John S. Lyons, Ph.D.
Chapin Hall at the University of Chicago

# Transformational Collaborative Outcomes Management
# Creating and managing systems that care

## It's about personal change

# Keys to implementation

- Support staff throughout the learning process—creating a learning culture
- Understand what it is and what it is not.
- Leadership buy-in/support. Need an organizational champion with some clout
- Embed in the process of care—specifically treatment planning and supervision at minimum
- Create a culture that celebrates success rather than enables complaint
- Embrace information culture opportunities—streamline paperwork and increase respect for the accuracy of documentation

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# Child and Adolescent Needs and Strengths (CANS)

## The CANS is not the point

# 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

# Next Problem. How do you engineer effectiveness?

- Because of our service management mentality the lowest paid, least experienced people spend the most time with our youth and families.
- Need to take collective wisdom and somehow help young staff get up to speed on being effective really fast.
- Pilots don't fly planes anymore. Planes fly themselves. Is there a lesson there for us?

# Third problem. Where's the love? Have we lost faith in each other caring about our youth and families?

- 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

# Complicated versus Complex Systems

- Similarities
  - Both have many component parts.
  - Both require integration for the system to function effectively
- Differences
  - In complicated systems all component parts are 100% predictable
  - In complex systems component parts are not 100% predictable—human being are never 100% predictable

# Only two known strategies to integrate complex system

- Hierarchical integration
  - Higher authority tells people what to do and they do it
  - Works well when there is a single line of authority
- Collaborative integration
  - Try to establish a consensus understanding and plan
  - Only possible workable integration strategy where there are multiple lines of authority

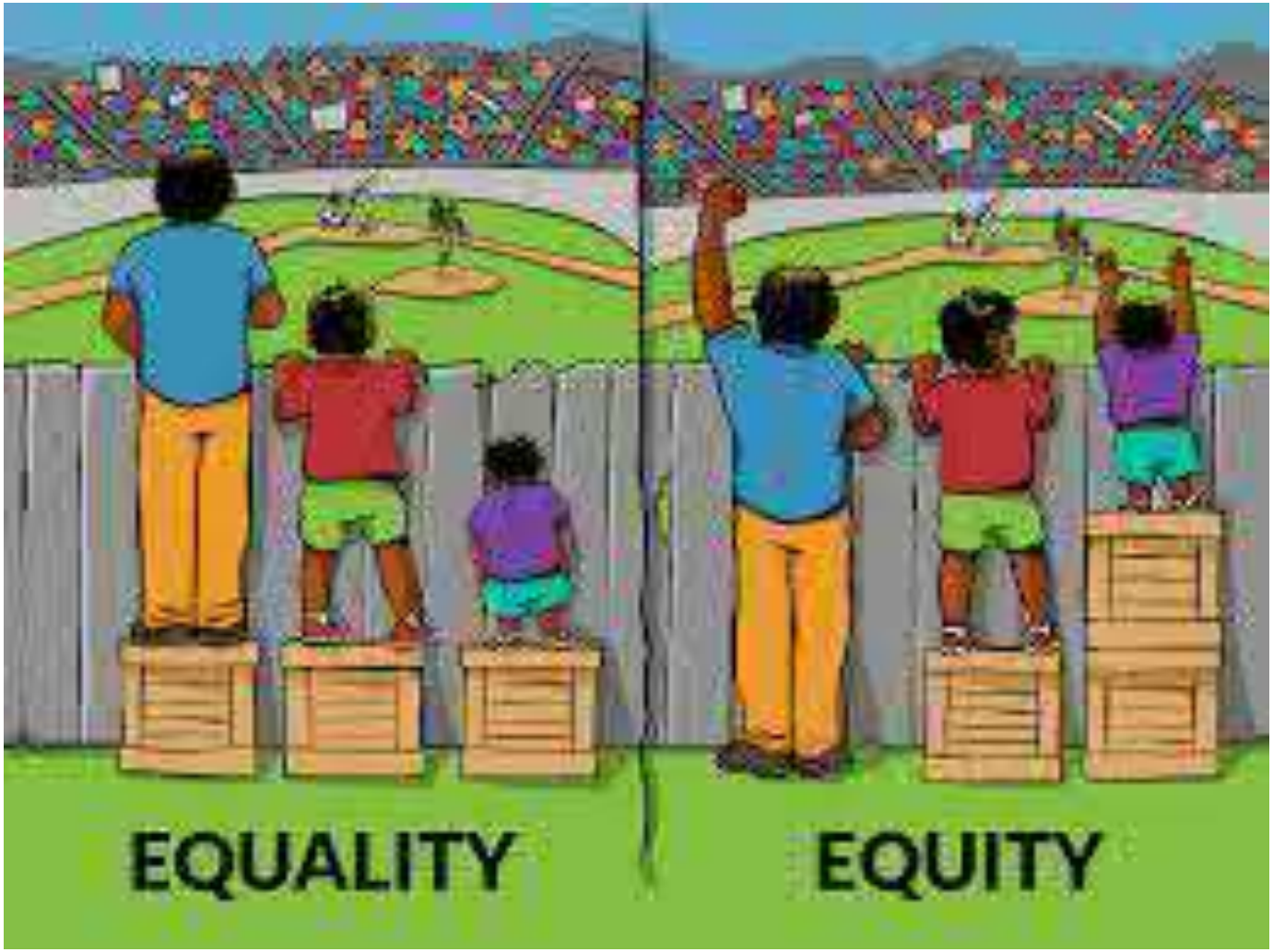
# Transformational Collaborative Outcomes Management

Developing a shared vision— a shared understanding of the problems and how they came about, shared goals and a set of actions to achieve those goals– is key to any change happening.

# Restoring Trust—the essential outcome of conflict management

- 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

# Equality vs Equity in the definition of fairness



# 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.

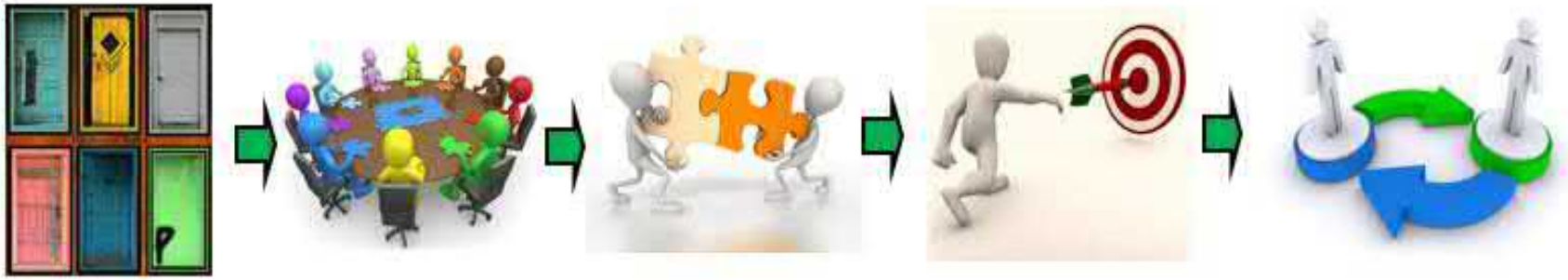
# The Philosophy: Transformational Collaborative Outcomes Management (TCOM)

- ***Transformational*** 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 the children and families we serve
- 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

# TCOM Key Decision Points



# Decision Support on Key Decisions

- Should be informed by the needs of the individual (child and family)
  - Although other considerations must be included
- Information about these needs must be available PRIOR to decisions being made
- Documentation should reflect these effective decision making processes
  - Information efficiency promotes clinical effectiveness. Work smarter not harder

# Why I don't think traditional measurement approaches help us manage transformations

- 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'

# Key Characteristics of the CANS

- Shared Vision approach
  - *About the child not the child-in-care*
  - *Consider culture and development before establishing the action levels*
  - *About the 'what' not the 'why'*
- Information Science approach (relevant, actionable and timely)
  - *Each item is relevant for decision support for children and families*
  - *Levels of the items translate immediately into action*
  - *Is it relevant in the last 30 days?*

# TCOM Grid of Tactics

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

# Defining a Need

- A **need** is a characteristic of a person (within an environment) that describes a situation where external assistance could be beneficial. It is the interaction of the person and environment that is key to understanding the presence of a need. Although the personal characteristics might directly create a need, it is MORE LIKELY that the person's environment effects the *expression* of that need. And, although environmental characteristics might directly create a need, it is more likely that the presence of specific personal characteristics effects the expression of the need.

# Defining a Strength

- A strength is a characteristic of a person in the environment that describes a situation that promotes meaning and wellbeing in that person's life. While some strengths are more *personal characteristics* (e.g., musical talent) and other strengths are more *characteristics of the environment* (e.g. family), it is generally the case that it is the ***interaction*** of the person and environment that is key to understanding the presence of a **strength**.

# Action Levels

- Needs
  - 0 No evidence, no need for action
  - 1 Watchful waiting/prevention
  - 2 Action
  - 3 Immediate/intensive action
- Strengths
  - 0 Centerpiece strength—focus of plan
  - 1 Useful strength (but not focus)
  - 2 Identified strength but need to build
  - 3 Not yet identified

# Promoting Collaborative Treatment Planning

- Collaboration is interactive and ongoing
- Skill building to get from the what to the why
  - Importance of client's theory of change *and* clinical expertise
- Transparency and use of data with clients and families
- Supervisor training and support
  - How does the client/family make sense of these ratings?
  - Supervise like the client is in the room
- Clinical practices focused on client centered approaches
- Revised documentation and timelines

# A SIMPLE VERSION OF THE PROCESS OF CARE

- START with the 'WHAT' (describe the circumstance)
- CONSIDER the 'WHY' (understand what is happening. This is a clinical formulation)
- DETERMINE the 'HOW' (develop a plan to help)

# Getting to the How

- Clear need to bundle actionable items into treatment targets
- Help to focus on high impact needs or the most annoying problem.
- Work together to understand the complexity of the needs

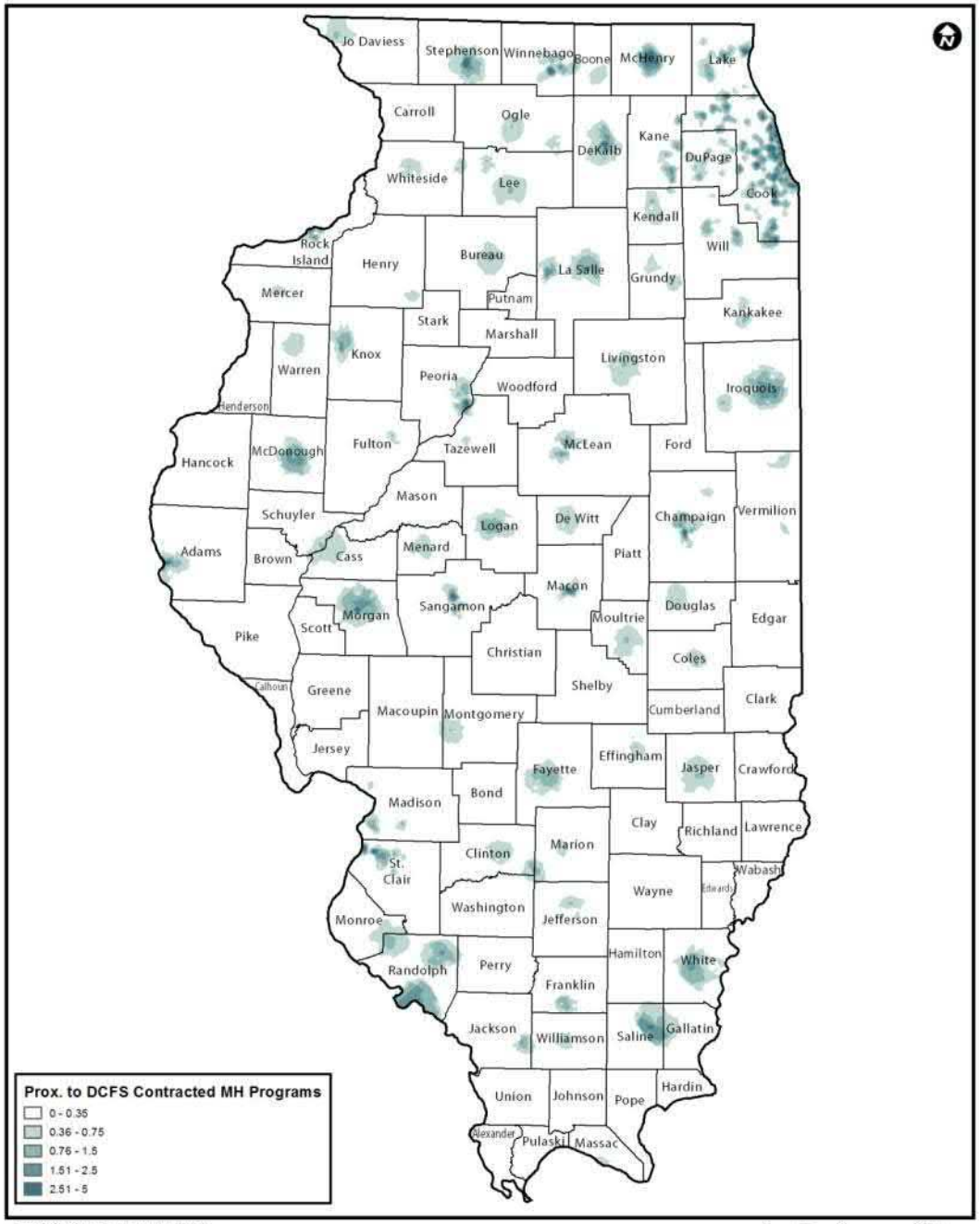
# Treatment Planning Form

- Background Needs (ratings of 2 or 3)
  - Can't change
  - Choose not to address at this time
- Treatment Targets (ratings of 2 or 3)
  - Causes
- Anticipated Outcomes (ratings of 2 or 3)
  - Effects
- Useful Strengths (ratings of 0 or 1)
- Strengths to build (ratings of 1, 2 or 3)

By using Provider and Child proximity scores IDCFS will be able to realign contracted services to better serve children and families:

1. *Eliminates waste by identifying contracted services that may be at locations which are difficult for children reach.*
    - ***A proximity threshold***
2. Identifies areas where DCFS needs to recruit new providers, or encourage providers to relocate, in order to improve service proximity for children.
    - Convert clusters of children into 'hot spots'
    - Convert clusters of providers into 'cold spots'
3. Optimizes current contracts by placing them with providers that children can easily reach.
    - Allows you to model impacts prior to action.

**DCFS Wards with MH Needs & Proximity to MH Programs April 2012**




Source: Northwestern University MHSPP

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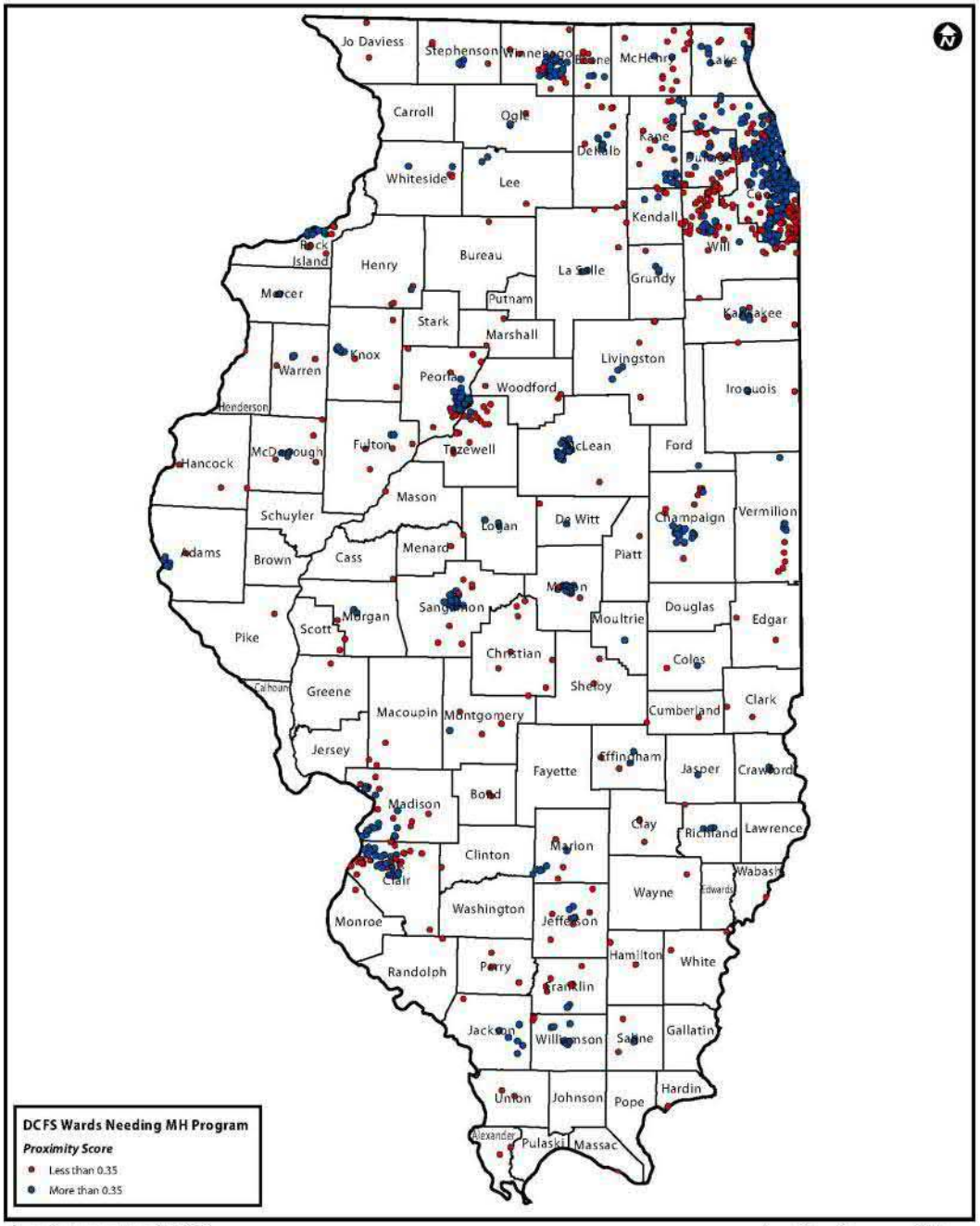
## Need for DCFS Contracted MH Programs April 2012




Source: Northwestern University MHSPP

# 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

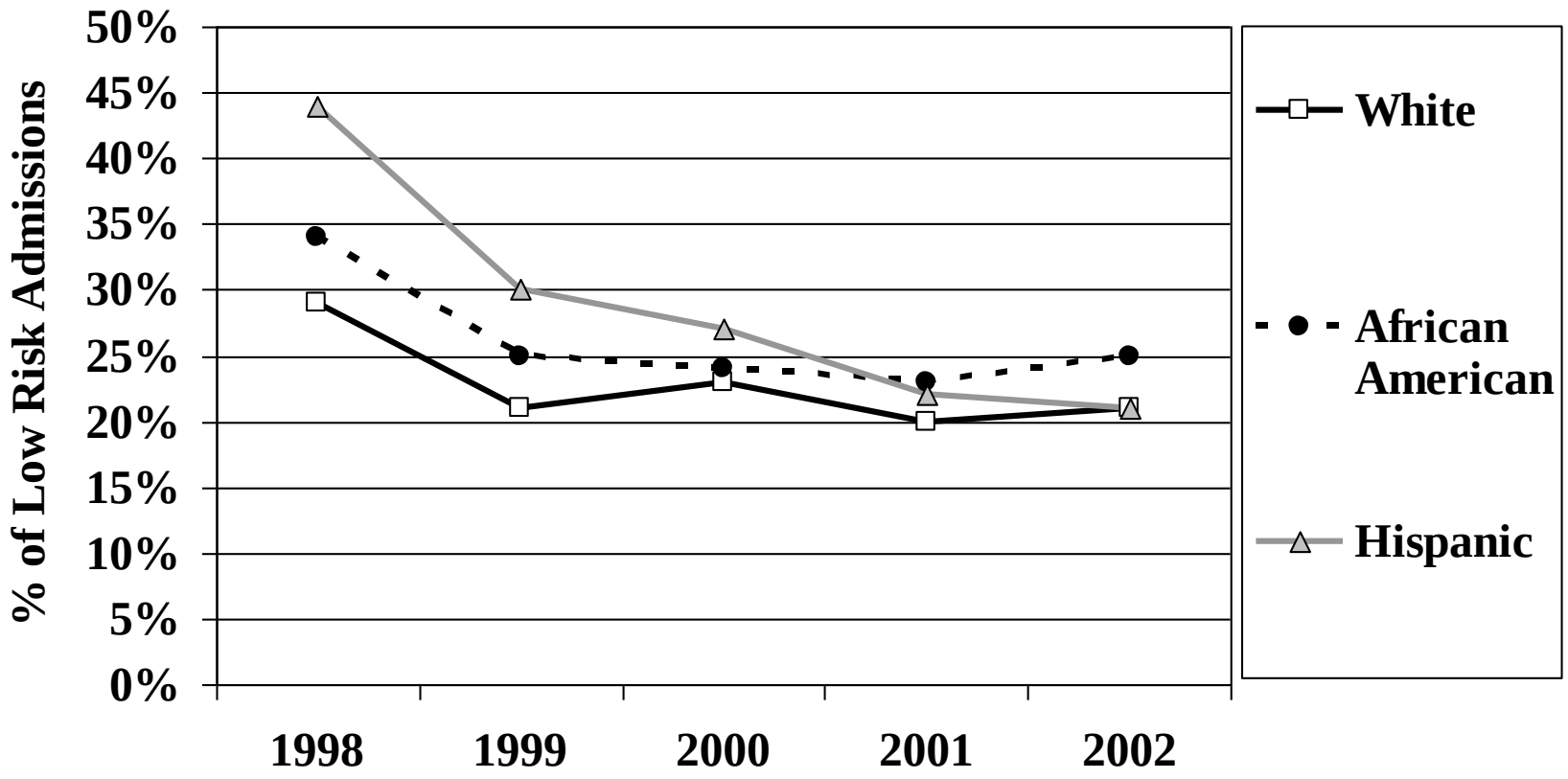
- Review and sign off on any CANS/ANSA before submitted
- Discuss any case by first reviewing the CANS/ANSA so that it serves as Cliff/Coles Notes on the case
- Shadow a supervisee doing a CANS/ANSA with a family or individual
- Have a supervisee shadow supervisor doing a CANS/ANSA with a family or individual
- 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

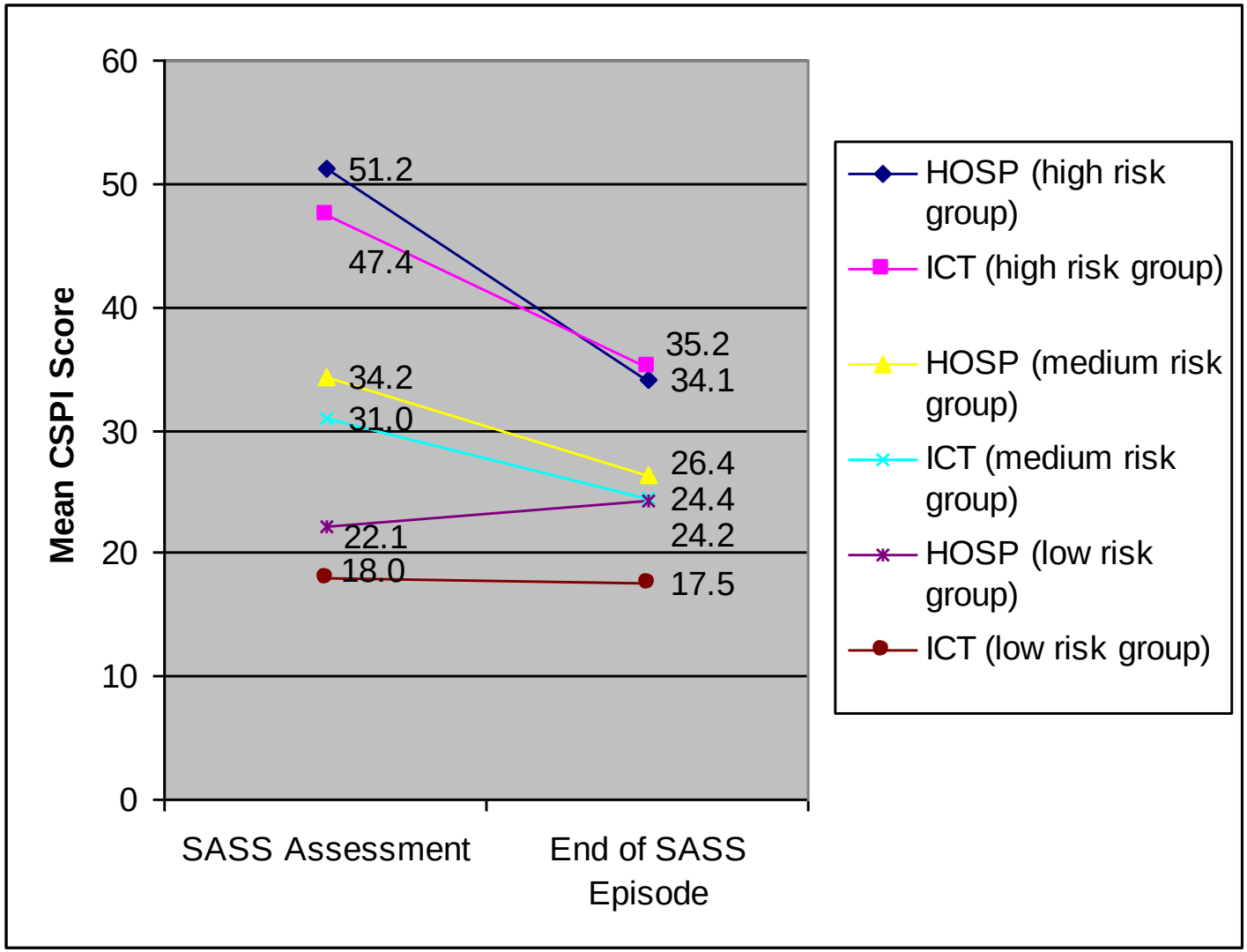


# Key Decision Support CSPI Indicators
# Sorted by Order of Importance in Predicting Psychiatric Hospital Admission

| 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)



# 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

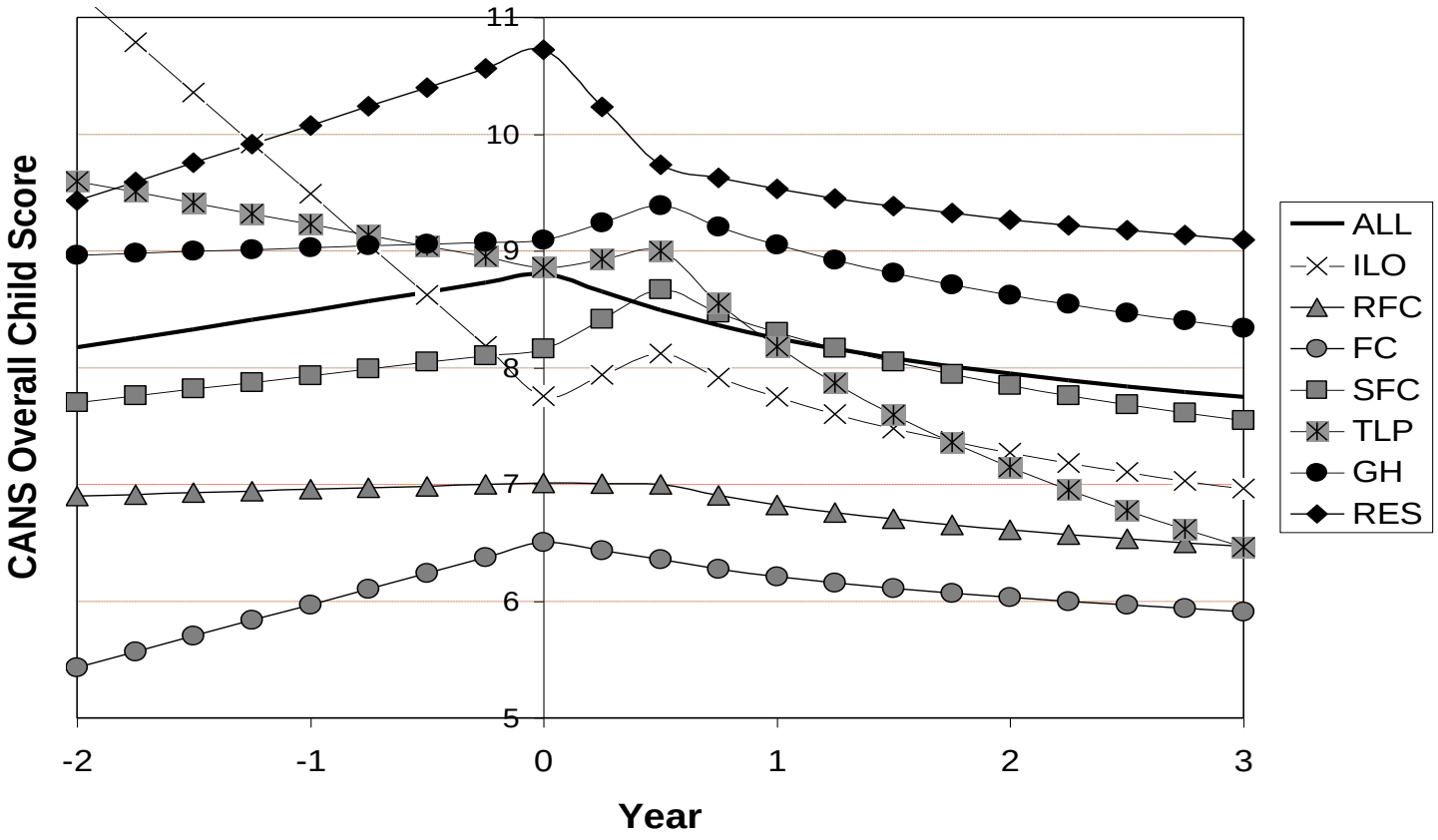
Table 2. Outcomes on Behavioral and Emotional Needs of 5248 youth over a residential treatment episode of care using items of the Child and Adolescent Needs and Strengths

| Mental Health | %Presenting | %Resolved | %Improved | %Identified | %Worsened | %Transitioning | %NetGain |
|---|---|---|---|---|---|---|---|
| Anger Control | 60.2% | 47.1% | 56.1% | 25.6% | 14.0% | 42.0% | 30.2% |
| Psychosis | 10.9% | 70.5% | 74.7% | 5.0% | 10.8% | 7.6% | 30.2% |
| Adj to Trauma | 48.5% | 50.1% | 60.1% | 22.2% | 15.2% | 35.0% | 27.8% |
| Depression | 48.0% | 52.0% | 55.9% | 24.5% | 5.3% | 35.8% | 25.4% |
| Opposition | 49.5% | 42.7% | 50.5% | 22.9% | 12.5% | 37.9% | 23.4% |
| Conduct | 29.6% | 59.3% | 66.1% | 16.7% | 14.6% | 23.8% | 19.6% |
| Attention-Impulse | 49.7% | 46.7% | 55.1% | 20.0% | 9.1% | 40.1% | 19.3% |
| Anxiety | 29.5% | 50.9% | 54.1% | 19.0% | 6.0% | 25.1% | 14.9% |
| Substance Use | 16.0% | 55.8% | 61.1% | 11.6% | 17.3% | 15.5% | 3.1% |

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

| Dangerous Behavior | %Presenting | %Resolved | %Improved | %Identified | %Worsened | %Transitioning | %NetGain |
|---|---|---|---|---|---|---|---|
| Suicide | 11.0% | 82.0% | 83.9% | 3.9% | 10.3% | 5.4% | 50.9% |
| Sexual Aggression | 11.6% | 76.7% | 82.9% | 5.0% | 14.0% | 6.5% | 43.9% |
| Self Injury | 9.2% | 80.2% | 83.0% | 3.7% | 20.3% | 5.2% | 43.4% |
| Danger to Others | 37.6% | 66.1% | 69.8% | 27.2% | 8.6% | 23.3% | 38.0% |
| Other Self Harm | 17.1% | 78.4% | 80.7% | 9.0% | 5.2% | 11.2% | 34.5% |
| Runaway | 37.2% | 49.2% | 58.1% | 22.5% | 35.7% | 33.0% | 11.3% |

# 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
  - aggreggate and use this information to inform policy decisions
  - change financing structures to support transformation management, not service receipt.
  - trust each other

# What is a Myth

- 1.a traditional or legendary story, usually concer ning some being or hero or even, with or without a determinable basis of fact or a natural explanation,
- 2.stories or matter of this kind: *realm of myth.*
- 3.any invented story, idea, or concept: *His account of the event is pure myth.*
- 4.an imaginary or fictitious thing or person.
- 5.an unproved or false collective belief that is used to justify a social institution.

# The Myths

- 1. We are running a service delivery system
- 2. Outcomes management is a form of program evaluation
- 3. Program evaluation is a form of applied research
- 4. Objective is better than subjective
- 5. You have to triangulate your outcomes by measuring different perspectives
- 6. Status at discharge represents an outcome
- 7. Changes in means represents meaningful changes in people

# Understanding the Business of Residential Treatment: The Hierarchy of Offerings

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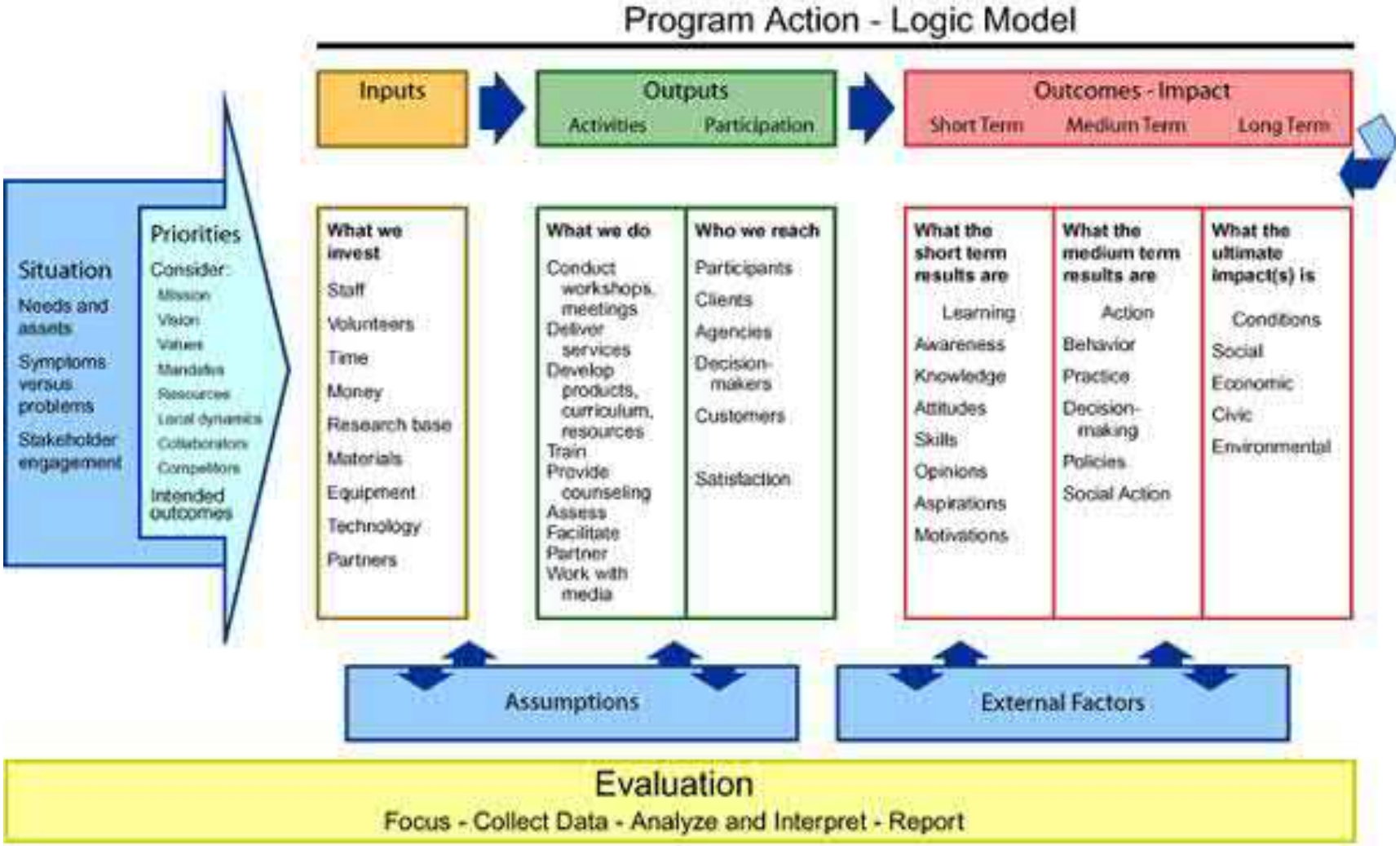
**Myth 2: Outcome Management is not program evaluation and Myth 3: Program evaluation is not research. Therefore, Outcomes Management is not research**

**It is engineering……**


Program Action - Logic Model
Inputs
Outputs
Activities
Participation
Outcomes - Impact
Short Term
Medium Term
Long Term
Situation
Needs and assets
Symptoms versus problems
Stakeholder engagement
Priorities
Consider:
Mission
Vision
Values
Mandates
Resources
Local dynamics
Collaborators
Competitors
Intended outcomes
What we invest
Staff
Volunteers
Time
Money
Research base
Materials
Equipment
Technology
Partners
What we do
Conduct workshops, meetings
Deliver services
Develop products, curriculum, resources
Train
Provide counseling
Assess
Facilitate
Partner
Work with media
Who we reach
Participants
Clients
Agencies
Decision-makers
Customers
Satisfaction
What the short term results are
Learning
Awareness
Knowledge
Attitudes
Skills
Opinions
Aspirations
Motivations
What the medium term results are
Action
Behavior
Practice
Decision-making
Policies
Social Action
What the ultimate impact(s) is
Conditions
Social
Economic
Civic
Environmental
Assumptions
External Factors
Evaluation
Focus - Collect Data - Analyze and Interpret - Report

## INPUTS

***Inputs*** are the resources used by the program.

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

## OUTPUTS

### ACTIVITIES

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

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

### AUDIENCE

***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)

***Satisfaction*** refers to participants' satisfaction with their experience in the program and how it was implemented

## OUTCOMES

### SHORT-TERM INTERMEDIATE LONG-TERM

***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

# Engineering

- 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).

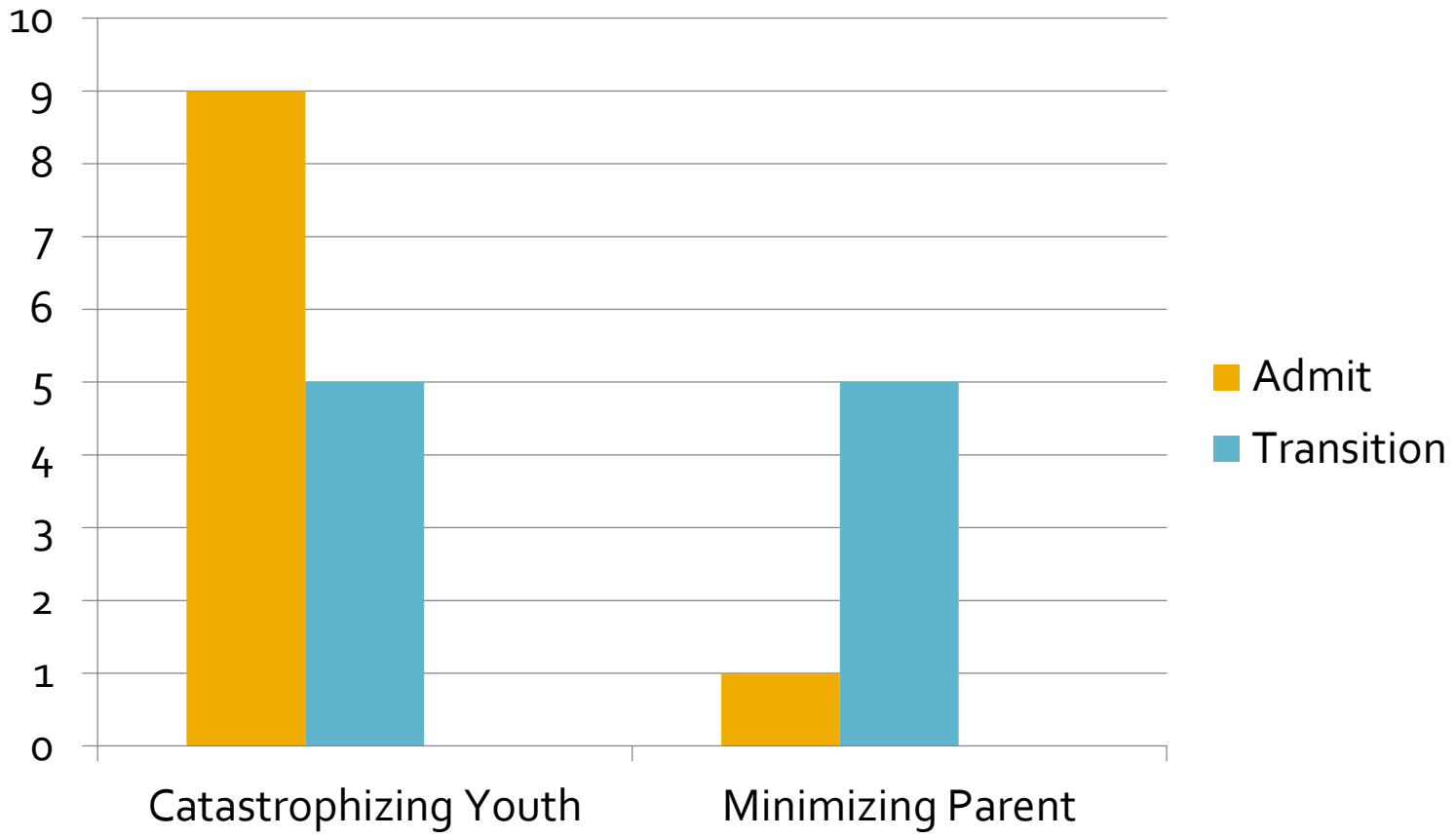
# Myth 4: Objective is better than subjective

- 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 that very specific ratings
- Subjective does not means unreliable. It means that judgment is involved. How can you be clinically, culturally or developmentally sensitive without exercising judgment

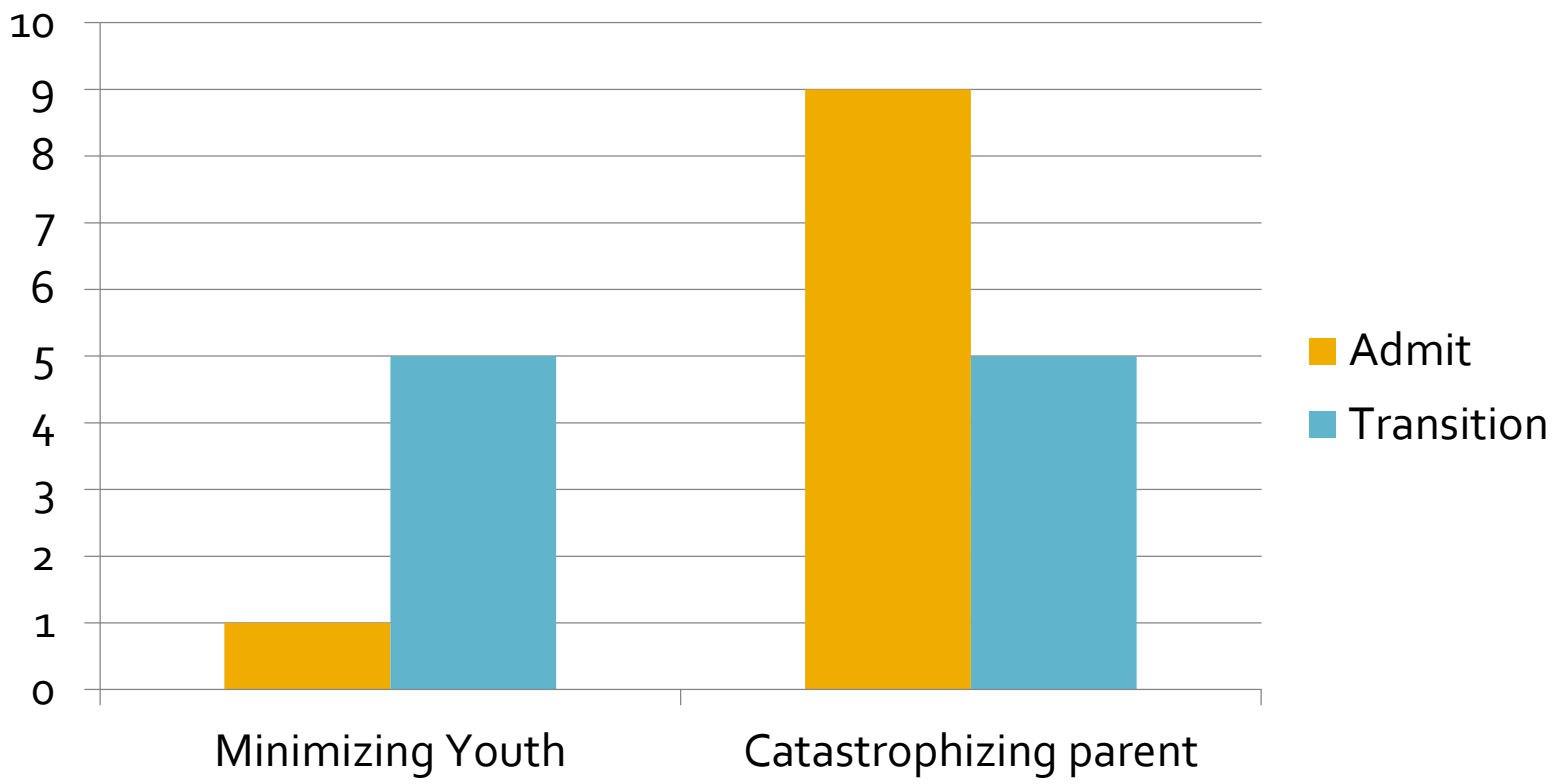
# Myth 5: You must triangulate by measuring multiple perspectives

- 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.

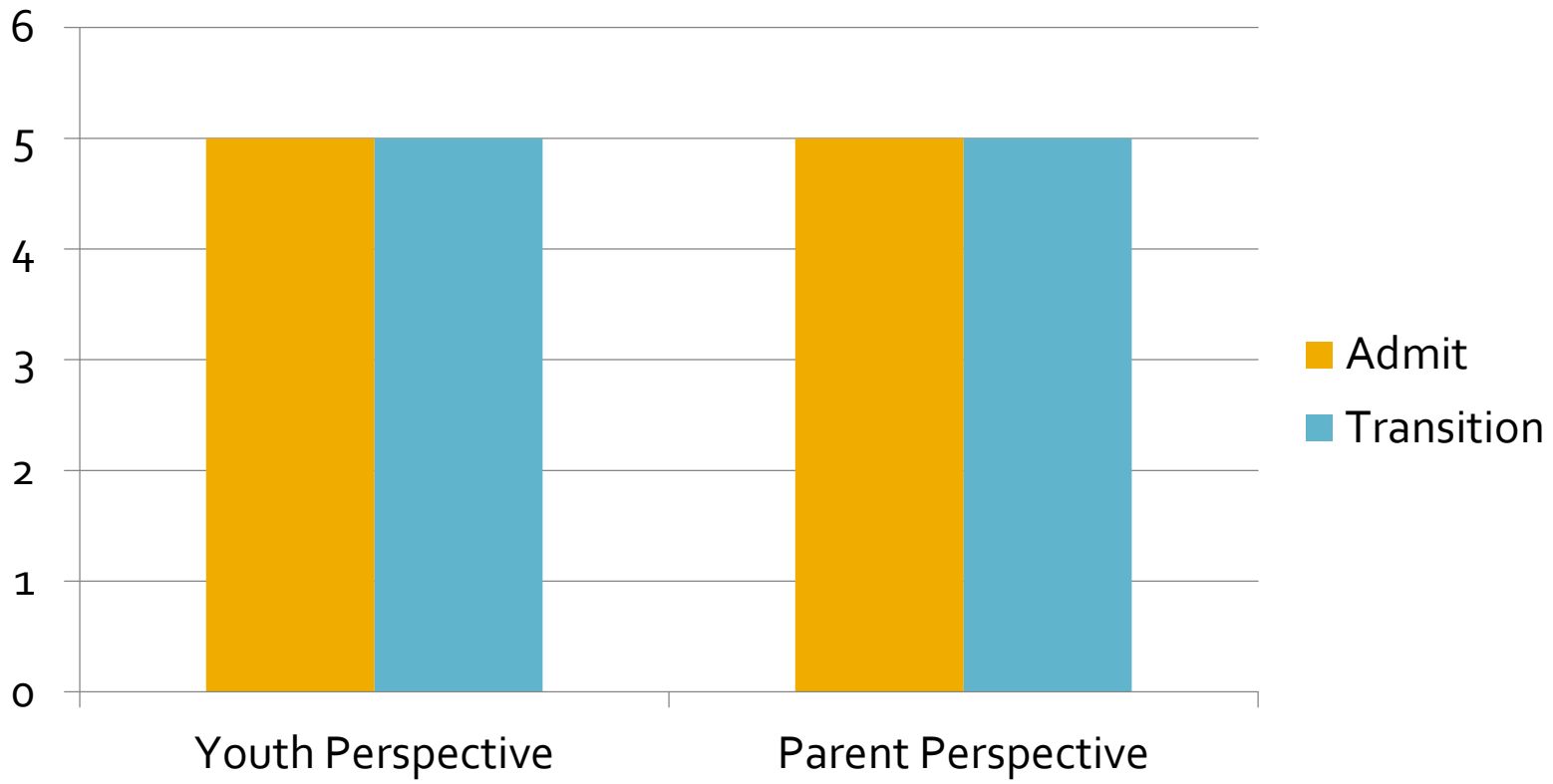
# Scenario 1: Youth is distressed and the parent is minimizing the situation. With treatment the youth feels better and the parents come to realize the youth's mental heath needs



# 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



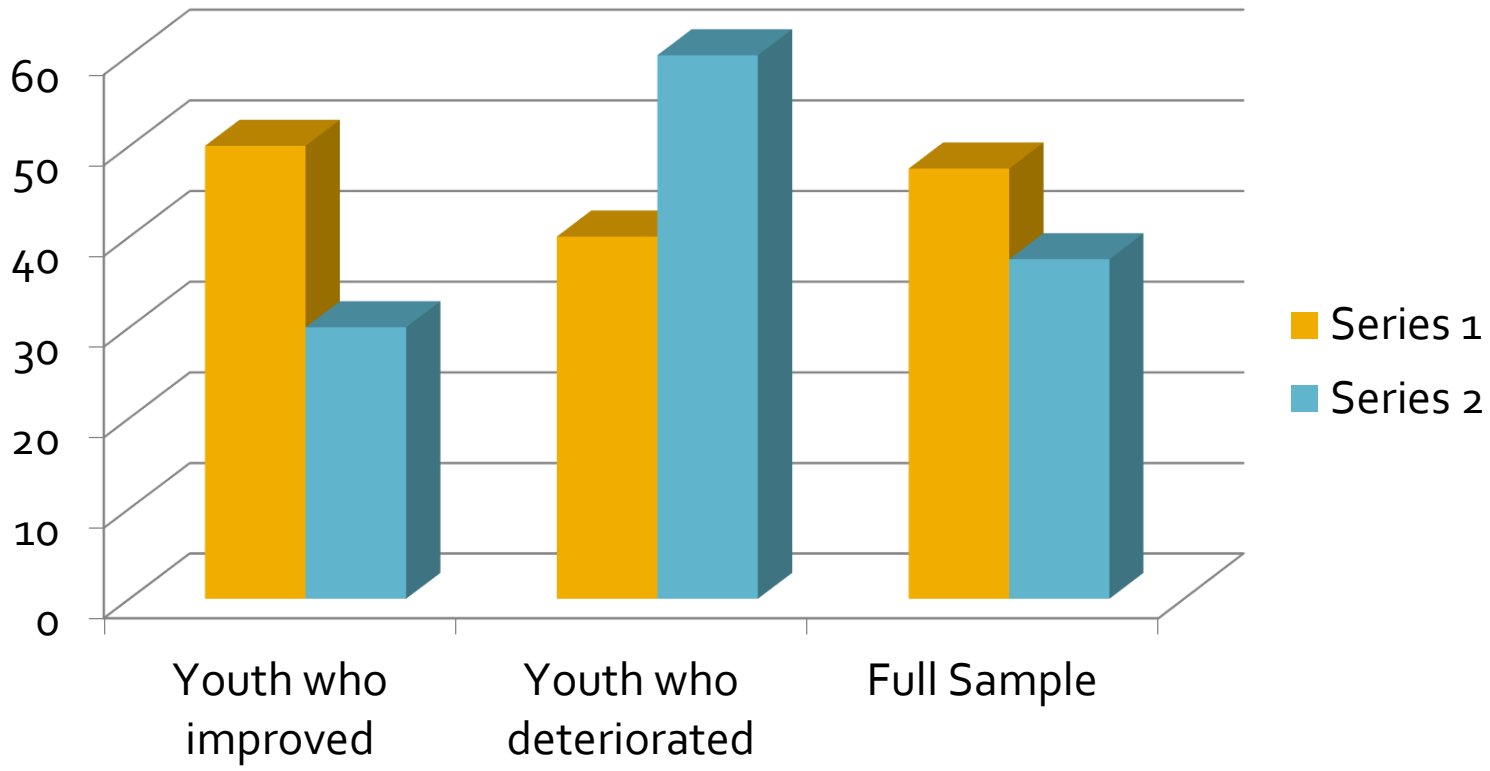
# Myth 6 Status at discharge represents an outcome

- There is a large body of research that demonstrates that the people who need our interventions the least have the best outcomes.
- All of that research uses status at discharge as the definition of an outcome.
- Of course, many of these individuals who 'need it the least, have already achieved the positive status prior to the intervention.
- This body of research is simply irrelevant for the business of personal change

# Myth 7. Means reflect meaningful change

- 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



# Barriers to Collaboration

- Pathology/deficit based model required by funders
- Not enough time. Focus on "getting the numbers up"
- Cautious about disallowances; documentation must highlight deficits
- "Not how I was taught in school"
- Focus on clinical expertise and theoretical orientation
- Pressure to focus on the referring party
- Misunderstanding of recovery and wraparound

# Keys to implementation

- Support staff throughout the learning process—creating a learning culture
- Understand what it is and what it is not.
- Leadership buy-in/support. Need an organizational champion with some clout
- Embed in the process of care—specifically treatment planning and supervision at minimum
- Create a culture that celebrates success rather than enables complaint
- Embrace information culture opportunities—streamline paperwork and increase respect for the accuracy of documentation

# Distinguish between a 'centerpiece' piece and a 'useful' strength

- Useful
  - Play youth hockey
  - Sing in a choir
  - Supportive family members
  - Interested in what happens around them
- Centerpiece
  - Good enough at hockey to get drafted or scholarship
  - Soloist in choir, could get scholarship
  - Parents fully committed to doing everything in their power to support the success of their children
  - Constantly seeks new stimuli, exposure, opportunities to learn

# CANS as Conversation vs Checklist

- Don't treat it like an assessment
- Don't go through it in the order of the form
- Encourage the family to tell their story in their words and then work with them to translate it into a common language
- Listen as family member talk and remember key things that say that would translate into CANS needs or strengths

# CANS as unstructured conversation

- Scripted interview protocols are generally more useful to clinicians than to families. Some families like them others find them off putting.
- The CANS is not an assessment it is a structured way of communicating the output of an assessment process

# Benjamin Franklin

Tell me and I forget

Teach me and I remember

Involve me and I learn

# Challenging Items

- Traumatic Experiences
  - Community Violence
- Strengths (remember the action levels)
- Behavioral/Emotional Needs
  - Emotional/Physiological Regulations
    - Attention/Concentration, Impulsivity, Anxiety
  - Conduct
- Caregiver