SECTION - THERAPY SERVICES
ADMINISTRATIVE DIRECTIVE NO. 438

Effective Date: April 13, 2006

SUBJECT: CLINICAL OUTCOME EVALUATION SYSTEM

Cancellation: This directive cancels Administrative Directive No. 438 dated August 1, 2005, same subject.

I. PURPOSE

The purpose of the clinical outcome evaluation system at CSH is to evaluate the results of individual care. Consisting of an organized set of measures, this system provides data with which to monitor ongoing clinical performance. This system focuses on three primary areas: individual factors, intervention factors, and post-hospital outcomes. It provides a mechanism to address the question of what types of individuals, given what forms of intervention, demonstrate what kinds of outcomes.

II. AUTHORITY

Authority is obtained from the California Administrative Code, Title 22, Division 5, Section 70577 established in conformity with the Joint Commission on Accreditation of Healthcare Organization (JCAHO); and policy and procedures as approved by the Hospital Executive Director.

III. POLICY

In order to provide an integrated and comprehensive understanding of the complex relationships among individual factors, intervention factors, and post-hospital outcomes, a centralized clinical outcome evaluation process is utilized. Primary responsibility for this outcome evaluation process lies with the Director of Evaluation and Development Services (EDS), under the supervision of the Clinical Administrator, the Director of EDS ensures the applicability and compatibility of the various clinical measures used for outcome evaluation at CSH, as well as the integration of local procedures with the statewide outcome evaluation system. The staff of EDS performs centralized evaluation functions.

IV. METHOD

EDS is responsible for the appropriate regulation of hospital wide databases and associated data analyses under its authority. Such databases include hospital wide progress tracking and outcome databases (e.g. phase movement and group outcome data), repositories for data generated by EDS assessment services (e.g. Psychophysiology Lab, Neuropsychological Service, and the Assessments Center), data managed by EDS for the Psychology Department, and databases that cross Program or Commitment lines (e.g. PCL-R2 data). The Director of EDS ensures

procedures are in place to maintain confidentiality, to safeguard information, and to de-identify data whenever necessary and possible.

Program Mall Management is responsible for the development, administration and reporting of specific measures to evaluate specific activities conducted within the Mall or program. The discipline chief monitors the adequacy of assessment procedures conducted by each professional discipline.

Responsibility for the collection of data on an individual's change over the course of hospitalization lies with the Program. Program staff enters data from selected instruments into the Clinical Delivery System (CDS) database and the hospital individuals tracking system.

Evaluation and Development Services staff in collaboration with the Mall Director and Assessment Service Director is responsible for organizing data generated by the outcome measures on a quarterly basis.

V. AREAS OF MEASUREMENT AND INSTRUMENTATION

There are three primary areas of measurement in the overall outcome evaluation system: individual factors, intervention factors, and post hospital outcomes.

A. Individual Factors:

There are two basic segments of relevant individual factors. The first is individual characteristics that are essentially static and include such variables as commitment status, demographic variables (e.g. gender, age, etc.) and criminal and psychiatric history. These variables play an important role in mediating treatment outcomes, and are accessed through the Department of Mental Health's Admission, Discharge, and Transfer (ADT) database.

The second segment is the assessment of individual characteristics and strengths. These are assessed using the following instruments and/or services:

1. Functional Skills: The integrated assessment and Coalinga Relapse prevention Skills Profile (CRSP) provide standard evaluations of the psychosocial skills relevant to the recovery of our individual population. These data provide the baseline for evaluation on individual's response to service and as the basis for planning to enhance those skill areas identified as important for discharge readiness.

2. Psychiatric Symptoms: Factors related to psychiatric symptoms that have been demonstrated to affect the adequacy of the post hospital adaptation include the severity, chronicity and persistence of symptoms. Data on these dimensions are used not only for service planning, but are also applied to outcome evaluation. Psychiatric symptoms are assessed initially by the admitting psychiatrist for the degree of functional impairment and subjective distress that they cause the individual. Because symptoms may change

significantly beginning shortly after a individual's admission to CSH, baseline measures on the integrated assessment are obtained as early in the admission process as possible. Subsequent evaluations using the symptom tool occur upon the individual's transfer to a new unit and at the time of the monthly medication review. These evaluations focus on the degree to which symptoms prove responsive to treatment.

3. Psychopathy: HARE Psychopathy Checklist-Revised-Second Edition (PCL-R2). Personality traits are assessed in terms of their impact on response to treatment and need for enhanced security. The degree of psychopathy is significant in the patient population and must be accounted for in clinical decisions about amenability to treatment and the nature of supervision required. Current indications are that highly psychopathic or otherwise character disordered individuals respond differently to treatment. Thus data on these traits are necessary for empirically evaluating the effects of various treatments on individual patient outcomes.

4. Neurocognitive functioning: Neuropsychological and cognitive abilities are assessed in order to make effective treatment planning decisions, enabling treatment teams to place individuals into treatment modalities which are best suited to the individual's cognitive strengths and weaknesses. Data on neurocognitive functioning are also used to accurately evaluate overall treatment outcome by controlling for variables anticipated to affect individuals response to treatment.

5. Sex Offender Characteristics: Sex Offender Assessment Battery. Sexual offenders committed under the Welfare & Institution Code and who have entered treatment are assessed with a variety of measures. These assessments may include but are not limited to the following: MMPI-2, MCMI-III, Multiphasic Sex Inventory II, Psychosexual Life History, penile plethysmograph, and polygraphs.

B. Intervention Factors:

Measures in this area focus on the amount and types of service received as well as individual progress during hospitalization. Specific measures include:

1. Number and Type of interventions: Activities are designed to address specific areas as identified in the Wellness and Recovery Plans. For example, treatment groups are directed towards identified skills such as substance abuse management, anger management, symptom self-management, and medication self-management.

2. Treatment activity outcome measures: Skill building activities at CSH have specific treatment protocols that define goals and objectives in terms that can be empirically measured. Outcome data are collected using a standardized format to assess individuals' functioning in relation to specific treatment activities. In this way the association of individual activities to overall individual outcomes can be evaluated.

3. Coalinga Relapse prevention Skills Profile: The CRSP is used to assess the nature and degree of change an individual demonstrates over the course of his stay at CSH. This measure is used for ongoing planning, to assess readiness for discharge, and to assess an individual's overall response to hospitalization for outcome evaluation purposes. The ASP Domain VIII is incorporated into database at regular intervals. This data is retrieved and utilized to evaluate change in scores over the course of an individual's hospital stay.

C. Post-Hospital Outcomes:

The primary goal of treatment is the individual's successful performance in the post-discharge environment. Therefore a separate set of measures that reflect post-discharge functioning is essential to outcome evaluation. These measures assess the individual's ability to manage symptoms and apply skills acquired during hospitalization. From these data, understanding can be developed about the effects of services on recidivism, the post-discharge environmental factors associated with recidivism, and the types of individuals most likely to re-offend. Data from these measures are managed, analyzed and reported quarterly to the Clinical Administrator by the Evaluation and Development Services staff. The measures of post-hospital functioning include:

1. Individual Satisfaction: Individual Evaluation Form. Staff from the Admission Suite is responsible for soliciting responses on this self-report instrument that is completed by individuals at the time of their discharge. The measure allows individuals to provide feedback on the adequacy of services from their perspective. It is completed anonymously to encourage disclosure, and requests only enough identifying information to analyze the data in terms of commitment type, program, and disposition. These data are used to evaluate ongoing individual satisfaction and opportunities for improvement.

2. Short term post-discharge functioning: Post-Hospital Inventory. This measure consists of a structured telephone interview completed by staff of Evaluation and Development Services three months after the time of discharge. Samples of individuals of different commitment types and dispositional tracks are generated and staff in the post-hospital setting who is familiar with the individual in the sample are contacted and interviewed. The information gathered includes functioning in the areas of managing symptoms, adherence to prescriptions, treatment compliance, assaultiveness, substance abuse, activities of daily living, work and school. The inventory also includes questions about the adequacy of documentation and communication from the hospital to the receiving program. For those individuals who are no longer successfully functioning in the intended discharge environment, information is gathered about the causes of the placement failure.

3. Re-hospitalization and Recidivism: Access to data collected on discharged persons allows the hospital to determine outcomes in terms of recidivism

and re-hospitalization. Data is requested from the Department of Justice, in the form of Criminal Identification and Information (CI&I) reports, for individuals who have been discharged from CSH for three years. This information is supplemented by data from the Admission, Discharge, and Transfer database (ADT) maintained by the Department of Mental Health and the Offender Based Information System database (OBIS), maintained by the California Department of Corrections.

VI. DATA INTERPRETATION/OUTCOME EVALUATION

The major task of the clinical outcome evaluation system is to assess the relationships between the measures of individual factors, intervention factors, and post-discharge functioning. Statistical procedures, including survival analysis, are applied to the data collected on individual factors and intervention factors to account for variations in post-hospital outcomes. In this way an empirical understanding can be gained of the essential question as to what types of individuals, given what forms of intervention, demonstrate what kinds of clinical outcomes. In addition to routine outcome evaluations performed by Evaluation and Development Services (EDS), proposals for data access and focused program evaluations are received from Program Managers, Service Area Directors, Service Chiefs, and clinical and administrative staff. Proposals must be submitted in writing to the Director of EDS and reviewed for their applicability as program evaluation. Proposals may be sent to the Hospital Coordinator of Research for review to see if research approval is required before proceeding with a project. Proposals that are deemed within the purview of program evaluation will be accepted and EDS will provide assistance with the following tasks as needed for each project: data entry, database creation, data review, data analysis, and interpretation of the statistical findings. Similar data review and analysis is also available for research projects approved through the Research and Human Subjects Committee.

There are many variables in the post-hospital environment over which the hospital has no direct control that influence outcome in terms of individual relapse or re-offense. Therefore post-hospital measures and data analysis techniques must account for the effect of such factors so that the effect of treatment in the person's subsequent adaptation can be more clearly understood.

The understanding that is derived from the analysis of treatment and post-hospital outcome data is used to modify treatment practices to enhance outcomes and improve efficiency of service delivery.

W. T. VOSS
Executive Director

Cross Reference(s):
A.D. No. 406 Polygraphs
A.D. No. 414 Research
A.D. No. 434 Active Treatment Interventions
A.D. No. 446 Wellness and Recovery Planning