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ABSTRACT

Beginning in the fall of 1999, all programs of the Child and Youth Services Administration of the District of Columbia Commission on Mental Health Services were ordered to implement a performance improvement plan. This report looks at how successful one clinic was in improving performance in one year. The objectives were to: (1) increase the number of children receiving services; (2) increase the percentage of Hispanics and other multicultural groups receiving services; (3) help children improve their school performance; (4) encourage families to participate; and (5) monitor content and quality of services. The evaluation found that trying to improve all five objectives at the same time was a difficult task. The clinic had seen a marked increase in clients with histories of severe psychiatric problems, aggression, and violence. Public mental health systems with limited resources must make hard choices about resource allocation if the referrals continue to swell with complicated cases. The pressures to serve more clients, increase each family's involvement, and improve record keeping are often at cross-purposes. The recommendation was made that clear priorities be established so that the mission of prevention and training are maintained as performance improvement plans go forward. Data tables and the Service Satisfaction Questionnaire are appended. (Contains 10 references.) (JDM)

Running head: MEETING PERFORMANCE IMPROVEMENT TARGETS

Meeting Performance Improvement Targets

In a Children's Outpatient Clinic

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Abstract

A public outpatient clinic implemented a 7-point performance improvement plan in FY 2000. Client census increased 10%. Hispanic clients increased to 15% of the total. Family satisfaction with the quality and appropriateness of care remained above 90%. Measures of family involvement in treatment planning showed no consistent trend. Quality of medical records documentation remained stable. Outcome measurement was not implemented. Family membership on the advisory board remained at one-third. This case study illustrates lessons for mental health institutions undertaking similar initiatives.

Meeting Performance Improvement Targets

In a Children's Outpatient Clinic

How successfully can a public mental health clinic improve performance in one year? Nationwide, the public is demanding that providers improve accountability, increase productivity, serve a more diverse clientele, and collaborate better with clients and families in designing and delivering services (e.g., Hatry, et al, 1997; Osher et al., 1999; D.C. Action for Children, 1999). This paper is a case study of how one program, a children's outpatient clinic, has striven to implement a performance improvement plan (AMBHA Committee on Quality Improvement and Clinical Services, 1998).

Beginning in fall 1999, all programs of the Child and Youth Services Administration of the District of Columbia Commission on Mental Health Services were ordered to implement a seven-point performance improvement plan. The plan's objectives were specified as follows:

1. Increase the number of children receiving services, to serve up to 12% of District of Columbia children with serious emotional disturbance.
2. Increase the percentage of Hispanic and other multicultural residents served to at least 4%.
3. Document that families are satisfied with the quality and appropriateness of care, using consumer satisfaction surveys.
4. Encourage families to participate in the treatment planning process for their children.
5. Monitor the content and quality of medical record documentation.
6. Measure children's improvement in school performance.

7. Increase family members' participation on advisory boards to at least 51%.

How are clinics to meet these challenges, particularly without additional resources? The plan would appear to require the program manager to guide significant changes in organizational culture and customary practices (e.g., Kotter, 1996; Kouzes & Posner, 1995; Conner, 1995). For example, staff would need to find ways to serve more clients, while maintaining and even improving customer satisfaction and medical records documentation. They would need to find ways to serve clients from diverse cultural backgrounds, who often speak different languages. Relationships between staff and families would need to be rethought and renegotiated: hierarchical doctor-patient modes of relating would need to become more collaborative and family-driven (e.g., Osher et al, 1999).

Results and Discussion

Number of clients served. Over the period 10/99-7/00, the clinic's census of registered clients was recorded quarterly. Results are shown in Table 1. From the first to the fourth quarter of plan implementation, census increased eight percent. Factors contributing to the growth included increased referrals from the community; use of more trainees (three social work students and an art therapy intern were placed at the clinic, in addition to the five psychology and two psychiatry trainees); somewhat higher caseloads for staff; and an effort to discharge more quickly clients who did not attend treatment sessions regularly. Impediments to further growth included a fluctuating flow of referrals; increasing severity of clients' difficulties (necessitating more intensive services per client); the clinic's ongoing commitment to prevention and training activities as well as treatment; and the existence of two to three vacancies in clinical staff positions for most of the year.

Multicultural clients served. The number of Hispanic and other multicultural clients served by the clinic increased from fifteen (eight percent of the total census) in the first quarter to thirty (14 percent) in the fourth quarter (Table 2). Crucial to this success was the establishment of a bilingual treatment team, comprising a clinical psychologist, a clinical social worker, and two trainees, one in each of these disciplines. The team conducted an outreach campaign in local community-based organizations and schools which generated a large number of referrals. Nevertheless, the initiative faced challenges by year's end. The departure of a bilingual trainee would soon reduce the capacity of the team to treat Hispanic clients. There was ongoing difficulty in recruiting more bilingual staff to open positions. And a large variety of Asian, African, and other multicultural consumers continued not to be served at all.

Family Satisfaction. The clinic had administered family satisfaction surveys for some years. A revised survey introduced a five-point Likert scale as well as open-ended questions (Satisfaction Survey is reproduced as Figure 1). The survey was also translated into Spanish. A ten percent sample of family members was given the survey during visits to the clinic. Average satisfaction was at 4.8 on a five-point scale in the March, 2000 survey. Challenges to implementation included the low response rate to surveys, and the difficulty in selecting a random sample. Moreover, the nearly uniformly positive responses on the survey meant that few if any suggestions were generated for program improvement.

Family Involvement in Treatment Planning. This was measured by a retrospective review of six items documented in the medical record. Families were considered involved if they: discussed the treatment plan with the clinician; attended the treatment planning conference; signed the treatment plan (preferably on the date of the treatment planning conference); and/or indicated

their approval of the treatment plan. Percent compliance with indicators fluctuated over the course of the year, (see Table 3) with the first quarter at 67% and the fourth quarter at 60%. Fluctuation appeared to be due largely to sampling variation, and to failure of some clinicians to document all treatment-planning-related contacts with families. More important, significant challenges to clinician-family collaboration are posed by the multi-problem nature of many client families, and the fact that working parents cannot often take time off from work to attend clinic sessions.

Medical records quality. The quality of medical records in the clinic was measured by rating randomly selected records on ten items (Table 4). Average compliance on all items ranged between 78 and 87 percent, with no discernible trend over the year. When sorted by clinician, these data suggested that whereas certain staff maintained consistently high rates of compliance, others continued habits of substandard record keeping. It also appeared that some clinicians were affected more than others by staff vacancies and assumed additional job duties, compromising their record keeping. To rectify this situation, the following measures have begun to be implemented: increased frequency and number of records reviews, utilizing reviewers from other programs; more written feedback to individual clinicians; and a more explicit link between record keeping and annual performance ratings.

Children's school performance. Children's school performance was envisioned as a set of outcome measures, and discussed extensively in the planning phases of the performance improvement plan. Outpatient clinics were exempted from implementing these measures, for several reasons. Staff resources were insufficient to gather report card data from schools on a regular basis. No method was devised to aggregate the multiple data from a report card into

meaningful summary measures for individual clients. Finally, there were no resources available to analyze the data, had it been gathered. Individual clinicians continue to track their clients' school performance on a case-by-case basis.

Advisory boards will have at least 51% consumer membership. Parents of current and former clients constituted two of six members of the clinic's advisory board. The center director frequently asked staff and current board members to suggest additional appropriate candidates for board membership, and no suggestions were forthcoming. Those family members asked directly have declined to participated, citing work and family commitments. It appears that recruiting additional family members to the advisory board, and/or devising other ways for family members to participate in program evaluation and governance, is a long-term project (Woodbridge & Huang, 2000).

Conclusions

There is an upper limit on the number of clients a clinic can serve. The clinic has seen a marked increase during the past year in clients with histories of multiple hospitalizations, severe psychiatric symptoms, criminal history, aggression and violence, and history of residential treatment. The more severely-disturbed the clientele which is deemed suitable for outpatient treatment, the more service time each client will require, and therefore the smaller the caseload each clinician, and the clinic as a whole, ought to carry (Henggeler et al, 1998). If the clinic receives more of these referrals and cannot refer them for services elsewhere, then the overall clinic target for the number of clients served will need to be decreased. Public mental health systems with limited resources therefore face hard choices in resource allocation.

Making a children's mental health system truly "family-driven" takes time. It sometimes

seems that families have little time to attend meetings, fill out surveys, or join advisory boards. On the other hand, staff and administrators need to be more flexible, accessible and available, to set askid time to reach out to families, to really invite families and really listen to them. In addition, other means of increasing families' involvement will need to be devised. These may include public meetings, advisory councils, participation in administrative decisions, and use of hired parent advocates. Such efforts, it is anticipated, will bear rich fruit in increased communication, understanding, and perceived responsiveness.

Measuring outcomes requires an investment of organizational resources. The data needs of administration, the public, and clinicians themselves are not identical. Staff tend to perceive data collection as both burdensome and irrelevant to clinical decision-making (Bickman, 1999).

It is hard to improve everything at once. The pressures to serve more clients, increase each family's involvement, and improve record keeping are often at cross purposes with one another. These priorities in turn draw time and attention away from other core activities of the clinic's mission such as prevention and training. These issues will need to be addressed, and clear priorities established, as implementation of the performance improvement plan goes forward in succeeding years.

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Author note

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Tables

Table 1

Client Census by Quarter

Quarter	Client Census
10/99	194
1/00	215
4/00	218
7/00	210

Table 2

Multicultural Consumers Served

Quarter	Multicultural Consumers Served	Percent of Clinic Census
10/99	15	8
1/00	25	12
4/00	33	15
7/00	30	14

Table 3

Family Involvement in Treatment Planning

Item	Percentage in compliance			
	Oct-99	Jan-00	Mar-00	July-00
Treatment plan indicates family involvement in treatment planning	80	87	83	79
TP documents family attendance/attempts to include them in TP conference	70	87	83	75
Family member signed most current TP	80	75	63	63
Date of family member's signature corresponds with date of TP conference	70	50	38	42
Progress note documents family contact/involvement in TP process	70	75	96	50
Progress note documents family member's response to TP	30	50	67	50

Table 4

Quality of Medical Record Documentation

Medical Records Category	Percentage in compliance			
	Oct-99	Jan-00	Mar-00	July-00
Treatment plan current	100	75	54	100
Goals specific and objective	90	83	79	100
Interventions measurable and time-limited	80	95	88	96
TP problem list corresponds to handwritten problem list	60	79	83	92
Assessments and updates current	100	66	63	50
Treatment plan has corresponding progress note	70	75	71	42
Progress notes correspond to TP goals/interventions	100	95	96	100
Progress notes indexed to current TP problem list	70	70	58	63
Consumer/family responses documented in progress notes	100	95	96	92
Progress notes document active treatment interventions	100	87	88	100
Average of all medical records items	87	82	78	84

Figure 1

Northwest Family Center
1536 U Street, N.W., Third Floor
Washington, D.C. 20009

SERVICE SATISFACTION QUESTIONNAIRE

Dear parent/guardian:

The Northwest Family Center would like your help in improving our services to children and families. Please take a few minutes to complete this survey. Your name will not be used in any reporting of this survey. Your suggestions will help us to better serve your family and others.

When you have finished, please put your survey in the box provided.

David B. Sacks, Psy.D.
Clinical Administrator

How satisfied are you that ...	Never 1	Seldom 2	Sometimes 3	Often 4	Always 5
1. Northwest Family Center staff treat you and your family with dignity and respect.	1	2	3	4	5
2. Staff is honest with you and your family.	1	2	3	4	5
3. Staff listens to you and your family's problems.	1	2	3	4	5
4. You and your family can freely ask questions about the treatment plan.	1	2	3	4	5
5. Staff clearly answers your and your family's questions about the treatment plan.	1	2	3	4	5
6. The staff clearly implement your family's requests for specific services/treatment interventions.	1	2	3	4	5
7. The staff makes a special effort to include you and your family members.	1	2	3	4	5

How satisfied are you that ...	Never 1	Seldom 2	Sometimes 3	Often 4	Always 5
8. You and your family are active participants in the treatment plan.	1	2	3	4	5
9. You and your family are expected to attend treatment planning meetings.	1	2	3	4	5
10. The activities included in the treatment plan will help to improve the problem.	1	2	3	4	5
11. The finished treatment plan clearly includes you and your family's concerns.	1	2	3	4	5
12. You and your family understand the treatment plan.	1	2	3	4	5
13. You and your family are well treated by the staff.	1	2	3	4	5

What do you find most helpful about your work with Northwest Family Center?

Finally, please write your suggestions for improving our services:

If you would like to be contacted regarding this survey, please given your name and telephone number, and the Clinical Administrator will call you:

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