HCRTP | Promising Approaches

for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems

4: Accountability and Quality Assurance in Managed Care Systems

Mary I. Armstrong

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Introduction

Health Care Reform Tracking Project

Since 1995, the **Health Care Reform Tracking Project** (**HCRTP**) has been tracking publicly-financed managed care initiatives and their impact on children with mental health and substance abuse (i.e., behavioral health) disorders and their families. The HCRTP is co-funded by the National Institute on Disability and Rehabilitation Research in the U.S. Department of Education and the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services. Supplemental funding has been provided by the Administration for Children and Families of the U.S. Department of Health and Human Services, the David and Lucile Packard Foundation, and the Center for Health Care Strategies, Inc. to incorporate a special analysis related to children involved in the child welfare system. The HCRTP is being conducted jointly by the Research and Training Center for Children's Mental Health at the University of South Florida, the Human Service Collaborative of Washington, D.C. and the National Technical Assistance Center for Children's Mental Health at Georgetown University.

The **HCRTP Promising Approaches Series** is comprised of a number of thematic issue papers that describe promising strategies, approaches, and features of service delivery to children and adolescents with behavioral health disorders and their families (particularly for children with serious and complex disorders) in publicly-financed managed care systems. The series draws on the findings of the HCRTP to date, highlighting relevant issues and approaches that have surfaced through the HCRTP's all-state surveys and in-depth impact analyses in a smaller sample of 18 states. The papers are intended to be technical assistance resources for states and communities as they refine their managed care systems to better serve children and families.

Methodology for Study of Promising Approaches

The strategies and approaches described in the **Promising Approaches Series** were identified by key state and local informants via the state surveys and site visit interviews conducted as part of the HCRTP. More detailed information was then gathered about these promising approaches and features by members of the HCRTP team, including researchers, family members, and practitioners. In some cases, sites were visited so that targeted interviews could be conducted with key stakeholders, such as system purchasers and managers, managed care organization representatives, providers, family members, and other child-serving agency representatives. In other cases, telephone interviews were conducted with key state and local officials and family members, and supporting documentation was gathered and reviewed.

The series intentionally avoids using the term, "model approaches." Although strategies, approaches, and features of managed care systems described in the series are perceived by a diverse cross-section of key stakeholders to support effective service delivery for children with behavioral health disorders and their families, the HCRTP has not formally evaluated these approaches. In addition, none of these approaches or strategies is without problems and challenges, and each would require adaptation to individual state and local circumstances. Also, a given state or locality described in the series may be implementing an effective strategy or approach in one part of its managed care system and yet be struggling with other aspects of the system.

The series does not describe the universe of promising approaches that are underway in states and localities. Rather, it provides a snapshot of promising approaches that have been identified through the HCRTP to date. New, innovative approaches are continually surfacing as the public sector continues to experiment with managed care.

Each approach or strategy that is described in the series is instructive in its own right. At the same time, the commonalities that exist across these strategies and approaches help illustrate how effective service delivery systems are organized within a managed care environment for this population.

Each paper in the series focuses on a specific aspect of publicly-financed managed care systems. This paper is on **Promising Approaches to Managed Care Accountability and Quality Assurance**.

Overview

Promising Approaches 4: Accountability and Quality Assurance in Managed Care Systems

This paper identifies a number of managed care accountability and quality assurance approaches that support effective service-delivery to children with serious emotional problems and their families. These promising approaches include both statewide approaches focused on a total population (Delaware, Pennsylvania, Iowa, and Utah) and local sites (HealthChoices in Allegheny County, PA; Dawn Project in Marion County, IN; and Delaware County, PA) focused on a specific geographic area (see **Table 1**).

Table 1	
Promising Approaches to Accountability and Quality Assurance in Managed Care Systems	
Statewide Approaches	**Local Approaches**
Delaware	Allegheny County, PA
Iowa	Delaware County, PA
Pennsylvania	Marion County, Indiana
Utah	

The paper addresses four areas of accountability: (1) availability of data for decision making, (2) types of system performance information collected and tracked, (3) measurement of clinical and functional outcomes, and (4) quality measurement. The discussion of each area begins with a brief review of the accountability and quality assurance issues related to public sector behavioral health managed care that have been identified through the Health Care Reform Tracking Project.

The discussion of accountability and quality assurance issues highlights differences between **carve out** and **integrated designs**, design differences which the HCRTP has been analyzing since its inception. Following the review of each accountability issue, the paper describes related promising approaches. The final section for each issue summarizes the common characteristics and challenges described by key stakeholders as well as recommendations to other states and communities. The paper concludes with a list of resource contacts for the promising approaches, and a list of national organizations addressing these issues.

I. Availability of Data for Decision-Making

Since 1995 the Tracking Project has explored the extent to which adequate data are available in managed care systems to guide decision-making regarding children's behavioral health services. In both impact analyses, key stakeholders in most states reported that management information systems (MIS) were insufficient to meet the accountability needs of managed care systems. They also cited problems with obtaining encounter data from managed care organizations (MCOs), a lack of electronic data reporting systems, and a lack of resources to manage and analyze data in a timely manner for either decision-making or quality assurance purposes.

According to the *2000 State Survey*, which was based on a sample of 35 managed care systems in 34 states, adequate data were available to guide decision making in 59% of the reforms, leaving 41% of the reforms without adequate data. The survey also found that adequate data related to child behavioral health services are more likely to be available in carve outs (63%) than in integrated reforms (43%).

In reforms without adequate data to guide managed care decision-making, the most frequently cited reasons for data inadequacies, as shown on **Table 2**, were inadequate MIS systems and lack of encounter data from MCOs.

Table 2 Reasons for Lack of Adequate Data in Reforms without Adequate Data			
	2000		
	Carve Out	**Integrated**	**Total**
Lack of encounter data	50%	50%	50%
Lack of staff capacity to analyze data	40%	25%	36%
Inadequate MIS system	50%	75%	57%
No tracking children's behavioral health services	20%	25%	21%
Other	30%	0%	21%

Promising Approaches for Making Data Available for Decision Making

- ### Delaware's Family and Child Tracking System (FACTS)

  Delaware's Department of Services for Children, Youth, and their Families is an integrated state agency for children's services. The Department includes four divisions: (1) child mental health services, (2) child welfare, (3) juvenile justice, and (4) a support division. The MIS system is situated within the support division and is used by the children's mental health, child welfare, and juvenile justice divisions. Development of the **Family and Child Tracking System** (**FACTS**) was initiated in 1993. Three quarters of the development and

startup costs for FACTS were paid by **Statewide Automated Child Welfare Information Systems** (**SACWIS**), an initiative authorized by Congress in 1993 to help states meet data collection and reporting requirements of the Social Security Act. SACWIS continues to fund half the maintenance costs for FACTS.

The data indicators for FACTS include demographic information, identified problems, screening data, level of care recommendations, service providers, and service utilization and cost data. The system includes a service admission form (with specific goals), screening information, treatment progress notes, and service plans. Care managers become familiar with a newly-assigned case by reviewing FACTS data (e.g., the service admission form includes previous service history, previous contacts with child welfare and/ or juvenile justice, and whether the child is active now in either system). Although behavioral healthcare providers develop treatment plans that are not entered into FACTS, they are expected to incorporate the service plan goals that appear in FACTS into their treatment plan. In addition, the service plan is used for service authorization, and counselors from the child welfare and juvenile justice divisions are able to access the progress notes for children who are on their caseloads. Multi-division access to client data is designed to enhance service integration for the child and family receiving services.

In addition to its use as a management information system, FACTS is also a care management tool. Care managers receive automatic reminders of due dates for Progress Reviews, Clinical Necessity Reviews (certification of medical necessity), etc. Delinquency reports are sent to supervisors on a regular basis.

In Delaware, the **Division of Child Mental Health Services** (**DCMHS**) serves as the managed care organization for children in the public sector who use more than a basic behavioral health benefit (defined as 30 hours of mental health and/or substance abuse services annually). Providers who are members of the Division's provider network submit data to FACTS on a monthly basis and receive a bundled case rate of $4,239/client/month. If data are not submitted on a client, the provider does not receive payment for that client.

DCMHS uses FACTS to submit cost recovery claims to Medicaid. The division receives division-wide reports and team-level reports on cost and service utilization from FACTS on a quarterly basis.

FACTS data entry is PC (personal computer) based. According to users, data entry is easy, and it takes about 20 minutes to enter data on a new child. Data can be submitted 24 hours a day, 7 days a week, including through a remote access *CITRIX* system. Delaware is exploring transition to a web-based format using the *Enterprise* system, however there are concerns about confidentiality of data. There are routine reports for use in system management and there is also an ad hoc reporting capability where staff and providers can request specific or one-time reports from FACTS but the process is slower than desired due to the limited number of staff who have the training and experience to query the system. Providers can request a limited number of reports from FACTS, but the process reportedly is cumbersome.

FACTS is available free-of-charge to other states and communities. In Maryland, juvenile justice uses FACTS as its MIS system.

Advice to other states and communities regarding data management systems:

- Make the system PC-based for data entry and distributed via a client server system which is not dependent on Local Area Networks.
- Include an easy way for users to correct errors and maintain database integrity.
- Get advice from potential users during system development.
- Make sure that users can easily retrieve data and reports.
- Provide training and support to users during implementation.
- Include funds for a maintenance budget (e.g., funds are needed to make FACTS compliant with the new HIPAA requirements).

II. Types of System Performance Information Collected and Tracked

The findings of the *2000 State Survey* are consistent with previous survey findings with regard to the types of performance indicators most likely to be tracked by public managed care systems. These indicators are: (1) service utilization, (2) access (measured by child behavioral health penetration rates), and (3) total cost of child behavioral health services. Carve outs are similar to integrated systems in the rate at which they track service utilization and penetration. However, there is a dramatic difference in the rate at which they track the cost of children's behavioral health services. As shown in **Table 3**, nearly all carve outs (96%), but very few integrated systems (21%), track the total cost of children's behavioral health services. Also, carve outs are more likely to track the service utilization of children involved in the child welfare system.

Table 3 Percent of Reforms Tracking and Using Various Types of System Performance Information				
	2000			
System Information	**Not Tracked**	**Carve Out**	**Integrated**	**Total**
Child behavioral health penetration rates	15%	86%	83%	85%
Child behavioral health service utilization	0%	100%	100%	100%
Child behavioral health service utilization by culturally diverse group	25%	79%	60%	75%
Behavioral health services utilization by children in child welfare	26%	78%	50%	74%
Behavioral health services utilization by children in juvenile justice	54%	45%	50%	46%
Total aggregate cost of children served with behavioral health services	7%	96%	21%	93%
Cost per child served with behavioral health services	21%	87%	50%	79%
Cost shifting among child-serving systems	84%	13%	25%	16%

The two system-level performance indicators least likely to be tracked by managed care systems reportedly are service utilization by children in the juvenile justice system, tracked by fewer than half of the reforms (46%), and cost shifting among child serving systems, tracked by only 16% of the reforms. Despite the low rate of systematic tracking of cost shifting, allegations of cost shifting resulting from managed care reforms have been widespread and were made by stakeholders in both the 1997 and 1999 impact analyses as well as being reported in the *2000 State Survey*.
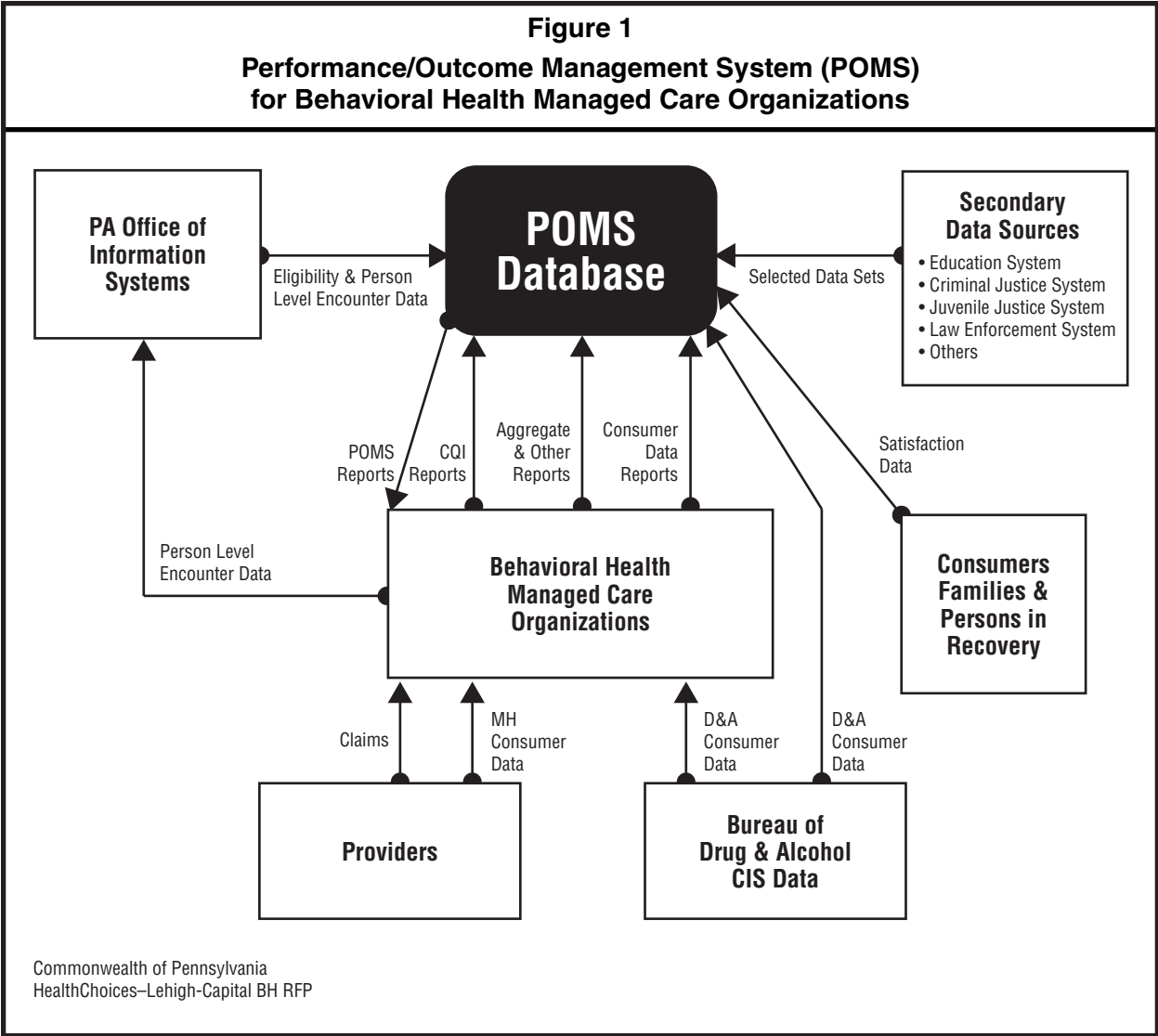
Although the few systems that reportedly collect information on cost shifting use the information for system planning, data collected for most of the other performance indicators is used for system planning in only about one-third to one-half of the reforms. The *1999 Impact Analysis* also found that few data were available in states in the sample, despite reports that performance information was being collected. Furthermore, the *2000 State Survey* indicates a gap between information that is tracked and information that is used for system planning, and a continuing problem in the capacity of managed care systems to generate data in a format and time period that is helpful for planning and decision-making.

Promising Approaches in Tracking System Performance Information

- ## Pennsylvania's Performance/Outcomes Management System (POMS)

  HealthChoices is Pennsylvania's statewide Medicaid managed care program that is being implemented in stages across the state. The goals of HealthChoices are to improve access to care, quality of care, continuity of care, and management of scarce Medicaid resources. Behavioral health services are administered and financed separately from physical health through a behavioral health carve out. Counties have the right of first opportunity to act as their own managed care entity through a contractual arrangement with the state **Office of Mental Health and Substance Abuse Services**. Counties may choose to subcontract managed care functions to nonprofit or commercial organizations.

  The state Office of Mental Health and Substance Abuse Services has created a performance monitoring system, tied to a **Continuous Quality Improvement** (**CQI**) process. The **Performance/Outcomes Management System** (**POMS**) consists of a database that is updated on a periodic basis through batch data file extracts that are obtained from a variety of data sources, including encounter data, enrollee eligibility and demographic data, consumer/family satisfaction reports, behavioral health organizations' quarterly status files, and performance indicator reports. Work has begun to obtain secondary data through data exchange agreements with other state agencies, as feasible, such as the education system and the juvenile justice system (see **Figure 1**).

Figure 1
Performance/Outcome Management System (POMS)
for Behavioral Health Managed Care Organizations

Commonwealth of Pennsylvania
HealthChoices–Lehigh-Capital BH RFP

The POMS serves three primary functions:

- Provides accountability for public funds expended through the State's capitation payments to the behavioral health organizations (BHOs)
- Provides a fair and objective evaluation of the BHOs that can be used for outcome-oriented incentives and sanctions
- Supports the Department and the BHOs in the implementation of a collaborative continuous quality improvement process

The integrated database provides the basis for producing quantitative performance indicators related to the following system-level outcomes:

- Increase community tenure and less restrictive services
- Increase vocational and educational status
- Reduce criminal/delinquent activity
- Improve health care

- Increase penetration rates
- Increase consumer/family satisfaction
- Implement continuous quality improvement actions
- Increase the range of services and improve utilization patterns

Each outcome is measured by a set of performance indicators. For example, the outcome regarding increasing vocational and educational status is measured by the following indicators: (1) increasing school attendance, (2) increasing school retention, (3) increasing school performance, and (4) improving school behavior.

The POMS is used for a number of purposes, including production of an **Early Warning** monitoring system. The Early Warning system is a quarterly report that compares all HealthChoices counties with one another on a number of quality indicators and reports on quarterly trends on a statewide basis. The indicators include:

- Rates of authorization by service categories
- Percent of members with a service denial
- Grievances
- 30-day inpatient readmissions
- Service authorizations for racial minorities
- Feedback from stakeholders (consumers, family members, providers, organizations)

• HealthChoices in Allegheny County, Pennsylvania

The Department of Human Services in Allegheny County subcontracts with two entities, **Allegheny HealthChoices** and **Community Care Behavioral Health**, for the administration and operation of behavioral health managed care. The County is responsible for governance, financial risk, and administrative oversight of program operations. Community Care provides the managed care functions for the County, with an emphasis on management of high risk and priority populations. Community Care also assumes financial risk on behalf of the County. The role of Allegheny HealthChoices is to monitor the performance and outcomes of the managed care functions performed by Community Care.

Allegheny HealthChoices and Community Care share responsibility for the tracking and monitoring of system performance indicators. Allegheny HealthChoices tracks and analyzes program trends in the areas of: health outcomes; consumer and family satisfaction; quality of service; provider performance; financial management and outcomes; and coordination of care. Data sources include: claims data; complaints and grievances; ombudsman activities; consumer/family satisfaction data; clinical/fiscal chart audits; and focus studies of special topics. Quality measures for children include: access standards (different requirements for various children's services); average length of stay in intensive services; utilization family-based services as an in-plan alternative; and the quality of treatment and discharge planning.

Community Care has developed a **Children's Team**, which oversees the entire spectrum of services for children and adolescents. The team's mission includes communication and collaboration with child serving systems, maintaining children in the least restrictive and least intrusive environment, and securing the safety and needs of all children. Its decision-making process is based upon Pennsylvania's medical necessity

criteria and the application of the system of care principles of child-centered, family-focused, community-based, multi-system, culturally competent, and least-restrictive environment. Managed care strategies used by the Children's Team of Community Care include care management, a physician advisor review process, team approval of new programs and services, the development of performance standards for levels of care, provider meetings and training, utilization management, and quality reviews. For example, the monitoring plan for children's behavioral health rehabilitation services includes the use of outcomes data through the Columbia Impairment Scale, review of monthly reports of service utilization, and quality reviews.

• Iowa's Monitoring Plan for Performance Indicators

In 1999 Iowa's Medicaid agency and the Department of Public Health integrated two separate carve outs for mental health and substance abuse services into one statewide behavioral health care program, the **Iowa Plan for Behavioral Health**. The two state agencies contract with one for-profit managed care organization on a prepaid capitation basis to provide comprehensive mental health and substance abuse services statewide.

The Iowa Plan for Behavioral Health contract for fiscal year 2003 includes a set of performance indicators that are divided into three broad categories: (1) indicators with monitoring only, (2) indicators carrying financial incentives, and (3) indicators with financial penalties. The performance indicators that are "monitored only" (i.e., without fiscal incentives or penalties) fall within the domains of: (1) consumer involvement and quality of life, (2) network management, (3) access and array, (4) quality and appropriateness, (5) integration and interface, (6) quality of care, and (7) administrative accountability. Examples of performance indicators with monitoring only are:

- Consumer satisfaction surveys shall be conducted at least two times per contract period.
- 98% of all enrollees who request any Iowa Plan service will be offered a service.
- The number of Iowa Plan enrollees, reported overall and separately for children and adults, for whom wraparound and rehabilitation and support services were provided during the month.

 For each of the nine performance indicators carrying financial incentives, the contract specifies the annual dollar amount the contractor shall be paid if the indicator is attained ($110,000 to $120,000). Examples of performance indicators with financial incentives are:

- The percent of involuntary admissions for mental health treatment to 24 hour inpatient settings shall not exceed 20% of all children admissions and 15% of all adult admissions.
- Based on claims during the contract period, the contractor shall provide services to at least 13.5% of Iowa Plan enrollees.
- At least 4.5% of mental health service expenditures will be used in the provision of integrated services and supports, including natural supports, consumer run programs, and services delivered in the home of the enrollee.

For the 10 performance indicators with financial penalties, the state assesses damages if the contractor fails to comply with the minimum performance expectations for any two quarters in a contract period. The first occurrence of non-compliance for a performance

indicator is assessed a penalty of $5,000, the second occurrence penalty ranges from $10,000 to $25,000, and the penalty for a third occurrence is either $15,000 or $50,000. Performance indicators with financial penalties include:

- The percentage of enrollees under the age of 18 discharged from a mental health inpatient setting to a homeless or emergency shelter shall not exceed 3% of all mental health inpatient discharges of children under the age of 18.
- The contractor shall arrange or participate in at least 20 Joint Treatment Planning conferences per month.
- Medicaid claims shall be paid or denied within the following time periods:
  - 85% within 12 calendar days
  - 90% within 30 calendar days
  - 100% within 90 calendar days

The perception of the Iowa Plan administrators is that the use of financial incentives and penalties tied to performance indicators in the managed care contract has a number of advantages. First, the performance indicators provide an opportunity for the managed care organization to influence provider behaviors. Second, the indicators direct attention of the managed care organization and the provider network to client outcomes. Third, spending levels can be monitored because the percentage of services offered that are authorized is reported on a monthly basis. Finally, the data that are collected regarding the performance indicators are useful in refuting myths about both process and outcomes.

Advice to other states and communities regarding tracking system performance information:

- Know what performance outcomes and indicators you want to collect before the system is implemented.
- Make sure that the performance indicators include what is needed for waivers and other administrative requirements.
- Re-organize at the state level one year before implementation so that the infrastructure (e.g., Management Information System) is in place.
- Engage all stakeholders (advocates, county government, legislators, consumers/families, and providers) early in the development process.
- Recognize that performance outcomes systems can be burdensome and time-intensive for providers.
- Develop a strategy for providing feedback to MCOs, providers, and parents.
- Commitment to quality improvement entails resources for increased personnel and different skill sets.
- Be cautious about making changes post-implementation in system level performance outcomes.
- Define each indicator with the managed care organizations, including data elements (numerator and denominator) and the data source.
- Recognize and address the challenge of balancing quality and cost.

III. Measurement of Clinical and Functional Outcomes

The *2000 State Survey* found a continuing increase in the measurement of child-level clinical and functional outcomes related to children's behavioral health in managed care systems. As shown in **Table 4**, the percentage of systems that reportedly measure child outcomes related to children's behavioral health increased from 52% in 1995, to 63% in 1997-98, and to 90% in 2000.

	1995 Total	1997–98 Total	2000 Carve Out	2000 Integrated	2000 Total	Percent of Change 1995 –2000	Percent of Change 1997/98 –2000
Table 4 **Measurement of Clinical and Functional Outcomes in Managed Care Systems Related to Children's Behavioral Health**							
Managed care reform measures clinical and functional outcomes	51%	63%	96%	71%	90%	+39%	+27%
Managed care reform does not measure clinical and functional outcomes	49%	37%	4%	29%	10%	-39%	-27%

Despite the steady increase in reforms measuring clinical and functional outcomes, the findings of the impact analyses indicated that the outcome measurement systems in most managed care systems were at an early stage of development. The early developmental stage is still evident in the *2000 State Survey*.

As shown in **Table 5,** only about one fourth (26%) of the reforms (all carve outs) have results from their outcome measurement systems. Another 26% described their outcome measurement systems as implemented, but with no results available yet. Finally, in 44% of the reforms, outcome measurement was described as being at an early stage of development, and an additional 4% reported that the system was developed but not yet implemented. Carve outs reportedly are ahead of integrated systems in the measurement of children's behavioral health clinical and functional outcomes. More integrated systems are at early stages of this process or have outcome measurement systems but no results as yet.

Table 5 Stage of Development of Measurement of Clinical and Functional Outcomes			
	2000		
	Carve Out	**Integrated**	**Total**
In early stage of developing measurement system	41%	60%	44%
Developed but not yet implemented measurement system	5%	0%	4%
Implementing measurement system but do not yet have results	23%	40%	26%
Implementing measurement system and have results	32%	0%	26%

Promising Approaches in Measurement of Clinical and Functional Outcomes

• The Dawn Project, Marion County (Indianapolis), Indiana

The Dawn Project is a behavioral health carve out serving children who have serious emotional problems in Marion County, Indiana. The target population includes children who are involved in at least two child-serving systems, are at risk of or in residential placement, and have serious functional impairments at home, in school, and in the community. Several state and county agencies contract with **Indiana Behavioral Health Choices**, a non-profit managed care entity, to administer the Dawn Project's performance information system as well as the clinical and financial processes. Choices uses an individualized, strengths-based approach to serve children and families, using child and family teams and a community resource network.

Choices has developed a technological infrastructure that provides fiscal and clinical accountability to its key stakeholders, including payers, providers, and children and families. In 1999, Dawn worked with an **Outcome Committee** of its Community Consortium to develop a set of performance indicators and outcome measures. After using these indicators for a three-year period, there was agreement that some outcomes were difficult to measure. The Outcome Committee re-convened to examine outcome definitions and measures, data collection, and data interpretation. In February 2002 the Dawn Project adopted a new set of performance indicators, including clinical and functional outcomes. The organizing framework for the new outcome measures is made up of the following goals:

- Provide high quality care that results in improved outcomes for the child and family
- Include parents/families in decision-making
- Decrease the cost of serving children with the most disturbed and disturbing conditions in Marion County
- Be accountable to all stakeholders

Table 6 shows the clinical and functional outcomes for the first goal noted above. As shown in **Table 6**, a set of outcomes defines each goal, and performance indicators measure progress towards each outcome.

Table 6 The Dawn Project: Outcome Measures			
Goal #1:	**Provide high quality care, which results in improved outcomes for the child and family.**		
I. Improved child and family functioning			
	A.	**Improved school functioning**	
		1.	Grade reports, attendance reports, behavior reports, suspension/expulsion reports
		2.	The Clinical Manager Treatment Plan level rating
	B.	**Improved records with the child welfare and the juvenile justice system**	
		1.	Percent of families with no further substantiated incidences of child abuse or neglect, which results in removal of the child from the home during involvement.
		2.	Percent of families with no further substantiated incidences of child abuse or neglect, which results in removal of the child from the home for a period of six and twelve months from disenrollment.
		3.	Percent of children with no further incidences of delinquency, runaway or truancy charges, or violation of terms of probation which results in placement failure during enrollment.
		4.	Percent of children with no further incidences of delinquency, runaway or truancy charges, or violation of terms of probation which results in placement failure for a period of six and twelve months from disenrollment.
	C.	**Improved records for community supervision for Department Corrections youth**	
		1.	Number of youth with arrests for offenses more severe than original offense
		2.	Number of youth with arrests for offenses less severe than original offense
		3.	Number of youth with technical violations other than for placement
		4.	Number of youth with technical violations that include placement failure
		5.	Number of youth with technical violations for placement failure only.
		6.	Number of youth with arrests in first year after disenrollment.
	D.	**Improved CAFAS scores**	
		1.	Measured with CAFAS at intake, every six months, and discharge
	E.	**Progress in Service Coordination Plan**	
		1.	Measured by monthly team report and The Clinical Manager Treatment Plan level rating
	F.	**Fewer days in out of home placement**	
		1.	Measured by Dawn national evaluation placement data
II. Increased family autonomy			
	A.	**Decrease in number of paid providers**	
		1.	Measured by service usage and payment data
	B.	**Caregiver Strain Questionnaire**	
		1.	Measured by Questionnaire at intake, every 6 months until discharge, and12 months after discharge

In the Dawn Project, data collection is the responsibility of the Service Coordinators. Service Coordinators input data (demographics, case history, treatment plans, progress notes) into *Clinical Manager*, a software program that serves as both a clinical medical record and a fiscal record. Each Service Coordinator has a desktop computer, and each supervisor has two laptop computers available for the unit. For those Service Coordinators who prefer to do data entry out of the office, laptops can be signed out and data entry accomplished through a dial-up system.

There are several characteristics of the Dawn Project that help to ensure accurate and timely data:

- Data entry is addressed in the productivity standards for the Service Coordinators, partly because the Progress Notes are used to bill Medicaid and other payers.
- The model is supervisory-intensive (7: 1). Caseloads are relatively small (8 to 10).
- Supervisors review treatment plans weekly with the Service Coordinators, and a psychiatrist reviews plans every 60 days.
- Service Coordinators are observed "in action" on a quarterly basis.
- Supervisors are responsible for pre-authorization of services and for managing their unit's budget.
- Supervisors recognize the value of "real-time data" as a management tool.

Advice to other states and communities regarding clinical and functional outcome systems:

- Clinical and functional outcome measurement is always a "work in progress." A system needs to be in place for continuous review and modification.
- Key stakeholders need to be involved in the development and monitoring of clinical and functional outcomes. Families, for example, need to be asked what is important for them regarding their child's progress.
- Incentives need to be in place that facilitate and support data collection.
- Data need to be available for quality assurance, management, and planning activities.

IV. Quality Measurement

The *1997–98 State Survey* found that the majority of managed care systems (88%) incorporate some child-specific quality measures related to behavioral health, with carve outs more likely to do so than reforms with integrated designs. The majority of reforms responding to the *2000 State Survey* also reported including some child-specific measures related to behavioral health in their quality measurement systems (71%), although this represents a 17% decrease in reforms with child-specific quality measures (see **Table7**).

	1997–98 Total	2000			Percent of Change 1997/98–2000
		Carve Out	Integrated	Total	
Managed care system incorporates child-specific behavioral health quality measures	88%	74%	57%	71%	-17%
Managed care system does not incorporate child-specific behavioral health quality measures	12%	26%	43%	29%	+17%

Table 7
Percent of Reforms Incorporating Quality Measures Specific to Child and Adolescent Behavioral Health Services

The Tracking Project has also identified the methods that states use to measure quality. The *1999 Impact Analysis* identified the following processes:

- On-site reviews and audits of MCOs
- Focus groups with consumers and family members
- Report card with standard indicators for each MCO, enabling comparisons among MCOs
- Committees and work groups focusing on quality
- Review and analysis of grievances, appeals, and complaints
- Requirements that each MCO develop and implement its own quality measurement and improvement process
- Contract with external entity to conduct quality reviews and studies

Promising Approaches in Quality Measurement

• Utah's Prepaid Mental Health Plan

Utah operates one Medicaid managed care carve out program for mental health services, known as the **Prepaid Mental Health Plan**, for TANF, disabled populations and medically needy individuals residing in 25 of its 29 counties. The state Medicaid authority has sole-source contracts with eight Community Mental Health Centers using a capitation payment method. Each PMPH subcontracts with hospitals for inpatient psychiatric care, and to varying extents, with community providers for outpatient mental health services.

Utah's quality monitoring approach includes a children's team that visits each PMHP annually. For a sample of clients, team members review records, meet with staff, and meet with families to assess the quality of care. During the development of the monitoring process, the Division of Mental Health contracted with **Utah Allies as Families**, the statewide family organization and Utah's chapter of the **Federation of Families for Children's Mental Health**, to develop a survey instrument for interviewing families. The family organization worked with a children's mental health researcher to develop and validate the instrument, known as the **Family Perception of Care Scale**. Initially, Families as Allies was subcontracted to conduct the site visits, including interviewing parents and administering the survey. Survey data were analyzed and reported for each PMHP and on a statewide basis. The Division of Mental Health subsequently developed a similar survey instrument. Currently family members are members of the monitoring teams and the revised survey instrument is used for family interviews.

• Delaware County's Family Satisfaction Team

As noted earlier about Pennsylvania, in **HealthChoices Behavioral Health Services**, counties operate Pennsylvania's behavioral health managed care system. Counties have the choice of either subcontracting with a private sector BHO or forming their own nonprofit managed care organization to manage care for both mental health and substance abuse services. Each managed care entity is responsible to implement a comprehensive approach for the measurement of consumer and family satisfaction, including a **Family Satisfaction Team Program**.

In Delaware County, Pennsylvania the county Department of Human Services subcontracts with **Magellan Behavioral Health** to perform the managed care functions. The county's Office of Behavioral Health and Magellan have developed a **DelCare Quality Improvement Plan for HealthChoices**. Evaluation of consumer and family perceptions and experience is a critical component of this quality improvement process. The county Office of Behavioral Health subcontracts with the **Parents Involved Network** of the **Mental Health Association of Southeastern Pennsylvania** for the operation of the Family Satisfaction Team.

The Family Satisfaction Team is composed of a team leader and three family members. The team assesses family satisfaction with service delivery and the process for accessing the services. The team's motto is, "evaluating satisfaction through family interaction," and its goal is to ensure that services provided to children and adolescents are child-centered and family-driven. The process developed by the team focuses on surveying parents who have recently participated in an interagency service planning team meeting. The domains covered by the survey include: (1) provision of information to families beforehand regarding the interagency team meeting process, (2) whether the family felt comfortable during the meeting, (3) quality of the assessment and service plan, and (4) the accessibility of the meeting. Findings from the survey are compiled and reported on a regular basis to Magellan, the County, and providers. As a result of this process, the following actions have taken place:

- Providers have developed methods to ensure that families can bring an advocate and/or support person to team meetings.
- Meetings are scheduled at times convenient for the family.
- Magellan has taken steps to ensure that the same care manager follows an assigned child throughout treatment.

Resources

More detailed information about each of the accountability approaches described in this paper can be obtained from the following individuals:

Allegheny County, Pennsylvania

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Delaware

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Iowa

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Dawn Project

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Utah

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North Salt Lake, UT 84054
Phone: (801) 292-2515
Email: awfamilies@msn.com

Delaware County, PA

Christina Corp
Delaware County Parents Involved Network
135 Long Lane, 3rd Floor
Upper Darby, PA 19082-3116
Phone: (610) 713-9401
E-mail: ccorp@mhasp.org

The following national groups and organizations have useful information and resources in the areas of accountability and quality assurance in managed care systems.

The Children's Mental Health Benchmarking Project

The goal of this project is to gather, compare, and disseminate administrative data from states and counties so that policymakers can compare their own locality to others in regard to certain key indicators. The project focuses on developing indicators in the domains of access, utilization, expenditures and intersystem involvement.

Contact Information:

Richard H. Dougherty
Dougherty Management Associates, Inc.
(721) 865-8003
E-mail: public@doughertymanagement .com
Web: http://www.doughertymanagement.com/

Outcomes Roundtable for Children and Families

The mission for the Outcomes Roundtable is to bring together multiple perspectives and expertise to provide leadership that stimulates culturally competent and data driven improvement in policy, practice, and research for children and youth with emotional and behavioral problems and their families. The current focus is the development of an appropriate outcome accountability system within child service systems.

Contact Information:

Ann Doucette
E-mail: adoucette@aol.com

Trina Osher
E-mail: tosher3@comcast.net

The Forum on Performance Measures in Behavioral Healthcare and Related Service Systems

The purpose of the Forum is to facilitate common approaches to the development, testing, and adoption of performance measures in behavioral healthcare and related services. The Forum provides a venue for collaboration, coordination, and communication among various initiatives, both public and private, which are working to measure service access and delivery, quality, and outcomes.

Contact Information:

John Bartlett
(404)942-3616
E-mail: johnbarlett@performancemeasures.org

Appendix

All reports of the HCRTP are available from the Research and Training Center for Children's Mental Health, University of South Florida (813) 974-6271:

Armstrong, M. I., (2002). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems – 4: Accountability and quality assurance in managed care systems.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #211-4)

Hepburn, K. & McCarthy, J. (2003). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems – 3: Making interagency initiatives work for the children and families in the child welfare system.* Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development. (Georgetown University Publication #211-3)

McCarthy, J. & McCullough, C. (2003). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems – 2: A view from the child welfare system.* Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development. (Georgetown University Publication #211-2)

Pires, S.A (2002). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems – 1: Managed care design & financing.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #211-1)

Stroul, B.A., Pires, S.A, & Armstrong, M.I. (2001). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families – 2000 State Survey.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #198)

Pires, S.A., Stroul, B.A., & Armstrong, M.I. (2000). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families – 1999 Impact Analysis.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #183)

Pires, S.A., Armstrong, M.I., & Stroul, B.A. (1999). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families – 1997/98 State Survey.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #175)

Stroul, B.A., Pires, S.A., & Armstrong, M.I. (1998). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families – 1997 Impact Analysis.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #213)

Pires, S.A., Stroul, B.A., Roebuck, L., Friedman, R.M., & Chambers, K.L. (1996). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families – 1995 State Survey.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #212)

The following special analyses related to the child welfare population are available from the National Technical Assistance Center for Children's Mental Health, Georgetown University (202) 687-5000:

McCarthy, J. & Valentine, C. (2000). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families – Child Welfare Impact Analysis – 1999.* Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Schulzinger, R., McCarthy, J., Meyers, J., de la Cruz Irvine, M., & Vincent, P. (1999). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families – Special Analysis – Child Welfare Managed Care Reform Initiatives.* Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

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