Approved January 17, 2002

MHSIP Report Card 2.0 Workgroup Meeting
The Westin Grand Hotel
2350 M Street, N.W.
Washington, D.C.

November 15-16, 2001

Meeting Minutes

Participants: Neal Adams, Ellen Alderton, John Allen, David Brown, Steve Davis, Vijay Ganju, Olinda Gonzalez, Pamela Greenberg, Gordon Gibson, Ron Homburg, Cindy Hopkins, Randy Koch, Melanie Lewis, Ted Lutterman, Mary Smith, and Dow Wieman.

Vijay Ganju welcomed the group and presented the charge for the day.

First cut approach: What should be included in the MHSIP Report Card Version 2.0 (MRC V2)?
What key areas are missing?
Develop a proposal for activities to be completed within the next several months.

Mary Smith provided an overview of the MHSIP program and history, projects, organizational structure (Regional Users Groups – *RUGS*), mission, and the MHSIP Consumer Oriented Mental Health Report Card Version 1. Also described were some specific components of the report card including the original 40-item consumer survey, as well as recommended assessment instruments (e.g. CAFAS, and the Rosenberg Self-Esteem Scale as proxy for recovery). It was emphasized that the Report Card is broader than the consumer survey, although it is one of the most implemented components (e.g., many of the forty-five states receiving CMHS State Reform Grants implemented a consumer survey based on the Report Card). Report Card Version 2 will require more of a focus on children and adolescents and field testing (similar to what was accomplished with CMHS State Reform grants). The MHSIP Consumer Oriented Report Card framework (e.g., access, appropriateness, and outcomes) has been the basis for many initiatives, including the Five-State study, the NASMHPD President's Task Force framework on performance measurement and the CMHS sponsored 16-state grants. The Report Card has been endorsed by many organizations, including NAMI and NASMHPC. The framework has also contributed to work on the Performance Measurement Forum that was held at the Carter Center earlier this year.

It was also noted that the National Committee on Quality Assurance (NCQA) contracted with a consultant, with support from HSRI et al., to compare the MHSIP and CABHS survey. This work led to the development of the ECHO, which is under consideration by AMBHA and other managed behavioral health organizations for use.

The MHSIP Consumer Oriented Report Card Toolkit developed in collaboration with Human Services Research Institute (HSRI) was also briefly discussed. The toolkit was released some time after the release of Version 1 of the Report Card. One of the goals of for this version of the Report Card is to update and release the new Toolkit at the same time as the release of Version 2.

PRINCIPLES

The following principles will guide the development of Version 2:

1. Consumer-oriented
2. Outcome focused
3. Based on lessons learned from performance measurement initiatives (AMBHA, NAMI, etc.)
4. Broad-based
5. Public and private sectors
6. Incorporates efforts of other organizations/workgroups
7. User-friendly format
8. Understandable by audiences at many levels
9. Includes information re: implementation strategies, methodologies
10. Consolidation, not Are-invention@

It was suggested that the principal of consumer-oriented be replaced by "consumer-focused or consumer driven".

The Workgroup recommended that the following issues be incorporated into work on Version 2.0:

How the measures are to be used
Need for systematic evaluation of implementation of measures
Historical context of the Report Card
IOM Quality Chasm Report recommendations inform the Version 2.0 process
Parsimony/pragmatism re: implementation
Include areas not covered adequately first time
Presentation of information
Level of analysis and application
Bench marking aspect
Cost of implementing
Fidelity issues re: adoption of Version 2.0
Cultural competence

The time line of June 1, 2002 for the development of a working draft of Version 2 was also discussed. Although it was agreed that there might not be a measure for every domain, the draft will include placeholders. The idea of modularity was discussed. It may be that modules are needed for different population sub-groups, e.g., persons with SMI, children and adolescents, settings, managed care. There will be a need to specify

for which sub-group each indicator will apply. Work on Version 2 will be limited by resources, e.g., whether we can provide guidelines for different users to implement.

There was also discussion of the differences between the Report Version 2 and the work of the Performance Measurement Forum. The following distinction was made: the work of the Forum is focused on common measures, while the work of the MRC V2 group will be broader and more modular. A position paper that describes this distinction in more detail will be released imminently by Dr. Ron Manderscheid.

REVIEW OF PERFORMANCE MEASUREMENT INITIATIVES

Representatives of each organization described the work that they have been doing in relation to performance measurement, with an emphasis on lessons learned for incorporation in the MRC V2 project.

American Managed Behavioral Health Association - AMBHA (Pam Greenberg)

The membership of AMBHA consists of 10 managed behavioral health organizations (MBHOs) that cover over 110 million lives. The goals of PERMS, the AMHBA performance measurement system, are that the measures are meaningful, measurable, and manageable. PERMS Version 2.0 was released in 1998 with 19 measures based (mostly) on claims data.

Lessons Learned:
(1) Coding issues (claims coding was suspect in some instances)
(2) Missing data (especially pharmacy data not always available to MBHOs);
(3) There were differences in benefit packages managed by MBHOs (e.g.,MBHOs don't always have access to data or control of benefits);
(4) Inaccurate or missing member data limits survey follow-up, (e.g., if phone number not reported or wrong – this lesson was learned from the piloting of the ECHO survey);
(5) Claim systems don't always capture secondary diagnosis to indicate dual diagnosis;
(6) Clear specification of calculations/data sources is critical for accurate comparisons.

Six measures (in the domains of access, quality and outcome) were identified as "feasible" for future performance measurement work:
1. Access to Care: Percentage of Members Receiving Inpatient and Outpatient Services for Mental Health.
2. Quality of Care: Family Visits for Children Undergoing Mental Health Treatment - the percentage of patients who are 12 years or younger with any mental health diagnosis, and had at least one psychotherapy session involving a family.
3. Quality of Care: Availability of Psychotherapy and/or Medication Management for Patients with Schizophrenia - the percentage of patients with diagnosed schizophrenia who are 18 years or older, and had at least 4 visits to a psychiatrist or DO for psychotherapy or medication management.
4. Access to Care: Change in Provider Availability - The number of providers terminated (either provider or MBHO initiated) in the preceding year who had received

authorizations to provide outpatient services, stated as a percentage of the total number of active network providers available within the conclusion of the reporting period.
5. Quality of Care: Engagement Rates for Treatment of Depression - The percentage of ambulatory patients with a primary diagnosis of a major depression disorder (MDD) who have at least 4 ambulatory visits related to their MDD within eight (8) weeks of the initial diagnosis.
6. Quality of Care: Ambulatory Follow-up within 7 and 30 Days of Discharge for Substance Abuse (Detox and Inpatient Care).

AMBHA aimed to move standard performance measurement forward, especially with NCQA, for behavioral health. It was noted that under the MBHO accreditation program MBHOs are not required to report any HEDIS measures at this time. With regard to the development of consumer surveys, the PERMS survey was never implemented. Additionally, MBHOs were not at the table for development of CABHS, but were included in ECHO work.

Recent work of the NCQA regarding the ECHO was briefly discussed. It was noted that ECHO items related to perceived improvement (outcomes) may be dropped, which would eliminate the consumer perspective. With regard to how the ECHO and the MHSIP Consumer Survey work could proceed in the future, it was noted that both surveys might include some of the same items so there is some commonality although additional items would potentially be needed for different settings/populations. The protocol (e.g. who and how administered, required follow-up, etc.) for the ECHO was also discussed in some detail. Four or five MBHOs were involved in pilot testing the ECHO---not all followed the protocol, nor were all able to get necessary client data from their MCOs.

American College of Mental Health Administrators – ACMHA (Neal Adams)

In March 1998, ACMHA issued a report recommending a short list of core performance indicators. ACHMA has been working with national accreditation organizations on performance measurement, with whom a final report was issued in Spring 2001. The report established a common taxonomy and language across organizations. It also specified a hierarchy of specification and activities. Changes in the accrediting organizations (at COA, CARF and NCQA) have had an impact on further work. However, the potential for impact as an impetus for change in behavioral health remains since states are moving more to adoption of accreditation requirements. Because of differences between the accreditation organizations, the aim of the performance measurement report was to develop universal concepts. The greatest commonality in this work was in terms of measures that relied on consumers' perception of care, although there is recognition of the difficulty and cost of collecting more objective data. Three domains were addressed: access, quality of care, and outcomes. The results of a national consumer forum revealed that recovery and safety (in community and in treatment) concerns were also important, as well as knowledge re: competence of service providers.

National Alliance for the Mentally Ill – NAMI (Ron Homberg)

A copy of *"What is NAMI Looking for in Managed Care"* was circulated amongst the Workgroup. NAMI has previously developed a Report Card to evaluate the "readiness" of 6-8 MBHOs to serve public mental health clients. The following criteria were used:

The mental health system needs to adequately serve persons with serious mental illness by addressing the following:

1. Programs with a continuum of care available 24-7.
2. Access to medications based on clinical judgment, not cost.
3. Availability of evidence-based services.
4. Peer education and supports integrated with all programs—needs more scientific proof of benefits.
5. Non-discrimination in health care, employment, housing, etc.
6. Crisis response capabilities to avoid jail/prison as the de facto treatment source.
7. Sufficient availability of acute care beds, so people can be voluntarily admitted when needed.
8. Long-term care capability (a suggestion was made to look at the Independent Living movement in other disability fields for examples that avoid congregate living).
9. Consumer-family involvement at every level.
10. Foster recovery whenever possible.
11. Strategies to reduce unnecessary criminalization, i.e., links to the criminal justice system.
12. Good data collection, tracking and evaluation.
13. Adequate funding

Based on the survey, most organizations failed (see handout).

Fuller Torrey has also performed state visits and prepared reports based on these experiences in the past. Additionally, OMIRA—Omnibus Mental Illness Recovery Act—contained some service oriented measures (e.g., access to new medications, ACT, housing, employment, de-criminalization, seclusion and restraint, increase family and consumer involvement, monitoring).

National Council of Community Behavioral Health Care - NCCBHC (Gordon Gibson)

The National Council of Community Behavioral Health Care does not currently have a performance measurement system in place. Indiana, the state in which Gordon is located, surveyed 200 JCAHO Oryx indicator systems and rejected them all, then built their own with help from Fred Newman. Gordon's agency, the *Center for Behavioral Health* is serving in an Oryx data processing capacity for 6-7 organizations with sites in Ohio, Florida, Georgia, Illinois, Pennsylvania, and Indiana by establishing a data warehouse.

Lessons learned: It was noted that few centers find the Oryx reported data useful for making comparisons or corrections within their agencies' programs and that this is an

aspect that should be addressed in MRC V2. It is also difficult to develop a "culture of measurement" and data collection system within an agency—providers/clinicians want to continue to treat independently. The NCCBH is also concerned that multiple payers have multiple measurement demands for providers.

Performance Measurement Forum (David Brown)

Participants in the Forum include the public-private sector, providers, accreditors, etc. Four populations are the focus of the Forum: adult mental health and adult substance abuse, children and adolescent (mental health) and substance abuse prevention.
The adult mental health workgroup meeting started with a discussion of establishing a common framework for developing performance measures. The IOM report, *Crossing the Quality Chasm*, with a crosswalk to the MHSIP framework, was used as the basis for the framework adopted by the Forum. The next meeting of the Forum will be in September or October of 2002. It was noted that the MRC V2 workgroup needs to be consistent with, and be a vehicle to implement performance measures developed by the Forum. Five members of the Adult mental health workgroup are also on the MRC V2 workgroup, so ensuring consistency should be feasible. A workgroup on methodology has been established to support work performed under the auspices of the Forum.

Recovery Workgroup (Jeanne Dumont)

The Recovery Workgroup is currently sponsored by MIMH, the Columbia School of Social Work's Center for the Study of Social Work Practice, HSRI, CMHS, NASMHPD NTAC, and is applying for additional funding. The recent work on development of a recovery tool focuses on: *What facilitates or hinders recovery.* From this broad-based approach, indicators will be developed that identify a recovery-facilitating and hindering environment. It was noted that a goal of the MRC V2 workgroup will be to integrate this work into the report card. Phase 1 of the Recovery Workgroup has been to conduct ten focus groups in 9 states, perform a content analysis, derive concepts and themes, combine this information across states, and then produce a report. Phase 2, working from Phase 1 findings and themes, will focus on developing performance indicators using themes identified from Phase I. Once completed, an instrument will be produced and piloted.

The workgroup is currently completing coding of the individual transcripts and has planned a meeting on December 2-4 to combine themes across the states. Recoding based on a master codebook will then take place with the final report from Phase I expected by the end of March.

One challenge of this work is how to word items so that they are meaningful to people with varied recovery experiences. The instrument to be developed is envisioned as a consumer self-report instrument that will be part of the MHSIP Report Card. There might be some system level indicators, like service choice (e.g., - the percentage of services consumers can choose vs. the percentage not selectable).

National Association of State Mental Health Program Directors (NASMHPD)/ NASMHPD Research Institute-NRI (Ted Lutterman)

The NASMHPD framework incorporated some MRC V1 measures, but added additional indicators related to inpatient treatment, infrastructure, and children. This work led to the 5-state feasibility study, 16-state grants, and the new Data Infrastructure Grants. NASMHPD has also developed a performance measurement system for reporting to the JCAHO Oryx system in which 48 states participate. Data quality checks are performed on site visits to reporting facilities, randomly and for cause. NRI has also surveyed states re: level of implementation of MHSIP measures. This information provides an assessment of the utility and burden (to states) of implementing each indicator. An inpatient version of the MHSIP survey, created with consumer input to add questions re: respect for rights, etc.,-- has also been developed. It has been approved by JCAHO for reporting starting in January.

Center for Mental Health Services - CMHS (Olinda Gonzalez)

Olinda provided an overview of performance measurement projects supported by CMHS. State Reform grants were awarded to many states in 1996, and in 1998 the 16-state project to pilot NASMHPD framework indicators was initiated. The process used in the 16 State Study was to establish workgroups for each indicator to operationally define measures. Age, ethnicity, gender and diagnosis breakdowns were created and incorporated into data collection for each indicator. The extent to which states were able to report on the 32 indicators included in the project varied--two indicators were reported by 16 states; no state reported all 32. The Data Infrastructure Grants fund the collection of some of the 16-state indicators and data for Mental Health Block Grant reporting.

There was a brief discussion regarding the measures to be included in MRC V2. It was suggested that we need not be constrained by existing measures, like the BPRS, that we may want to develop our own. It was also noted that on the other hand, states have invested a lot in some instruments and may be reluctant to change. Whatever measures are selected, cultural competence must be addressed.

Human Services Research Institute - HSRI (Dow Wieman)

Dow Wieman provided an overview of some of the work that the HSRI has been involved in that is related to performance measurement. These include the Performance Measurement Forum, work on the MHSIP-CABHS Survey convergence to the ECHO, an Evaluation Consortium on Medicaid managed care, and the Center for Quality Assessment and Improvement in mental health including a national inventory of process measures for quality improvement. Other projects include support of the Recovery Workgroup, developing Cultural Competence performance indicators and testing them in the Cambridge Health Alliance, and surveying states about cultural competence with NASMHPD NTAC and the Georgetown Children's MH TA Center.

CHILDREN'S OUTCOMES ROUNDTABLE – COR (Randy Koch)

Randy provided an overview of the work being performed by the Children's Outcome Roundtable (COR) which was initiated 6 years ago, and is currently in the process of re-organization; Astrid Beigel and Randy co-chair the measurement sub-committee and Ann Doucette and Trina Osher co-chair the Roundtable. The Roundtable has been focusing on a report on children's measures developed by Dick Dougherty and re-organizing it in relation to the domains of access, appropriateness, outcomes, cost, etc. The COR is interested in coordinating with other activities, including the MRC V2 effort. The COR is coordinating the Performance Measurement work of the Forum on children's measures, and focusing on mental health as well as substance abuse issues.

Review and Discussion of MRC V2 Charge and other Issues:

In response to the question, *What is missing in the MRC V2 charge?* the following issues were generated:

(1) It is important to include values that underlie MRC V2. MRCv1 was value-driven, tempered by pragmatism. Some values have changed or are defined differently today, compared to 1996.
(2) Consider using the IOM domains, rather than the 1996 MHSIP domains.

Additional issues discussed included the following:
(1) The group will need to reach a consensus regarding a strategic process that group members can take back to the organizations they represent.
(2) Consider objective, non-survey measures of consumer issues, like consumer participation in treatment planning by treating the activity as a service event.
(3) We need to determine what will be recommended regarding federal/state actions to encourage and facilitate service and data integration.
(4) Determine what will facilitate states, MCOs, MBHOs, etc. implementing MRC V2, e.g., tying to HIPAA standards.
(5) Develop ways to disseminate information (e.g., MHSIP website presentation of to-date materials of the MRC V2 workgroup, timeline of activities, toolkit info, etc.).

CONSOLIDATION OF PERFORMANCE MEASURES

The next task addressed by the Workgroup was to begin the work of consolidating performance measures based on the lessons learned thus far, as well as the frequency with which indicators have been adopted by behavioral health organizations.

Several issues were raised:
(1) Does the consensus include all the concerns, populations, etc. a report card should include, and does it identify which populations each indicator addresses;
(2) The strategy for MRC V2 shouldn't just survey those people already in service about access; ask those on waiting lists or otherwise not in service;

(3) The development process should begin by throwing out what didn't work in MRC V1 and then move on with what's left.
(4) Would the IOM framework (cross-tabulated with target groups, e.g. inpatient outpatient, adult, child, etc.) serve us better than the MSHIP V1 framework

The group was reminded to remember our principle of building on lessons learned, as well as previous MRC V1 content, and not to eliminate topics we want to address even if a previously defined measure didn't work. We may be able to identify a better measure.

It was decided that the strategy to be pursued would be one in which we started with lessons learned from behavioral health performance measurement initiatives, rather than abandoning them.

The IOM framework translates into the MHSIP framework in the following way.

Access	Timeliness
Appropriateness/Quality	Person-centered Safety
Outcomes	Effectiveness
Prevention	
Structure/Management	Efficiency Equity

It was agreed that further study of the IOM framework is needed, however, the translation of the MRC V1 framework into the IOM framework is not equivalent.

Performance Measures that Should be Included in the Report Card based on consensus across performance measurement systems:

Access

Penetration rate (utilization) (level of care)
Perception of access
Objective measures of timeliness
Denials/disenrollment barriers
Access to medication (pharmacy, prescription)

It was noted that it is important to consider jail, prison, school and workplace as locations of services. Also, definitions may vary by setting. In private sector insurance, penetration is based on people in the plan; in the public sector, it depends on dollars available to serve people in need.

Appropriateness

- Consumer perception of care
- Evidence based practices (EBPs)
- Cultural competence (cuts across all of the domains)
- Involuntary treatment
- Safety
- Participation in treatment planning
- Continuity of care
- Physical health (linkages, screenings)
- Person-centeredness
- Continuity (plan prior to discharge)
- Family member (person of significance participating in treatment planning)
- Readmission (180 days?)
- Specialized services/specialists
- Information for informed choices

Outcomes

- AIMS should not be included; include weight gain, sexual dysfunction, memory loss
- The standard should be -- Global side effects (see ECHO survey)
  0-10(symptom rating side effects)
- Do not use CAFAS (use public sector instruments)
- Recovery (successful graduation)
- Symptoms management
- Well-being

Additional Items for Consideration in Version 2 of the MHSIP Consumer Report Card

- Equity
- Failure (harm)
- Holistic approaches (diet, etc.)
- Empowerment/self-advocacy
- Supported education

- Complaint resolution
- Cost
- Fidelity
- Selection/adverse selection

- Screening for substance abuse
- Consumer involvement in policy development and planning
- School performance (children)
  - satisfaction
  - level of involvement
  - outcomes

- Goal attainment (indivdualized)
- Pharmacy
- Employment -ADA
- Availability of peer support
- Access for persons without 3rd party coverage
- Mortality
- Dissatisfaction
- Extent of EBPs
- Cultural appropriateness of services
- Involvement with criminal justice
- Family involvement

Juvenile justice involvement (children)
Therapeutic foster care (children)
Prevention/education/health promotion
Cross-systems integration (e.g., housing)
Turnover rates (among-direct care providers)
Engagement
-- discrimination assessment -- active treatment
Reduction in homelessness
% in hospital/year
Dental care
Prevention
Competence of workforce

Intensive in-home treatment (children)
Access to people in jails
Locus of service (office or institutional) - service centers, jails, work, recreation
Graduation/recovery/well being
% filing complaints
Dual diagnosis
Level of demand vs. system capacity
- rationing; resource availability and allocation
Policy/Regulations (look at issues)
- comparability
Physical health/primary care integration
Early intervention
Diversity of workforce
Infrastructure

Time Table for Continued Work

December 7, 2001	Materials to Workgroup
December 18, 2001	Conference Call at 3:00 p.m. Eastern Time
January 17-18, 2002	Tentative Meeting Date
March 7-8, 2002	Tentative Meeting Date

Mission Statement

The group reviewed a draft of a workgroup mission statement developed by Neal Adams and recommended that several clauses be retained. The mission statement will be revised by Mary and Vijay and distributed to the workgroup for review.

Values Underlying Report Card V2

The Workgroup also briefly discussed the desire to be explicit in terms of the values underlying MRC V2. Some of these might include the following:

People will get state of the art services
Providers will respond to individual needs and preferences
People will receive services safely

Do no harm philosophy (safety, effectiveness, well-being, choice, and recovery)

The following was suggested for further study:

(1) Approach the core set of values as stated in the IOM study.
(2) Identify key values and see to what extent the measures reflect them. Also share the values with the Children's Outcome Roundtable for feedback.
(3) Identify a few values that could be tied to the domains.

Communication/Challenge

The need for ensuring that an effective communication feedback loop is developed was also discussed by the Workgroup, and the following issues discussed:

(1) How do you communicate the activities of the workgroup in a systematic way so that information is disseminated to the organizations represented by Workgroup members?
(2) How will the workgroup receive feedback from the various organizations? These organizations include the President's Roundtable, Outcomes Roundtable for Children and Families, Office of Consumer Affairs, NAMPAC, NAMI, others.
(3) What will the Workgroup members report to the groups that they represent?

Recommendations for addressing these issues included the following:

A formal document should be generated from each meeting that can be circulated to the various groups; enough time should be allowed for circulation and review by various stakeholders; post document on the MHSIP Web site; share the document with mental health planning councils; identify ways in which to reach people who are in the field receiving services; don't restrict dissemination to posting on Web sites—look for a broader forum; ask Workgroup members what organizations they will contact; share information about the Workgroup activities at conferences and solicit feedback (note: develop a formal information packet); submit information for inclusion in newsletters like MHSIP Reports, Paul Weaver's publication (Mental Health America), Mental Health Weekly, MHSIP Updates, etc.; Consider using outside consultants to help produce a specific paper or to provide technical expertise.

Vijay and Mary will develop a draft press release on this meeting that will be shared/reviewed by the Workgroup members before it is distributed to the press or others.

Steve Davis will establish a Listserv on the MHSIP Web site for the purpose of sharing information among Workgroup members.

MRC V 2 Toolkit Development

The development of the toolkit was briefly discussed along with the notion of parallel development. Information that can be incorporated is currently available on a number of areas (e.g. consumer surveys-- work done by Judy Hall and Molly Brunk on the 16 State Study, risk adjustment—Toolkit by HSRI and Michael Hendryx, etc.). Efforts should be undertaken to expand on and provide detailed guidance re: sampling, comparability, and analysis, to help guard against misuse and misinterpretation of information.

The Meeting adjourned at 3:10 P.M.

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