X. Quality and Outcome Measurement

The 1997-98 State Survey explored quality and outcome measurement in managed care reforms with respect to a number of issues: whether quality and outcomes measures are specific to children and adolescents, the extent to which families are involved in quality measurement, the types of outcomes that are measured, sources of information for outcome measurement, the existence of mechanisms to track the impact of managed care reforms on other child serving systems, and whether evaluations of managed care reforms include a focus on children and adolescents receiving behavioral health services.

Use of a Quality Measurement System

As shown on Table 59, 100% of the reforms in 1997-98 reportedly incorporate some type of quality measurement system. This finding is consistent with the emphasis in managed care on accountability and performance measurement. Further, the majority of reforms (88%) reportedly incorporate quality measures specific to child and adolescent behavioral health services. It should be noted that 100% of the carve out reforms were reported to have measures specific to children and adolescents, as compared with only 62% of the integrated reforms.

Table 59

Percent of Reforms Incorporating a Quality Measurement System

Quality Measurement System	1997–98 Carve Out	1997–98 Integrated	1997–98 Total
Included	100%	100%	100%
Child-Specific Measures	100%	62%	88%

Involvement of Families in Quality Measurement Systems

The 1997-98 survey gathered information about the ways in which families are involved in quality measurement systems. The survey sought to identify the mechanisms used to obtain information from families about the quality of services (such as participation in focus groups and completing surveys) as well as their participation in the design of the quality measurement system and monitoring of the quality measurement process.

As shown on Table 60, families are typically involved in quality measurement processes for managed care systems by responding to surveys, an approach reportedly used by 77% of all reforms. Participation of families in focus groups was cited less frequently; this approach reportedly is used by 44% of all reforms.

Table 60 Percent of Reforms with Family Roles in Quality Measurement Processes			
Role	Carve Out	1997–98 Integrated	Total
Not Involved	0%	31%	11%
Focus Groups	58%	15%	44%
Surveys	85%	62%	77%
Design of Process	58%	15%	44%
Monitoring of Process	46%	0%	31%
Other	12%	8%	11%

In addition to serving as a source of information about system quality, some states are beginning to involve families in the design and oversight of quality measurement processes in managed care systems. A significant proportion of managed care systems (44%) reportedly involve families in designing quality measures and/or quality measurement processes. In addition, respondents indicated that families play a role in monitoring the quality measurement process in nearly one-third of the reforms (31%).

In comparing carve outs and integrated reforms, the most striking finding is that 31% of the integrated reforms do not involve family members in any manner in their quality measurement process. In contrast, all the carve out reforms identified one or more roles for families in their quality measurement processes. For each of the family roles explored by the survey, the rate of participation in carve out reforms is notably higher than that in integrated reforms. Also, carve outs reportedly involve families in multiple roles, whereas respondents tended to identify only one way in which families are involved in the quality measurement processes of integrated reforms.

Several respondents identified additional ways in which family members are involved in quality measurement. Oregon's reform requires MCOs to involve families in their own quality measurement systems. In Pennsylvania, the managed care system involves family members in consumer satisfaction teams which review service delivery systems and complaints regarding the managed care system.

Types of Outcomes Used to Measure Children's Behavioral Health Services

Both the 1995 and the 1997-98 surveys revealed that reforms are using a wide array of outcome measures to assess child and adolescent behavioral health services. Across all reforms, the dimension receiving the most attention in 1997-98 was access, with 90% of the reforms indicating that access is measured (Table 61). Service utilization patterns and parent satisfaction also are measured extensively by managed care systems, each is reportedly measured in 80% of the reforms. (It is interesting to note that while parent satisfaction is measured by managed care systems, fewer–63%–were

reported to assess youth satisfaction.) These findings reflect a change from the 1995 State Survey which found that cost was the dimension most often measured by reforms at that time. Cost is still receiving considerable attention; respondents indicated that cost is measured in 78% of the reforms, reflecting only a slight decrease from the 83% reported to track cost in 1995.

Table 61

Percent of Reforms Measuring Various Types of Outcomes

Outcome	1995 Total	1997–98			95–97/98 Change
		Carve Out	Integrated	Total	
Cost	83%	82%	69%	78%	-5%
Access	80%	96%	77%	90%	+10%
Service Pattern	77%	89%	62%	80%	+3%
Clinical and Functional Outcomes	51%	82%	23%	63%	+12%
Parent Satisfaction	69%	96%	62%	80%	+11%
Youth Satisfaction	60%	75%	38%	63%	+3%
Other	11%	11%	15%	12%	+1%
None	9%	0%	8%	2%	-7%

Another dimension receiving relatively less attention in managed care systems in 1997-98 is clinical and functional outcomes, reportedly measured in 63% of the total reforms. In 1995, clinical and functional treatment outcomes were also the least likely type of outcomes to be measured by reforms. These findings are consistent with the 1997 Impact Analysis which revealed that the focus of reforms appeared to be on measures related to process or cost, and that measurement of clinical and functional outcomes for behavioral health managed care systems was at an early stage of development, especially for children and adolescents. None of the states in the Impact Analysis sample reported having a well-developed outcome measurement system in place, although stakeholders in six of the ten states reported that the development of outcome measurement systems was in process. The reports that states are working on the development of outcome measurement systems were substantiated by the reported increase from the 1995 survey to 1997-98 survey in the measurement of clinical and functional outcomes—from 51% to 63% of the reforms. The measurement of parent satisfaction also increased by 11 percentage points from 1995 to 1997-98.

In comparing the differences between carve outs and integrated reforms in 1997-98, the most significant finding is that carve outs consistently were more likely to measure each type of outcome than integrated reforms. The pattern is most striking in the domain of clinical and functional outcomes, which is measured by 82% of the carve out reforms and by only 23% of the integrated reforms. Another dimension with a dramatic difference is the area of youth satisfaction, measured by 75% of the carve out reforms but by only 38% of the integrated reforms. Matrix 5 displays the types of outcome information measured by state.

Matrix 5

Types of Outcomes Measured by Managed Care Reforms Related to Child and Adolescent Behavioral Health Services

N/A Not Available

Types of Outcomes		Cost	Access	Service Utilization Patterns	Clinical and Functional Outcomes	Parent Satisfaction	Youth Satisfaction	Other	None
Carve Out (n=28)									
Alaska	AK			●	●	●	●		
Arizona	AZ		●	●	●	●			
Arkansas	AR	●	●		●	●	●		
California	CA	●	●	●	●	●	●		
Colorado	CO	●	●	●	●	●			
Delaware	DE	●	●						
District of Columbia	DC	●	●	●	●	●	●		
Florida	FL	●	●	●	●	●			
Indiana	IN	●	●	●	●	●	●		
Iowa–Mental Health	IA	●	●	●	●	●	●		
Iowa–Substance Abuse	IA	●	●	●	●		●		
Kentucky	KY	●	●	●	●	●	●		
Maine (N/A)	ME								
Maryland	MD	●	●	●	●	●	●		
Massachusetts	MA	●	●	●				●	
Michigan	MI	●	●	●	●	●	●		
Montana	MT	●	●	●	●	●	●		
Nebraska	NE	●	●	●	●	●	●		
New Jersey	NJ	●	●	●	●	●	●		
New York	NY	●	●	●	●	●	●		
North Carolina	NC	●	●	●	●	●	●	●	
Oregon	OR	●	●	●	●	●	●		
Pennsylvania	PA	●	●	●	●	●		●	
Tennessee	TN		●	●	●	●	●		
Texas (BH)	TX	●	●	●	●	●	●	●	
Utah	UT	●	●	●	●	●	●	●	
Washington	WA	●	●	●	●	●	●		
Wisconsin	WI	●	●			●	●		
Integrated (n=15)									
Connecticut	CT	●	●	●		●			
Hawaii	HI	●	●	●					
Maryland (SA)	MD								●
Minnesota	MN							●	
Missouri (N/A)	MO								
Nevada (N/A)	NV								
New Hampshire (N/A)	NH								
New Mexico	NM		●			●	●		
North Dakota (N/A)	ND								
Ohio	OH				●				
Oklahoma (N/A)	OK								
Oregon (SA)	OR	●	●	●	●	●	●		
Rhode Island	RI								●
Texas (PH/BH)	TX	●	●	●	●	●	●	●	
Vermont	VT								●

Sources of Information for Outcome Measurement

As shown on Table 62, in both 1995 and 1997-98, providers and families were identified as the major source of information for the measurement of outcomes by managed care systems. For both groups, there was an increase in the proportion of reforms indicating that they are a source of outcome information—from 73% to 87% for providers and from 68% to 82% for families. Although no information is available from 1995, 53% of all reforms in 1997-98 reportedly use the child welfare system as a source of information for outcome measurement, and about one-third use family organizations as sources.

Table 62

Percent of Reforms with Various Sources of Information for Outcome Measurement

Sources of Information	1995 Total	1997–98 Carve Out	1997–98 Integrated	1997–98 Total	95–97/98 Change
Families	68%	93%	55%	82%	+14%
Providers	73%	96%	64%	87%	+14%
Child Welfare	Not Asked	48%	27%	42%	NA
Other Systems	38%	44%	18%	37%	-1%
Family Organizations	Not Asked	44%	0%	32%	NA
Other	24%	19%	27%	21%	-3%
None	6%	4%	9%	5%	-1%

The differences between carve out reforms and integrated health/behavioral health reforms in the sources of information used is striking. For example, in 1997-98, families are used as sources of information by 93% of the carve outs but by only 55% of the integrated reforms. Providers are used as information sources by 96% of the carve outs, but are used by only 64% of the integrated reforms. Family organizations are used by 44% of the carve out reforms as sources of information, but are not used as information sources by any of the integrated reforms. Similarly, the collection of outcome information from child welfare and other child serving systems occurs much more frequently in the carve outs than in the integrated reforms.

Tracking Impact of Reforms on Other Child Serving Systems

As is shown on Table 63, only 31% of all reforms are tracking the impact of managed care on other child serving systems, such as child welfare, juvenile justice, and education. The results from the 1997 Impact Analysis concur with this finding. Stakeholders in only one state involved in the Impact Analysis sample reported efforts to track the effects of managed care reforms on other child-serving systems, particularly with respect to the shifting of children and costs to these systems. Despite the lack of systematic tracking, respondents in eight of the ten states alleged that cost shifting was occurring from the managed care system to other children's systems.

Table 63 Percent of Reforms Tracking Impact on Other Child-Serving Systems			
Tracking Impact	Carve Out	1997–98 Integrated	Total
Yes	36%	20%	31%
No	64%	80%	69%

A higher proportion of the carve out reforms (36%) reportedly are tracking impact on other systems than of the integrated reforms (20%). Respondents noted that two additional carve out reforms were in the process of developing tracking mechanisms.

Formal Evaluations with a Child and Adolescent Focus

As is shown on Table 64, slightly less than half (47%) of the reforms with formal evaluations of their managed care systems underway indicated that these evaluations have a specific child and adolescent focus. This finding is consistent with the 1997 Impact Analysis which found that of the five reforms with a formal evaluation, two included a specific focus on children and adolescents.

Table 64 Percent of Reforms with Evaluations with a Child and Adolescent Focus			
With Child Focus	Carve Out	1997–98 Integrated	Total
Yes	62%	18%	47%
No	38%	82%	53%

Again, there is a noteworthy difference between the carve out and integrated reforms in the 1997-98 survey. Nearly two-thirds (62%) of the carve out reforms with evaluations include a specific child and adolescent focus. In contrast, only 18% of the integrated reforms include this focus.