



Mental Health Statistics Improvement Program

Updates

May 1998

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47th National Conference on Mental Health Statistics

**“Behavioral health Care Confronts a Difficult Future:
Need for Collaboration, Improved Practices, Data, and Analysis”**

Sponsored by
Center for Mental Health Services
&
Mental Health Statistics Improvement Program

May 26-29, 1998
(Pre-conference activities begin at noon on 5/26)

Location: Renaissance Mayflower Hotel
1127 Connecticut Avenue, N.W.
Washington, D.C. 20036
Telephone: (202) 347-3000
Fax: (202) 466-9083

Hotel Reservations

Hotel reservations should be made as soon as possible, but no later than May 8, 1998. You may telephone the hotel directly. Identify yourself as a participant of the CMHS National Conference on Mental Health Statistics to receive the special conference rate of \$126 per night (including tax) for a single room.

Agenda

All questions regarding the agenda should be directed to Allen Keme at CMHS (301) 443-3343.

MESSAGE FROM THE CHAIR

The Future of MHSIP

What is the future of MHSIP as a program and as a community?

As we approach the cusp of the millenium, this is a good vantage point to review the past and speculate about the future.

Since its inception, MHSIP has provided leadership in the field of mental health information systems and data standards within the circumscribed world of State and local public mental health agencies. Even after FN-10 (the MHSIP bible) was released and the CMHS grants to implement MHSIP minimum standards were given to States, MHSIP still remained a puzzling acronym to mental health commissioners and other mental health program managers.

In the new environment of managed care and government downsizing, this has changed. Performance measures and outcomes are on center stage and the work done under MHSIP auspices are at the forefront. The foresight of the MHSIP Advisory Group, under the leadership of John Hornik, to create a task force to develop a consumer-oriented mental health report card has paid off.

CMHS through its State reform grant initiative has supported the implementation of performance measures based on the MHSIP report card in 40 States. Some of the MHSIP measures have been adopted by other mental health performance measurement initiatives, including AMBHA, NASMHPD, ACMHA, and NCQA. NCQA has adapted the consumer survey in the MHSIP report card for inclusion in the testing set of the 1999 HEDIS. The standardized framework of performance measures endorsed by all 50

commissioners depends heavily on measures in the report card.

Even with such success, however, there is no systematic evaluation under way of State's experiences with the implementation of performance measurement systems. Protocols for such implementation are still under development. The analytical work needed to cull out useful indicators has not taken place, nor is it planned.

Clearly, the impact of MHSIP has extended beyond its traditional community. No longer can the MHSIP Advisory Group corral the variegated adaptations and uses of MHSIP measures. A more formal, planned, organized and well funded approach is needed to buttress and support the ad hoc work that has occurred to this point.

Under MHSIP auspices, there are several key projects coming to fruition: The minimum set for enrollment/encounter data for managed care (chair: Sharon Guidera), the operational definition of recovery (chairs: Ruth Ralph and Jean Campbell); and the FN-11 project which updates FN-10 (chair: Steve Davis). Each of these projects has the potential of spawning an entire program of activities. But the organizational support and resources must be there to make this happen.

At the same time, the organization and roles of mental health agencies, at both State and local levels, are changing. The distinction between public and private systems is blurred. Mental health agencies are becoming behavioral health agencies. In some States, mental health agencies have become a part of larger health and human services agencies. MHSIP must adapt to these changes by inviting this expanded group of participants to join the family.

The bottom line is that MHSIP is alive and thriving. Its current programmatic direction will continue but we are entering a period which will be characterized by review, refinement, and reformation. An essential

catalyst will be resources for coordination, analysis and technical assistance. As a community, MHSIP can only grow.

The year 2000 may be a problem for information systems but for MHSIP it bodes well.

Vijay Ganju
Chair
MHSIP Ad Hoc Advisory Group

USER GROUP NEWS

THE SOUTHERN STATES MHSIP USERS GROUP (SoSMUG)

The Spring meeting of the Southern States MHSIP Users Group (SoSMUG) was held in Oklahoma City, April 14-15.

Representatives were present from all member states except Texas. Other attendees were CMHS liaison Olinda Gonzalez and logistics contractor Pat Smith. Jack Wackwitz of Colorado Mental Health Services also attended as guest speaker.

The topic of the meeting was consumer surveys. SoSmug distributed a questionnaire to its membership to ascertain the status of consumer survey projects. Among the items covered were survey methodology and level of compliance with the Consumer Survey included as part of the MHSIP Consumer-Oriented Mental Health Report Card (April 1996). The responses to the questionnaires were disseminated at the meeting. Verbal reports by MHSIP representatives also focused primarily on consumer surveys, with several states sharing copies of their survey instruments.

Jack Wackwitz spoke to the group concerning his statistical analysis of data from five states that used all or portions of the MHSIP Consumer Survey. The five States were Colorado, New Mexico, Rhode Island, Texas and Virginia which comprised a total data set of 6900 responses. The analysis indicated consistent difficulties with

negatively worded questions. Questions were also analyzed in terms of their representation of the major domains of access, appropriateness, outcomes, and satisfaction. Results suggested that an accurate assessment for each domain could be obtained through between four and seven questions. Dr. Wackwitz provided the membership with a paper detailing the information outlined in his presentation. The implications of this study was discussed by the group, along with questions as to whether this and other utilization studies might be reflected in any future revision of the MHSIP Consumer Survey.

The Southern states have had some turnover in MHSIP representatives. New representatives who have come on board during the past year are: Carroll Benson, Georgia; Betty Jones, Tennessee; Randy Lemoine, Louisiana; and Sen-Yoni Musingo, Florida. At the Oklahoma City meeting Fred Hobbs of South Carolina was elected Vice-Chairperson of the group. Carroll Benson and Betty Jones were elected to the Steering Committee. Organizational by-laws were amended to create a membership position for a person representing mental health consumers. Larry Fricks of Georgia has served in this capacity for the past year. The amendment gives formal recognition to the position and grants it voting rights.

Ed Payne
MS

WESTERN STATES DECISION SUPPORT GROUP (WSDSG)

The WSDSG has met three times in the last year. Meetings have focused on performance indicators, source data from consumer surveys and the involvement of consumers in the selection, process and monitoring of outcome measures. Western states continue to improve their performance monitoring systems and to learn from each other at the meetings. Information provided on Federal initiatives, such as the Five State Feasibility Project

and the upcoming grant for piloting indicators has been useful.

Of particular note was one meeting held jointly with SoSMUG (Southeastern MHSIP Users Group). The expanded participation afforded a breadth and freshness to the sessions that was beneficial and enjoyable. Due to the success of this meeting, WSDSG plans to hold one joint meeting each year.

The WSDSG has chosen two inter-state research topics, one on needs assessment and one on consumer surveys. The first phase of the Needs Assessment Project is complete. Activities in this phase included a WSDSG needs assessment workshop, technical assistance from CMHS and consultation from the Frontier Mental Health Services Network (Drs. Goldsmith, Ciarlo and Holzer). A report on the workshop and subsequent analysis has been published and distributed. Additional steps are being taken to bolster the needs assessment capability of states, and another report will be out this year.

Preliminary ground work is being done on the Consumer Survey Project. We anticipate further definition of this project at the next WSDSG user meeting.

David Miller
NV

STATE HIGHLIGHTS

California: Adult Performance Outcomes. After extensive pilot testing by 9 counties during the past year, guided by the Performance Outcome Advisory Group and the Performance Outcomes Technical Work Group, the Department of Mental Health has chosen to implement the BASIS-32 and the Lehman TL-30S as the instruments for adult performance outcome measures. These instruments will be administered when the coordinated care plan is developed (This plan must be developed for all person who receive services for over 60 days.), annually thereafter, and at

discharge. There will be a phased-in implementation by counties with both forms required in all counties by April 1999.

Kathryn Styc
CA

Connecticut: In July 1997 DMHAS became responsible for the behavioral health care benefit for local welfare recipients (General Assistance). As an interim step, a contract was executed for an ASO (Administrative Service Organization) to perform Utilization Management and claims management. A RFP was issued for the Department to contract with an ASO for these functions, plus some contract management services. An award decision is expected in November.

The purpose of the MHSIP grant is to:

1. Define key performance indicators
2. Integrate various data bases and report on those indicators
3. Develop an Eis to allow easy access to current performance levels on indicators

Connecticut has defined a set of client outcome measures that are in the domains of *access*, *appropriateness* and *outcomes*. These are a subset of the MHSIP consumer survey, the survey questions are:

1. No service wanted was denied because I could not pay for it.
2. The location of services was convenient (parking, public transportation, distance, etc.)
3. Staff returned my calls within 24 hours.
4. Staff were sensitive to my cultural/ethnic background
5. Staff helped me to obtain the information I needed, so that I could take charge of managing my illness.

As a direct result of services that I received:

6. I deal more effectively with daily problems.
7. I am better able to deal with crisis

8. I can deal better with people and situations that used to be a problem for me.
9. If I had to do it over again, I would choose to get services from this agency.

The process to choose these outcomes included consumers, people in recovery, family members and providers. As a result of the ONE-MHSIP meeting last Fall, Connecticut is looking into dealing with literacy and language issues for surveys. Plans are for distribution and collection to start in the first quarter 1998.

Connecticut's main data sources are from state operated services, private but state funded services, services that are used by our target population from other payers. Our direction is to integrate all of these between mental health and addiction services. Of course, all of the data sets have different definitions and client identifiers; some do not have unique client identifiers. Goals are to integrate, standardize and define data (data dictionary); then construct a data warehouse.

Lorenzo DeBenedictis
CT

Delaware: The Division of Alcoholism, Drug Abuse and Mental Health (DADAMH) has been working on a Decision Support System (DSS) for about two years. The overall goal is to make the Division's extensive array of raw data into accessible information. In addition, related data such as Medicaid claims and encounter data will be easier to access and report upon.

Two sets of performance indicators have been developed. Sixteen indicators have been defined for the behavioral health component of the Medicaid Managed Care Organizations (MCOs). In addition, DADAMH has defined 26 performance indicators for the treatment system it manages directly. Indicators are classified in five domains, accessibility, appropriateness, efficiency, outcome, and provider capacity.

Approximately one third of the DADAMH indicators can be derived using existing data. The other two thirds require special data collection tools. Four outcome instruments have been developed, which are jointly called the Integrated Behavioral Health Assessment (IBHA). These instruments measure consumer satisfaction, problem severity, level of functioning, substance abuse, and living status. All the instruments have been designed to scan the data into electronic files to reduce data entry time.

The state did a pilot test of the Consumer/Client Satisfaction Survey (CCSS) and the Colorado Client Assessment Record – Delaware Version (CCAR-DE). The test were completed at the end of 1997.

Maurice Tippet
DE

Louisiana: The state is in the final, no-cost extension year of its MHSIP Decision Support Grant. The grant objectives have included: training decision support personnel in the use of analysis and presentation software, providing workshops on data based decision making; creation of a decision support system using Microsoft access and a statewide information data system for the community and hospital-based services; and the establishment of the Mental Health Information Resource Center within the Central Office. The state's MHSIP State Reform Grant is still within its first few months of implementation. The objectives of this grant are threefold: to develop a data warehouse of OMH administrative databases, Medicaid files, and the consumer survey responses; to develop a performance outcomes monitoring system; and to develop a mental health services report card.

Randy Lemoine
LA

Mississippi: The state is in the final few Months of its MHSIP Stage 2 grant. The Department of Mental Health is piloting a consumer survey instrument in conjunction with the Mental Health Association of the Capital Area. The survey is based upon the MHSIP Consumer Survey, with some changes based on the input of local consumers and family members. The State is also piloting the use of a set of functional assessment instruments for various population groups.

Ed Payne
MS

New York: The last issue of MHSIP Updates contained a summary of a presentation made by Chip Felton of the ONE-MHSIP group concerning level of functioning of consumers eligible for New York State's upcoming managed care mental health Special Needs Plans. Unfortunately, the summary inaccurately portrayed the findings discussed in the presentation. What follows is a correction: Mr. Felton discussed an analysis conducted in New York State that examined the relationship between level of functioning and mental health service expenditures under fee-for-service. Medicaid claims data were matched with functional assessment scores for a sample of consumers enrolled in mental health outpatient programs. The sample included individuals who were high utilizers of mental health services, a target population for specialty mental health managed care plans soon to be implemented in New York State, and others who used fewer services. For both groups, there was very little correlation (0.14) between fee-for-service mental health service expenditures and level of functioning. By clinician-report, at most 28% of the consumers were "low functioning," defined as a score of below 50 on the GAF. Self-report (BASIS-32) data revealed a similar pattern. Hypotheses were discussed, including the suggestion that the result reflect the inability of fee-for-service systems to rationally allocate care. The

findings clearly suggest, though, that high service use cannot be used as a proxy for low level of functioning and this has implications for states seeking to use fee-for-service claims data to define target populations for specialty mental health care plans.

Chip Felton
NY

Pennsylvania: The state of Pennsylvania is continuing MHSIP activities through the support of a 1996 State Reform Grant entitled "PA – To Implement Performance Objectives to Monitor MCOs." The overall goal of the grant is to establish performance objectives which evaluate the effectiveness of the emerging public sector managed care programs which were effective on February 1, 1997, when the Department of Public Welfare (DPW) implemented zone one of a new health care delivery system to serve Medical Assistance (MA) eligible persons. The program includes a behavioral health carve-out for mental health and substance abuse which is administered by the Office of Mental Health and Substance Abuse Services (OMHSAS).

During year one of the grant, a plan was developed for evaluating and managing the behavioral health managed care organizations (BH-MCO) by using system-wide outcome measures. Year two of the grant has been focused on ensuring that the Performance Outcome Management database is designed to produce both analytical and outcome measurement reports, designing outcome report formats and providing training/technical assistance to the BH-MCOs around compliance with data reporting requirements. The expansion of public sector managed care into geographic zone two is proceeding on schedule, with a Request for Proposal distributed, the bidder selection process completed, and contract negotiations under way, with start-up scheduled for January 1, 1999. When geographic zone two is implemented, approximately 70% of the

Pennsylvania MA population will be covered under capitation.

Grant year one carry over funds have been requested to support the distribution, collection, data entry and analysis of consumer satisfaction surveys for adults, youth and families of children. The survey instruments are being developed by members of the State-wide Consumer/Family Satisfaction Teams (CTSs), with the MHSIP Mental Health Report Card forming the basis for the adult satisfaction survey. The surveys will be distributed by the CSTs to a sample of the population served within the first year of the managed care program.

Carolyn Parkes
PA

Rhode Island: Rhode Island completed the data collection process for the Rhode Island Consumer Questionnaire on October 31, 1997 and presented survey results at a statewide forum on March 4, 1998. The Division of Integrated Mental Health Services (DIMHS) and the National Alliance for the Mentally Ill – Rhode Island (NAM-RI) will continue working together to conduct several local presentations of survey results to groups of consumers, family members, and providers across the State.

Rhode Island conducted a 3-month pilot of the Rhode Island Outcome Evaluation Instrument that includes 40 items of the MHSIP Report Card Consumer Survey. Three community mental health centers participated in the pilot by presenting every community support client with the survey at the time of their annual treatment plan rewrite. In addition to testing the instruments themselves, we tested the overall methodology, including new software that eliminates manual data entry. DIMHS staff members are currently analyzing data to make appropriate recommendations regarding the sample size and frequency of data collection at each community mental health center for statewide implementation scheduled to begin in FY '98.

Five organizations responded to a DIMHS request for proposals to provide Internet access and training to consumers of mental health services in Rhode Island. Four of the five proposals were selected for funding. The mini-grant activities began in October 1997 and will continue through September 1998. Each grant recipient is tailoring their Internet access site to the specific needs of the community.

Laurie Hutchison
RI

Tennessee: The MHSIP State Reform grant has been used to design a performance measurement system for the TennCare Partners Program's Behavioral Health Organizations (BHO), and has produced a draft format for a BHO Report Card. Tennessee has completed a TennCare Partners Program Consumer Satisfaction Survey. This was presented at a Tennessee Association of Mental Health Organizations conference. Within the Division of Mental Health Services performance measures are being tailored to measure outcomes of those programs directly funded by the Division.

Betty Jones
TN

West Virginia: The State is testing algorithms to determine eligibility and type of services. These algorithms have been developed for adults and children/adolescents with mental illness, chemical dependency, or mental retardation. Determination for Medicaid eligibility will be phased in after a pilot study focusing on adults with mental illness is completed. In addition to the Medicaid population, the algorithms will be applied to the indigent care population. Information about population case mix will be utilized as part of the rate methodology for case rate reimbursement. In other activities, satisfaction surveys for family members of adults and children with mental illness are being finalized. The second annual

satisfaction survey of consumers has been completed.

James Elzey
WV

The United States Virgin Islands: The Virgin Islands has submitted an application in its second attempt to obtain funding through the State Reform Grant process. The Virgin Islands previously received MHSIP Stage I funding that supported the Division's MIS activities. The activities begun under MHSIP I were abruptly halted when the grant ended in 1996. The local government continues to experience very serious economic problems with a deficit approaching a billion dollars. This, then, underscores the search for alternative funding that will enable us to maintain some technological footing as we approach the new millennium.

Jaslene Williams
VI

CONSUMER ISSUES

Consumer and Family Issues Explored through the SMHA Profiling System

In the past few years that has been an ongoing convergence of values and issues in mental health as data collection and service delivery have become linked through computerized outcomes management systems, data warehousing, and electronic health record technologies. It is important to know if states are collecting and disseminating data that reflect the values of consumers and family members, promotes shared decision-making, and improves that quality of services people receive. Are states collecting data on recovery, involuntary commitment, or the negative outcomes of service delivery such as medication side effects? Do they monitor the attitudes and behaviors of service delivery personnel? What are the protections for privacy and confidentiality of

sensitive clinical information? Are they funding family preservation and support services?

It appears that some states have been proactive in moving towards a consumer-directed mental health service delivery system. The first sightings of these islands of excellence in identifying the technical assistance needs of consumer/survivor and family stakeholder Groups within State Mental Health Agencies is cause for enthusiasm. This report presents the analysis of responses to the consumer component and family questions included in the second cycle of the State Mental Health Agency (SMHA) Profiling System (1995-1996). Conducted by the mental health consumer researcher, Jean Campbell, Ph.D., at the Missouri Institute of Mental Health (MIMH), the analysis enables people to find the states where consumers and family members are making a difference. Such information can help to identify models of service delivery, improve information exchange, and facilitate the mental health planning process.

The report features descriptive statistics, pie charts, bar graphs, maps, and appendices with complete data tables for responses from 46 states for the consumer-related questions and 47 states for family questions. Pearson correlation coefficients were computed to assess the strength of relationships between consumer participation and the availability of programs and policies that promote consumer choice. These factors were found to be strongly correlated. The strength of the relationships between consumer involvement in research and planning and the availability of information important to consumers were also tested and found to be significant. Findings showed that consumer participation in policy, planning, resource allocation, service provision and research could have a dramatic impact on the extent of consumer service choice at both the system and the individual level. The successful role of Offices of Consumer

Affairs in maintaining a consumer presence at the senior management level of SMHAs was a key discovery. On the other hand, consumer participation on program planning and resource allocation is limited. Most states do not answer many questions that are of particular importance to consumers, such as the level of state involvement in recovery efforts, number of advance directives on file, or consumer needs and preferences for housing and supports.

There was little expectation from the consumer participants that states would have more than a few affirmative responses to the questions developed. Their suspicions are clearly justified by the data that was obtained. There are also surprising exceptions. This report provides a storehouse of information that can facilitate the development of a research agenda for consumers and family members interested in evaluating service delivery systems from the perspective of the customers. This information enables people to compare states on consumer and family issues, and to look at particular states for individual SMHA responses. State programs and trends can be identified, survey protocols obtained, and SMHA data requested based on the responses to the SMHA Profiling System. For example, the findings of this report suggest that few states are promoting community-based peer and family support programs that target the needs of minority groups such as people who are homeless, elderly, in the forensic system, or people of color, and women. The SMHA Profiling System could be used to monitor which states are collecting data on service utilization, quality, satisfaction, recovery and other consumer-oriented outcomes for these groups. Further, where numbers of people served or dollars spent are reported in the SMHA Profiling System, if common protocols for calculation are used, the effect of resource allocations on policy and research could be determined.

When mental health service information begins to enhance individual choice, power,

and knowledge, the delivery of services can take a quantum leap forward towards effective and humane shared decision-making. Collaborative efforts to define and collect relevant, appropriate information consistent with personal health care values and the desires of consumers and their family members, are important first steps. Yet, without incorporating mechanisms for data distribution and feedback, there is little opportunity to integrate the values and goals of service recipients. Since data cannot be accessed unless presented and distributed to interested stakeholders, the information in this report is presented in a manner designed to be user-friendly. Therefore, the data can be used by busy politicians and senior managers who set policy and budgets, by people who use the mental health services, and even by bean counters who monitor system activities. Some readers will simply want to scan the frequencies represented in the report by bar graphs, pie charts, and state maps; others can search the data tables and drill down for rich and significant details.

Ultimately, the capacity to use the data presented in this report has wide implications for setting federal and state funding priorities, and for empowering people with the data to dialogue among key stakeholders about supporting consumer and family initiatives. Such knowledge holds the promise for partnerships in treatment and accountability, but only if people work together as equals, and if consumer participation is valued and supported at all levels.

Copies of Identifying the Technical Assistance Needs of Consumer/Survivor and Family Stakeholder Groups within State Mental Health Agencies can be obtained at a cost of \$15 from the Missouri Institute of Mental Health Continuing Education Division, 5400 Arsenal Street, St. Louis, Missouri 63139. Also, copies of the Executive Summary are available at a cost of \$5 from NTAC, 66 Canal Center Plaza, Suite 302, Alexandria, Virginia 22314. For

more information contact Jean Campbell, Ph.D., at (314) 644-7829.

Jean Campbell, Ph.D.
Research Assistant Professor
Missouri Institute of Mental Health

MHSIP GRANT

FY '98 State Indicator Pilot Grant

The Center for Mental Health Services FY '98 State Indicator Pilot Grant was announced on April 8, 1998 in the Federal Register. This grant provides the opportunity for State mental health agencies to pilot test performance indicator recommended in the 1997/98 Five State Feasibility Assessment Project in which five States identified and tested feasible, meaningful, and comparable indicators. Major domains include outcomes, consumer evaluation of care, consumer status, community services and state hospitals. These grants provide \$100,000 a year for three years. The receipt date for applications is June 8. Many of these indicators have been recommended for inclusion in the CMHS Mental Health Block Grant guidelines for 1999. A new feature of this grant is the participation of respective State planners in this pilot project. The GFA application is available by calling Olinda Gonzalez at 301-443-3343 (E-mail ogonzale@samhsa.gov) or by accessing SAMHSA's World Wide Web Home Page (address: <http://www.samhsa.gov>) or the CMHS Knowledge Exchange Network (E-mail address: <http://www.mentalhealth.org>).

MANAGED CARE

This article is reprinted from SAMHSA News, Volume VI, No. 1, Winter 1998.

SAMHSA Measures Performance and Outcomes of Managed Care Treatment

Measuring the success of treatment for mental and addictive disorders – often called behavioral health care – is a problem that has confounded provision of services for these disorders for more than half a century. The history of behavioral health care has been marked by confusion, misunderstanding, and stigmatization concerning the causes of these disorders, as well as disagreements over appropriate treatment and definitions of recovery. The rapid growth of managed care as a means to control costs and improve the quality of services has escalated the need for accurate and widely accepted ways to measure both the performance of service delivery and the treatment outcomes resulting from services provided.

Managed care has had an impact on all stakeholders: consumers of services and their families who may be faced with a change in provider or in services offered; service providers who may find their clinical decisions modified based on financial considerations; and health care payers such as private companies and State agencies that are called upon to be active purchasers by comparing and assessing competing plans.

In response to this need for standardized measures, SAMHSA has initiated several significant activities to try to assist the field. In the vanguard of these efforts is the *MHSIP Consumer-Oriented Mental Health Report Card*, released by SAMHSA's Center for Mental Health Services (CMHS) in 1996.

The *Report Card* grew out of the work of a special task force convened by the CMHS Mental Health Statistics Improvement Program (MHSIP). MHSIP is a voluntary network of providers, advisory groups, associations, State agencies, and consumers that assists CMHS in collecting and evaluating mental health statistics as part of its mandate to improve mental health services.

The MHSIP Task Force included mental health consumers; representatives of Federal, State, and local mental health and substance abuse agencies; advocacy groups; researchers; and policy analysts. The *Report Card* is especially useful for **consumers**, who can use it to compare and evaluate various mental health service options, but is helpful to other groups as well. By using the *Report Card*.

- **Advocacy groups** can promote better services;
- **Health care purchasers** can evaluate managed care organizations or provider systems;
- **Providers** can monitor the performance of their systems; and
- **State mental health agencies and other funding sources** can monitor quality and outcome across different provider systems.

But the true significance of the *Report Card* goes beyond this. According to Ronald W. Manderscheid, Ph.D., who coordinated the development of the *Report Card* and serves as Chief of the Survey and Analysis Branch within the CMHS Division of State and Community Systems Development, “A primary challenge is to move the managed health care field from competition based on price to competition based on quality.”

If behavioral health care services are to be viable in the long run, he says, independent measures of value must be developed. If key stakeholders have access to a valid assessment of quality of service and measures of positive outcomes, they can justify the financial investment that needs to be made in behavioral health care services. Payers will be more willing to cover the costs of mental health services when concrete outcomes are measured and reported.

“Unless we are successful in these endeavors,” says Dr. Manderscheid, “the field runs the risk that progressively

decreasing amounts of money will be spent on mental health and substance abuse services.”

MHSIP Report Card Unique Features

The MHSIP *Report Card* has several unique features that distinguish it from other health and behavioral health care report cards. These include a consumer focus, an emphasis on outcomes, relevance to a range of mental health conditions, and a grounding in research together with consideration of practical issues.

Consumer focus

The MHSIP *Report Card* is the only rating scheme that focuses directly on the consumer rather than on issues of fiscal management or efficiency. This goes beyond the inclusion of consumers in the development of the *Report Card*. The indicators and measures it contains are specifically designed to respond to consumer concerns about various aspects of mental health treatment.

The *Report Card* includes objective measures of a provider’s commitment to mental health care (as indicated by such things as average resources expended on mental health services) as well as consumer assessments of the accessibility, appropriateness, and outcomes of the services.

Emphasis on outcomes

The *Report Card* is based on the assumption that mental health systems should produce specific outcomes. Examples of the kind of outcomes measured by the *Report Card* include reduction in symptom distress, increase in independent functioning, and improved performance at work and school. To achieve these outcomes, the service system must offer a range of choices that are voluntary, easily accessible, culturally appropriate, focused on recovery, and designed to promote consumer inclusion.

Outcome data can be difficult to interpret because they are effected by the characteristics of the consumers in the managed care pool. In addition, although consumers consider “recovery” and “personhood” – concepts that entail dignity, self-mastery, self-esteem, and self-worth – to be critical, there are no widely accepted, operational definitions. The MHSIP Task Force did not shy away from these challenges, but developed the *Report Card* based on what should be measured rather than what is convenient or easy to measure.

Accent on serious mental illness

The *Report Card* measures are designed specifically for adults with serious mental illnesses, although they can also be applied more broadly. The *Report Card* is also relevant to children with serious emotional disturbances and to adults with a dual diagnosis of mental illness and substance abuse disorder.

Grounding in research and practicality

In developing the *Report Card*, the task force based its work on research, including an extensive review of the literature on performance measures, outcomes, and other report cards. The task force was also conscious of practical issues and went to considerable effort to design the *Report Card* to minimize the cost and burden of the data collection on users.

Design

The *Report Card* is organized around four key domains: access, appropriateness, outcomes, and prevention. Within each domain, the task force outlined the main concerns of consumers and then developed indicators that can be measured to rate the responsiveness of the provider to those concerns.

For example, a key concern in the domain of “access” is quick and convenient entry into services. An indicator for this concern is the average length of time from request of services until the first meeting with a mental health professional.

In another example, a key concern in the domain of “outcomes” is increase in productive activity. An indicator for this concern is the average change in the number of days lost from work.

The *Report Card* suggests several sources for obtaining data, including data from client records such as enrollment and financial claims records, instruments designed to be administered by clinicians when the client enters service and at intervals thereafter to assess outcomes, and a consumer survey to be completed annually by clients. The consumer survey has received considerable attention as a way to report the consumer point of view in performance and outcomes.

Future Directions

The *Report Card* has been widely recognized and endorsed by such organizations as the National Alliance for the Mentally Ill, the National Association of State Mental Health Program Directors, the National Association of State Mental Health Planning Councils, and the American Association of Behavioral Health Care.

But the *Report Card* is still a work in progress. It is being tested and refined across the country through a series of pilot projects in which elements are being adopted and assessed in a variety of settings.

CMHS has provided grants to 31 States to establish performance monitoring in their State mental health data systems. Twenty-two States have chosen to use the *Report Card* as a framework for selecting performance indicators in their pilot tests and in the design of statewide data-gathering systems. States have been particularly receptive to adopting the consumer component of the *Report Card*.

Although previously only six States were using some form of a consumer survey, currently 22 States have adopted the MHSIP survey or a similar instrument.

Based on the experiences of the pilot States, the *Report Card* will be further refined and additional guidance provided to States on the establishment of consistent and consumer-focused performance measures in mental health services.

Other Performance Measurement Projects

SAMHSA Associate Administrator for Managed Care Eric Goplerun, Ph.D., emphasizes that the *Report Card* is one of several efforts in which SAMHSA is participating to develop performance measures in managed care.

Other projects are underway to help managed care purchasers deal with issues of access, expense, and accountability, and to extend performance measurement to populations that are served in a wide range of systems of care.

Among these projects are:

- The Performance Measurement Consensus Project, in which SAMHSA and the Health Care Financing Administration (HCFA) are jointly funding a unique collaboration between the National Association of State Mental Health Program Directors, the National Association of State Alcohol and Drug Abuse Directors, and the National Association of State Medicaid Directors. The purpose is to create consensus around a set of quality assurance and performance measures that public purchasers of managed behavioral health care services could use to contract for Medicaid managed behavioral health care services;
- The Quality Improvement Systems for Managed Care, an effort to achieve as much consensus and coordination as possible between HCFA and individual State Medicaid programs by designing a new approach to the oversight of quality of care delivered by Medicare and Medicaid managed care plans;
- The American College of Mental Health Administration Santa Fe Summit 1997, the first in a series of consensus-

building activities to be conducted by the College, to develop performance measures for mental health and substance abuse care.

“Our goal in all four of these efforts is to develop a set of core performance measures that will help improve the delivery of services for behavioral health care in managed care settings,” says Dr. Goplerud.

To obtain a copy of the MHSIP *Consumer-oriented Mental Health Report Card*, contact the Knowledge Exchange Network (KEN), a service of SAMHSA, at PO Box 42490, Washington, DC 20015. Telephone: (800) 789-CMHS (2647) or (301) 443-9006 (TTY). To order electronically: [<http://www.samhsa.gov>].

-By Kathryn Stewart

PUBLICATION LISTING

Survey and Analysis Branch Documents on Managed Care

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Managed Behavioral Healthcare: History, Models, Key Issues, and Future Course. October 1994.

Mental Health United States, 1996.

Managed Behavioral Healthcare Procurement: Design, Financing, Procurement, and Monitoring of Managed Behavioral Healthcare Plans. November 1996.

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The Division of State and Community Systems Development, CMHS, Joyce T. Berry, Ph.D., Director, continues to provide financial support for the MHSIP Ad Hoc Advisory Group, with primary liaison by Ronald W. Manderscheid, Ph.D. The Advisory Group welcomes your questions, comments, and suggestions.

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