

Recovery Oriented Evaluation and Administration
Dave Pilon, Ph.D. CPRP

In the recent discussions that the committee has held regarding evaluation priorities, I find that I am mostly in agreement with the priorities that have been put forward by CCCMHA and the CMHDA IDEA group. However, I have been bothered by a persistently nagging feeling that in all the discussions of evaluation priorities we are somehow missing the point. Our underlying paradigm seems to be that evaluation is a discrete activity (or set of activities) with a beginning and an end that is conducted by an outside entity (such as a university). Our approach to evaluation has not embraced a continuous quality improvement paradigm in which counties and programs take responsibility for and conduct their own ongoing CQI activities.

As I see it, this paradigm has resulted in three distinct problems.

1. We focus on the largest and most obvious quality of life outcomes that show the biggest improvement very early in the recovery process to the extent that we have no measure that demonstrates recovery over the entire span of recovery.

No doubt some of you are thinking, “Dave, haven’t you been the biggest proponent of the quality of life outcomes?” The answer is “Yes, and I still am.” However, the nature of the CQI data makes them most appropriate for members in the earliest stages of recovery. When consumers are first enrolled in FSPs, they tend to show rapid improvement in domains such as independent living, employment and education. Both the AB 2034 and FSP data suggest that a great deal of improvement takes place in these domains in the first 12 – 18 months of service and then tends to level off. But what domains or elements should we use to demonstrate continued improvement for our members once they have gotten housed and gotten a job or gone back to school? Additionally, since it appears that the best programs are getting about 20% of their members employed, how do we demonstrate improvement with the other 80% of our members who do not get jobs or go back to school?

What is needed is a general measure that is able to be sensitive enough to reflect progress (or the lack of it) at both the early and late stages of the recovery process. While this measure naturally will be correlated with the quality of life domains, it should also reflect certain qualities of recovery that are not determined by such domains as residential or employment status. Because of this it will allow us to determine if a consumer is continuing to recover even if he is still living in a Board and Care or has not gotten a job or gone back to school. It will also allow us to determine when the consumer is ready to leave the intensive services of the FSP and move to a lower level of care.

2. A failure to create a system of feedback loops and performance benchmarks that allow us to know what programs are getting superior outcomes and which programs are not.

The FSP outcomes, as they find expression in the Data Collection and Reporting system, are primarily a longitudinal approach to performance measurement. They are intended to compare a number of objective quality of life domains of consumers prior to coming into the FSP with their quality of life on those same domains after they have been in the program. While we would probably all agree that any

decreases in the level of hospitalization utilization, for example, are better than increases, what level of decrease should we expect for our investment? If the overall mental health system achieves a 5% decrease in the number of hospital days from the year prior to enrollment in an FSP, is this adequate to justify the heavy resource investment that we have made in the FSPs? More broadly, could this be considered a “good” outcome?

If there were little or no variance between programs and systems in their outcomes, this would be a relatively easy question to answer. However, one can easily imagine a situation in which some programs or systems may actually have increases in their post-FSP hospitalization rates but that fact is obscured because their results are averaged along with programs/systems that are having much greater success in lowering the hospitalization rate.

In most of behavioral healthcare, the question of what is a “good” outcome cannot be answered in any absolute sense and must be placed in context by comparing outcomes between similar programs and systems, a process generally referred to as “benchmarking.” FSP employment outcomes may be the best example of why benchmarking is necessary. It is well known that the employment rate of people with severe and persistent mental illnesses is far below that of the general public. While the unemployment rate of the general public at this time is 9.2%, various estimates of the unemployment rate for people being served in the public mental health system hover around 95%. Given the starting point of the population they serve, it is unrealistic to hold FSPs accountable for reducing unemployment to anything near the rate for the general population. However, it is quite possible to compare the relative success of different FSPs in improving the employment rate of the people they serve. If all FSPs average 12% of their participants being employed, programs that manage to get 20% of their participants employed would likely be considered “high-performing” while those getting 5% of their participants employed would be considered “low-performing.”

Benchmarking is crucial for the quality improvement process for two reasons. First, by knowing where an FSP stands in relation to the average, it allows programs to set reasonable performance improvement goals. A program that currently has 5% of its participants employed would probably be unlikely to achieve a goal of improving its employment rate to 20%. However, increasing its rate to 8% or even 10% of its population may be a reasonable goal. Second, unless we identify the programs that are high-performing or low-performing, it is impossible to systematically identify how those programs differ in ways that are responsible for producing those different outcomes. Benchmarking enables us to determine if there are differences between high-performing and low-performing programs in culture and practices. Lower performing programs could then be provided with training in adopting the general and specific practices that are associated with the outcomes in the higher performing programs, resulting in an overall improvement in the quality of the public mental health system.

Of course, one cannot identify the “higher performing” programs without also identifying the “lower performing” programs. Unlike the children of Lake Wobegone, all FSPs will not be above average in their outcomes. There are few issues that generate as much anxiety and concern among behavioral healthcare administrators than the idea that their outcomes will be subjected to a comparison with the outcomes of other programs and systems. Driven by these fears, administrators will either avoid taking

part in such comparisons if they can and, failing that, will employ fear-based management practices and techniques.

In my experience, it is the rare leader/manager who is able to transform this fear and anxiety into the development of a learning culture that embraces lower performance as an opportunity for quality improvement. As will be mentioned a bit later, Mark Ragins' coined the term "recovery-oriented management" which to my mind applies to the group of administrators who are able to take this approach with their staff. In all the discussions of evaluation priorities, we have not spent any time talking about how we will help our mental health department and contract agency administrators to adopt this approach to quality improvement. There seems to be an underlying assumption that this is an individual responsibility of the administrator rather than a communal responsibility of the system. We must prioritize the provision of training and technical assistance to these administrators to enable them to let go of the fear and embrace a continuous quality improvement approach.

3. The production of data that, while they may have meaning for people at the higher levels of the system (e.g., legislators, supervisors, department chiefs, CEOs) are essentially meaningless to people at the lower levels (consumers, line staff and their supervisors).

At the recent USPRA conference, Mark Ragins, Medical Director for MHALA received the John Beard Award for lifetime achievement. During the award ceremony, the master of ceremonies conducted brief "interviews" with each of the recipients, asking them questions about their work, their values, their philosophies, etc. What struck me was the response of the audience to Mark's answer to the question: "What do you see as the next frontier in psychiatric rehabilitation?" To which Mark responded: "I think it is recovery-oriented administration. We need to understand how we can treat our staff as well as we expect them to treat the members they work with." I can guarantee you that no response got louder or longer applause from the audience (mostly made up of line staff) than this one.

Sitting there in the audience, I have to admit to feeling more than a little annoyed at this response. As an administrator, I like to think that I am creating a pretty good work environment (not to mention the fact that we are PAYING people...). But when I think about it more deeply, I have to admit that it is probably in the area of evaluation and quality improvement that we (MHALA) do our worst work around improving the quality of the employee experience. Like most agencies, we tend to see our staff as producers rather than as consumers of the data. The reports that we generate from the data, while meaningful to me and other executive level management, have little relevance to line staff and their immediate supervisors.

Because the data are meaningless to them, it is a constant challenge to get staff to take the data collection and reporting requirements seriously. We appear to have few tools to "motivate" our staff in this area other than threats and fear. What I find fairly ironic about this situation is that we would never resort to these kinds of approaches with the people we serve. Our staff are simply amazing in their ability to find ways to collaborate with our members, to push the authority for their care down to the members themselves and rarely if ever resort to threats and intimidation. That most certainly would NOT be recovery-oriented care.

So why do we resort to intimidation and fear with our employees? The simple answer is that it is part of the job and after all, we are paying them to do it. But if we hold ourselves, as administrators, to the same expectations with our staff that we hold with our staff in relation to their members, it begs the question: How do we push the authority for the evaluation and quality improvement processes down to the line level staff and their immediate supervisors? More specifically, can we make the data collection and reporting process meaningful and relevant to line staff in a way that empowers them and makes them more effective in their work?

In my view, the biggest barrier to both improving the quality of our data and being able to actually use the data to improve the effectiveness of our services will be the extent to which we can make the data meaningful to our line staff. Data quality will never improve until the data have intrinsic meaning to the staff who are producing the data and the managers who are supporting and supervising them. On a practical level, what this means is that whenever we create a report, we must take the perspective of the person who is actually generating the data that are going into the report and at least try to understand how those data can be made meaningful to them. Certainly in some cases this may not be possible, but we can at least expend the effort to determine if it can be done.