# III. Measurement of Clinical and Functional Outcomes

The *2000 State Survey* found a continuing increase in the measurement of child-level clinical and functional outcomes related to children's behavioral health in managed care systems. As shown in **Table 4**, the percentage of systems that reportedly measure child outcomes related to children's behavioral health increased from 52% in 1995, to 63% in 1997-98, and to 90% in 2000.

**Table 4**

**Measurement of Clinical and Functional Outcomes in Managed Care Systems Related to Children's Behavioral Health**

| | 1995 Total | 1997–98 Total | 2000 | | | Percent of Change | |
|---|---|---|---|---|---|---|---|
| | | | Carve Out | Integrated | Total | 1995 –2000 | 1997/98 –2000 |
| Managed care reform measures clinical and functional outcomes | 51% | 63% | 96% | 71% | 90% | +39% | +27% |
| Managed care reform does not measure clinical and functional outcomes | 49% | 37% | 4% | 29% | 10% | -39% | -27% |

Despite the steady increase in reforms measuring clinical and functional outcomes, the findings of the impact analyses indicated that the outcome measurement systems in most managed care systems were at an early stage of development. The early developmental stage is still evident in the *2000 State Survey*.

As shown in **Table 5,** only about one fourth (26%) of the reforms (all carve outs) have results from their outcome measurement systems. Another 26% described their outcome measurement systems as implemented, but with no results available yet. Finally, in 44% of the reforms, outcome measurement was described as being at an early stage of development, and an additional 4% reported that the system was developed but not yet implemented. Carve outs reportedly are ahead of integrated systems in the measurement of children's behavioral health clinical and functional outcomes. More integrated systems are at early stages of this process or have outcome measurement systems but no results as yet.

| Table 5<br>Stage of Development of Measurement of Clinical and Functional Outcomes | | | |
|---|---|---|---|
| | 2000 | | |
| | Carve Out | Integrated | Total |
| In early stage of developing measurement system | 41% | 60% | 44% |
| Developed but not yet implemented measurement system | 5% | 0% | 4% |
| Implementing measurement system but do not yet have results | 23% | 40% | 26% |
| Implementing measurement system and have results | 32% | 0% | 26% |

# Promising Approaches in Measurement of Clinical and Functional Outcomes

## • The Dawn Project, Marion County (Indianapolis), Indiana

**The Dawn Project** is a behavioral health carve out serving children who have serious emotional problems in Marion County, Indiana. The target population includes children who are involved in at least two child-serving systems, are at risk of or in residential placement, and have serious functional impairments at home, in school, and in the community. Several state and county agencies contract with **Indiana Behavioral Health Choices**, a non-profit managed care entity, to administer the Dawn Project's performance information system as well as the clinical and financial processes. Choices uses an individualized, strengths-based approach to serve children and families, using child and family teams and a community resource network.

Choices has developed a technological infrastructure that provides fiscal and clinical accountability to its key stakeholders, including payers, providers, and children and families. In 1999, Dawn worked with an **Outcome Committee** of its Community Consortium to develop a set of performance indicators and outcome measures. After using these indicators for a three-year period, there was agreement that some outcomes were difficult to measure. The Outcome Committee re-convened to examine outcome definitions and measures, data collection, and data interpretation. In February 2002 the Dawn Project adopted a new set of performance indicators, including clinical and functional outcomes. The organizing framework for the new outcome measures is made up of the following goals:

- Provide high quality care that results in improved outcomes for the child and family
- Include parents/families in decision-making
- Decrease the cost of serving children with the most disturbed and disturbing conditions in Marion County
- Be accountable to all stakeholders

**Table 6** shows the clinical and functional outcomes for the first goal noted above. As shown in **Table 6**, a set of outcomes defines each goal, and performance indicators measure progress towards each outcome.

**Table 6**
**The Dawn Project: Outcome Measures**

| | |
|---|---|
| **Goal #1:** | **Provide high quality care, which results in improved outcomes for the child and family.** |
| **I. Improved child and family functioning** | |
| **A.** | **Improved school functioning** |
| | 1. Grade reports, attendance reports, behavior reports, suspension/expulsion reports |
| | 2. The Clinical Manager Treatment Plan level rating |
| **B.** | **Improved records with the child welfare and the juvenile justice system** |
| | 1. Percent of families with no further substantiated incidences of child abuse or neglect, which results in removal of the child from the home during involvement. |
| | 2. Percent of families with no further substantiated incidences of child abuse or neglect, which results in removal of the child from the home for a period of six and twelve months from disenrollment. |
| | 3. Percent of children with no further incidences of delinquency, runaway or truancy charges, or violation of terms of probation which results in placement failure during enrollment. |
| | 4. Percent of children with no further incidences of delinquency, runaway or truancy charges, or violation of terms of probation which results in placement failure for a period of six and twelve months from disenrollment. |
| **C.** | **Improved records for community supervision for Department Corrections youth** |
| | 1. Number of youth with arrests for offenses more severe than original offense |
| | 2. Number of youth with arrests for offenses less severe than original offense |
| | 3. Number of youth with technical violations other than for placement |
| | 4. Number of youth with technical violations that include placement failure |
| | 5. Number of youth with technical violations for placement failure only. |
| | 6. Number of youth with arrests in first year after disenrollment. |
| **D.** | **Improved CAFAS scores** |
| | 1. Measured with CAFAS at intake, every six months, and discharge |
| **E.** | **Progress in Service Coordination Plan** |
| | 1. Measured by monthly team report and The Clinical Manager Treatment Plan level rating |
| **F.** | **Fewer days in out of home placement** |
| | 1. Measured by Dawn national evaluation placement data |
| **II. Increased family autonomy** | |
| **A.** | **Decrease in number of paid providers** |
| | 1. Measured by service usage and payment data |
| **B.** | **Caregiver Strain Questionnaire** |
| | 1. Measured by Questionnaire at intake, every 6 months until discharge, and12 months after discharge |

In the Dawn Project, data collection is the responsibility of the Service Coordinators. Service Coordinators input data (demographics, case history, treatment plans, progress notes) into *Clinical Manager*, a software program that serves as both a clinical medical record and a fiscal record. Each Service Coordinator has a desktop computer, and each supervisor has two laptop computers available for the unit. For those Service Coordinators who prefer to do data entry out of the office, laptops can be signed out and data entry accomplished through a dial-up system.

There are several characteristics of the Dawn Project that help to ensure accurate and timely data:

- Data entry is addressed in the productivity standards for the Service Coordinators, partly because the Progress Notes are used to bill Medicaid and other payers.
- The model is supervisory-intensive (7: 1). Caseloads are relatively small (8 to 10).
- Supervisors review treatment plans weekly with the Service Coordinators, and a psychiatrist reviews plans every 60 days.
- Service Coordinators are observed “in action” on a quarterly basis.
- Supervisors are responsible for pre-authorization of services and for managing their unit's budget.
- Supervisors recognize the value of “real-time data” as a management tool.

## Advice to other states and communities regarding clinical and functional outcome systems:

- Clinical and functional outcome measurement is always a “work in progress.” A system needs to be in place for continuous review and modification.
- Key stakeholders need to be involved in the development and monitoring of clinical and functional outcomes. Families, for example, need to be asked what is important for them regarding their child's progress.
- Incentives need to be in place that facilitate and support data collection.
- Data need to be available for quality assurance, management, and planning activities.