Summit 1997

Preserving Quality And Value In the Managed Care Equation

THE CORE SET OF VALUES AND INDICATORS ENDORSED BY ACMHA

SECTION I: KEY VALUE THEMES

By the close of the SANTA FE SUMMIT on March 22, the group accepted these value statements as central. They have been edited to make them as clear as possible to a broad cross-section of readers.

(1) Consumers and families are at the core of performance measurement.

The centrality of the concerns of primary consumers was a consistent theme of the SUMMIT. This value statement is intended to highlight the central role of primary consumers (which includes families of children and adolescents). The role of family members of adults was also addressed, with special attention to their needs for information and involvement to the extent possible.

(2) Consumer/customer choice must be a driving value for all systems of care, including their design, delivery, evaluation and accreditation.

Choice is an increasingly important element in the delivery of mental health and addictive disorders treatment, and it is a concern that cuts across public and private sectors. In an era of increasingly managed care, choice will sometimes be limited within a plan or system, but this value statement highlights the high priority that should be given to the broadest range of choices possible.

(3) Issues of ethnicity, race, age and developmental status, gender, language, culture, spirituality, disability are consciously addressed in ensuring access and availability of services.

ACMHA and the SUMMIT participants are concerned that all systems of care become or remain sensitive to their customers. One size does not fit all in providing mental health and substance abuse services, and due diligence is required in the design and delivery of culturally and linguistically competent care.

(4) Mental health and substance abuse delivery systems must be accountable to both internal and external stakeholders for meeting the mental health needs of the people they serve in ways that are effective and efficient, and that accountability must be based on reliable, comparable data.

To be credible, claims of the quality of care given can no longer rely on assertions of good intent. Data must assist delivery systems to improve, and provide a meaningful yardstick for comparing costs and outcomes to people outside of those systems. .

(5) Access to mental health and substance abuse services must be quick, easy and convenient, and outreach and follow-up must be seen as part of the access continuum.

Attention to access is not new, but the SUMMIT participants strongly urge continued attention to the basic issues of ease and speed of access. Outreach and follow-up are part of an access continuum.

(6) A true public health vision of community health must drive outcomes measurement, which means that universal access and integrated primary and behavioral healthcare are the ultimate goal of effective systems.

The participants in Santa Fe recognize the complexity of America=s healthcare systems, but believe that there must be a vision of true community health at the core of all health planning and delivery. This value statement is not intended to denigrate carve-out or specialty care models, but it does reflect the critical importance of coordination. A true public health vision requires attention to prevention and to the health status of entire populations, not just risk-adjusted subpopulations or high-risk populations.

(7) Children who have mental health and substance abuse problems:

- ***should be able to receive effective services in their homes and schools without disruptive removals from either setting;***
- ***should be able to remain safe and out of trouble with law enforcement;***
- ***should remain connected to family and peers while in treatment;***
- ***should receive services that are family focused and health centered***.

These value statements are difficult to operationalize, of course, but they focus attention on the most normalizing aspects of life for children and adolescents, and away from an over-emphasis on problems and deficits. An orientation towards families as opposed to individuals is not consistent in any area of health care delivery today, and purchasers and providers alike face many challenges in making these value statements have meaning. Nonetheless, ACMHA and the SUMMIT participants view the family focus for children and adolescents as not only a desirable, but a necessary and achievable goal.

(8) Adults with mental health and substance abuse problems:

- ***should be able to maintain a stable, comfortable and safe living environment;***
- ***should be able to engage in chosen, productive daily activity;***
- ***should be able to remain safe and out of trouble with law enforcement;***
- ***should receive treatment that is consumer-centered and which maximizes independence and self-care skills;***

- ***should receive services designed to enhance total health and maintain social connections and improved quality of life.***

The preceding value statements about adults speak to consumers= concerns about self-determination and dignity. In the field, we are coming to grips with consumers= demands for real power in mental health and substance abuse service design, delivery and evaluation. While the concerns of families of adults who have severe and persistent mental illnesses have legitimate (and all-too-often ignored) needs for information and involvement in the care of their loved ones, the ultimate authority must remain with the adult consumer. These statements also reflect a concern that persons who do not have ready access to appropriate care for mental and addictive disorders can too easily fall prey to incarceration, homelessness and other social problems that could be prevented.

SECTION II: THE KEY INDICATORS

The SANTA FE SUMMIT workgroups generated mountains of paper and logged hundreds of collective hours of conference calls. In order for this report to receive wide distribution, that level of detail is impossible, the following indicators are much abbreviated and every effort has been made to keep the language simple and unambiguous. The indicators are grouped by four of the domains (OUTCOMES, PROCESS, ACCESS, and STRUCTURE).

The domain of PREVENTION is addressed in a separate section [Section IV], and there is a special section on outcomes for a risk-adjusted group of children and adolescents [Section III].

ACMHA is using the definitions of **indicators** and **measures** developed as part of CARF=s Strategic Outcomes Initiative.

An **INDICATOR** is a@ Domain (e.g., effectiveness, efficiency or satisfaction; either process or outcome) or variable used to point to program quality or performance.

A **MEASURE** is a ASpecific instrument or data element used to quantify or calibrate an indicator.

A. OUTCOME INDICATORS

The outcome indicators are broken into two sections: the first three indicators are appropriate for **all populations**, both the commercially insured and working populations, as well as persons with serious and persistent mental or addictive disorders. The remaining measures are seen as relevant primarily for individuals with serious disorders. The measures used to assess performance are different for the two populations.

ALL ADULTS:

O-I-1. ***Adults [including those with serious and persistent mental or chemical dependency disorders] reside in their own homes or living arrangements of their own choosing.***

ACMHA believes that the ability to choose and maintain a stable home environment is a useful indicator of the effectiveness of services for people with mental health and substance abuse disorders. Both types of disorders can expose the individual to the risk of homelessness, transience, or serial supervised living environments. This indicator is intended to capture individuals who are hospitalized, in jail for reasons directly related to their mental illnesses, or homebound. For employed populations, the measures can be less rigorous, but ACMHA believes that it should be part of a core set of domains.

O-I-2. ***Adults [including those with serious and persistent mental or chemical dependency disorders] are working.***

For employed and commercially insured populations, absences from work and missed productivity are important indicators. For persons with serious and persistent mental and addictive disorders, this is increasingly seen as an essential element of recovery models. For some individuals, Awork@ may be understood as meaningful daily activities (including job training, volunteer work, etc.), but consumer participants successfully urged the College to keep the language focused on WORK. Again, different measures are appropriate, but the indicator is part of the core set.

O-I-3. ***Adults [including those with serious and persistent mental or chemical dependency disorders] have good physical health and report good mental health [psychological well being].***

It is vital that both general health and mental health be assessed in determining the effectiveness of interventions. Behavioral health services for all populations need to be integrated with primary health care to guarantee the best outcomes. There will be different measures for different population groups, but the value of general health is sufficient to place this indicator in the core set for all populations.

INDICATORS FOR ADULTS WITH SERIOUS AND PERSISTENT DISORDERS:

O-I-4. ***Adults with serious and persistent mental or chemical dependency disorders report feeling safe.***

The issue of safety was highlighted in the work of the SUMMIT. Persons with serious disorders can be at unusual risk for victimization, and often report feeling unsafe because of the reduced social and economic status that often accompanies a chronic illness. Consumers also express concerns about being victimized by public institutions and practices that deprive them of free movement and choices.

O-I-5. ***Adults with serious and persistent mental or chemical dependency disorders avoid trouble with the law.***

Obviously, people with mental and addictive disorders can commit crimes and have criminal responsibility for the consequences of their actions. This indicator seeks to address the dangers of the use of jails and prisons as a *de facto* alternative to viable community services.

O-I-6. ***Adults with serious and persistent mental or chemical dependency disorders maintain a social support network.***

The presence of social supports is well documented as enhancing the quality of life for persons with serious and persistent mental and addictive disorders, and these networks can play a pivotal role in relapse prevention and recovery.

O-I-7. ***Adults with serious and persistent mental or addictive disorders are able to manage their daily lives.***

Consumers frequently report concerns about managing their daily lives effectively, including symptom management and conflict resolution. This indicator can help assess the effectiveness of a system=s most basic interventions.

O-I-8. ***Adults with serious and persistent mental or addictive disorders report a positive quality of life.***

Quality of life is the ultimate test of any health care intervention, and this indicator fits with the others as part of a comprehensive core set.

B. PROCESS INDICATORS

The process indicators are designed to reflect on a system=s performance in serving the needs of the individuals it serves. The essential role of the consumer in all aspects of care is highlighted in this section, reflecting emerging practice for both privately and publicly insured populations.

P-I-1. ***Consumers actively participate in decisions concerning their treatment.***

This is a bedrock performance issue for ACMHA, and reflects the value statements of the SUMMIT. Consumers are essential partners in all aspects of the therapeutic enterprise. In the case of individuals under 18, Aconsumer@ should be understood to include family members or guardians actively participating in treatment. [See special section on children and adolescents in Section III.)

P-I-2. ***Consumers who receive inpatient services* receive face-to-face follow up care within seven days of discharge. [*@Inpatient services@ are defined as A24-hour, medically supervised services for a primary mental or substance abuse diagnosis.]***

There is face validity in the field for the importance of follow-up care for individuals whose mental and addictive disorders are so severe as to require intensive and restrictive levels of care. Failure to engage persons in ambulatory follow-up care after discharge from inpatient treatment is a powerful signal that continuity of care is not present.

P-I-3. ***Consumers with mental health and addictive disorders are engaged in treatment.***

While it is possible that a single treatment or assessment visit is needed, the norm would be that continuing care is expected with a valid mental illness or substance abuse diagnosis. Failure to continue in regular treatment is especially highly correlated with successful outcomes for persons with substance abuse disorders and persistent mental health conditions.

P-I-4. ***Consumers receive adequate information to make informed choices.***

This indicator is inextricably tied to indicator **P-I-1** and indicator **P-I-3** ; active participation in treatment can only be achieved when consumers are provided with useful information about those choices.

P-I-5. ***Consumers receive mental health inpatient services in a voluntary, non-coercive manner.***

Some persons with mental illnesses may require involuntary hospitalization to protect themselves or others from harm. However, a well functioning service delivery system should be able to minimize unplanned, coercive hospital admissions through care management and effective alternative treatment resources. High rates of involuntary hospitalization may indicate inadequacies in ambulatory care services that are less intrusive/restrictive.

P-I-6. ***Consumers are satisfied with the services they receive.***

Consumers of substance abuse and mental health services (and their families and guardians) are the best resources for determining whether or not systems are meeting their needs and expectations. It is especially important that clients with these disorders receive services that preserve the dignity and respect of the individual and family.

P-I-7. ***The system of care assumes responsibility for continuous and integrated care appropriate to the needs of children and families. [Also see Section IV, special section on children.]***

Children with mental health and substance abuse problems are likely to be involved with many systems: schools, child welfare agencies, primary care and pediatric specialty care, juvenile justice and others. Children=s disorders often tend to have periodic changes and care can become episode-driven without consistency. Coordination and integration of care is essential across the developmental span.

C. ACCESS INDICATORS

The Access indicators identified by the SUMMIT reflect an attempt to move to more meaningful indicators of access than counts of phone rings or drop rates--although these have been useful proxies for access in systems that can track these data. The methodological issues in collecting and analyzing these data are considerable.

A-I-1. ***Consumer experiences of treatment (both positive and negative) are assessed on dimensions of appropriateness, timeliness and sensitivity of services delivered. [Also addressed in P-I-6]***

Customer satisfaction is another bedrock indicator. The methodologies for measuring this variable are numerous, and need to also include measures of **dis**satisfaction.

A-I-2. ***Service denials, terminations, or refusals are assessed.***

Denials, terminations or refusals for services (adjusted for benefits included in a service plan) can serve as a barometer of access. [Serious concerns have been raised about this indicator, because of the issue of the *clinical appropriateness* of some denials, e.g. the denial of a request for a more restrictive level of care than is indicated for a child, a request for a specific medication that is contraindicated medically, etc.]

A-I-3. ***Penetration rates demonstrate benchmarked levels of service delivery to like populations.***

The attempt here is to insure that services are at expected levels, neither significantly higher nor lower than is the norm.

A-I-4. ***Access to a full range of services is demonstrable.***

Easy access to a narrow range of services is not genuine access. (As the folk-adage puts it: AIf all you have is a hammer, everything looks like a nail.@) This indicator would encompass referral linkages and other strategies to offer a comprehensive array. This would have to be risk-adjusted for benefit packages that have limited scope.

A-I-5. ***Children and their families receive the appropriate services that they need, when they need them.***

This indicator and A-I-6 below were developed and proposed to the SUMMIT process by a group of child and adolescent experts convened by SAMHSA in late 1997. This indicator overlaps somewhat with other ACCESS indicators, but the special emphasis on child and family indicators is seen as essential.

A-I-6. ***Children and their families are being assessed for and offered services at appropriate levels.***

This indicator seeks to highlight the importance of both penetration and proper matching of children and families to needed levels of care. Of special concern are children being under-identified and hence under-served, as well as children being over-served, for example in the instance of over- or inappropriate utilization of out-of-home placements, restrictive settings , etc.

D. STRUCTURE INDICATORS

The structure indicators lend themselves more to traditional accreditation and survey techniques, as opposed to true Aoutcome@ indicators, but are included as relevant to the over-all initiative.

S-I-1. ***The organization=s structure is consistent with the delivery of mental and addictive disorder treatment, with effective consumer and professional representation in policy making.***

In integrated systems, it is important to ensure that the special needs of persons with mental and addictive disorders are addressed by the structure. The involvement of consumers and professionals in policy is essential in all environments, whether private or public, managed or fee for service.

S-I-2. ***Consumer rights are clearly defined and procedures for resolution of complaints and grievances are in place and easy to use.***

This is an essential element in most current certification protocols. ACMHA is especially concerned that measures reflect the system=s capacities and performance in making complaint and grievance processes genuinely non-threatening and responsive.

S-I-3. ***Staffing levels are appropriate for delivery of the array of services and provide for meeting the diverse needs of the individuals served, including linguistic and cultural competence.***

The issue of staffing is enormously complex, and is not responsive to a one-size-fits-all mentality. Of special concern here is the cultural/linguistic element of this indicator.

S-I-4. ***Data on clients is secure, available only to those who need to know.***

Confidentiality remains an especially vexing concern in the mental and addictive disorders field, not least of all because of federal and state laws regulating access to consumer information.

S-I-5. ***There are appropriate linkages to other service systems with which consumers need to interact.***

Persons with addictive and mental disorders frequently require services from more than one specialty service, and often need services from other social support systems. In the instance of children, adolescents and their families, this is even more of a need.

S-I-6. ***There is continuity of care within the organization and effective integration with external care-giving systems.***

This indicator is a close corollary to **S-I-5**, but an indicator of both internal and external continuity of care is important.

S-I-7. ***There is a single, fixed point of responsibility for each client.***

All populations need this simple structural support. Consumers and families with complex service needs are better served when there is a single reference point.

S-I-8. ***There is a quality assurance system in place to examine adverse clinical events.***

Systems need to be able to assess their own vulnerability to incidents such as suicide, aggressive acts and other high risk incidents.

S-I-9. ***Consumers and families are educated about their rights, the array of services available to them, and likely outcomes of treatment interventions.***

ACMHA is concerned here with improving the effectiveness of systems= communications with their service users. Again, this is a measure with high relevance for all populations.