionable vs Not Actionable and
  - Useful vs Not Useful

- **Dimension Scores**
  - Average items and multiply by 10

- **Total Score**
  - Combine dimension scores for functioning, symptoms and risks

- **Reliable Change Indices**
Table 2. Outcomes on Behavioral and Emotional Needs of 5248 youth over a residential treatment episode of care using items of the Child and Adolescent Needs and Strengths

<table>
<thead>
<tr>
<th>Condition</th>
<th>%Presenting</th>
<th>%Resolved</th>
<th>%Improved</th>
<th>%Identified</th>
<th>%Worsened</th>
<th>%Transitioning</th>
<th>%NetGain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger Control</td>
<td>60.2%</td>
<td>47.1%</td>
<td>56.1%</td>
<td>25.6%</td>
<td>14.0%</td>
<td>42.0%</td>
<td>30.2%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>10.9%</td>
<td>70.5%</td>
<td>74.7%</td>
<td>5.0%</td>
<td>10.8%</td>
<td>7.6%</td>
<td>30.2%</td>
</tr>
<tr>
<td>Adj to Trauma</td>
<td>48.5%</td>
<td>50.1%</td>
<td>60.1%</td>
<td>22.2%</td>
<td>15.2%</td>
<td>35.0%</td>
<td>27.8%</td>
</tr>
<tr>
<td>Depression</td>
<td>48.0%</td>
<td>52.0%</td>
<td>55.9%</td>
<td>24.5%</td>
<td>5.3%</td>
<td>35.8%</td>
<td>25.4%</td>
</tr>
<tr>
<td>Opposition</td>
<td>49.5%</td>
<td>42.7%</td>
<td>50.5%</td>
<td>22.9%</td>
<td>12.5%</td>
<td>37.9%</td>
<td>23.4%</td>
</tr>
<tr>
<td>Conduct</td>
<td>29.6%</td>
<td>59.3%</td>
<td>66.1%</td>
<td>16.7%</td>
<td>14.6%</td>
<td>23.8%</td>
<td>19.6%</td>
</tr>
<tr>
<td>Attention-Impulse</td>
<td>49.7%</td>
<td>46.7%</td>
<td>55.1%</td>
<td>20.0%</td>
<td>9.1%</td>
<td>40.1%</td>
<td>19.3%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>29.5%</td>
<td>50.9%</td>
<td>54.1%</td>
<td>19.0%</td>
<td>6.0%</td>
<td>25.1%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Substance Use</td>
<td>16.0%</td>
<td>55.8%</td>
<td>61.1%</td>
<td>11.6%</td>
<td>17.3%</td>
<td>15.5%</td>
<td>3.1%</td>
</tr>
</tbody>
</table>
Outcomes on Behavioral and Emotional Needs of 5248 youth over a residential treatment episode of care using items of the Child and Adolescent Needs and Strengths

<table>
<thead>
<tr>
<th>Dangerous Behavior</th>
<th>%Presenting</th>
<th>%Resolved</th>
<th>%Improved</th>
<th>%Identified</th>
<th>%Worsened</th>
<th>%Transitioning</th>
<th>%NetGain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide</td>
<td>11.0%</td>
<td>82.0%</td>
<td>83.9%</td>
<td>3.9%</td>
<td>10.3%</td>
<td>5.4%</td>
<td>50.9%</td>
</tr>
<tr>
<td>Sexual Aggression</td>
<td>11.6%</td>
<td>76.7%</td>
<td>82.9%</td>
<td>5.0%</td>
<td>14.0%</td>
<td>6.5%</td>
<td>43.9%</td>
</tr>
<tr>
<td>Self Injury</td>
<td>9.2%</td>
<td>80.2%</td>
<td>83.0%</td>
<td>3.7%</td>
<td>20.3%</td>
<td>5.2%</td>
<td>43.4%</td>
</tr>
<tr>
<td>Danger to Others</td>
<td>37.6%</td>
<td>66.1%</td>
<td>69.8%</td>
<td>27.2%</td>
<td>8.6%</td>
<td>23.3%</td>
<td>38.0%</td>
</tr>
<tr>
<td>Other Self Harm</td>
<td>17.1%</td>
<td>78.4%</td>
<td>80.7%</td>
<td>9.0%</td>
<td>5.2%</td>
<td>11.2%</td>
<td>34.5%</td>
</tr>
<tr>
<td>Runaway</td>
<td>37.2%</td>
<td>49.2%</td>
<td>58.1%</td>
<td>22.5%</td>
<td>35.7%</td>
<td>33.0%</td>
<td>11.3%</td>
</tr>
</tbody>
</table>
Illinois Trajectories of Recovery before and after entering different types of Child Welfare Placements
Shifting to Transformational Management is not easy

- To be successful we must learn to:
  - embed shared vision approaches into the treatment planning and supervision at the individual level
  - treat documentation with the same level of respect that we treat our youth and families
  - aggregate and use this information to inform policy decisions
  - change financing structures to support transformation management, not service receipt.
  - trust each other