

# IX. Requirements for Data Collection Related to System Guidelines

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## Summary

Although vitally important for improving both the quality of care and the efficiency of operations, system guidelines are in the earliest stages of development. Whereas clinical guidelines specify interventions, activities, and procedures that research and experience indicate should lead to desirable clinical outcomes, system guidelines specify practices within a system of care in regard to non-clinical operations related to infrastructural, executive, and managerial functions; clinical and service-delivery operations; and ancillary functions that support clinical and related programs. System guidelines must be distinguished from standards which assert what ought to be, reflect community or organizational values and principles, and have sanctions for failure to comply and incentives to encourage compliance. Guidelines suggest ways to achieve these standards; the best guidelines also suggest ways to measure performance and determine whether the standards have been met.

Although we do not yet have guidelines to show the structure and operation of entire systems that are integrated and effective, we do have the beginnings of such guidelines in the National Alliance for the Mentally Ill's (NAMI) recently published manual on the Program for Assertive Community Treatment (PACT); operational manuals that prescribe procedures for both organizational practices (e.g., institutional accreditation, provider credentialing, personnel and financing management, buildings and grounds maintenance) and clinical interventions (e.g., involuntary commitment, seclusion and restraint); and the tools used by some state mental health authorities for evaluating provider and institutional performance.

We will describe three types of system guidelines, each relevant to different functions and structures within a system. Type I system guidelines specify non-clinical operations related to the system's infrastructure such as collecting and dispersing money, maintaining buildings and grounds, and building and using information systems. They also address executive functions related to policy-making, regulation-setting, planning and evaluation, and oversight and monitoring and managerial functions such as program development, budgeting, quality improvement, and administration of financial and human resources.

Type II system guidelines specify the organization of clinical operations, i.e., the service components of the system, their operation, and how they relate to each other to support integrated care. Type II system guidelines do not recommend treatments--these are found in clinical guidelines. Rather, they describe the core clinical service functions of the system and the kinds of clinical and related programs that it should operate to provide effective treatments for mental illness (e.g., mental health centers and crisis intervention teams, sheltered workshops and social clubs, medical care and therapeutic housing). Type II guidelines address operational aspects of these programs: treatment team composition, size, ratios, caseload and staff scheduling; how clinical programs should relate to each other through meetings, medical records, supervision, and collaboration. "Level of care guidelines" could also be considered examples of Type II system guidelines

Type III system guidelines specify the organization of ancillary functions that are necessary to support the clinical and related programs provided by the system. They also correspond to and support implementation of clinical guidelines for specific treatments and clinical and related interventions. They address ancillary services such as transportation and housing, food services, fleet management, and facility maintenance, and suggest the ways the mental health system should relate to other systems such as health care, social services, child welfare, and corrections. They provide guidance for the movement of consumers between systems and outline the practices that will ensure coordinated and continuous care.

# IX. Requirements for Data Collection Related to System Guidelines

## What is the Intended Purpose or Function?

### Definition of system guidelines

To understand the purpose of system guidelines in the prototype information system, it is necessary, first, to define our terms. Guidelines in the mental health field specify interventions, activities, and procedures that research and experience indicate should lead to desirable clinical outcomes and effective system performance. Clinical guidelines specify treatments, for example, recommending that an episode of major depression be treated with particular medications in combination with psychotherapy or that psychosocial rehabilitation be included in the care of people with schizophrenia. System guidelines specify practices within a system of care in regard to executive and managerial functions; clinical and service-delivery operations; and ancillary functions that support clinical and related programs.

Whether the procedures recommended by guidelines do, in fact, lead to desirable clinical outcomes and effective system performance can be measured with various kinds of instruments. Fidelity measures help determine how closely actual provider behavior and system performance adhere to the clinical or system performance recommendations of the guidelines. Clinical outcome measures and system performance indicators show, respectively, the effects of treatment on the consumer and the extent to which a system meets benchmarks for access, appropriateness, quality, outcomes, and satisfaction. By applying these measurement tools we can identify where improvements are needed, in the guideline or in performance, and what those improvements should be.

Indeed, the ultimate test of any guideline, whether at the clinical- or system-level, is whether it contributes to improving care. For a system guideline, the test is whether it helps improve the overall quality of care provided by the system and the outcomes realized by individual consumers. Measurement is an essential step in improving care and outcomes: by clearly articulating best practices in system guidelines, and then by applying fidelity measures, performance indicators, and outcome measures we highlight where and how we need to improve a system to achieve its objectives and demonstrate where change is needed in the guideline or in the system's capacity to adhere to it.

A mental health care system involves a complex set of functions and structures all directed toward the goal of providing mental health services for the people in its community. In addition to clinical treatments, people with mental illness need medical care, vocational and psychosocial rehabilitation, and supportive services such as housing, income assistance, and so on. If we think of each intervention and service as a building block, then a system of care consists of many building blocks--agencies, organizations, and programs that provide services and deliver interventions--that have a functional relationship with each other. Historically, systems have been described in terms of their organizational and financial structure and evaluated in regard to their capacity for integration, adaptation, pattern maintenance, goal attainment. Systems may be hierarchical, with one level superordinate and regulatory to others, or they may consist of entities at the same level.

To deliver its services, a system must also perform various executive and managerial functions for itself and its components. In a state mental health agency, for example, executive functions are performed by the Central Office and tend to involve policy-making and regulation-setting, planning and evaluation, oversight and monitoring, etc. Managerial functions are performed at the local program level: administration of financial and human resources, maintenance of buildings and grounds, development of information systems, quality improvement, etc.

Quality care for all consumers in a system depends on how these "blocks" are assembled. In some systems, the many different kinds of blocks--interventions and services and executive and managerial functions—are disconnected, neither building upon nor interacting with each other. The structure of such systems is weak and inefficient; some blocks are duplicated and others are missing. However, where the structure is strong and effective, where there are close connections between the blocks with services and interventions well-integrated and good communication with executive and managerial entities, there is “systemness”, cohesion, and strength. In these systems, the components communicate and all functions—executive, managerial, and service—are performed effectively and efficiently.

Although we do not yet have guidelines that show the structure and operation of entire systems that are integrated and effective, we do have the beginnings of such guidelines. The National Alliance for the Mentally Ill's (NAMI) recently published manual on the Program for Assertive Community Treatment (PACT) which describes step-by-step creation and operation of the PACT model of community-based treatment for persons with severe and persistent mental illness. This manual is, in effect, a set of the three types of system guidelines described below.

Less well-developed guidelines also exist, even though users might not use this term to describe them. Most systems and organizations within them have operational manuals that suggest and even prescribe procedures for both organizational practices (e.g., institutional accreditation, provider credentialing, personnel and financing management, buildings and grounds maintenance) and clinical interventions (e.g., involuntary commitment, seclusion and restraint).

Some state mental health authorities and managed behavioral health care organizations have developed tools for evaluating provider and institutional performance that could be considered prototypical system guidelines. For example, the Texas Department of Mental Health and Mental Retardation (TXMHMR) has implemented Quality Services Oversight-State Mental Health Facilities (QSO-SMHF) as part of its Improving Organizational Performance System (IOPS) initiative that "integrates planning with performance measurement, assessment, and improvement functions involving all levels of the TXMHMR organization into a single system." IOPS addresses the performance of the system of care and has as its goal quality improvement: it is "designed to focus multiple programs toward the interlocking agency mission and interdependent goals. The analysis of performance data provided by QSO is essential to effective quality improvement strategies." (Texas MHMR, 1999). On a monthly or quarterly basis internal and external reviewers evaluate facility performance through standardized procedures, instruments, and scoring guides that assess achievement of specified performance indicators for clinical processes (e.g., medical and psychiatric treatment, special procedures such as restraint and seclusion, cultural competency and sensitivity of staff, patient satisfaction, handling of abuse and neglect, and protection of patient rights) and administrative processes (e.g., performance tracking, budgeting and accounting, human resources, and information services). Just as the PACT manual is a set of system guidelines for a particular program, IOPS is a set of prototypical system guidelines for an entire system of care.

Guidelines must be distinguished from standards. Standards assert what ought to be. Reflecting community or organizational values and principles, standards have sanctions for failure to comply and incentives that encourage compliance. Standards are requirements; guidelines are recommendations. Standards are set by entities that regulate and oversee systems of care: Federal, state, and local governments, accrediting organizations such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the National Commission on Quality Assurance (NCQA), the Council on Accreditation (COA), the Council on Accreditation of Residential Facilities (CARF). Guidelines are written by organizations and systems of care themselves to suggest procedures that will help practitioners meet the standards. Standards are set for and apply to all systems of care; they are general and sweeping. Guidelines refer to and are developed only for the resources available in a given system; they are particular and vary across systems.

There is a dynamic developmental relationship among customary practices, guidelines that recommend best practices, and standards that stipulate sanctions for failure to follow certain practices: as standards are promulgated, guidelines use research and consensus to show the best practices and suggest ways of practicing that will meet standards. The PACT manual shows this relationship in that it presents Program Standards in Appendix 8 and procedures for medication and pharmacies that we would call system guidelines in Appendix 7. Similarly, the IOPS scoring guides cite both the state and Federal (e.g., JCAHO) standards that lie behind the practices they recommend.

### **Types of System Guidelines**

There are three types of system guidelines, each relevant to different functions and structures within a system; together, they constitute a complete set of system guidelines. Some systems have already developed and implemented one or more of these types of guidelines; the PACT manual and the Texas IOPS are examples containing all three types.

Figure 1 is a model of a mental health care system that is linked to other systems such as health care, social services, corrections, and child welfare. There are three major functions—executive, managerial, and clinical service—and associated organizational structures—central office, local programs, clinical and related programs and their supports. One type of system guideline is applicable to these different functions and structures. The executive and managerial functions are carried out through the central office and local programs, respectively, and are specified by Type I system guidelines. Core clinical service functions and the clinical and related programs that perform them are specified in Type II system guidelines. Finally, ancillary functions and structures that enable and support provision of core clinical services and linkages to other human service systems are specified in Type III system guidelines.

#### ***Type I System Guidelines***

Type I system guidelines specify non-clinical operations related to the system's infrastructure such as collecting and dispersing money, maintaining buildings and grounds, and building and using information systems. These guidelines also address Central Office executive functions related to policy-making, regulation-setting, planning and evaluation, and oversight and monitoring. They might recommend, for example, that consumers and families should participate in policy, planning, and evaluation activities or that oversight and monitoring should be conducted regularly and frequently using standardized instruments. Finally, Type I system guidelines address the managerial functions of local program administrators such as program development, budgeting, quality improvement, and administration of financial and human resources. Such guidelines might specify

procedures for hiring and firing and for developing and implementing continuous quality improvement activities.

The PACT manual is specifying Type I system guidelines when it addresses administrative matters such as hours of operation, program budget, location and staffing of headquarters, staff transportation, medical record management, client funds management, and the need for written policies and procedures (Allness and Knoedler 1999, pp 9-28). We would also consider Type I guidelines to cover practices involved in working out and implementing interagency agreements for services outside the mental health system such as health care and housing. In IOPS, prototypical Type I guidelines can be found in the scoring guides for planning and performance tracking; budgeting; accounting; fixed assets; human resources; facility contracting, procurement and warehousing; and community relations.

### ***Type II System Guidelines***

Type II guidelines specify the organization of clinical operations, i.e., the service components of the system, their operation, and how they relate to each other to support integrated care. Type II system guidelines do not recommend treatments—these are found in clinical guidelines. Rather, they describe the organization of core clinical service functions of the system and the kinds of clinical and related programs that it should operate to provide effective treatments for mental illness.

In the PACT manual, we would consider Type II system guidelines to be the specifications of the core clinical functions of the program: "treatment for the primary manifestations (i.e., symptoms and impairments) of the illness itself; rehabilitation to help each person build his or her strengths and cope with the effects of mental illness on adult activities (e.g., employment, home life and activities of daily living, and social and interpersonal relationships); emotional and practical support to help individuals sustain a good quality of life and negotiate complex social and health care systems" (Allness and Knoedler 1999 p 53, italics added).

The PACT manual provides detailed descriptions of clinical and related programs: for treatment, community mental health centers and crisis intervention teams; for rehabilitation, sheltered workshops and social clubs; and for practical support, medical care and therapeutic housing. The manual also specifies how these programs should operate: treatment team composition, size, ratios, caseload and staff scheduling. Finally, the PACT manual suggests how clinical and related programs should relate to each other: discussion at daily staff meetings, communication in writing through daily logs, staff assignment schedules, treatment plans, and medical records; consultation and clinical supervision; and collaboration with other service providers. Were the IOPS patient education, assessment, and treatment scoring guide to be written in a different format, it would similarly specify practices for treatment facilities.

"Level of care guidelines" could also be considered examples of Type II system guidelines in that they specify the levels of care a system should provide (e.g., inpatient, observation, intensive outpatient, outpatient), the services that should be available at each level, and the medical necessity criteria for use of each one.

### ***Type III System Guidelines***

Type III system guidelines specify the organization of ancillary service functions that are necessary to support the clinical and related programs provided by the system and describe their operation. They also correspond to and support implementation of clinical guidelines for specific treatments and

clinical and related interventions. For example, if a care system requires providers to follow clinical guidelines that suggest use of particular psychotropic medications (e.g., atypical antipsychotics or mood stabilizers) there should be system guidelines for the operation of pharmacies to dispense these medications and laboratories to monitor drug blood levels and other physiological parameters. The PACT medication and pharmacy policies and procedures are an example of such guidelines as are the IOPS scoring guides for medication internal controls.

Type III guidelines also address ancillary services such as transportation and housing—not the clinical/treatment aspects of therapeutic housing, which would be a Type II guideline, but instead the practices related to location, quality, maintenance, and leasing/purchasing. IOPS, for example, addresses food services, fleet management, and facility maintenance. Finally, Type III guidelines suggests the ways the mental health system should relate to other systems such as health care, social services, child welfare, and corrections. They provide guidance for the movement of consumers between systems and outline the practices that will ensure coordinated and continuous care.

Because systems are structured and function differently, their system guidelines will differ. Only an organization that values consumer and family participation and quality of care would write Type I system guidelines to facilitate stakeholder participation and quality improvement activities (see Figure 1); an organization without these values would not. Similarly, the Type II system guidelines presented in the model would be found only in a community that supports PACT, whereas the Type III system guidelines might be developed and implemented wherever clinical guidelines are utilized.

System guidelines are relevant at both a person- and population-level of analysis. An example of a Type II system guideline at the person-level of analysis are the recommendations in the PACT manual that specify clinical operations for treatment services for individuals. We do not know of any Type II system guidelines at the population-level, but these would specify the organization of screening and other prevention services for communities. The quality of these person-level and population-level interventions (treatment or prevention) and their outcomes are determined by clinical- and system-level variables. The factors that operate at the clinical level--e.g., clinical guidelines and clinician skill and training--are generally accepted as important. The factors that operate at the system level--planning, evaluation, quality improvement, service integration, comprehensive and continuous care, information systems--have been examined in the past (e.g., ACCESS and RWJ and Fort Bragg), but currently they are less well-recognized as equally critical to consumer outcomes. Just as clinical guidelines have an accepted role in improving quality of care, so too do the three types of system guidelines.

## **What Information Is Required to Accomplish this Purpose?**

### **Important Beginnings**

Although system guidelines are less developed than clinical guidelines, there are some important beginnings. First, the standard-setting organizations noted above have promulgated licensure standards for facilities, “conditions of participation” in financing arrangements, accreditation standards for service-delivery systems, etc. They have also set standards for care: for example, the newly revised National Committee on Quality Assurance [NCQA] Health Plan Employer Data and Information Set [HEDIS] 1999 states that a system of care should ensure that all persons discharged from hospital have an outpatient follow-up visit within seven days

Second, the PACT manual contains all three types of system guidelines for the operation of a service program that depends on the existence of a system of care. Furthermore, the manual presents the evidence-base for its recommendations by reviewing the literature on PACT and other system-oriented interventions such as case management—just as do clinical guidelines such as those prepared by the American Psychiatric Association and even includes studies on fidelity measurement.

Third, the IOPS has in its scoring guides created prototypes of all three types of system guidelines for a statewide system of care. Although not currently presented as guidelines, they could be rewritten for that purpose.

Fourth, a combined research- and consensus-base for best practices for systems exists in the experience with and evaluation of demonstration projects such as the Center for Mental Health Services' Access to Community Care and Effective Services and Supports (ACCESS) and the Robert Wood Johnson Foundation's Program on Chronic Mental Illness (RWJ PCMI). For example, the RWJF PCMI demonstration showed that local mental health authorities were feasible, desired by the public, and associated with increased systems integration and continuity of care. It also showed clinical and social improvement only for consumers who received specialized services such as assertive community treatment and supported housing. Similarly, preliminary evidence from the ACCESS demonstration supports a positive association between systems integration and residential stability for previously homeless individuals.

Finally, there is a growing evidence-base from which system guidelines can be developed in the investigations of the effectiveness of various service system interventions for example, in the research on treatments embedded in an organizational matrix such as ACT, in the studies on combined treatments such as those for people with both mental illness and substance abuse, and in the investigations of specific aspects of services integration. This literature on system-oriented interventions and various approaches to organizing and financing treatment could be used to formulate system guidelines, although more systematic effectiveness research is needed on some interventions before recommending that they be adopted, e.g., the various approaches to emergency treatment such as mobile crisis teams.

Some examples of research findings that could already be transformed into system guidelines include the following:

- Studies demonstrate that provision of mental health and substance abuse services by separate service delivery systems creates substantial barriers to obtaining treatment in one system for clients who “belong to” the other system.
- Research suggests that systems should be designed according to the particular characteristics of the local environment.
- Investigations on the use of primary care as the base for mental health services as compared to a specialty mental health system suggest that differences generally are a matter of local adaptation to historical patterns of practice and the traditional preferences of consumers and their families.

In other cases, more study is needed to create an evidence-base for system guidelines. For example, although research on the effectiveness of combined treatments such as pharmacotherapy and psychotherapy provides a model for studying the effects of combined services, to date, there are no studies that clearly demonstrate the most efficient solution to service mix. An important area to examine before making recommendations in a system guideline would be the differences in cost-efficiencies and outcomes for combining psychotherapy and pharmacotherapy in a single provider (a psychiatrist) or dividing these treatments between a non-physician (social worker, psychologist, or nurse) and a physician.

## **Development and Implementation of System Guidelines**

The PACT program offers experience with developing and implementing system guidelines and IOPS shows how they can be used for quality improvement. Experts in these and related activities are coming closer to achieving consensus on best practices and on how to disseminate this information to the field. For example, the Child and Adolescent Service System Program (CASSP) is developing system guidelines for children's services.

### **Fidelity Measures**

Fidelity measures are used to determine whether a given intervention conforms to a pattern of recommended practice. In research, investigators use fidelity measures to assess the extent to which a particular intervention is faithful to the design under study, so that effects are attributable correctly to a specified intervention. In practice, monitors of service system quality would use the same measures to assess adherence to guideline recommendations.

The early literature on community support systems noted the difficulty in determining whether a community support system actually existed in a community (Tessler and Goldman, 1982). John Brekke and colleagues developed a fidelity measure to study the implementation of community support programs in the field (Brekke and Test, 1992). John McGrew developed a set of fidelity measures for ACT with Gary Bond; and their work was elaborated by Greg Teague and used by a growing number of investigators, including those involved in the ACCESS evaluation (McGrew et al., 1994).

In the hands of these investigators, fidelity measures represent evidence-based indicators that certain specific programmatic approaches have been implemented and are in operation. For example, the Brekke and Test measures indicate that a community support system has been implemented and the McGrew, et. al. measures indicate that PACT, specifically, has been implemented. Because these measures are multi-dimensional, they actually specify which structures and processes are in place and in operation. For example, the PACT measures not only can be used to make a dichotomous determination (i.e., PACT is or is not in place); they can also be used to characterize a case management program (i.e., what structures and processes are or are not in place).

New fidelity measures have been developed for studying program implementation in the **CMHS** employment services demonstration and the supported housing demonstration. This work currently is in its earliest stages and is unpublished.

## **Guideline Dissemination**

Research on disseminating innovations in improving care bear on the implementation of systems guidelines. Quality of care research has fueled the drive for measures and ultimately the call for guidelines and, although the emphasis has been on clinical guidelines, such research is relevant also to system guidelines. Like their clinical counterparts, system guidelines not only promulgate the "best practices", but also educate practitioners and recipients about the recommended care. And, as with clinical guidelines, we expect that the principal problem facing developers of system guidelines will be to find ways to change behavior to conform to recommendations.

The field needs methods for disseminating system guidelines and explaining their evidentiary base. Diffusion of innovation is an area of considerable interest and some initial research activity, but there is very little evidence available in regard to mental health services. In regard to clinicians, we know that traditional approaches to continuing professional education are not very effective in changing practice. Instead, an array of financial incentives and intensive training strategies may have some effect. Research on behavior change strategies for non-clinicians, i.e., executives, managers, administrators, and support staff, would be found in the literature on organizational behavior and human resources in industry and business. System guidelines developers may want to follow the lead of the Schizophrenia PORT and the American Psychiatric Practice Research Network by introducing their system guidelines through specialized, intensive face-to-face training and a variant on "academic detailing."

## **Barriers to Implementation**

An important barrier to implementing system guidelines is the fragmented structure of government in which each agency, or even various departments within a single agency, have their own standards and regulations. This problem is especially thorny for multi-service workers who must span several delivery systems to accomplish their tasks on behalf of clients who have a diverse set of needs. For example, mental health treatment for persons with schizophrenia who also abuse drugs is hampered by the different (and perhaps conflicting) requirements of substance abuse agencies and their mental health counterparts. Although the field knows that parallel or sequential treatment is inferior to integrated care, actual integration of mental health and substance abuse programs is immensely difficult.

System guidelines that support service integration provide an opportunity to influence the behavior and activities of managers and clinicians, and to shape the structures and processes of a unified system for delivering services to persons with co-occurring disorders. A system guideline, for example, would recommend that a person with a co-occurring disorder be served in a program where the individual's provider is trained to deal with both substance abuse and mental illness.

## **What Future Efforts are Required for Readiness?**

Further development of system guidelines requires:

- clearer understanding of and consensus on the types of system guidelines proposed above;

- performance standards for organizations and systems that address issues of program availability, access, facility characteristics, staff expertise/training, and credentialing;
- performance indicators derived from these standards that can be operationalized as system guidelines;
- scientific evidence supporting the effectiveness of specific system practices in improving the quality of care and meeting quality standards;
- consensus-based experiential evidence where scientific data are lacking;
- fidelity measures that will demonstrate the extent to which practices conform to guidelines; and
- a process for disseminating and implementing system guidelines so that they can contribute to effective system practices;
- methods for evaluating and refining system guidelines based on feedback from experience and fidelity measurement so that the guidelines continually evolve to meet the quality needs of the system of care.

Work to date provides a starting point for these efforts.

### ***CMHS Activities***

The Survey and Analysis Branch of CMHS has supported a review of the literature, a focus group, and a technical expert work group, to develop and refine the concept of system guidelines and examine their place in the information system prototype. Further definition of systems, contents and processes, and identification of best practices for systems should go hand-in-hand with development and implementation of system guidelines. Definitions should reflect real-world organizational arrangements and practices.

### ***Performance Standards and Indicators***

Standards for organizations and systems currently exist in accreditation standards (such as those set by JCAHO) and performance indicators and report cards provide measurement tools to determine whether standards are being met (e.g., HEDIS, MHSIP consumer-oriented report card). Developers of system guidelines should work closely with experts in these fields to develop system guidelines that are relevant to existing standards and indicators, including those for children's services.

### ***Fidelity Measures***

The work on fidelity measures described above should be expanded in tandem with system guideline development and implementation activities. Fidelity measures and how to use them should be part of dissemination and education efforts.

### ***Consensus-based Evidence***

As with clinical guidelines, consensus on the best practices should be used when scientific evidence is lacking. Standard-setting activities on a national level (e.g., by NCQA and JCAHO) as well as local,

program- and system-specific quality assurance activities provide preliminary consensus-based evidence for system standards.

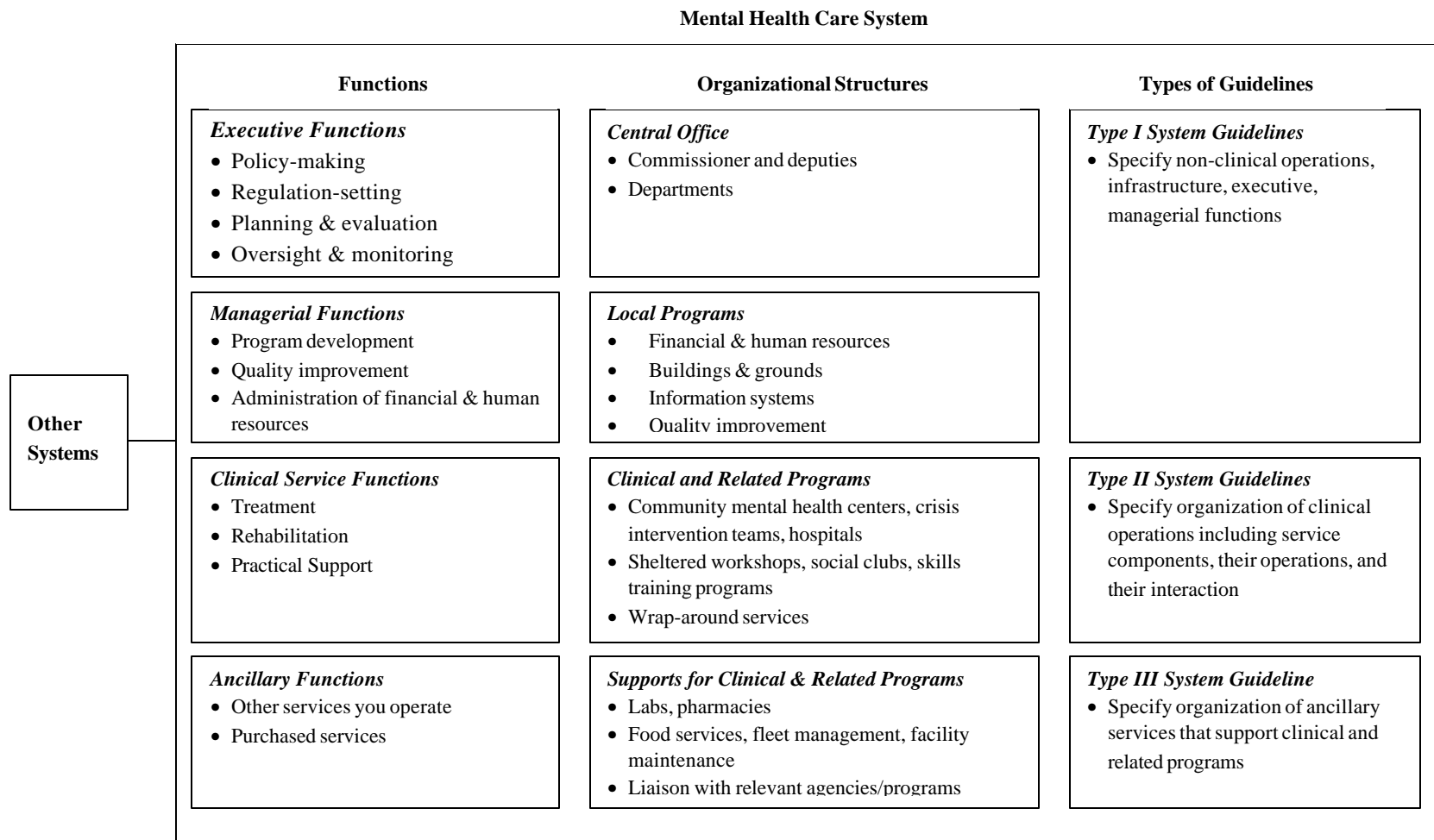
Lessons learned. Lessons learned from clinical guideline development and implementation suggest the following process:

- All stakeholders in a system should participate in designing, developing, and implementing system guidelines. Given the complexities of systems and the different types of users (consumers, clinicians, administrators, support staff), the input of all those who affect and are affected by the operation of the system should contribute to enunciating values, setting standards, and specifying guidelines for performance.
- Make explicit the values and standards that underlie pragmatic recommendations.
- Early in the process, establish guidelines for developing guidelines including timeframes for accomplishing tasks.
- Base system guidelines on research evidence followed by expert consensus. There needs to be a process and procedures for collecting and evaluating scientific data, and for gathering consensus-based evidence where scientific data are lacking.
- Ensure that system guidelines address population-level issues such as prevention and screening.
- Prepare guidelines that can be implemented and that will be useful to a broad range of systems.
- Identify methods for determining the fidelity between actual practice and the guidelines.
- Establish a process for encouraging organizations to adopt and adhere to system guidelines. As with clinical guidelines, developers must strike a balance between recommending uniform practices and allowing flexibility for special settings and circumstances — without the latter, practitioners and organizations will not support or follow the guidelines. If the guidelines are good, easy to implement, and meet the needs of large numbers of organizations, they will be adopted over time. Enforcement by government and private regulatory agencies may be necessary, but probably is less effective than enthusiastic endorsement by members of the system.
- Establish a process for evaluating fidelity, measuring outcomes, and revising the guidelines.
- Link system guideline development and implementation with overall quality improvement efforts including guideline-specific indicators and measures to assess performance relative to the guidelines.

- Coordinate system guideline development with other components of the information system prototype, particularly the organizational and human resources minimum data set, clinical guidelines, and system performance indicators and report cards.

Figure 1

Model of Mental Health Care System and System Guidelines



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