AMERICAN COLLEGE OF MENTAL HEALTH ADMINISTRATION

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FINANCING RESULTS AND VALUE IN BEHAVIORAL HEALTH SERVICES

American College of Mental Health Administration

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THE AMERICAN COLLEGE OF MENTAL HEALTH ADMINISTRATION

Financing Results and Value in Behavioral Health Services

May 12, 2003

PREAMBLE

This paper was originally conceived during the March 2001 American College of Mental Health Administration's Santa Fe Summit on Financing for Results. That Summit explored the issues surrounding financing of behavioral health services in the public sector, specifically within the specialty behavioral health arena. The Summit was held prior to the events of 9/11/01 and prior to the economic recession that has engulfed the United States and that has resulted in 47 of 50 states facing severe economic crises as of the final writing of this paper. The Summit and the majority of the writing on this paper also occurred prior to the implementation of the President's New Freedom Commission on Mental Health that has begun to highlight the fragmentation of financing streams for public and private behavioral healthcare.

These changes and conditions have profoundly affected our nation and the financing of behavioral health in this country. In addition to affecting the priorities and the amount of funds available, these conditions have raised significant questions about the isolation of behavioral health as a specialty system and have caused behavioral health care leaders to begin considering how leadership in behavioral healthcare finance will have to change to meet the times. These changes will of necessity require that behavioral healthcare leaders understand how public and private financing mechanisms interact and how behavioral healthcare leadership will have to span multiple systems and financing streams now more than ever. Other systems such as child welfare, corrections, juvenile justice, Medicare, Medicaid and public schools are increasingly funding and providing behavioral healthcare for the same people as those served in the behavioral healthcare specialty arena – and more.

These issues are beyond the scope of this paper, but may in fact be the subject of discussion and dialogue among ACMHA members in near future years. This paper is a reflection of a prior era that has almost passed in a frighteningly short time, and yet is a product that can benefit leaders facing new times. Even acknowledging the huge changes that have occurred since the initial Summit discussions, the call to action is even more critical now than two years ago. Understanding how financing mechanisms work, what they create and what they cause is essential if we are to make the most of increasingly limited and increasingly complex resource streams in today's healthcare market.

I. INTRODUCTION – WHY A PAPER ON FINANCING FOR RESULTS AND VALUE?

The American College of Mental Health Administration (ACMHA) consists of consumers, family members, clinicians from all disciplines, academicians, researchers, attorneys, family members, public policy-makers and analysts, business leaders and advocates – all of whom are engaged in issues or the practice of administration of behavioral healthcare programs. This paper is a product of ACMHA's commitment to the discussion and debate of issues affecting quality in the delivery and administration of behavioral health services in the United States, and to helping the field of behavioral healthcare administration move from controversy to consensus.

This commitment has taken the form of a series of Summits, held annually in Santa Fe, New Mexico, over the last five years (see Appendix A). These Summits bring together public and private behavioral health administrators from across the country and from all sectors and guilds in order to identify issues and reach consensus about concepts, changes or products to improve the field of behavioral health. Each Summit has built on the one before, and each has resulted in a deepened understanding in the field of the barriers and the possibilities in this time of change and in the context of a health care field increasingly committed to managing and improving the quality and outcomes of care.

Critical Questions

Several critical questions emerged from the March 2001 ACMHA Santa Fe Summit entitled Financing for Results:

1. If we want to buy prevention, outcomes and recovery, then why do our current fund sources buy units, episodes, programs and "heads" (via capitation)?

2. If we want to buy organized systems of care and care that is individually designed and recovery based, then why do we continue to fund individual providers for units of service rather than systems of care, or individual consumers for individually based results?

3. How do expenditure patterns affect service delivery patterns?

4. Do we need more money in addition to "better" money?

5. Are there payment mechanisms that are more conducive to getting good results than others? And what are the barriers to their use?

6. Who decides what "good results" are for a given system, population, or individual?

7. Why is there such antipathy to paying for administration (or even profit) when the clamor is for more accountability, data, quality, oversight, and qualified staff?

These questions form the basis for this paper's exploration of a different paradigm of what adds "value" in publicly funded behavioral healthcare systems, and provides the framework for ACMHA's call to behavioral healthcare administrators to take a new approach to considerations behind funding decisions and payment mechanisms.

This paper is written from ACMHA members' experiences as administrators rather than as an economic treatise, and reflects a commitment to the principles and values espoused by ACMHA in earlier documents stemming from earlier summits. (See **www.acmha.org**.) It is hoped that this analysis will contribute a practical, down-to-earth perspective useful to the behavioral health field, especially behavioral health administrators.

II. FINANCING TRENDS, HISTORY, AND LESSONS LEARNED

Trends in the Field

There are a number of emerging trends in behavioral health that form the context for the field's financing dilemmas.

- Both public and private payers are increasing the demand for quality of care including increased access, specific performance and outcomes, and decreased costs.
- The costs of health and behavioral health care and the costs of healthcare coverage for employers are once again increasing dramatically (as much as 13 percent annually) after a period of relative stability for the last several years.
- Medicaid is now the single largest payer of behavioral healthcare. It represents 20 percent of all expenditures for behavioral healthcare and 35 percent of all public expenditures for such care.[1]
- Medicaid is the second highest expenditure of States' budgets and is growing faster than any other portion of these budgets. Prescription drugs and a range of services (rehabilitative, community-based and in-home) – all critical to the quality of care and life of persons with mental illness/emotional disturbance and their families – are among the "optional" services targeted for cuts by many States as they struggle to balance their budgets. Individuals eligible for both Medicaid and Medicare may represent from one-third to one-half of the Medicaid eligible adults with serious mental illnesses.
- The actuarially defined "common cost" of behavioral healthcare benefits has declined more than three times as much as health care benefits (54.7 percent compared to 14.2 percent).[2]
- A higher percentage of employer health care plans are imposing annual visit limits for outpatient behavioral health care than in 1988.[3]
- Inpatient and residential treatment lengths of stay for adult and child/adolescents have declined dramatically in the last several years.[4]
- Adult consumers and their families are increasing the demand for services that assist in recovery and a return to a desired quality of life, not just in control of symptoms or stabilization and maintenance of effects of an illness.
- Child-serving systems are demanding that attention be given to children and adolescents entering their doors who are in need of services in a variety of

[1] Coffey, R.M., Mark, T., King, E., et al. (2000). National estimates of expenditures for mental health and substance abuse treatment, 1997, SAMHSA Publication No. SMA-00-3499, Rockville, MD. SAMHSA, 2000.
[2] Hay Group. (1999). Health care plan design and cost trends – 1988 through 1998. Prepared for National Association of Psychiatric Health Systems and Association of Behavioral Group Practices. Available from the World Wide Web: http://www.naphs.org/News/hay99/hay99toc.html.
[3] Ibid.
[4] Ibid.

settings, including schools, juvenile detention settings, and state custody placements.

- Persons recovering from addictive disorders and providers that serve them are demanding more recognition of the role and impact of addictions and of the need for and value of funding for prevention and treatment services to reduce harm and enhance the likelihood of abstinence.
- Courts and correctional facilities are bringing to the forefront the numbers of adults and children/adolescents who are in their systems that need treatment for mental health and addictive disorders, and the costs to those systems and to society of not serving such individuals.
- Foster care systems are increasingly shouldering the burden of children and families with significant behavioral health needs that are not being addressed by under-resourced behavioral healthcare systems.
- Advocates for increased involuntary treatment are suggesting that legal vehicles such as mental health courts and outpatient commitment are tools not only to assure clients accept and stay in treatment, but also to assure that service systems provide the kind of attention to those clients who are subject to these constraints.[5]
- Federal initiatives over the last thirty years have focused on service delivery that is community-based, consumer-driven, and cost-effective while attending to quality and accountability.
- Current state and federal funding constraints[6] require both diligence in protecting resources and opportunities to fundamentally reshape the way services and outcomes are purchased and provided.[7]

These trends require that the behavioral health field become more sophisticated in looking across systems to coordinate services and funding, and that the field take a hard look at what it wants to buy, that is the value it seeks to add with the services it purchases, and the results it expects to achieve. The field also must take stock of what it has learned about funding mechanisms over the last fifty years, and consider how to carry those lessons forward as funding streams and mechanisms constrict and become more complex in the years to come.

Changing Financing Mechanisms

The behavioral health field has learned much in the last fifty years about what it wants and needs and about how to get it using financing mechanisms that provide the right

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[5] Advocates opposed to these efforts argue that there is no evidence that such mandates actually work in the long run or that they increase resources and system responses to clients. Rather, they worry that these approaches may simply shift limited resources to persons who wind up higher in the "queue" simply by virtue of court orders rather than due to a thoughtful and affirmative public policy decision about what kinds of individuals should get what kind of services, given limited public resources.

[6] 47 of the 50 states are making some form of reductions in expenditures on healthcare such as reductions in services, elimination of eligible populations, co-pays or other cost-sharing techniques, limitations on access to certain prescription drugs, and provider rate cuts.

[7] The President's New Freedom Commission on Mental Health will provide a framework for some of these opportunities in its report to be issued in 2003.

incentives and avoid perverse ones. ***Above all, the field has learned that finances drive behavior.***[8] ***While critical, a statement of values, a strategic plan, research on evidence-based practices, and even regulatory efforts cannot overcome the reality that what is paid for is what will be provided.*** Frequently, what is paid for well or easily or with a high reimbursement rate will have more to do with what services are provided and in what manner than professional standards or the non-financial actions of system leaders and stakeholders.

Because of the power of financing, behavioral health system leaders sometimes see a change in the financing mechanism as the chief method for effecting service delivery changes. While financing mechanisms can assist or impede the successful implementation of system values or purchasers' desires for beneficiaries, they cannot, in and of themselves, form the base of a high-quality, high-value system or a set of services. Systems do not change overnight — to achieve high-value services with the desired outcomes for the money spent, the process must have order and must be planned for over time. Changing financing mechanisms without articulating the desired outcomes or without being able to track those outcomes is likely to result only in different but still ineffective financial incentives or in unintended consequences for services and service recipients.

Throughout the recent history of behavioral health services, the field has seen a number of major changes in financing mechanisms. Each of these changes has come with a promise for better services and outcomes along with better use of limited dollars. In some cases, these changes have proposed to bring more money to treat persons with mental illness or addiction; in others, the changes seek to change the financial incentives in order to discourage or encourage certain types of services delivered in certain types of locations or settings. Some changes have been about increasing accountability; others have been explicitly about the desire to reduce or contain care delivery costs. The field is watching a return to financing mechanisms of the past, infused with learning from financing mechanisms currently in use or used in the past decade or two, but with different purposes in mind. The lessons learned from these changes are applicable today as financing mechanisms return to their roots and yet now seek to provide the greatest flexibility while simultaneously offering the most promise for desired outcomes and accountability. A brief recap of these changing trends is in order.

<u>The Early Days: Pay Globally, Decide Locally</u> – The earliest financing mechanisms in both public and private behavioral health saw payers determining the types of services to be offered and the population served, while the actual clinical decisions were left to the providers themselves.

The public-sector funding approach was grant-based: payers — usually the federal/state/county behavioral health authority — set broad parameters for the services and populations to be served and funded those services through grant awards based on

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[8] Frank, R.G., and McGuire, T. (2001). The mental health economy and mental health economics. Mental Health, United States, 2000. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Rockville, MD.

budgeted costs for staff, operations, and facilities, while leaving clinical decisions to local providers. Examples of grant-funded services include community mental health centers (CMHCs) and, later on, specialty services (e.g., drug and alcohol treatment and prevention programs). These early financing mechanisms often included few performance expectations or individual recipient outcome expectations. Rather, they required providers to offer a minimum list of services for an identified population (often defined geographically).

Private-sector employers buying health care insurance initially approached purchasing behavioral health services (to the extent this coverage was available) in somewhat the same way as public sector payers did. Employers negotiated with insurers about the services they wanted available for a specific population (their employees). Each service was paid at an established usual and customary fee for that service/procedure in that area; for some services, the employee assumed a co-pay or percentage. The provider was again left to make the appropriate clinical decision, so long as the fee for that service did not exceed the norm for the particular community. Performance expectations and clinical outcomes were not considered or not explicit in the financing process.

In both cases, the provider or practitioner was considered to know the right thing to do and at the right price. Additionally, accountability and oversight was limited to whether the population served received the services purchased and whether the cost was within the negotiated amount.

Cost Containment, Capitation & Managed Care – In the 1970s, private-sector companies experiencing runaway health care costs embraced the idea of managed care. Managed care was an extension of the health maintenance organization (HMO), in which clinicians agreed to provide care for a set population for a set price to the payer so long as care was provided by its staff. HMOs benefited both payers and insured alike by offering accessible, preventative care at less cost to both parties.

Central to the managed care approach is capitation – that is, the payment of a set amount per covered individual for a set menu of services. This approach also removes the treating professional from the clinical decision-making process by introducing the concept of outside reviewers — and deniers — of clinical care. This financing mechanism introduced incentives to use less expensive interventions and in some cases simply less care for less people. Given that the driver for some of these early mechanisms was containing costs, these incentives seemed appropriate from the payers' perspective until too little services, too many service denials and too much funding spent on things other than service delivery began to be experienced by service recipients and payers alike. Early on, neither public nor private payers included protections against these incentives, but payers soon began to require an identified percentage of funds to be used for services and to limit expenditures for administration or profit.

Managed care and/or HMO type arrangements (including preferred provider organizations and point -of-service plans) have become the typical approach of employer-purchased behavioral health care, although additional requirements about quality and outcomes have been introduced as experience with the mechanism has increased. Employers (especially large ones) are demanding certain performance standards such as access indicators, “medical loss ratio” (i.e., amount of dollars spent for services versus administration or profit), and care outcomes.

Public Sector Managed Care – Increased Accountability and Quality? – While the private sector eagerly welcomed managed care’s cost-containing approaches, the public sector moved more slowly. The grant-based funding of the 1950s evolved into service contract purchasing two decades later. Service contracting allowed public payers to purchase, often in advance, a defined number of units of a defined type of service (e.g., counseling units or residential bed days). The payer was clearer about what it was buying but was no more able to manage the quality or outcome of those services than under grant-based funding mechanisms.

By the 1980s, Medicaid became an increasingly important part of the behavioral health care dollar, and its influence began to be felt throughout the public sector. First, a fee-for-service approach was embraced by public-sector payers, who saw the value of this mechanism for tracking and accounting for services provided for individual service recipients and for target populations. While fee-for service financing did allow public payers to more adequately account for behavioral health care service units and to define more clearly who gets and is eligible for those units of service, it did not increase the payers’ ability to determine the quality of those service units or the results of services provided. Additionally, some advocacy groups began to maintain that the fee-for-service approach prevents flexibility and individually tailored approaches to care so needed by publicly funded clients.

As Medicaid costs began to increase dramatically in the 1980s and 1990s, state Medicaid administrators began to request waivers to use HMOs, managed care and other cost containment mechanisms in their programs. The federal government approved these waivers on the condition that access, individual rights, and outcomes are ensured for Medicaid-eligible clients. The private sector’s experience with performance and quality oversight also provided information upon which public sector payers learned about tempering financial incentives with quality and accountability incentives.

Managed care did help contain costs and, in some instances, increased access to care. It also helped to bring accountability in the form of specific performance and reporting requirements that allows the tracking of persons served, services received and costs per person and per service. However, unless contracts contain a clear commitment to system performance and service recipient outcomes, capitated financing mechanisms alone has not been shown to increase quality of care or individual outcomes. And, contract language alone cannot provide the grounding for quality and outcome efforts without additional actions at regulatory, strategic, advocacy and leadership levels.

Lessons Learned

The search for performance, quality, and outcomes has grown as rapidly as the demand for cost containment and accountability. The search to tie services to value in both an economic as well as a social sense has begun. In these searches, new financing mechanisms have been created and tested to increase incentives to provide care (e.g., risk corridors), to provide care to populations most in need (risk adjusted rates), or to increase flexibility to be creative about the types of services needed to produce specified outcomes for specific individuals and families (case rates).

- Interestingly enough, some public payers are coming full circle to a grant-based approach called "global budgeting". The idea behind this approach is to give a specified amount of dollars for a specific population (sometimes loosely or directly related to the expected number of individuals to be served, somewhat akin to case rates) but to incorporate all the learning from the last 50 years of financing creativity. In some cases, this global funding is being tied to choices each individual or family might make for their own care and treatment.[9] (See Chapter IV later in this paper.)

The challenge at this point in history is to assure that our financing mechanisms are not implemented in a vacuum. They must align with the underlying values of behavioral healthcare, support the broader goal of bringing state of the art care to clients and their families, and improve the quality of services provided.

[9] This idea is becoming especially popular conceptually in the developmental disabilities and long term care fields, to allow what is termed self-directed care by a particular service recipient. In this approach, the individual and/or family determine what they need and create a service plan with the help of a service professional using a specified amount of funds set aside for such individuals with similar levels of need. The goal is to support self-determination and autonomy as well as to help assure successful community living and prevent unnecessary institutional or facility-based care.

III. RETHINKING VALUE AND DRIVING PRINCIPLES

Shifting the Paradigm of Value

No discussion of the financing of mental health and substance abuse services with an eye to quality for and accountability to various stakeholders would be complete without some consideration of the concept of value. Value is a complex construct incorporating notions of worth, merit, desirability and benefit that can be viewed as the economic expression of principles, beliefs and social *values*. It is at the interface of economic value and broader human values that we consider variables and attributes other than cost as components of financing objectives and strategies.

In what has been described as the "commodification" of mental health services over the past ten to twenty years, the equation

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$

has come to be the widely accepted paradigm for expressing value and has substantially influenced financing decisions.[10] In rethinking finance, we must reconsider the value proposition and reaffirm core values.

A new and emerging view is that the value of mental health services is realized in its contribution to the promotion of social capital.[11] Social capital refers to features of social organization, such as networks, norms, and trust that facilitate coordination and cooperation for mutual benefit. These institutions and relationships "shape the quality and quantity of a society's social interactions. Social capital is not just the sum of the institutions which underpin a society – it is the glue that holds them together."[12] The development of social capital complements and supports the growth of both economic and human capital and is key to continued economic progress.

[10] For other discussions of the value in behavioral health purchasing, see Frank, R. G., McGuire, T.G., Normand, S. T., and Goldman, H. H. (1999). The value of mental health care at the system level: The case for treating depression. Health Affairs, 18(4), 71-88; Cullen, M., and Whiteford, H. (June 2001). The interrelations of social capital with health and mental health. National Mental Health Strategy. Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Commonwealth of Australia: Canberra ACT; and (2001) The business case for improving health care: Opportunities to maximize corporate resources, unpublished paper available from Ronald Manderscheid, Chief, Survey and Analysis Branch, SAMHSA, Center for Mental Health Services. Rockville, MD.

[11] The concept of social capital can be traced back to the work of Alexis de Tocqueville (1835), Emile Durkheim (1893 and 1897), and Max Weber; while the first coining of the word began with Hanifan (1916) while referring to education and local communities. Others who have contributed to this body of work include Bourdieu (1979) and Bourdieu and Passeron (1970) (OECD 2001). Most recently, Bob Rosenheck of the Veterans Administration has utilized the concept of social capital in behavioral health research.

[12] http://www.worldbank.org/poverty/scapital/whatsc.htm.

In this new paradigm, the successful and effective financing of mental health services is not merely the concern of the health sector or a limited sub-group. Rather, the financing of mental health services and the assurance of equity becomes a more general societal concern impacting all institutions within both the business community as well as government. This fact is borne out in some ways by the increasing diversification of mental health services into areas of social financing other than specialized mental health agencies and systems. For example, the expanding role of criminal justice, education, housing, and child welfare systems in paying for aspects of mental health care for some populations is an indication of the impact, and subsequently the "value" of mental health care seen from the public safety, educational, and even economic or neighborhood development perspectives.

How then does "value" get redefined in this larger construct and how do mental health administrators think about the larger concept of value in determining what to buy? The first step is to in fact define the value expected or desired to be gained through the purchase and delivery of mental health care, and then to consciously construct financing mechanisms (along with other influencing factors) that are most likely to produce that value.

Principles to Guide Financing Decisions

The principles upon which a definition of value should be rooted and that describe the systems of behavioral health care that should be supported by all financial mechanisms are recovery and resiliency. They reflect the performance characteristics of high-quality systems of behavioral health care advanced in the Institute of Medicine's report, *Crossing the Quality Chasm,* [CITE] as major areas for improvement for all health care systems in the 21st century.

Resilience and Recovery as a Return on Investment

The language describing the principles of resilience and recovery is changing, but the concepts remain constant: a healing process that is ongoing and variable, not linear and finite; that views individuals as individuals, not as diagnoses; that strengthens the self, and promotes hope and positive social and familial roles, rather than reinforces hopelessness and dependence. The goal is not a "cure" — or stabilization or mitigation — but rather a personal transformation[13] through which one learns both to accept one's limitations and to discover who one can be and do.

Resilience. For children/adolescents experiencing the effects of mental illness, emotional disorder, or addiction, the healing process is not an individual one. Developmentally, the child/adolescent is still in the process of becoming a fully functioning, independent or interdependent adult. By legal definition, the child/ adolescent is part of a larger social group, i.e., the family. Therefore, in considering the care of the child/adolescent, the whole family must be considered — whatever happens

[13] Deegan, P.E. (2001). Recovery as a self-directed process of transformation and healing. Available on the World Wide Web at http://www.intentionalcare.org/articles/articles_trans.pdf.

with the child/adolescent will directly affect siblings and parents, and when parents or siblings have unattended issues of their own, the child/adolescent will find it difficult to cope with life choices and engage in age-appropriate positive activities.

As with adults, good treatment can help an individual within a family learn coping skills or control behavior while treatment is ongoing, but will not likely overcome the effects of the total family system. Bad or no treatment can result in skills being lost and behaviors of both the child and adults within the family being inappropriate in a variety of settings (school, work, home, etc.).

For a child/adolescent and his/her family, regaining functioning is not the goal so much as identifying and building on strengths and gaining the skills and resources (or resourcefulness) to fulfill appropriate roles in society as family members, siblings, students, parents, and sometimes workers and life partners. This approach, which promotes the concept of individual and group "resilience," addresses the strengths that help individuals and the family and regain or begin to behave in appropriate family roles. A resiliency approach also helps the family identify and address the risks that are associated with deepening or prolonging any dysfunction that is likely to result in the child/adolescent having long-lasting issues of delinquency, violence, addiction, or emotional disturbance. This approach can also help the child/adolescent move toward the individual responsibility necessary to maturity — in essence, a move toward what we think of as "recovery" for adults.

Recovery. Recovery describes a philosophical approach that assumes an adult dealing with mental illness and/or substance abuse not only can but must take responsibility for his/her own care and his/her own process of returning to a state of functioning and quality of life in spite of the effects of mental illness or without the effects of addiction. Some posit that such an approach can lead beyond recovery even to the concept of thriving,[14] that is, gaining insights, awareness, and capabilities because of adversity from a traumatic event or condition such as experiencing mental illness (and at times the iatrogenic effects of mental health treatment) and/or addiction.

The idea of "recovery" shifts the focus from brief episodes of acute intervention to models that reflect an understanding of, and focus upon, the long-term recovery process.[15] Rather than being one-sided, practitioners build a partnership with an adult with mental illness and/or addiction (and where acceptable to the adult, with his or her family) in which the individual comes to terms with his/her own illness and/or addiction and takes responsibility for managing his/her own choices in life, including his/her own services. This kind of partnership in which the individual directs and the clinician or service provider assists the individual in accomplishing his/her service and life goals

[14] The concept of thriving is based on research and was presented along with other ideas in this paragraph by Judith Cook, Ph.D., Director, National Research and Training Center on Psychiatric Disability, to the John D. and Catherine T. MacArthur Initiative on Mandated Community Treatment Research in April, 2002. Chicago, IL. Ms. Cook can be reached at (312) 422-8180.

[15] White William (2002). The rhetoric of recovery advocacy: An essay on the power of language. Posted on the Alliance Project website (www.defeataddiction.org). Mr. White can be reached at bwhite@chestnut.org.

rather than the service provider deciding diagnoses or directing services can result in recovery or even thriving.

Consequently, adults with mental or addictive disorders do not "get rehabilitated," and service providers cannot “empower” them. They are not passive recipients of rehabilitation services. Rather, they experience themselves as "recovering" a new sense of self and purpose within and beyond the limits of the disability or addiction.[16]

Similarly, “treatment”, in which the application of good clinical or addiction services may result in stabilization and the ability to live with or in spite of disability or addiction, implies an individual’s passive involvement in the process. “Treatment” assumes that bad or no clinical/ addiction services may result in succumbing, that is, the individual will be unable to get better, to overcome the disability, or to live at all. Again, an individual in recovery discovers within the process the self-knowledge to rise beyond his/her illness or addiction.

The perspective of “recovery" is not isolated from other disability groups. As with other groups, those individuals with mental illness and/or substance abuse disorders have needs and aspirations. They need to meet the challenges of the disability or addiction and reestablish a new and valued sense of integrity and purpose within and beyond the limits of the disability (and in many cases beyond the limits of the formal service delivery system). The aspiration is to live, work, play and love in a community in which one has the opportunity to and does make a significant contribution.

The principles described above assume that practices must be aligned to promote these principles and that financing of practices must promote or at least not get in the way of this alignment.

Practices that can promote these principles include, but are not limited to:

- Individual and family direction in treatment planning and implementation;
- Self-help and peer support groups;
- Service recipient and family-operated initiatives and services;
- Community-based care in sufficient types, amounts and lengths to assure good outcomes and individual and family choices in their recovery and resiliency processes;
- Individuals in recovery and families working toward resiliency having roles within the system as employees, trainers, volunteers, advisors and program evaluators.
- Medications available to meet consumer/family needs and provide choices, including choices of medications and choices about the role of medications for either psychiatric or addiction conditions in their resiliency/recovery plan;

[16] Deegan, P.E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11 (4), 11-19.

- Family, consumer, and community education.

Implementation of these practices should be seen as a fiscally sound "return on investment," since their intended "product" is an individual who is a self-sufficient, productive citizen of his/her community. As such, the individual and family add value rather than detracting from the value of the community, both fiscally and socially.

The Institute of Medicine Report

The Institute of Medicine (IOM) report, *Crossing the Quality Chasm*,[17] provides a conceptual framework for measuring and improving the quality of health care in general. ACMHA has begun work to translate this report to reflect the characteristics specific to the behavioral health care field, with specific attention to the principles of recovery and resiliency. The IOM report cites six major aims, thirteen recommendations and ten guiding rules as a blueprint for change in the next generation health care systems. According to the IOM, health care should be:

- Safe
- Effective
- Patient-centered
- Timely
- Efficient, and
- Equitable.

Each of these aims requires thinking about the financing mechanisms most likely to achieve them.

Additionally, one of the thirteen recommendations is relevant to the issue of financing mechanisms.

> Recommendation 10: Private and public purchasers should examine their current payment methods to remove barriers that currently impede quality improvement, and to build in stronger incentives for quality enhancement.

The IOM report framework is utilized in this paper as a set of organizing concepts to discuss the aims for the behavioral healthcare field and the financing mechanisms that impede or enhance those aims. These six (6) aims from the IOM report and the guiding

[17] **Crossing the Quality Chasm: A New Health System for the 21st Century. (2001). National Academy of Sciences, Institute of Medicine, Committee on Quality Health Care in America. Washington, D.C.**

principles for each serve as a tool and a benchmark against which the usefulness of various financial strategies and mechanisms can be assessed.

As the IOM aims are translated to behavioral health care, further definition emerges for each of them. Objectives to achieve these aims are indicated along with financing considerations or strategies for achieving these objectives.

1. **Safety:** Service recipients and their families should **not be harmed** by the care that is intended to help them. The environment in which individuals and families are served should be **safe**, in all its processes, at all times. To be safe, **care is seamless**, that is, all parts of services are working as an integrated whole, particularly at points of transition between and among caregivers and across sites of care. Service recipients are **informed of uncertainty, risks and treatment choices**; they participate in treatment as fully as they are able.

SAFETY objectives might include:

- Assure latest, most effective medications are available for adults and children/adolescents for mental or addictive disorders that reduce the probability of side effects.
- Train front line staff in violence and crisis prevention and intervention.
- Train staff on the awareness of, and reduction in and eventual elimination of the use of restraints and seclusion as a treatment intervention.
- Train law enforcement to promote safety of individuals and families with behavioral health needs who come to their attention.

Financial strategies might include:

- Include new generation medications on pharmaceutical formularies.
- Assure utilization review processes do not require fail first trials on medications likely to have lesser effectiveness or have more side effects.
- Include incentives for achieving measurable reductions in the use of seclusion and restraint and in the reduction of events of client harm.
- Include incentives for system wide development of individual and family education programs that increase their ability to self manage their recovery/resiliency process.
- Fund training of law enforcement staff in the safe handling of persons with mentally illness, emotional disturbance and/or addictive diseases.
- Fund advocacy and rights protection activities overseen by or delivered by/with clients/families and advocates with experience in the system of care.

2. **Effectiveness:** Services and interventions are **evidenced-based** that integrate the best research evidence with clinical expertise and client/family experience and values. Service providers consistently avoid both the **under-use of effective care** and the **overuse of ineffective care** that is more likely to harm than help clients. Effectiveness is measured by what the individual and/or family wants and needs given the recovery and resiliency goals he/she/they set for themselves. The service delivery system **continuously monitors the results of the treatment** and services provided, in both system and client terms, and uses findings to improve care for all clients.

EFFECTIVENESS objectives might include:

- Train staff in methods of conveying hope to clients and families about their recovery and resilience, and work to empower them in the self-management of that process.
- Expand caregivers' roles from “case manager” to teacher, coach, motivator, and mentor.
- Ensure that providers use clinical pathways, based on evidence-based practices.
- Provide for the formal education of individuals and families regarding effectiveness of particular services and the evidence-base behind offered treatment and services.
- Build services that are prevention oriented, rather than simply managing crises.
- Ensure proper matching between diagnosis, strengths, needs, goals and services.

Financial strategies might include:

- Align the revenues with financing long-term recovery.
- Fund training for staff and new practitioners in recovery/resiliency concepts and in newly emerging treatment and service technologies.
- Allow creativity in re-engineering staff’s role (job descriptions, qualifications, training) to support resiliency and recovery.
- Finance work force development to address adequate salaries, improve staff quality, and reduce turnover.
- Provide flexible funding for wrap-around services.
- Identify and eliminate financial disincentives to recovery.
- Stop paying for practices that have been shown to be ineffective or harmful.
- Include incentives for use of evidenced-based practice; give providers flexibility to move funds from less effective to more effective services.
- Balance the drive to maximize revenues with purchasing the right things.
- Fund appropriate lengths of stay in care in order to assure continuing care and improved outcomes.
- Shift from paying for symptom reduction to paying for outcomes, well-being and improved functioning.
- Assure that “getting better” doesn’t result in losing access to supports.
- Consider supportive housing and supportive employment as core services to be funded.

3. **Person/Family-centeredness:** Client care demonstrates **respect** for the individual's and/or family's culture, values, preferences, and expressed needs. A person/family-centered system designs opportunities for clients and families to be **informed about and to take responsibility for decisions** about their treatment and their own process of recovery and/or resiliency. Person-centered care is **highly customized** and incorporates **cultural competence**, including culturally specific treatment approaches, e.g. traditional healers. Person-centered care offsets the vulnerable status of illness by **coordinating care and assuring smooth transitions** across settings, and from a health care to self-care setting. **Mandated treatment is reduced or eliminated** in favor of active outreach and engagement. When individuals are mandated to receive services (e.g., drug/mental health courts, civil commitment, etc.), those mandates are based on evidence that the mandated services will result in better outcomes than giving the individual/family other choices of services.

PERSON/FAMILY-CENTEREDNESS objectives might include:

- Be person/family-centered, flexible and individualized rather than compartmentalizing the clients by eligibility or diagnostic status or by level of care
- Minimize and eliminate use of involuntary commitments, and mandated treatment to the extent possible.
- Collaborate with clients and families with jointly agreed to conditions of treatment.
- Welcome family members as members of the client's treatment team.
- Inform clients/families about their treatment options; educate them about the nature of their illnesses and any treatment side effects so that they can truly share in the making of decisions about their care.
- Communicate hope and belief in the client's recovery.
- Provide timely, sufficient and relevant information for clients and families about diagnosis, prognosis and how they can manage their care and wellness.
- Create improved outcomes by staying with the client over all phases of care: from detoxification to treatment, from crisis to recovery, etc.

Financial strategies might include:

- Remove funding restrictions so that treatment can be individualized, especially for those with co-occurring conditions.
- Include incentives for use of effective non-mandated interventions.
- Continuation of treatment is not conditioned on mandatory participation in other treatments; supportive services that will assist the client/family in their recovery/resiliency process is not to be conditioned on participation in other forms of treatment or care.
- Provide sufficient funding for consumer and family-operated services.
- Pay for quality treatment planning time so that clients' 'voice' can be heard.
- Develop strategies for client's/family's purchasing choices.
- Support a continuum of training, away from maintenance and towards hopefulness.
- Dedicate funds for peer support services so that consumers can see that recovery is possible.
- Purchase client and family education services in support of their role as informed decision makers.
- Create incentives for "linked" episodes of care.
- Develop provider networks that maximize consumer choices rather than franchise or monopolies.

4. **Timeliness:** The provision of care should be a **smooth flowing, high quality process** that is available within reasonable times and distances when the client/family needs services or intervention and when the client/family is ready for treatment or support. Clients and families do not experience **long waits** for service, are provided **quick responses** to inquiries, and receive attention to problems before they have advanced to more serious stages of illness.

TIMELINESS objectives might include:

- Ensure easy access to the system, i.e., "no wrong door" to care.
- Build systems so that services required and chosen are available within a reasonable distance and time, and would be of sufficient duration to assure recovery/resiliency success and relapse prevention.
- Hire and retain staff who are competent in conducting holistic assessments of clients not limited by a particular funding stream or silo. Comprehensive holistic assessments guide treatment planning.
- Build a "can do attitude" among treatment teams that have creative approaches to meeting the client's needs without undue delay.

Financial strategies might include:

- De-categorize funding so that dollars are attached to the individual or family with an identified outcome, rather than to a particular program or provider.
- Include incentives for building a single comprehensive assessment that is shared with all caregivers.
- Create disincentives for the delivery of services that are not tied to the comprehensive assessment.
- Remove barriers to ‘quick response’ by allowing a variety of clinicians to triage clients’ initial needs.
- Have strategies for paying for client engagement in treatment.
- Assure that the funding of a client's care is seamless, allowing transitions when the client/family is ready (e.g., from detoxification to treatment or hospital to housing) without disruption or additional waiting.

5. **Efficiency:** Resources in the care system are **not wasted**, that is, used without benefit to the clients and families the system is intending to help. **Quality improvement mechanisms** address effectiveness, safety, person-centeredness, timeliness and equity. **Administrative costs are reduced** where they are not adding value to the system's care or accountability. Efficient systems of care use resources to get the **best value possible** for the money spent.

EFFICIENCY objectives might include:	**Financial strategies might include:**
• Eliminate “quality waste” in public systems	• Reduce over-use of ineffective services, with a common understanding of what constitutes “effectiveness.” • Purchase ‘data-based services’ in adequate proportions, e.g. proportion of dollars spent for treatment of co-occurring psychiatric and addictive disorders is based on their prevalence in the treatment system.
• Reduce treatment dependency and promote the client's/family’s highest level of self-sufficiency, independence and well-being • Incorporate a client's/family’s social/community life goals for themselves.	• Adopt self-care and disability management strategies, e.g. client- or family-managed care. • Create incentives for appropriate treatment savings and re-direction into resiliency- and recovery-oriented services. • “Zero-base” all regulations, retaining only those which reinforce recovery, quality and administrative efficiency.
• Manage administrative costs so that they add value to the system	• Identify with stakeholders appropriate administrative activities such as staff training, quality oversight, reporting and accounting, data management, etc., and their realistic costs. • Set administrative allowance caps for providers and system managers at all levels.

6. **Equity:** Treatment and services are designed to improve health status and support the recovery/resiliency process and **reduce disparities in access to and effectiveness of care** among subgroups needing services. The **availability of care** is based on the client's individual needs and not on personal characteristics unrelated to the client's condition or reason for seeking care or assistance. **Quality of care does not differ** because of gender, race, age, ethnicity, income, education, religion, beliefs, disability, sexual orientation, or location of residence.

EQUITY objectives might include:

- Ensure that care is available regardless of income status, but income determines client's contribution.
- Ensure that care is available based on clinical need rather than "covered benefits."
- Reduce inequities of access to, quantity of and quality of care.
- Plan for the health status of subgroups (i.e., the epidemiology of disorders among ethnic groups) would inform the priority foci of community systems of care.

Financial strategies might include:

- Eliminate restrictions on who public providers can serve but establish sliding fee scales for treatment services.
- Allow federal, state and local funding streams to be "blended" in order to better leverage funds and increase population coverage.
- Increase flexibility in federal block grants requirements to support and promote attention to "co-morbidity conditions" in the population in need, particularly those with co-occurring mental illness and substance abuse disorders.
- Examine financial incentives or disincentives (e.g., co-pays) to accessing inpatient versus outpatient care.
- Incorporate risk adjusted rates.
- Promote 'honest pricing" determining the costs of care for various subgroups based on differences in outreach, engagement (including language issues), and types of practitioners and treatment modalities
- Support research into true differences among subgroups that require different service approaches.

IV. TAKING THE LESSONS FORWARD – SELECTING AND IMPLEMENTING EFFECTIVE FINANCING MECHANISMS

Summarizing the Lessons Learned and Suggesting a Process

Interestingly enough, some public payers are coming full circle from grants to performance contracting to fee-for-service and back to a grant based approach to financing behavioral healthcare. Sometimes, these new financing mechanisms are based on specified amounts for individuals in like populations or levels of care, aggregated based on the number of expected persons to be served (or the number of persons for whom funding is available, or "slots"). This mechanism is sometimes called global budgeting, and attempts to combine multiple funding streams into one person-centered approach that is easier to administer and more focused on what each individual within the identified population needs and wants. The idea with this approach is to give a specified amount of dollars for a specific population, but to incorporate all the learning from the last 50 years of financing creativity. That is,

- explicitly define who is eligible and who has the highest priority for service;
- specifically define the services that will be funded for which types of populations;
- limit the proportions of funding that can be used for certain things such as administration or inpatient care;
- require that certain amounts or proportions of funding be spent on certain types of services such as peer supports or supportive housing;
- require specific reporting of critical data;
- require specific quality processes and products;
- require specific types of outcomes for persons served, sometimes with financial rewards or penalties for outcomes achieved or not achieved (e.g., withholds, shared risk and incentive pools, etc.);
- have certain types of consumer education and rights assistance such as member advocates or grievance and appeal processes, and
- specify requirements for participating in solving system issues that have resulted in lack of system coordination, bad outcomes, or inefficient performance.

In some cases, systems are moving toward consumer-directed financing mechanisms that will allow consumers to select their own services and providers or determine their own treatment needs with a set amount of funding provided for this purpose.

The challenge at this point in history is to assure that our financing mechanisms are not implemented in a vacuum. They must align with the underlying values of behavioral healthcare, support the broader goal of bringing state of the art care to clients and their families, and improve the quality of services provided.

Steps to Achieving System Goals

The steps learned by system administrators who tried (and sometimes failed) to implement financing strategies to achieve system goals can be described as follows:

1. First things first, i.e., know the populations to be served; articulate the desired individual and system outcomes and the incentives it will take to get the system to work toward achieving those outcomes; and identify the evidence-based practices that are more likely to achieve those results. (More time on outcomes; less time on "eligibility and benefits.")

2. Work on coordination among payers and funding streams to finance the same recovery and resiliency-oriented outcomes rather than changing the funding mechanisms within a single system or silo. (Spend time initially on cross-system collaborations and less categorical funding decisions.)

3. Recognize and adjust to local characteristics affecting services and funding. (Take into account what is happening where the changes are being imposed and the differences that may affect the implementation and results, including the cultural characteristics of the populations to be served.)

4. Identify barriers other than financing mechanisms that impede or promote desired outcomes. (Do not rely on financing mechanisms alone to achieve the desired results.)

5. Be cognizant of the unintended incentives of changing financing mechanisms. (Every financing approach has positive as well as perverse incentives; to not know or plan for them is to be ruled by them.)

6. Promote desired outcomes by utilizing funding mechanisms that provide incentives for positive outcomes and minimize the unintended incentives as one of several vehicles to promote the flexibility and integration of services specifically for the populations to be served and directed toward the outcomes to be achieved. (Think about regulatory, service development, and human resource approaches to achieving the outcomes as well as the financing mechanisms.)

7. Identify with stakeholders appropriate administrative activities and their likely costs.

8. Share data about the effects of these efforts. (Find out what difference it makes.)

9. Promote recovery and resiliency by making changes as data shows improvements. (Use data for decision-making.)

10. Put into place safeguards for recognizing and neutralizing undesired or unintended results, including unintended impacts on other systems. (Make sure the money is where the system's goals are.)

11. Adjust financing and other mechanisms that are not achieving the desired outcomes. (Do not be wedded to the financing mechanism if it, in conjunction with other strategies is not getting the expected results.)

A Framework for Considering Financing Strategies

It is an axiom of the health and behavioral healthcare systems that financing drives behavior. All financing strategies come with a variety of incentives, dilemmas and barriers that must be understood and in some cases overcome. These financing strategies can be characterized by the focus or construct upon which they are based. We must better understand the incentives (likely resulting positive behaviors) and disincentives (likely resulting negative behaviors) at multiple levels in order to identify the right combination of mechanisms to utilize in achieving the desired outcome. To the extent that the desired outcome is increased quality, it becomes critical to define exactly what is meant by "quality" in this context. The aims and principles discussed in Chapter III can help to shape these decisions.

A framework for thinking about the various types of financing mechanisms and examples of the dilemmas and barriers they impose is presented in Table 1. The examples in this table are simplistic and are used only to suggest a method of thinking about various financing mechanisms. All of these mechanisms have been used in one way or another. Most are used in conjunction with aspects of the other mechanisms (e.g., global budgets but with performance or units of service contract or reporting requirements). Therefore, they should not be thought of as stand alone mechanisms in most cases.

Before selecting any financing strategy, these issues should be considered. Current financing mechanisms should also be reviewed to determine what impacts they drive and whether these impacts are consistent with program or system values and aims. By affirmatively considering these incentives and disincentives as desired outcomes are developed, a more thoughtful approach can be used to select the financing mechanisms most likely to result in those outcomes. Affirmative consideration of these possible incentives and disincentives can also help a system or payer determine what other financing, regulatory, or quality improvement strategies can be used to mitigate the possible disincentives.

Funding Mechanism Type	Examples	Possible Incentive (Expected Positive Behaviors)	Possible Disincentive (Expected Negative Behaviors)	Examples of Aims Maximized
By Service or Setting	• Budget for a Crisis Service Connected to a Hospital Setting	• Service Availability Regardless of Utilization • Level of Care Options	• Use of Crisis Services Rather than Crisis Prevention • Increased Hospitalization	Safety, Timeliness
By Units of Service	• Fee-for-Service • Performance Based Contracts	• Increased Service Units Provided • Specific Performance or Service Defined and Used	• More Services for Fewer People • Highest Priced Unit Provided Most Often	Efficiency, Safety
By Provider	• Traditional CMHC Budgets or New Global Budgeting • State Hospital Budgets	• Increased Ability to Combine Funding Streams for An Individual Client • Reduction of Administrative Costs	• Reduction in Choice of Providers or Provider Types • Provider Drives Focus and Quality of Service	Effectiveness, Safety, Person/Family Centeredness
By Population	• Set Asides for Pregnant and Parenting Substance Abusing Women • SSI/SSDI Payments • Capitation w/ Admin/Profit Limitations	• Population-Specific Programs and Requirements • Assurance that a Given Population Will Be Served	• Other Populations in Need Not Served • Identified Population Served Regardless of Need	Efficiency, Equity, Effectiveness
By User	• Vouchers • Client/Family-Directed Services • Case Rates	• Services Driven By Individual Client Needs • Flexibility in Offering Non-Traditional Services	• Identification of More or Higher Need Users ("Woodwork" Phenomenon) • Reduced Services per User	Person/ Family Centeredness, Equity
By Program	• Grant or Program Budget • Prevention Set Aside	• Specific (Sometimes Otherwise Unavailable) Service Offered • Program Designed to Meet Criteria of the Evidence-Base	• Decreased Flexibility of Services Offered • More Clients Get a Particular Service or Program Whether Meets Their Individual Needs or Not	Effectiveness, Efficiency

Funding Mechanism Type	Examples	Possible Incentive (Expected Positive Behaviors)	Possible Disincentive (Expected Negative Behaviors)	Examples of Aims Maximized
By Geography	• CMHC Cachement Area Budgets	• Residents of a Particular (Possibly Underserved) Area Assured Services • Ability to Target Programs and Services to Unique Community Needs and Characteristics	• Discourages Specialization and Creates Coordination of Care Issues for Consumers Who Cross Geographic Areas • Some Areas Become Magnets for Higher Cost/Need Clients	Equity, Efficiency
By Outcome	• Vocational Rehabilitation/Ticket to Work • Payment for Each Housed Client • Payment for Each Individual Taken Out of the Hospital	• Increased Performance on Defined Outcomes • Reduced Expenditures on Services That Do Not Produce the Desired Outcome	• Services Driven to Produce a Particular Outcome Regardless of Client Need • "Creaming" of Clients for Whom the Outcome is More Likely to Be Achieved	Person/Family Centeredness, Effectiveness
Across Systems	• Purchasing Collaboratives	• Increased Ability to Combine Funding Streams for Individual Clients or Populations • Decreased Duplicative or Inconsistent Administrative Requirements at the Provider Level	• Increased Costs at the Payer or Purchaser Level (Coordination Costs Time and Money) • Attention and Funding Focused on a Limited Population or Set of Services	Efficiency, Equity, Effectiveness, Person/Family Centeredness, Timeliness

V. A CALL TO ACTION FROM THE AMERICAN COLLEGE OF MENTAL HEALTH ADMINISTRATION

Throughout this paper the focus has been on identifying creative solutions in tumultuous times for the purpose of moving toward financing strategies that purchase results and thus represent real value. As stated so clearly by Frank and McGuire (2001), incentives matter in the way mental health systems behave and the results they produce.[18] A focus on financing mechanisms that provide incentives to produce the principles and aims described in Chapter III is critical. Assuring that financing mechanisms do not provide disincentives to the accomplishment of these principles and aims is equally important for the consumers and families that rely on publicly funded services. ACMHA issues this call to action to assure the best possible value for the funding available for behavioral health care. Behavioral health administrators are encouraged to create opportunities for dialogue with their partners in funding agencies and other change agents around the following call to action.

Behavioral health administrators are urged to initiate the following actions:

1. Perform a "fearless inventory" of current and proposed financing mechanisms and the incentives and disincentives they produce.

Request or lead your agency/organization to conduct what the addictions recovery movement has called a "fearless inventory" of what you buy now, how you buy it and how you measure the value for the dollars spent. As an example, if you are a county, do you purchase units of service and reimburse based on the receipt of an Accounts Payable invoice that attests to the delivery of that number of units? Are there any performance indicators that address the quality of services delivered? Is program certification status tied to your reimbursement methodology? Are outcomes clearly defined and are financial incentives in place to drive the system toward those client-based outcomes? Are disincentives mitigated by financial, contractual or regulatory processes? By conducting this inventory, an administrator can begin the process of empowering his/her agency to craft its own future by spending smarter, rather than just spending more. The bottom line is, do you really know what you are buying?

2. Tie reimbursement schedules to the use of evidence-based practices.

Evidence already exists that this is a direction funders and purchasers are seriously considering. The current Secretary of Health and Human Services has indicated that this is a direction he intends to support. SAMHSA administrator Charles Curie references this strategy in his new "Science to Services" initiative. The National

[18] One interesting example of this is a recent study of a state behavioral health carve out by Busch, Frank and Lehman. In that system, the behavioral health managed care organization is not at risk for pharmaceutical costs and is at risk for psychosocial rehabilitation services. Patterns of use showed that utilization of atypical anti-psychotics rose under both the carve out and comparison regions. Use of atypicals was independent of the carve out design. The carve out was associated with a decreased likelihood of receiving psychosocial treatments studied. Personal communication with Alisa Busch, MD, MS, McLean Hospital, Belmont, MA. Ms. Busch can be contacted at abusch@hcp.med.harvard.edu.

Association of State Mental Health Program Directors (NASMHPD) is leading an effort through it NASMHPD Research Institute to assist states to implement evidence-based practices. One state, the New York State Office of Mental Health (NYSOMH) as part of its “Winds of Change” initiative, has already identified the need to use performance data in selected evidence-based areas to make regulatory and funding decisions. As part of New York’s initiative, some evidence-based or promising practices have been identified as meeting the criteria for “interventions for which there is consistent, scientific evidence showing they improve client outcomes.”

Some of the evidence-based and promising practices for adults include:

- Care Coordination: Assertive Community Treatment (ACT), Intensive Case Management (ICM)
- Supported Employment
- Wellness Self-Management
- Family Psychoeducation
- Integrated Treatment for Co-Occurring Substance Abuse and Mental Health Disorders
- Medication (and guidelines for practitioners to promote optimal prescribing practices)
- Self-help and Peer Support Services
- Post Traumatic Stress Disorder Treatment

Examples of evidence-based or promising practices for children and their families are:

- Functional Family Therapy
- Treatment Foster Care
- Multi-Systemic Therapy
- Systems of Care
- School-Based Mental Health Services
- Home-Based Crisis Intervention
- Evidence-Based Prescribing Practices for ADHD and Childhood Depression
- Intensive Case Management
- Family Education and Support Services

The Center for Mental Health Services currently is supporting several initiatives for the development of toolkits that are implementation guides for putting evidence-based practices in place.

Administrators are encouraged to add an evidence-based practice review to their inventory of what they are buying and how they buy it. Massachusetts and Iowa have demonstrated that providing financial rewards for desired practices and performance has been a powerful systems change incentive. Massachusetts offered a financial incentive to its behavioral managed care vendor to increase self-help and peer support programs for persons with mental illness throughout the state. Massachusetts has

maintained desired performance by requiring that in subsequent years the performance target must be maintained or a financial penalty will be applied. Using this method of offering incentives based on new measures of effectiveness and applying penalties to performance on old measures not maintained at the desired level, Massachusetts has been able to add new measures each year while maintaining the old.

Possibilities for providing incentives for the use of evidence-based practices are both feasible and doable today. For example, the use of dialectic behavioral therapy (DBT) for persons with diagnoses of borderline personality, for example, could receive a higher reimbursement rate than the use of traditional outpatient therapy. DBT is a time-limited therapy that follows a pre-determined manualized program. The cost-effectiveness of this model has been well documented.

3. Purchase differently.

The idea of network financing is being discussed today as a means of stretching the current behavioral health dollar by combining funding streams to purchase a continuum of care rather than buying units of service. Many agencies subcontract with numerous programs to provide "X" number of units of service in specific categorical areas. In network financing, all elements of a system of care are part of a single purchase agreement that specifies performance targets, coordination and collaboration requirements, quality management expectations and twenty-four hours per day, seven-days per week coverage. The uniqueness of this method of financing is that the purchaser can hold all subcontractors accountable not only to the purchaser but to each other as well.

Group purchasing or purchasing collaboratives is a second strategy for purchasing differently. In this model, one of the agencies in a network of agencies serves as the lead agency and manages group purchasing of durable materials, supplies etc. It is driven by volume discount.

The point is to think creatively about what the desired behavior or outcome is (cheaper prices, better outcomes, more flexibility, more consumer choice, more individualized care, etc.) and to affirmatively design financing mechanisms to support those goals.

4. Seek funding for demonstration projects that use new financial strategies to produce better outcomes, result and value.

Behavioral managed care executives have come to understand the role that self-help and drop-in centers play in supporting community-based treatment for persons with serious mental illness. The provision of opportunities for these individuals to develop dense social networks by participating in mutual support groups is well documented (Forquer and Knight, Psychiatric Services, January 2000). Creating these opportunities has become an important component of utilization management strategies as reflected in reduced use of high-end services and substitution of new, low-end services.

Yet challenges are often encountered in how to use Medicaid dollars to support such initiatives. While capitated programs have had the most success funding these types of initiatives, fee-for-service programs have often been frustrated by current categorical rules. The availability of funds for consumer and family-operated services has also been limited, sometimes due to credentialing issues of the consumer/family providers. Demonstration programs that supported different funding approaches that allow flexible use of funding to purchase consumer/family operated programs and outcomes and results rather than traditional healthcare units would be a major step forward in creating mechanisms to buy smarter, not spend more.

APPENDIX A

THE ROLE OF THE SANTA FE SUMMITS

ACMHA's annual Summits began in 1997 with a Summit exploring the core values and the vision that needed to be driving the field. This Summit's work was memorialized in a publication entitled *Preserving Quality And Value In the Managed Care Equation* that is still used to guide ACMHA's work and is often cited as guiding principles within the behavioral healthcare field. The 1998 Summit topic was Integration of Mental Health and Other Services. It addressed both Addiction Services and Primary Care. This Summit resulted in focused work on critical performance indicators and outcomes that all services and systems should be expected to produce. A parallel track on performance and outcome indicators with national accrediting bodies began that same year culminating in a report released in 2000 entitled *A Proposed Consensus Set of Indicators for Behavioral Health.* This monograph is being utilized by accrediting bodies as well as by federal bodies in their continuing work to quantify and measure the outcomes produced by services delivered.

The 1999 Summit continued to build on the themes of quality and outcomes by exploring the proliferation of practice guidelines by guilds, payers, and advocates. This Summit resulted in a paper entitled *Practice Guidelines in Mental Health and Addiction Services: Our Watershed or Waterloo?* This paper described the value and purpose of practice guidelines and the critical components that make practice guidelines effective. The paper also reflected the 1999 Summit's discourse on how to support and effect change in clinical practice. This Summit preceded and reflected the growing debate in the country about how to develop and implement evidence-based clinical practices and the difficulty of knowledge dissemination, transfer and adaptation in behavioral health.

As a result of the first three Summits, the next two Summits were conceived of as a two-year dialogue about making quality of care a reality. The 2000 Summit focused on the role of education and training of staff, consumers and families in assuring and improving quality of care, including the use of practice guidelines and movement toward outcomes-based practices. The outgrowth of this Summit was the Academic Behavioral Health Consortium (ABHC). Along with ACMHA, this Consortium sponsored a national dialogue conference on clinical education and training, held in Annapolis, Maryland in 2001. ABHC and ACMHA hope to see this national dialogue continue and are publishing the results of the meeting in a series of articles about education and training issues. Training and education reform are seen as two critical elements that will directly shape the ability of the behavioral healthcare system to respond to the innovations and new concepts that have been the subject of the ACHMA Summits and to other influential work such as that of the Institute of Medicine.

In 2001, the second of these two Summits entitled *Financing for Positive Results: Purchasing Quality and Outcomes in Behavioral Healthcare* moved the debate one step further by exploring the role that financing mechanisms in both public and private

sectors play in either inhibiting or enhancing what the field now recognizes as ways to assure and improve quality. This Summit determined that while the behavioral health field is often inadequately funded, there is sometimes a need for "better" money rather than simply more money. That is, funding currently available could be more effective if expectations were clearer, if flexibility were enhanced, if barriers to evidence-based care were removed and if financing streams allowed for more integrated rather than categorical care for a particular individual. This Summit also identified as key strategies that a greater proportion of public funds spent on behavioral health care should be spent on consumer and family-operated services, and that private sector payers should play a stronger role in identifying and funding expected outcomes for service recipients rather than just performance and cost expectations of managers of care.

In 2002, the Santa Fe Summit worked to create a means by which the behavioral health field could move towards developing a framework for quality and system reform relevant to the behavioral healthcare system based upon the National Academy of Science, Institute of Medicine (IOM) report entitled *Crossing the Quality Chasm: A New Health System for the 21st Century*. This Summit's work will result in a document for the behavioral health field adapted from the IOM report.

Summit 2003 takes on the issue of diversity as a construct of quality and access to services for everyone with behavioral healthcare needs.