

Section 3

Demonstrating Quality of Care

Quality mental health services encompass many aspects, including:

- Delivery of evidenced-based and best practices services to clients by qualified mental health professionals
- The nature of the relationship established between mental health provider and client
- Empowering the client in the recovery process
- Favorable client and provider outcomes

The use of standard clinical documentation serves to illustrate the quality of mental health services delivered. This can be achieved by clinical documents that:

- Address the quality accreditation standards of national organizations in a systematic fashion
- Are compliant with established rules and regulations
- Demonstrate the linkage of assessment, treatment planning and progress
- Incorporate evidence-based and best practices in terms of SAMI treatment, medication

algorithms, recovery and resiliency, et al.

- Provide the opportunity to record practice and the ability to follow progress in using the specific best practices

While clinical documentation cannot take the place of the interpersonal dialogue between client and provider, the forms can facilitate the consideration of medical and psychosocial domains important to this dialogue. Additionally, the use of standard documentation can help ensure that:

- Client input is invited, encouraged and utilized
- Provider decision-making rationale is recorded
- All issues, including social supports, vocational aspirations and housing, are considered along with clinical priorities in developing treatment plans
- Multiple providers can engage in an integrated treatment plan and process to benefit the client
- Practices are applied that include the client/family's priorities in the diagnosis and treatment process
- Clinical outcomes are achieved

Mental Health Recovery and Standardized Documentation

The Ohio Department of Mental Health adopted the nationally accepted definition of recovery as:

“A personal process of overcoming the negative impact of a psychiatric disability despite its continued presence.”

This recovery philosophy is based on the premise that given hope and full participation in innovative recovery programming, individuals can live a satisfying, and contributing life, even with limitations caused by a mental illness.

A recovery-oriented mental health system delivers quality clinical care and rehabilitation services that incorporate these core elements:

- Client-centered services
- Client input and client choice in service planning
- Client and provider accountability for participation

Client-centered services engage the client as an active participant in their treatment process. This

approach puts a focus on the client as an individual, and builds on the client’s strengths. It includes the client in the assessment of their needs and invites and encourages client participation in treatment planning. This approach to care provides support, offers hope and builds trusting relationships to create the opportunity for discussions that will:

- Aid in problem identification
- Support a more accurate diagnosis
- Lead to prioritized needs
- Give insight to a practical and workable set of goals and objectives to include in the client’s individualized service plan

Client participation in individualized service planning gives the client information and assistance to make informed decisions about their re-

covery goals, and the opportunity to identify and select recovery goals. This opportunity and encouragement for a client to make choices about the direction of their individualized service plan is critically important to recovery. A client is more inclined to commit to, and complete, activities involved in achieving a goal that they have selected.

Client and provider accountability for participation empowers the client to partner with their clinician, or case manager, on goal setting and taking manageable steps toward accomplishing them. It also identifies the role and accountability of the clinician and community for assisting and encouraging the client to accomplish the mutually-agreed upon goals.

There are nine essential concepts inherent to client recovery. These concepts and corresponding definitions are outlined in the table below:

Nine Essential Components for Client Recovery

Component	Definition of Component
Clinical Care	Receiving and benefiting from mental health services.
Peer Support and Relationships	Giving and receiving emotional support and assistance from other consumers based on a common understanding of issues and experiences impacting recovery.
Family Support	Giving and receiving emotional support and assistance from family members and/or significant others.
Work/Meaningful Activity	Participating in paid employment and/or other productive activities that provide psychological benefits that positively impact recovery.
Power and Control	Actively engaging in one’s own care and personal decision making that promotes recovery.
Stigma	Overcoming negative perceptions and stereotypes related to mental illnesses that hinder and/or negatively impact recovery.
Community Involvement	Interacting with people and organizations in the community for social enjoyment and civic fulfillment.
Access to Resources	Interacting with various people and places and gaining use of products, services, and technologies that promote recovery.
Education	Participating in both informal and formal methods of learning information that results in behavioral change that enhances recovery.

SOQIC Documentation Demonstrates Recovery

The SOQIC standardized forms were designed to demonstrate recovery, as well as medical necessity.

The forms:

- Use *client-first* language, in the diagnostic assessment and service planning process
- Demonstrate choice by allowing the client to prioritize and determine the areas they want to work on
- Identify strengths of the client
- Present options to clients that include the key com-

ponents of recovery that the client feels will have the strongest impact on his/her recovery

- Document roles, responsibilities and time frames for goal completion

Many of the activities that support client recovery also meet the requirements for medical necessity. Other activities that support client recovery, such as vocational education and transportation, are not medically necessary under Medicaid payer requirements, but may be reimbursable through other payer sources. The SOQIC forms support the proper documenting of these activities, as required by payers for reimbursement and accreditors for assuring quality of care.

The Importance of Resiliency in Mental Health Treatment

Resilience

The quality of being resilient; a) the ability to bounce back into shape, position, etc; b) the ability to recover strength, spirits, etc. quickly; buoyancy.

Webster's New World Dictionary

Mental Health allows us to also understand that social groups, such as families and communities, can be resilient, and defines resilience as “*the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats or other stresses – and to go on with life with a sense of mastery, competence, and hope.*”

Applicability to Mental Health Treatment

As the meaning of resiliency in human development continues to evolve, the applicability of resiliency to mental health treatment for both children and adults becomes clearer. For example:

- Benard (1991) defines resiliency as “*The inner strength of an individual to adapt and rebound in the face of significant adversity or risk that is a result of a dynamic interaction which takes into account the individual's strengths, risk and protective factors and is fostered by embracing the traits of social competence, problem-solving, autonomy, a sense of purpose and a belief in one's future.*”
- The President's New Freedom Commission on

The key elements of resiliency (Friedman, 2003, as adapted by Hernandez and Shepler, 2003) include:

- Connections to individuals, families, and institutions
 - Positive and supportive relationships and environments
- Competencies (SAT)
 - Skills - Abilities - Talents
- Contribution - Service orientation; valued by others
- Positive view of self and future - Self efficacy; and hope and optimism
- High expectations, standards, and monitoring - Community, family and individual

Integrating Resiliency into Mental Health Treatment

The elements of resiliency offer two main associations that are relevant to mental health policy and practices:

1. A preventative, “resiliency-building” approach
2. An orientation to individual and group strengths – not just deficits – in treatment and support.

A resilience-based mental health system is not seen as a separate concept to a system of care philosophy and/or evidenced-based practices, but rather a complementary one. Resilience can be integrated into, and inform other best practice models, serving to enhance them. Examples of evidenced-based and promising practices that employ elements of resilience include (but are not limited to):

- Wraparound
- Multisystemic Therapy
- Intensive Home and Community-Based Services
- Treatment Foster Care
- Functional Family Therapy
- Solution-focused therapies
- Early intervention home-visiting programs

Elements of resilience common to these programs include:

- Strength-based orientation
- A respectful partnership with youth and families
- Skill building and competency focus
- An emphasis on safety planning and risk reduction
- An emphasis on supporting and developing positive behaviors and talents
- Focus on parenting skills that are high in nurturance, supervision and monitoring

- Linkage to pro-social activities, peers, and mentors
- Development of positive school and community relationships

As demonstrated by these examples, resilience can be seen as a complementary construct to current evidenced-based practices and as a natural platform for creating an overarching strength-based framework for both prevention and intervention.

Proposed Components for a Resilience-Based Mental Health System

The Ohio Department of Mental Health recognizes the importance of the concept of resilience for all mental health clients. While the broad concept of resilience is recognized as a life-long process, ODMH and representatives of Boards and Providers are engaged in a process to develop a resilience-based approach to mental health treatment specifically for seriously emotionally disturbed youth.

Activities are currently underway to develop an approach that integrates resilience into systems of care for children and youth. Work thus far has identified the following proposed components to be included:

- Provide seriously emotionally disturbed (SED) youth and families access to a complete continuum of care, including formal and informal services and supports anchored in evidenced-based services, and common elements of resilience.
- Foster resilience at multiple levels: youth, family and community.
- Address both prevention and intervention across developmental ages and stages.
- Be family and youth driven at all levels (Including policy).
- Actively involve communities in the management, monitoring, and protection of each youth’s safety, behaviors, and well-being.

- Get “communities . . . to commit to a process of extreme persistence (and creativity) in the delivery of services and supports.” (VanDenBerg, 2002).
- Cross-system collaboration and support at all levels.
- Integrate elements of resilience into practice.
- Provide services that are hope and strength-based, with a balanced focus on asset building and risk reduction.
- Encourage supportive relationships and bonds between the youth and family, and between the youth, family and the greater community.
- Create opportunities for contributions, connections, and positive involvement.
- Promote environments that encourage high expectations and standards for its youth.
- Create positive learning environments that enhance abilities, skills, and talents.
- Identify outcome measurements include elements of positive change (assets, resources, hopefulness, functioning). (Masten, 2003)
- Use strength-based, continuous quality improvement process to foster resilience-based practice.

SOQIC Documentation Supports Resiliency

The SOQIC toolset offers mental health providers many opportunities to encourage and document a resiliency approach to treatment by:

- Focusing on identifying strengths, as well as problems
- Assessing developmental and family issues

- Addressing all the domains of life - both in assessment and in treatment planning
- Supporting the involvement and participation of the client and family in the treatment process

The SOQIC forms prompt for and support the documenting of these important components.

Sources for additional information on Resiliency:

The Resiliency Center: www.resiliencycenter.com

Project Resilience: www.projectresilience.com

The Resiliency Project:
www.edb.utexas.edu/steinhard/Resil.htm

The Search Institute: www.search-institute.org

References

- Benard, Bonnie. (1991). *Fostering Resiliency in Kids: Protective Factors in the Family, School, and Community*. Portland, OR: Western Regional Center for Drug-Free Schools and Communities.
- Friedman, R. (2003, March). Leadership Meeting: Ohio Statewide Implementation of Evidence-based Programs. Cleveland, Ohio.
- Hernandez, C. & Shepler, R. (2003, September) *Resiliency: Moving a System Forward*. A Presentation for the Licking and Knox Resiliency Team, Newark, Ohio.
- Masten, A. (2002, October). “Ordinary Magic: A Resilience Framework for Policy, Practice, and Prevention. Proceedings of Risk and Resilience: Protective Mechanisms and School-based Prevention Programs. Cambridge, Massachusetts. Available at www.riskandresilience.org
- Masten, A. (2001) “Ordinary Magic: Resilience Processes in Development,” *American Psychologist*. 56:227-238.
- VanDenBerg, J. (2002). *Advanced Issues in the Wrap-around Process*. (Available from Vroon VanDenBerg, LLP).

Defining Outcomes and Getting Results

Clients receiving mental health services want to see results, as do their families/guardians and their Provider treatment team. There are many factors that influence what specific results clients and Providers care about the most.

One tool available to assist clients and Providers in defining desired outcomes and measuring results toward achieving these outcomes is the Ohio Consumer Outcomes measures, which 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.

Consumer Outcomes System surveys can be used in a variety of ways by clients, families and providers throughout the treatment process.

- Clients and families can use the surveys to empower them in the recovery process. The surveys are designed to help the client/family identify problems, strengths, various aspects of their life they may want to focus on, and possible outcomes they may want to achieve, during the treatment process.

The principles of recovery and resilience indicate that clients, families and Providers get better results when the client's own goals and preferences

are used as the foundation for assessment and service planning.

- Providers can use the information from the Outcomes surveys to identify clients' functional deficits, strengths and treatment needs. Providers can also use the Outcomes information to monitor clients' progress, adjust services and to educate clients' families/guardians/significant others so they can be more effective in their support role during the treatment process.

Applying and Documenting Consumer Outcomes in the Treatment Plan

The SOQIC forms are designed to capture Consumer Outcomes System information in several places to:

- Assist Providers in integrating the use of Outcomes data to support assessment and treatment planning
- Gather information once and use it for multiple purposes
- Demonstrate quality of service by measuring results against defined Outcomes

Some examples of how Consumer Outcomes information is used in the SOQIC forms are shown in the table below and on the next page:

Child Diagnostic Assessment Form	Providers can use the Ohio Scales section to record baseline Consumer Outcomes scores for two life areas: <ul style="list-style-type: none">- Problem Severity Scale Score- Functioning Scale Score Problems and Functioning are measured from three perspectives, so space is allocated for Parent, Youth, and Worker observations.
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<p>Adult Diagnostic Assessment Form</p>	<p>Information from the Adult Consumer Form A or B, and the Provider Form A can be documented in several different sections of the DA Form to support assessment and planning processes.</p> <ul style="list-style-type: none"> • Social Information Section If information is available from the Outcomes System reports, the clinician may want to scan high and low scores on individual items to guide and supplement the clinical interview process. • Ohio Mental Health Consumer Outcomes Administered Section Provides the ability to record the scale scores for four different life areas: <ul style="list-style-type: none"> - Quality of Life - Symptom Distress - Empowerment - Functioning
<p>Diagnostic Assessment Update Form</p>	<p>This Update form can be used as the location to document repeat Outcomes measurement scores, and also baseline scores if these scores were not available at the time of completion of the Diagnostic Assessment. Specific space is allocated on both the Child and Adult DA Update forms for a summary of relevant Outcomes, which includes the date of the most recent Outcomes administration and the scale scores by the domain measured.</p>
<p>Individualized Service Plan</p>	<p>It is very important to use the results from the Consumer Outcomes to collaborate with the client in the process of developing the Individualized Service Plan and measuring subsequent progress. Many clients along with service provider workers have expressed how the collaborative use of the Outcomes System helps to identify life domains and specific areas that can then be translated into specific goals and objectives on the individualized Service Plan and subsequent measurement of progress.</p>
<p>Transfer/Discharge Summary Form</p>	<p>Baseline and discharge Outcomes measurement scores can be used to document progress, or lack of progress. The <i>Client's Response to Treatment and Discharge</i> section appears to be the best location to document these change scores.</p>

Clinical Use of Outcomes Scores

Each Outcome Survey Generates

- **Single item scores** - that show how a client/family views a *particular* concern and identifies global issues
- **Subscale scores** - that show how a client/family perceives a *set of items* that all relate to one another, such as quality of life, empowerment, or hopefulness and provide detailed information about the specific concerns, behaviors or situations that need to be addressed

Both *item* and *subscale* scores can be used to de-

velop treatment plans, goals and anticipated outcomes and to track progress or identify lack of progress.

The scores indicate the relative *strength* of these perceptions, but they **do not** indicate the *relative importance* or priority of these perceptions to the client, which is why thorough discussion is required with the client before deriving implications or devising recommendations.

Some examples of how outcomes scores may be used are shown in the following table.

<p>Adult Consumer Form A</p>	<p>Items 1 - 12 identify areas in a client's life that are particularly problematic of should be the focus of treatment planning (e.g., Meaningful Activity, Family Relationships, and Housing);</p> <p>Items 13 and 14 may suggest the need for referral to a physical health care provider, or whether the agency needs to address the client's concerns about medication;</p> <p>High scores in items 34 - 61 (empowerment) suggest strengths that can be built upon, and low empowerment ratings suggest the need for remedial goals;</p> <p>Individual items and subscale scores can help workers know where to advocate for the client, e.g., housing, benefits counseling, or personal safety.</p>
<p>Ohio Scales for Youth</p>	<p>The three versions of the Ohio Scales (i.e., parent or primary caretaker (P-form), youth (Y-form), and youth's agency worker (W-form) 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.</p> <p>Scores within the high range on the Problem Severity Scale and the low range on the Functioning Scale 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 <i>will be in the SED category and/or will likely require longer-term services.</i></p> <p>Risk behaviors identified on the instrument(s) suggest needs that must be addressed immediately in treatment.</p> <p>High scores in the Restrictiveness of Living Environments (ROLES) scale or Hopefulness scales could suggest high risk for the youth or family.</p>

Getting Additional Help with Clinical Use of Outcomes Data

In agencies that are using the ODMH Outcomes Data Entry and Reports Template, clinicians have access to additional tools to help them with treatment planning and monitoring. After entering data for a consumer, from any of the Outcomes instruments, the template generates three types of reports:

Red Flag Report

Lists all the items that have been rated with the most negative score or the next-most-negative score. This report highlights areas in which the client is having the most serious problems. As noted above, scores on the items indicate relative strength of the perceptions, but they do not indicate the relative importance or priority of these perceptions to the consumer. The Red Flag Report gives the clinician a useful tool to use with the client and prioritize which

areas need to be worked on, and in what order.

Strengths Report

Lists all the items that have been rated with the most positive score or the next-most-positive score. This report highlights all the areas that are going well in the client's life, and strengths that can be built upon in treatment planning.

Change Over Time Report

Presents a graphic display of a client's scores on the first, second and subsequent administrations of the Outcomes instruments. This report allows both the clinician and client to see the areas where the client has improved, declined or stayed the same over time. It helps to show progress and point to areas that may need to be addressed in further treatment planning and service provision.

For more information on these reports, please consult the ODMH Data Entry and Reports Template User's Guide on the Outcomes Web site, or call the Outcomes Help Desk at (614) 644-7840.

In agencies that are using Point of View (POV), this technology generates similar reports, except that they feature only those items that have been scored as most negative and most positive. A new product, the ARROW Report, blends Outcomes items with recovery areas. This report takes the consumer's greatest indicated problems and suggests activities for the ISP that might address these problems in a recovery framework. The ARROW Report is being pilot tested in a number of agencies currently using

the POV technology, and is expected to be available to all agencies before mid 2005.

In agencies using other technologies to input Outcomes data, clinicians can use the hard copies of the instrument to sit down with consumers, identify the items scored most negatively and most positively and use this information as the basis for a discussion with the client about treatment planning.

For detailed guidance about scoring, interpreting and applying the Consumer Outcomes data, please call the Outcomes Help Desk or consult the Consumer Outcomes Procedural Manual which is available on the ODMH website at www.mh.state.oh.us/initiatives/outcomes/outcomes.html

Developing Individualized Service Plans

General Discussion

Developing and documenting appropriate individualized service (treatment) plans is critically important to the delivery of quality mental health services.

Most payers and clinical experts agree that a collaborative treatment planning process supports both:

- A high-quality approach to treatment planning and delivery, and
- A conservative approach from a billing/payer perspective

Collaborative treatment planning is most effective when it includes all of the Provider's team members (including the medical staff) together with the client and family. Since methods of collaboration and treatment planning can differ among Providers, it is critically important for Providers to:

- Define their own model for ensuring that this required collaboration takes place
- Develop policy and procedures for treatment planning that demonstrate and provide evidence of collaboration, for payers and accreditors

ODMH Requirements for Collaboration

In Ohio, the treatment plan must be developed through a collaborative process among the providers, and between the providers and the client and family/guardian. Integration of services and supports for the client/family are essential to quality mental health treatment.

In Ohio, the individualized service (treatment) plan rule reads:

The development of the individualized service plan is a collaborative process between the client and the service provider(s) based on a diagnostic assessment, a continuing assessment of needs, and a successful identification of interventions/services.

The individualized service plan (ISP) documentation must include: (OAC 5122-27-05)

1. A description of the specific mental health needs of the client.

2. Anticipated treatment outcomes...mutually agreed on by the Provider and the client.
3. Names and/or descriptions of all services being provided. Such services shall be linked to specific mental health needs and treatment outcomes.
4. Evidence that the plan has been developed with the active participation of the client, and as appropriate family, parents, guardian or significant other.
5. As relevant, evidence of the inability or refusal of clients to participate in the service planning.

6. Signature(s) of the agency staff member(s) responsible for developing the ISP, date and evidence of clinical supervision. (*Note: ODADAS requires the client/family/guardian signature on ISP's.*)

While this collaboration among the Provider's treatment team and the client can take on many forms, the ISP must be developed and contain the specific information, as defined above. Each Provider Agency is responsible for defining internal policies, procedures and practices to ensure compliance with this rule. (*See OAC 5122-27-05 [A].*)

Accrediting Bodies View of Collaboration

Accrediting body standards emphasize a collaborative and client/family centered treatment planning process. Accrediting bodies further expect Providers to demonstrate this collaborative process, including how the *client and family* are actively involved in the treatment process, through:

- Documentation in the clinical record
- Agency policies and procedures

Although none of the accrediting bodies specifically require that collaboration among *treatment team members* be documented in the medical record, they do:

- Emphasize the importance and necessity of a collaborative process
- Look for evidence of treatment team members' collaboration in agency policy, procedures and practice

CARF	<p>Reviews the agency's policy on client collaboration in development of treatment plans and determines if it is being followed.</p> <p>Requires that the treatment plan include "specific service or treatment objectives that are reflective of the expectations of the treatment team."</p> <p>Note: It is left up to Providers as to how to comply and/or document compliance with this standard.</p>
COA	<p>Requires the signature of the client or family/guardian on the treatment plan.</p> <p>Does not specifically address the issue of team collaboration in its treatment planning section, but does reference team input in the development of the ISP in its section on "Team Delivered Services."</p>
JCAHO	<p>Requires that client involvement be documented, but is not specific on how or where.</p> <p>Requires that treatment planning activities, ". . . are collaborative and interdisciplinary when more than one discipline is involved in the client's care, treatment, and services." Unlike JCAHO's standard on client involvement (described above) where documentation is required, the collaborative effort standard among the provider team does not have a documentation requirement.</p>

SOQIC Forms Demonstrate Collaboration

The SOQIC forms were designed to support an integrated treatment process and demonstrate collaborative treatment planning.

The integrated form set accomplishes this in a variety of ways.

Both the Diagnostic Assessment and the Individualized Service Plan (ISP) contain specific sections where collaboration between team members and the client can be documented.

Client/family input is prompted for in the Diagnostic Assessment and DA Update, not only in information gathering but also by requesting them to identify service preferences and their response to recommendations.

The Individual Service Plan is designed to bring together the treatment priorities of the client on a single plan with objectives and interventions addressing the same set of goals and meeting the criteria set forth in the ISP rule.

There are also some sections on the forms that Provider Agencies may choose to use to assist them in documenting Provider treatment team collaboration.

Examples of the sections include:

- Diagnostic Assessment and DA Update have fields to document input of other treatment team members
- ISP and ISP Revision/Review have multiple Signature lines for Provider team members
- ISP has fields where other team members, who may not be a part of the Provider organization can be listed
- Psychiatric Assessment contains sections that allow the physician/nurse practitioner to document that they have reviewed sections of the Diagnostic Assessment and are using that input to develop their recommendations

The absence of designated sections for documenting the actual content and type of collaboration among Provider's treatment team members was not an oversight by the SOQIC team. Given the wide range of practices in the Provider community, it was determined that the SOQIC forms would support payers' and accreditors requirements and Ohio's rules, rather than dictate or favor certain Provider practices.