

# THE PERFORMANCE IMPROVEMENT CENTER:

A Promising Approach for Improving Service  
Quality and Outcomes

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# THE PERFORMANCE IMPROVEMENT CENTER:

## A Promising Approach for Improving Service Quality and Outcomes

### INTRODUCTION

In the United States, five million children receive mental health treatment at an annual cost of approximately nine billion dollars. Given the scope of the problem, it is critical to ensure that children and their families have access to treatments that are known to be effective. Connecticut has invested significant resources to develop a comprehensive mental health treatment system for children, including a number of evidence-based treatments (EBTs)--interventions that have undergone rigorous scientific testing to ensure their effectiveness. When resources for mental health treatment are limited by economic factors, it is even more important to ensure that these limited resources are directed toward treatments that are known to work.

A comprehensive mental health treatment system for children incorporates EBTs with interventions that meet important needs, but for which EBTs are not available. In fact, these services are utilized to treat most children with mental health needs. As a result, it is critical to ensure that

these services are accessible, of the highest quality, implemented consistently across sites, and effective. A rigorous system of quality improvement can help all interventions achieve these important goals.

This report describes the Performance Improvement Center (PIC); a model approach to quality improvement that is currently being implemented for Emergency Mobile Psychiatric Services (EMPS) Crisis Intervention Services in Connecticut. The PIC takes a leading role on quality improvement activities in four areas: standardized practice development; standardized training; improving access and service quality; and conducting outcomes evaluation. Since 2009, the PIC has helped EMPS achieve significant improvements in these areas. In doing so, the PIC model has proven itself as a valuable and necessary approach for ensuring that children and families receive high-quality services that result in positive behavioral health outcomes.

## BACKGROUND

Recent estimates suggest that nearly 5 million children receive mental health care in the United States each year at an annual cost of nearly 9 billion dollars.<sup>1</sup> The skyrocketing costs of health care in the U.S. and the advent of managed care in the public and private sectors has led to a renewed focus on health care quality and outcomes. Treatments that promote optimal outcomes for youth and families and avoid wasteful spending are in high demand. In order to promote the availability of such treatments in community-based practice settings, it is increasingly necessary to develop strategies to determine what works and where to invest limited resources.

The quality of mental health care nationally was highlighted in a 1999 report by the Department of Health and Human Services and the Office of the U.S. Surgeon General<sup>2</sup> and a later report by the President's New Freedom Commission.<sup>3</sup> These reports described ongoing concerns with the quality of mental health care and made a number of recommendations to transform the mental health care system. The reports indicate that although effective treatments for mental health conditions have been developed, few of these treatments are available in practice settings. The reports highlight the need to accelerate research and practices that ensure the development and dissemination of effective mental health interventions for children and families.



**Quality improvement (QI) refers to a set of techniques used to improve service quality, performance, and outcomes.**

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Over the past decade, stakeholders in Connecticut have documented many of the same concerns and recommendations. A 2000 report by the Child Health and Development Institute described the disproportionate amount of money devoted to inpatient and residential treatment for a relatively small number of youth and recommended that Connecticut begin to shift these costs toward enhancement and further development of community-based mental health resources.<sup>4</sup> A subsequent report by the Governor's Blue Ribbon Commission further articulated the need to enhance community-based mental health services and to focus attention on delivering effective interventions in community settings, including a need to effectively manage the service delivery system and ensure accountability for service quality and outcomes.<sup>5</sup> In addition, the report called for a full "carve-out" of Medicaid spending on behavioral health and the establishment of a new entity, the Connecticut Behavioral Health Partnership, to oversee this spending. These recommendations and others led to enactment of legislation in 2005 known as *Connecticut Community KidCare*. Drawing on these national and local findings and reforms, and informed by subsequent implementation efforts, a 2009 report by the Connecticut Department of Children and Families (DCF) laid out a plan for delivering mental health treatment to children and families.<sup>6</sup> Among the core elements of that plan was an increased emphasis on implementing community-based services (including evidence-based treatments) and a call to support **quality improvement (QI)**

efforts that would promote accountability for service quality and outcomes among all child and family interventions.

## **The Important Role of Quality Improvement in Child and Family Interventions**

Taken together, these national and statewide findings and reforms underscore the growing consensus that it is not enough to simply have services in place for children and families. It is important to ensure that the services are of high quality and are effective for children and families in real-world settings, which requires that specific QI supports are in place. Broadly defined, QI refers to a set of techniques used to improve service quality, performance, and outcomes. Traditional research focuses on establishing a causal relationship between an intervention and health or mental health outcomes. QI, on the other hand, is intended to monitor and facilitate improvements in the intervention itself, typically in three areas: structures, processes, and outcomes.<sup>7</sup> The most common purposes of QI are to:

- Optimize service quality
- Narrow the gap between the service model and delivery in practice settings
- Address variability in service delivery
- Optimize outcomes<sup>8</sup>

Measurement-based QI strategies (using quantitative data) and non-measurement-based QI strategies (e.g., standardized practice development, training) are used to address these areas. Common QI strategies include identifying and applying best practices from the scientific literature, providing training, providing consultation and technical assistance, developing practice standards and guidelines, measuring fidelity to intervention, measuring and reporting performance on service quality indicators, and measuring and reporting outcomes.

QI is often viewed as ancillary to direct care, and is therefore vulnerable to funding cuts during difficult financial times. An alternative perspective is to view QI as an integral component of direct services that cannot be divorced from the intervention itself. Further, QI is a means for ensuring that limited resources are being spent on services that produce the best possible outcomes. From this perspective, the value of QI is recognized as essential, *especially* when resources are limited. QI activities that focus on the structures, processes, and outcomes of child and family interventions can advance the evidence for these interventions. Recent research demonstrates that applying QI to mental health interventions can effectively improve quality and outcomes to a degree that is consistent with the outcomes of EBTs.<sup>9</sup> Consequently, investments in QI are a worthwhile endeavor, perhaps even more so when resources are limited.

The type of QI supports provided depends on the type of intervention, its stage of development, existing evidence for effectiveness, and the extent to which QI strategies are already employed. Child and family interventions can be classified into three broad classifications according to these dimensions: evidence-based treatments; best practice interventions; and usual care interventions.

*1. Evidence-based treatments* (EBTs) are approaches that have been demonstrated by rigorous clinical research to be effective in treating targeted health problems. EBTs generally are developed in academic settings before they are implemented in real-world settings and often are accompanied by well-defined treatment manuals that can facilitate replication with fidelity. In addition, EBTs often include a systematic approach to ongoing training, coaching and supervision, and model fidelity. EBTs generally include well-specified approaches to data collection and QI.

*2. Best practice interventions* are grounded in theory and relevant clinical research, but often are not accompanied by a detailed manual that supports replication with fidelity. Best practice interventions generally have research evidence to support effectiveness, but the evidence does not reach a threshold that qualifies the intervention as evidence-based. Systematic data collection and QI may be, but are not always, a part of best practice interventions.

3. *Usual care interventions*<sup>10</sup> may or may not be guided by theory or relevant clinical research. They typically do not have detailed manuals or systematic outcomes evaluation and QI data to support their effectiveness. Sometimes usual care interventions are referred to as “black box” interventions because it is difficult to articulate the specific approaches that are employed or determine with confidence whether they are effective. Usual care interventions generally are developed and guided by clinical experience and are usually monitored through clinical supervision.

States and communities need a range of interventions including evidence-based, best practice, and usual care, in order to address the complex and varying needs of children and families in real-world settings. Children and families that receive EBTs also receive the benefits of data collection, QI, and outcomes evaluation that ensure the intervention is effective. Best practice and usual care interventions would benefit from having similar quality improvement structures and supports to ensure that they are well-designed and described and ultimately determined to be effective for children and families.

## A Framework for Quality Improvement: The Performance Improvement Center

One approach for systematically improving the service quality and outcomes of care among best practice and usual care interventions is the Performance Improvement Center (PIC) model. This section describes the values and core activities of the PIC model.

The PIC model is guided by specific values:

- **Objectivity.** A PIC works together with a network of treatment providers, their funder(s), and other stakeholders to identify and accomplish shared goals. A PIC functions best in an intermediary role whereby it is viewed as a vital resource to all stakeholders and takes multiple perspectives into consideration in planning and implementing QI activities. The PIC approach can help reach consensus on the scope, goals, and intended outcomes of an intervention and develop a shared vision and specific strategies for achieving those goals and outcomes.
- **Collaboration.** The PIC includes in its approaches and activities a diverse group of stakeholders. An important task of the PIC is to promote a collective attitude that “we are all in this together.” When problems are encountered, the PIC

approach can help all parties avoid criticism and blame and instead frame problems as challenges to be overcome using teamwork and innovation.

- **Data-Informed Practice.** Whenever possible, the PIC model helps stakeholders frame problems and their solutions in measurable terms. At other times, non-measurement based strategies are informed by best practices and the best available evidence for effectiveness. One of the most important functions of a PIC is to identify areas that underlie service quality, identify data indicators to measure those areas, and report performance on those indicators over time in order to continually improve service delivery and outcomes.

- **Transparency.** The PIC model values sharing data and outcomes openly across a network of providers and stakeholders without blinding those results. Findings are not shared openly in order to embarrass providers that exhibit low performance or outcomes in a given area, but instead are used to promote teamwork and innovation, share best practices, and collectively elevate service quality and outcomes. Occasionally, data can inspire a spirit of healthy competition among providers in a manner that raises performance across the network. The PIC model values frequent reporting of findings through monthly and quarterly reports that are widely distributed and discussed in network-wide meetings. Providers work with each other

to identify practices that are working to improve service quality and outcomes and can be adopted by other sites.

In addition to the values of the PIC, there are also core activities that are the “active ingredients” for improving service quality and outcomes. The core activities of the PIC model include: standardized practice development; standardized training; improving access and service quality; and outcomes evaluation. These activities are summarized below and a case example is used later in this report to describe them more thoroughly.

- **Standardized Practice Development** involves working with providers to develop an assessment and treatment approach that can be monitored for consistency across sites. Common activities include developing documents, identifying screening and assessment measures, and measuring treatment fidelity across sites.

- **Standardized Training** involves identifying salient training needs, developing a standardized training curriculum, identifying expert trainers from within and outside of the provider network, ensuring delivery of required trainings, and ensuring the quality and effectiveness of the training curriculum.

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- **Improving Access and Service Quality** involves collecting and analyzing data to ensure services are accessible and capacity is sufficient to meet the demand as well as to ensure that services are of the highest quality. The PIC model emphasizes the use of data that are easy to understand and are useful to providers and other stakeholders. Various data reporting strategies are used including performance benchmarks, statewide averages, trending, performance improvement planning, and financial incentives for goal achievement. The PIC model also uses frequent data analysis and reporting to promote a data-informed culture among providers, emphasizing the important role of data and how it can be used in service delivery, supervision, and program management.
  - **Conducting Outcomes Evaluation** involves identifying important goals and associated outcomes of an intervention and measuring achievement of those goals over time. Child-, family-, system-level, and consumer satisfaction are common goals across many child and family interventions, but the PIC model also encourages incorporating other model-specific outcomes.

## CASE EXAMPLE: EMPS and the Performance Improvement Center

Guided by the values and core activities described above, the PIC approach has been applied to Emergency Mobile Psychiatric Services Crisis Intervention Services in Connecticut (EMPS). The EMPS Performance Improvement Center (EMPS PIC) is funded by the Connecticut Department of Children and Families (DCF) and is based at the Child Health and Development Institute (CHDI), a nonprofit research, policy, and practice change center focused on improvement in health and mental health care for children in Connecticut. Examples from the EMPS PIC demonstrate how the PIC model is being applied in a real-world practice setting to improve service delivery and outcomes.

Mobile crisis services were identified in the President's New Freedom Commission report as a service category in need of further development and expansion nationally and the Connecticut Community KidCare plan identified it as an area of need in Connecticut, resulting in the development of EMPS. Connecticut DCF designed EMPS to provide crisis mental health services in homes and communities in order to reduce barriers to accessing treatment and also prevent youth from entering care through emergency departments. Beginning in 2007, the State of Connecticut began a process to improve EMPS services after identifying concerns

## "The Performance Improvement Center (PIC) is an invaluable resource to the agencies that deliver EMPS services." (EMPS Manager)

with underutilization, variability in services across provider sites, lack of mobility, and slower than desired response times. In addition, the EMPS model of care was poorly defined, leading to variable implementation across sites, and very little data had been collected or reported related to service quality and outcomes of care. In 2007, under an existing consulting agreement, DCF commissioned CHDI's Connecticut Center for Effective Practice to conduct a needs assessment of EMPS, review the literature and national best practices in mobile crisis care, and provide recommendations to improve EMPS service quality and outcomes. DCF then re-designed and re-procured EMPS services between 2008 and 2009, a process that included Requests for Proposals for a Call Center that was awarded to 211-United Way, and for a Performance Improvement Center that was awarded to CHDI.<sup>11</sup>

EMPS now serves all cities and towns in Connecticut through a network of fifteen sites. EMPS provides mobile responses from 9 a.m. to 10 p.m. Monday through Friday, and 1 p.m. to 10 p.m. on weekends and holidays and telephonic responses are provided during all other hours. EMPS providers offer crisis stabilization and support, screening and assessment, brief intervention, and referral and linkage to ongoing care. Children under age 18 are eligible for EMPS regardless of insurance coverage or DCF involvement. EMPS services are accessed by dialing the Call Center (211) and pressing "1" to speak directly with a trained EMPS crisis intake specialist. These calls are then routed to the EMPS

provider that covers the city or town in which the child is currently located for a mobile response. Following the initial response, EMPS services can last for up to 45 days and includes access to psychiatric evaluation and medication management; coordination and collaboration with families, schools, and other referrers; and referral and linkage to ongoing services and supports as needed.

EMPS is not an EBT; in fact, there are currently no evidence-based models of mobile crisis care for youth and their families. The Substance Abuse and Mental Health Services Administration (SAMHSA), through its Service to Science Initiative, has identified EMPS as a promising practice and is providing technical assistance and support that will advance EMPS toward recognition as an EBT. Staff members at the EMPS PIC have helped support this effort by coordinating model development and evaluation research activities that will continue to advance evidence for EMPS's effectiveness.

### Results of the EMPS PIC

The EMPS PIC has introduced measurement-based and non-measurement-based activities in the four core activity areas described above: standardized practice development, standardized training, improving access and service quality, and measuring outcomes. This section highlights results in each of these areas.

### *Standardized Practice Development*

Establishing a consistent treatment model and monitoring implementation of that model is important to EMPS practice development, particularly as DCF, the PIC, EMPS providers, and other stakeholders seek to advance evaluation research findings and continue progressing EMPS toward classification as an EBT. This requires standardized EMPS practices that can be followed by all EMPS sites and will facilitate examination of fidelity to the EMPS model. To that end, PIC staff members have coordinated workgroups that bring together EMPS clinicians and supervisors, DCF administrators, parents, and consumers. The end product of these workgroups is typically a document that clearly articulates standards in various areas of EMPS practice and treatment.

For example, PIC staff members helped facilitate the development of **standardized screening and assessment measures and procedures**. EMPS clinicians may come into contact with youth and families with a multitude of presenting concerns and diagnoses, necessitating a range of screening and assessment measures. Consequently, there is a need for consistent guidance on the use of standardized screening and assessment measures, which is an important aspect of evidence-based practice. In this role, PIC staff members helped to identify the Structured Assessment of Violence Risk in Youth (SAVRY),<sup>12</sup> the Global Appraisal of Individual Needs-Short Screener (GAIN-SS)<sup>13</sup> for assessing

youth substance abuse, the UCLA-Post Traumatic Stress Index (UCLA PTSD Index)<sup>14</sup> for assessing trauma exposure and trauma-related symptoms, and other similar screening and assessment measures.

A second example is the development of **a model for follow-up clinical care**. EMPS services are intended to last up to 45 days and may vary in intensity and duration depending on acuity level and a child and family's needs and preferences. The model for follow-up care outlines phases of EMPS care that vary in intensity and duration of family contact based on these factors.

A next step for the PIC in the area of standardized practice development is to design and implement a fidelity-to-intervention study to ensure that all EMPS providers are adhering to the clinical practice guidelines that comprise the EMPS model.

### *Standardized Training*

EMPS clinicians must possess certain clinical competencies in order to effectively carry out the duties required of them. Beginning in 2009, PIC staff collaborated with DCF and EMPS providers to develop a comprehensive training plan. PIC staff conducted a needs assessment that involved EMPS clinicians and supervisors as well as key informants from DCF. Following this, PIC staff coordinated the development and delivery of a comprehensive statewide training curriculum. Over time, new modules have been added as training needs have

## Promote a data-informed culture by which providers integrate data into their routine program monitoring, supervision, and management activities.

emerged. The training curriculum focuses on promoting clinical competencies among EMPS clinicians as well as training on core EMPS practice elements. Examples of current training modules include:

- Crisis Assessment, Planning, and Intervention
- Violence Assessment
- Suicide Assessment
- Crisis Wraparound
- Cultural and Linguistic Competence
- Worker Safety and Self-Care
- Strength-Based Assessment and the System of Care
- Traumatic Stress and Trauma-Informed Care

Given that EMPS is a crisis service, trainings must accommodate busy schedules and must also preserve staffing levels that are sufficient to continue to respond to crises in the community while training occurs. To accomplish this, modules are implemented in four locations across the state to reduce travel time and each training module is delivered three times a year in each location, including once during evening hours.

### *Improving Access and Service Quality*

PIC staff members conduct and report service quality and provider performance analyses that are closely related to service quality and are intentionally simple to understand. PIC monthly, quarterly, and

annual reports comprise mostly figures and tables that are clear, concise, informative, and visually appealing. This is intended to promote a data-informed culture by which providers integrate data into their routine program monitoring, supervision, and management activities. The EMPS PIC model has helped ensure that stakeholders increasingly view data as a valuable element of service delivery that can help them provide the best possible services for children and families.

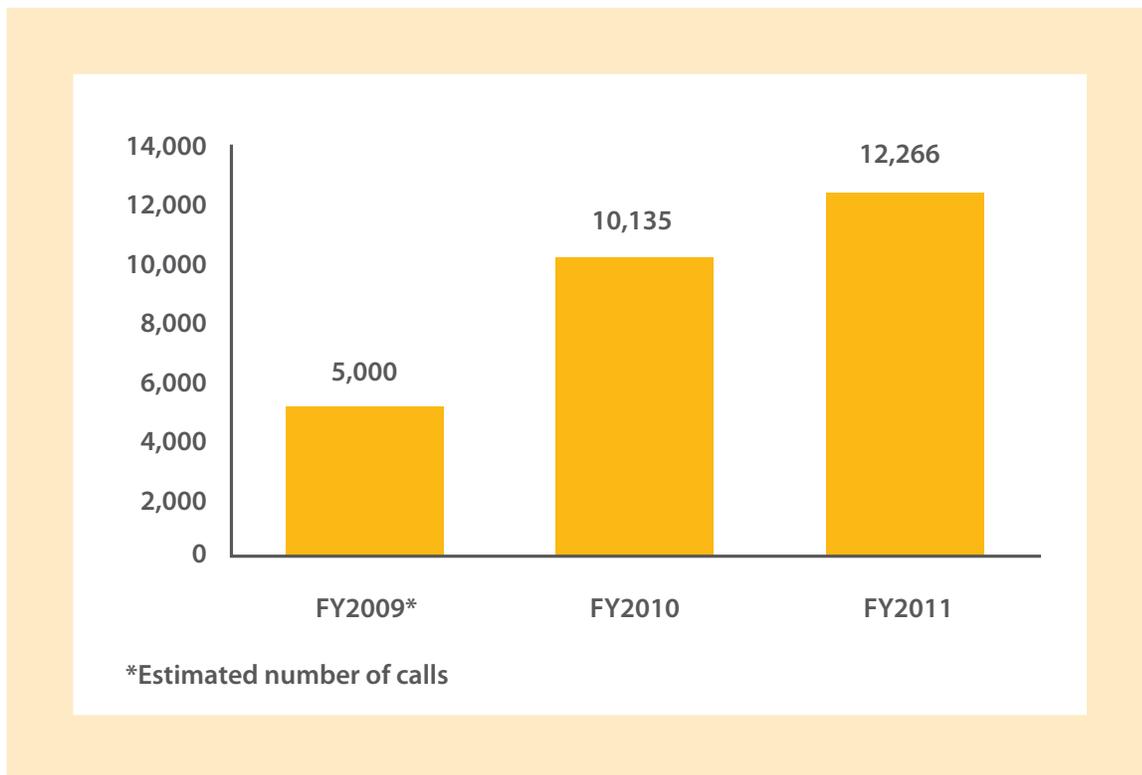
Based on DCF's original concerns with EMPS service access and quality, PIC staff helped identify volume, mobility, and response times as important areas for improvement. Various methods of data analysis and reporting are carried out in order to facilitate improvements across the EMPS network, including aggregate and site-specific reporting and comparisons to benchmarks, statewide averages, and a site's own past performance (trending). In addition, PIC staff members work with each site's management team to complete a quarterly Performance Improvement Plan that addresses two to three areas of underperformance. EMPS PIC staff members then help each site's management team identify action steps for addressing those practice areas and share best practices from other providers. Finally, PIC staff members identify an area of underperformance across the whole network and offer a small financial incentive (usually \$500) to providers that achieve a predetermined level of performance on that indicator. Though not a large

financial incentive, this has proved to be a fairly effective motivator for achieving improvements in specific practice areas.

In the area of EMPS service volume, total calls were examined across the network and for each site to determine changes in EMPS utilization over time. Volume has increased from approximately 5,000 calls in Fiscal Year 2009 to over 12,000 calls in

Fiscal Year 2011 (see Figure 1). The PIC takes the additional step of examining total calls for each of the 15 EMPS sites and standardizing call volume according to child population in their catchment area which helps providers determine how well EMPS is reaching the target population relative to other sites.

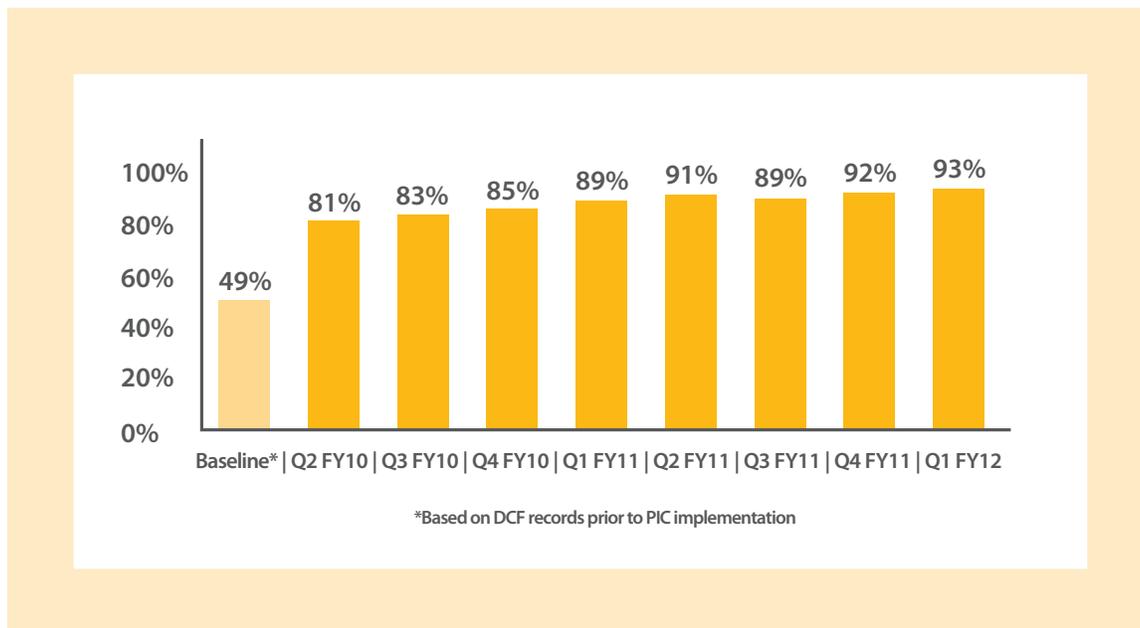
**Figure 1: Total Call Volume Statewide**



In the area of mobility, PIC staff members examine the percentage of all referrals that are provided with a face-to-face initial assessment. Early in PIC operations, PIC staff members worked with DCF to establish a mobility benchmark of 90%. Prior to PIC implementation 49% of all referrals received an initial mobile assessment. Currently, the statewide

mobility rate, shown in Figure 2, is 93%. Although not shown here, these results are also reported for each site individually. Over time, mobility rates have improved across all sites so that most of the 15 sites in a given reporting timeframe now achieve the 90% mobility benchmark.

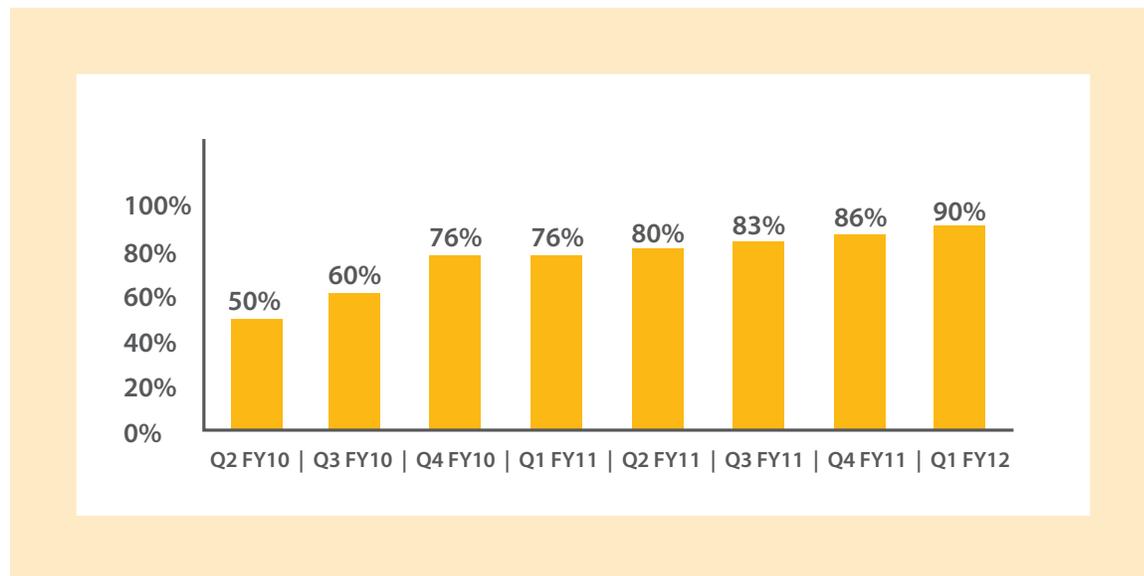
**Figure 2: Statewide Mobile Response by Quarter**



In the area of response time, PIC staff worked with DCF to establish a benchmark that at least 80% of all mobile responses would occur in 45 minutes or less. Baseline data on response time were not available for that measure, although internal DCF data reports indicated a median response time of approximately 60 minutes. Early in PIC implementation, the percentage of mobile response

that met the benchmark was only 50%. Current data indicates that 90% of mobile responses occur in 45 minutes or less (see Figure 3). Similar to mobility rates, response time results are reported for each site, and over time, performance has improved to the degree that most sites achieve the 80% benchmark for each reporting period.

**Figure 3: Statewide Total Mobile Episodes with a Response Time Under 45 Minutes by Quarter**



**"The PIC's timely 'user-friendly' presentation of data and accompanying analysis has allowed agencies and the service system as a whole to target those areas that will most effectively result in improvements to the care that youth and families receive during times of crisis." (EMPS Manager)**

*Child and Family Outcomes*

The PIC model also emphasizes measurement and reporting of child and family outcomes in its QI work. The primary outcome measure for EMPS is the Ohio Scales which consists of problem and functioning subscales that are rated by parents

and EMPS clinicians.<sup>15</sup> The results of this measure indicate that youth participating in EMPS experience statistically significant improvements in problem behavior and functioning, according to parent and clinician reports on the measure (see Table 1).

**Table 1: Statewide Ohio Scale Scores FY2011 (based on paired intake and discharge scores)**

	<b>N</b>	<b>Mean (Intake)</b>	<b>Mean (Discharge)</b>	<b>t-score</b>	<b>Sig.</b>
<b>Parent Functioning Score</b>	1318	42.09	43.85	6.10	p<.01
<b>Worker Functioning Score</b>	2754	42.19	44.60	16.85	p<.01
<b>Parent Problem Score</b>	1334	29.05	25.40	-12.72	p<.01
<b>Worker Problem Score</b>	2758	30.60	26.57	-23.2	p<.01

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Parent and referrer satisfaction with the Call Center and EMPS services are also important outcome measures. Staff members at the PIC helped to develop a satisfaction measure that is administered to a sample of 60 parents and 60 other referrers each quarter. Results on this measure indicate that parents and other referrers to EMPS are highly satisfied with services provided by the Call Center and EMPS providers statewide, with quarterly mean satisfaction ratings in the 4.8 to 4.9 range on a 5-point scale.

There are other outcome areas for which the PIC can play a key role in research design, analysis, and reporting. For example, a primary purpose of EMPS is to divert youth from emergency departments, inpatient hospitalization, and arrest and into community-based care options. Given that treatment in emergency departments and inpatient units are among the costliest interventions, an additional QI goal for EMPS in the outcomes domain is cost effectiveness. Staff at the EMPS PIC are working with DCF and EMPS providers to develop evaluation plans that will examine whether EMPS produces positive outcomes at a lower cost than these other treatment options.

## Conclusions and Recommendations

The PIC at CHDI has been a successful QI model for Connecticut's EMPS program. The PIC model has been used to standardize training and clinical practice, improve access and service quality, and measure and improve child and family outcomes. There are several ways in which the PIC model can be applied in practice settings to improve the overall standard of care in child-serving systems. Several recommendations are offered below.

### **Recommendation 1: Promote and support EBTs across the mental health system of care**

EBTs continue to be one of the most promising ways to improve the quality of mental health care in Connecticut, which currently has one of the most comprehensive arrays of EBTs of any state in the country. Connecticut can continue to explore other EBTs in children's mental health, particularly ones that are appropriate for outpatient settings, where more children and families are served than any other sector of the behavioral health service system.<sup>16</sup> Further, in order to support and sustain these models over time, and maintain positive outcomes, investments can be made to ensure implementation of EBTs with fidelity through model-specific training and quality improvement mechanisms.

**Recommendation 2: Monitor and promote the quality of best practice and usual care behavioral health services using the PIC model**

The PIC has been applied successfully to EMPS and has been a key supporting structure for standardizing training and clinical practices, improving service access and quality, and measuring and improving child and family outcomes. The PIC model has been demonstrated to be a viable and effective model to promote ongoing quality in the delivery of mental health services.

**Recommendation 3: Identify promising usual care interventions in Connecticut and systematically build evidence for effectiveness to move these practices toward the status of evidence-based treatments**

EBTs are not available to address the needs of all children and families, and there are several “home grown” models that meet important needs and demonstrate promising preliminary outcomes. As evidenced by EMPS, the PIC model can be used to help systematically move these interventions toward evidence-based status while ensuring accountability for quality and outcomes among all service providers.



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**Recommendation 4: Expand the PIC model to improve service quality and outcomes in other child-serving systems including child welfare, juvenile justice, health, and education**

The PIC model is flexible enough to be applied to any system that is implementing programs that may benefit from QI. In a time of fiscal constraints, Connecticut cannot afford to spend limited resources on services that are not maximizing their impact for the state's most vulnerable children and families. The state may also want to consider consolidating PIC quality improvement services under one roof to ensure a consistent approach and to capitalize on economies of scale.

**Recommendation 5: Continue to expand performance-based contracting**

Service quality and outcomes can be improved when minimum standards are clearly articulated in their contracts and accountability is ensured. Accountability to standards can be monitored through an ongoing, structured, data-driven process such as the PIC model.

**Recommendation 6: Continue to enhance existing, and develop new data systems**

Data systems that allow for transparent sharing of quality improvement and outcomes data across stakeholders would be beneficial for promoting higher quality care. In addition, the state may want to consider enhancing existing data systems across agencies in order to promote linking data across systems (e.g., education, behavioral health, juvenile justice, child welfare). Data should be reviewed in an ongoing manner, shared with providers and consumers, and be used to promote a culture of transparency and accountability.



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