American College of Mental Health Administration

ACMHA ARM CHAIR REFLECTIONS

The First Santa Fe Summit

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A Little Context

As a relatively new member of ACMHA, still starry-eyed in the company of such impressive leaders in the field (How DID I slip in?), I was honored to be asked to be program chair for the 1997 annual meeting of the College. This responsibility also came with membership on the Board of Directors, so I was doubly honored. Imagine my dismay at attending my first board meeting, at which it was made abundantly clear that the College's financial health—if not survival—depended on a successful '97 conference. No pressure.

Falling back on the tried-and-true practice of success, I sought out the brightest colleagues in ACMHA to serve as the planning committee and stayed out of their way. The result was the first Santa Fe Summit on Behavioral Health. The idea was to create a brand around a place, using the model of the Jackson Hole Group, and Santa Fe was the chosen venue. So far, the idea (for which credit goes to Emeritus Fellow Stu Gertner and current Fellow Sheila Baler) has proven quite prescient.

At the time, managed behavioral health care was on its ascent and there was energetic conversation about its positives and downsides. Wishing to stake out a special territory for ACMHA, we sought through this first Summit – and in succeeding years enhanced the notion – of serving as "neutral conveners" of opinion- and thought-leaders in the field. The theme for the first Summit: *Preserving Value and Quality in the Managed Care Equation.*

A Word or Two About Process

ACMHA's annual meetings had always had two important features: top quality content presentations and significant networking and mutual support opportunities. (The College was accurately described to me—I believe by sage HG Whittington as a "self-help group for bureaucrats.") We didn't want to tamper with that success, so we designed the meeting around focused presentations and then task oriented small groups to take advantage of the brain power in attendance. One of the most distinctive features of the meeting—made possible in large measure from the tireless work of Betty Downes—was the creation of a draft document reflecting on the deliberations of the Summit that was handed out at the closing session. (Note: do not try this at home.) As planners, we felt it was a successful meeting, although there are some who feel that we unleashed a fearsome genie from the bottle when we coerced participants into working so hard at the first Summit, setting a precedent that continues to this time. Subsequent to the meeting in Santa Fe, a small group worked to flesh out the draft

report, organize the findings, and create a more robust narrative. The meeting generated quite a bit of buzz in the field and there was quite high anticipation for the release of the report. To ensure that the report was as useful as possible the work group chairs, key ACMHA leaders, and a group of consumer leaders met a few months after the Summit to review the work in progress and to make recommendations for subsequent revisions. This work was done, which delayed the release until February 1998, wrecking our original and very aggressive timelines, but resulting in a much stronger and more polished product. It was released as the ***Final Report of the Santa Fe Summit '97: Preserving Quality and Value in the Managed Care Equation*** (February 1998) and is available from ACMHA at http://acmha.org/summit/download_1997.cfm.

Starting With Values

A core assumption of the meeting's design was that any effort to preserve quality and value in the managed care equation (and, frankly, in virtually any environment) is predicated on the ability to measure performance. The meeting and subsequent report identified a set of "core value themes" that should drive any considerations of quality and performance measurement for behavioral health; these value statements were adopted by ACMHA and were used as guideposts in the next Summit. Although there are eight, the first three are the sentinel ones: (1) consumers and families are at the core of performance measurement; (2) consumer/customer choice must be a driving value for all systems of care, including their design, delivery, evaluation and accreditation; and (3) issues of ethnicity, race, age and developmental status, gender, language, culture, spirituality, and disability are consciously addressed in ensuring access and availability of services.

As I reflect on them more than a decade later, they still look relevant and useful as guideposts. The key thing that stands out is the absence of the words "recovery" and "resilience." While the values are consistent with recovery principles, the language would be different today. There would also be greater emphasis on wellness and health promotion; at the Summit and in the final report, this was dealt with in a separate section on prevention.

A Set of Key Indicators

Partially guided by the classic Donabedian model that focuses on process, outcomes, and structure, we broke out the notion of "access to care"—which might have been considered as part of process—as a critical variable to highlight for work in behavioral health, especially in managed environments. Under outcomes, the report identifies three indicators for all adults with behavioral health concerns and five additional outcome indicators for persons with serious and persistent mental or substance use conditions. They focus, as the values would dictate, around choice, work, and social inclusion.

The work identified seven process indicators, several of which revolve around consumer involvement in all phases of engagement with treatment systems. The indicators specifically address "voluntary, non-coercive" services.

For the domain of access, the report identifies six indicators which seek to quantify and track such elements as service denials, timeliness, and appropriateness of services (i.e., the services that the person or family wished to have).

And finally, for structure, there are nine indicators in the report ranging from staffing levels to data security to consumer education.

Special Considerations for Children and Youth
While there was significant effort devoted to choosing indicators that "worked" for both adults and youth, ACMHA sought additional work in the area of youth-specific indicators and this work was included as a special chapter in the final report. This ancillary work identified eight value statements, selected indicators for each, and specified measures for them.

Prevention

Historically, the field of mental illnesses treatment has not devoted much energy to the issue of prevention; this is much less true of field of substance use conditions, which has a lengthy history and robust literature on prevention. At the Summit it was identified that the National Mental Health Association (now Mental Health America) had already begun a process to identify indicators for prevention. ACMHA wisely chose not to reinvent the wheel and accepted and published the MHA work in its final report.

Was There Any Impact?
The report was widely circulated and a number of people involved made presentations in a variety of settings—national conferences, work groups, and sector-specific meetings. The work was both informed by and helped to inform the ongoing Mental Health Statistics Improvement Project sponsored by the Center for Mental Health Services. But probably the most significant impact was a multi-year effort involving the five major accrediting organizations.

An Ambitious Undertaking
With ACMHA leadership, a working group of representatives from CARF, the Council on Accreditation for Children and Family Services (CoA), the Council on Quality and Leadership in Support of Persons with Disabilities, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), and the National Council on Quality Assurance (NCQA) met quarterly over a period of nearly four years to hammer out a consensus set of performance indicators among the organizations. It was a remarkable process that was characterized by genuine collegiality and candor, lively debate and hard-fought positions, great meals, and a common sense of commitment to improving the quality of services. The work product (*Interim Report: A Consensus Set of Performance Indicators for Behavioral Health* available from the College at http://acmha.org/publications/acmha_20.pdf) was published as an "interim report" in the hopes that funding could be secured to push the work further. As is often the case with really good ideas in our field, that was not to be, and the "interim" report has become something much closer to "final." This final/interim report picked up where the initial Summit report left off, incorporated much of that work, and moved the dial significantly in an arena that has lasting impact: accreditation. And it did so across the traditional silos that separate populations by age and diagnosis.

Hope Springs Eternal
I confess that I had expected much more than the field has been able to achieve in the intervening 12 years since that first Summit. Not only have we not moved nearly as far or as fast as many of us dared to hope, some of the basic infrastructure (especially data systems) remains inadequate to the challenge of collecting relevant data and applying it to metrics that

make sense as genuine indicators of quality. This is not to deny real progress, but more to lament the distance yet to be traveled. I believe that subsequent Summits (which also yielded lasting impacts) have highlighted some of the reasons that progress has been slower than hoped: the lack of consistent practice guidelines (1999), training and education (2000), and financing (2001) to name but three. In the intense environment of the current fiscal crisis, with a new president considering major changes to the healthcare non-system, there is renewed awareness of the importance of spending every scarce healthcare dollar in ways that actually work for consumers of healthcare. If we are wise, behavioral healthcare will be part of these reforms and we will focus on measurable improvements in the quality of services that are provided, and hence improve the quality of life of people who need those services.