

CQRT Overview

CQRT is a statewide consumer-run initiative that independently collects, analyzes and disseminates objective information about behavioral health care services and quality of life¹ issues that promote recovery and resiliency. CQRT data is used to promote continuous quality improvement of mental health services for all Ohio citizens with mental illness and behavioral disorders.

The CQRTs are stand-alone consumer and family-based entities, both in composition and ownership. These teams do not operate as an extension of the system, but as a part of the total mental health enterprise, as independent entities. Teams collaborate with each of the boards both as partners, and as experts at interpreting the views and concerns of persons who are SMD/SED and their families.

Consumer Quality Review Teams (CQRTs) represent an innovative approach to data gathering by utilizing teams of consumers, family members, and providers to assess and improve the quality and responsiveness of community mental health services. CQRTs review the quality of the whole system of care through the experiences of consumers. Data from the interviews are used for continuous quality improve at the state and local level.

The CQRT process is one of the most innovative consumer-run processes in the state. The process looks at the impact of mental health services from multiple perspectives to provide a balance perspective of what is happening in the public mental health sector in six areas:

1. availability [i.e., Are the services being provided?];
2. accessibility [i.e., How accessible are the services?];
3. appropriateness [i.e., Are these the type of services which should be provided?];
4. acceptability[i.e., Are the services as good as they should be?];
5. accountability [i.e., How is the quality controlled?]; and
6. affordability [i.e., How costly are the services? Who pays?].

¹ Quality of life refers to non-clinical or personal support network, which may be augmented, but not dominated, by formal mental health services. These may include, but are not limited to, housing, employment, education, diversion programs, and consumer groups.

CQRT Vision:

CQRT data is used to promote continuous quality improvement of mental health services for all Ohio citizens with mental illness and behavioral disorders.

CQRT Mission:

CQRT is a statewide consumer-run initiative that independently collects, analyzes and disseminates objective information about behavioral health care services and quality of life² issues that promote recovery and resiliency.

CQRT Values:

Respect:

We treat all people with respect and dignity. We are respectful of individual, community and cultural differences. We support individual choice and encourage the strengths of adults, children, youth and communities.

Integrity:

We are honest and ethical in all our dealings. We keep our promises, confidences and are accountable for our actions.

Dedication:

We are committed to helping every Ohioan with mental health needs.

Quality:

We strive to promote the highest quality of services to the people of Ohio. We evaluate the acceptability, accessibility, availability, appropriateness, and adequacy of services provided by the mental health system.

Teamwork

We promote innovative thinking and active partnerships that reach across system and organizational boundaries

CQRT AIMS to:

1. Create a system that cares more deeply about consumers.
2. Enhance quality of life for the SMD population.
3. Enhance the recovery process.
4. Provide greater accountability with regulatory relief.
5. Promote systems improvement.
6. Create a consumer-driven statewide assessment model.

² Quality of life refers to non-clinical or personal support network, which may be augmented, but not dominated, by formal mental health services. These may include, but are not limited to, housing, employment, education, diversion programs, and consumer groups.

CQRT HISTORY

In 1994, members of the Ohio Community Support Program Advisory Committee, now the Ohio Planning Council, visited the Philadelphia Consumer Satisfaction Team and the Georgia Consumer Satisfaction Program to observe a new concept of hiring consumers and family members in evaluating public mental health services. Visiting teams were comprised of a consumer, a family member and a mental health provider. The visit entailed interviewing consumers, providers and administrators of these programs as well as going into the field and observing actual satisfaction interviews.

Subsequent to the site visits, the Ohio Planning Council submitted a report with recommendations to the Ohio Department of Mental Health (ODMH) that satisfaction teams be established in Ohio.

Three movements influenced the importance of developing consumer satisfaction teams in Ohio:

- Research indicated a strong link between consumer satisfaction and outcomes
- The mental health system was moving toward a “recovery” model
- There was a shift to a quality assurance model for assessing systems performance rather than a “regulatory” model.

In 1996, the Ohio Department of Mental Health in collaboration with NAMI Ohio and Ohio Advocates for Mental Health established three (3) Consumer Quality Review Teams (CQRTs) to provide a consumer-driven mechanism for the external review of the publicly funded mental health system evaluating adult services in 21 counties and children’s services in an urban county.

In 1999, ODMH released an RFP to all Ohio counties for CQRT expansion funds. The two existing CQRTs made presentations to counties interested in responding to the RFP. As a result of this process, CQRT expanded from 22 counties into 43 of Ohio’s 88 counties with 16 counties evaluating adults services only, 23 both adults and children’s services, and one children’s services only CQRT.

In 2001 the CQRTs began using Mobile Office Units (MOUs) equipped with cubicles for interviewing – these are parked at provider agencies for easy access and have doubled the number of interviews collected.

As of January 2003, the CQRTs have interviewed over 6,000 consumers, family members and mental health providers, amassing the largest database ever collected on this population in Ohio and possibly in the country. The survey instrument asks both quantitative and qualitative questions, questions about recovery, physical health, and demographics. The data is analyzed according to 5 criteria about services: accessibility, availability, accountability, availability, and appropriateness.

The purpose of CQRT and the data collected is to improve the system of care according to the needs expressed by those whose lives are most profoundly impacted by that system. In addition to service gaps, interviews with consumers, families and service providers have identified much that is going well in the public mental health system. High levels of professionalism and competency across all levels of the mental health system were recognized. Advances in the recovery approach to treatment and services were identified.

CQRT also provides an employment opportunity for consumers and family members and a way of recognizing the expertise they have developed from their own personal knowledge of the mental health system.

Significant CQRT Findings³

Based upon a three-year site reviews, major findings centered around:

1. Access
2. Service Utilization
3. Service Knowledge
4. Continuity of Care
5. Meeting Client Need
6. Cultural Competence
7. Medications and Diagnosis
8. Doctor/Patient Interaction
9. Housing
10. Family Inclusion
11. Staff Issues
12. System Collaboration
13. Public Education

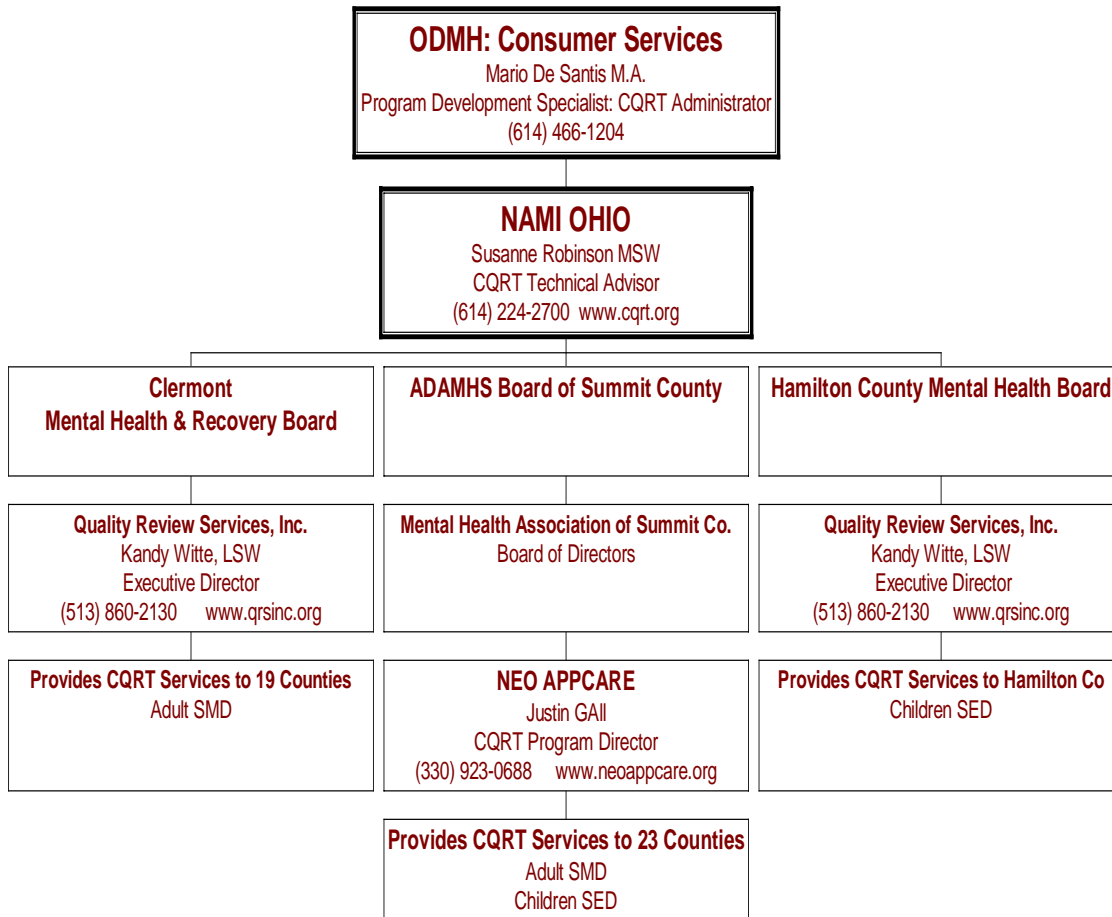
CQRT Organizational Chart

The CQRT initiative has an administrator, CQRT technical advisor, and two CQRT Program Directors. Mario De Santis is the CQRT Administrator for Consumer Services at ODMH. Mr. De Santis's primary responsibility is to oversee the statewide CQRT project. This includes collaborating with NAMI Ohio technical advisor Suzanne Robinson, and with the two CQRT Site Program Directors, Kandy Witte from QRS, INC., Inc. and Justin Gall from NEO/APPCARE.

³ A detailed explanation of the key findings can be found on page 6-8 in this document.

NAMI Ohio provides advocacy and education around Ohio and the nation promoting Ohio's CQRT project as a viable tool for meaningful systems change. Additionally, NAMI-Ohio provides technical support to QRS, INC., and NEO/APPCARE as requested, including focus group facilitation and the hiring of consultants in addressing project needs. NAMI will also be responsible for monitoring and reporting on how CQRT data has been used for continuous quality improvement of mental health services

QRS, INC., Inc. and NEO/APPCARE conduct the CQRT interviews and focus groups. Data are collected and analyzed to determine significant findings and provides valuable information for continuous quality improvement of mental health services.



Web Site

In collaboration with CQRT, NAMI Ohio will develop and maintain a CQRT web page, containing up to date information about the CQRT initiative, findings, and resources. Therefore, effective July 1, 2003, **WWW. CQRT.ORG** will be available.

KEY FINDING:ISSUES: ISSUES AND CONCERNS FROM ADULT CONSUMERS, FAMILY MEMBERS, AND PROVIDERS ACROSS THE 43 CQRT COUNTIES

1. Access

- Lack of transportation was a major barrier to access: viable models are rather scarce; resources are not being well utilized; this is not an issue, which is unique to rural areas.
- Services are often unavailable after hours and seldom on weekends.
- Long waiting time to access psychiatrist, even for emergency medications.
- Consumers' can't reach case managers when needed. Many reported a long wait time before callbacks, a smaller percentage reported no call backs ever.
- Family members felt that they seldom could access anyone in the system.

2. Service Utilization

- Out of the 15 services reviewed, utilization rates varied considerably. The highest rates were for case management and medications, while the lowest were for peer support, family counseling, vocational programs, and social programs (or activities).
- Most clients utilize 3-4 services.
- Vocational training and employment is limited.
- Consumers fear the hospitalization process, but are most anxious about the BHOs.

3. Service Knowledge

- Consumers are not well informed about available services. Many consumers were unaware of key services in their locality. This finding was independent of level of function or diagnosis.
- Providers are poorly informed about peer support programs. In fact, consumers were, on average, more aware of these programs than service providers. The concern is that this affects both the quality and types of referrals consumers receive from service providers.
- Family members are not well informed about available services.
- The community, at-large, seldom knows which local services exist, where, or when.

4. Continuity of Care

- Wraparound services are few.
- Follow-up after hospitalization is sometimes inconsistent, especially the transition from hospitalization to community living.
- Providers often reflect a crisis (reactive) approach to mental illness. Consumers perceived this when they are not seen unless a catastrophe occurs or a crisis is eminent, such as, suicide.

5. Meeting Client Needs

- Consumers consistently indicated that they are not very aware of the Client Right's process, nor the role of the CRO.
- Consumers who know the Client Right's Process expressed concern about the CRO's ability to fairly represent both agency and consumer concerns since these are often in opposition.
- Services with the higher satisfaction ratings were least available for consumers.
- Lengthy and duplicative intake process; also, paper proliferation is seen as wasteful.
- Persons without private insurance received less service exposure, independent of severity of condition.

6. Cultural Competence

- Discrimination was perceived by some persons of color (> 15% among persons of color).
- Services for the deaf and hearing impaired are often unavailable.
- Language interpretation services among providers are consistently lacking, statewide.
- Handicap access is very limited. This is much more the case in certain counties.
- Special outreach is sometimes unavailable to reach non-mainstream population groups.

7. Medications and Diagnosis

- Knowledge about medications is limited; information is poorly understood from patient inserts, which accompany medications.
- Consumer knowledge about diagnosis is sometimes lacking.
- Opportunity is needed to facilitate more consumers to obtain atypical medications, which are quite costly.

8. Doctor/Patient Interaction

- Time with psychiatrist is minimal.
- Limited time with doctor is more likely spent talking about medications than working on recovery, listening to patients, therapy, etc.
- An attitude of doctor aloofness and lack of warmth was perceived by a large number of consumers and family members.

9. Housing

- Nearly everyone agreed that more housing was needed; especially shared of group housing.
- Group homes often represent holding tanks rather than specialized care, since many are not licensed.
- Adaptive living in community needs greater attention.
- Housing models need greater dissemination for inclusion into MH system.

10. Family Inclusion

- Families don't feel sufficiently informed about mental illness.
- Family members feel they are seldom included in the treatment process because providers do not include them.
- Families are not in the loop to provide input into the system.
- Families feel they are an invaluable resource which is often underutilized by the MH system

11. Staff Issues

- Many services are perceived to be understaffed, more so for children's services.
- High caseloads and much paperwork exist among case managers (CM); notwithstanding, CM expends valuable time (average of 25%-50% FTE) in driving consumers to appointments.
- Consumers and significant others feel more respect needs to be demonstrated.
- There is staff burnout and a high turnover rate, most especially among case managers.

12. System Collaboration

- Providers are not well informed about each other.
- Referral numbers are low among providers; this also occurs among consumers with co-occurring disorders.
- Staff reports high levels of distrust among providers and low inter-agency communication.
- Providers reported little coordination among agencies. The system seems to be overburdened. Agencies perform tasks, which are independent and disconnected to each other, with high duplication and low efficiency.

13. Public Education

- Stigma is dampening good service efforts.
- The public has limited knowledge about mental illness, including service personnel, such as, police, courts, local government, and hospitals.
- Kids need orientation about MH in schools, as does the public sector, in general.
- Many respondents had a shared perspective that ADAMHS/CMH board members themselves lack needed knowledge and sensitivity about mental illness.