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Accreditation  
Organization  
Workgroup

A Proposed  
Consensus Set  
of  
Indicators For  
Behavioral Health

The American College  
of Mental Health  
Administration



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# Executive Summary

This is an interim report which summarizes the work-to-date in a nearly four year effort on the part of the American College of Mental Health Administration and five of the national accreditation organizations in mental health and substance abuse services. Working together as the ACMHA Accreditation Organization Workgroup they have attempted to reach agreement on a set of indicators and measures for the field. The five participating accreditation organizations include:

- CARF...The Rehabilitation Accreditation Commission
- The Council on Accreditation for Children and Family Services (COA)
- The Council on Quality and Leadership in Support of Persons with Disabilities (The Council)
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- The National Committee for Quality Assurance (NCQA)

The rationale, history and process of this project are detailed in sections Two and Three.

Substantial progress has been made by these organizations in reaching agreement on a framework and hierarchy for considering quality measurement, a common taxonomy, and a set of criteria or desirable attributes to guide decisions about the inclusion of specific indicators in any measurement set. The desirable attributes fall into three categories: importance of topic area addressed by the measure, usefulness in improving individual outcomes and measure design. Further specifics about these agreements are detailed in section Four.

Section Five focuses on the presentation of three tables which are the centerpiece of the Workgroup's conclusions on *what is important to measure*. Organized in three domains, ACCESS, PROCESS and OUTCOME, a total of thirty-five indicator definitions are proposed. Each table identifies a number of values and concerns along with indicator definitions to help measure and quantify quality. Many of the indicator definitions emphasize consumer perception of the experience of care. The tables also attempt to distinguish between those indicator definitions that are more likely applicable to quality measurement for comparison than those which may be more appropriate for internal quality improvement activities.

For the most part the indicator definitions are immediately applicable to concerns about adult mental health services. Some indicator definitions specifically address outcome issues pertaining to children. The broader applicability of the proposed indicator definitions requires further consideration.

The ACMHA Accreditation Organization Workgroup is committed to the value of consumer participation and accountability. Working with consumers as consultants, a first of its kind national video teleconference forum was held in April 2000. The objective was to enlist consumer input into the decisions about what was important to measure and the utility of information for consumers in making choices about mental health and substance abuse services. The Workgroup's proposed set of indicator definitions was also presented to other key stakeholder organizations for their review and comment. In response to this input, several modifications to the final list of proposed indicators were made before completion of this report. This vetting process is detailed in section Six.

Perhaps the greatest challenge in this entire endeavor is the transition from agreement about what is important to measure to agreement about how to actually collect data and calculate measures. Together, sections Seven and Eight address these concerns. There are many issues pertaining to data sources and data collection. Three primary data sources are identified. These include person served self-reported data, clinical records, and automated data systems. The opportunities and problems that need to be addressed in using each of these data sources is reviewed in detail and the possible data sources for each proposed indicator are identified.

The Workgroup recognizes that while the work done in reaching this level of agreement is of value, there remains much to be done in moving on towards actual implementation of these indicator definitions. There are numerous next steps that need to be addressed. If the field is to reach agreement not just about what is important to measure but how to measure, there are many issues to be resolved. Section Eight begins to identify some of these considerations which include the applicability of indicators to children's and substance abuse services, data collection, epidemiological measures, critical incident reporting, the availability of measures and instruments and field testing. The Workgroup believes that successfully resolving these issues will require greater participation by various stakeholders in the field. The Workgroup is interested and highly motivated to join in future efforts and collaborations.

# Introduction

## *Two.* **Introduction**

This publication is a summary report of work-to-date by the American College of Mental Health Administration (ACMHA) and five of the national accrediting organizations in mental health and substance abuse services. After over 2 years of working together as the ACMHA Accreditation Organization Workgroup, they are now ready to share the results of their efforts to reach consensus on performance indicators and measurement for the field. It is the narrative of a yet to be completed journey.

Although the workgroup started this initiative in June 1998, the process really began in 1996. It was then that the leadership of ACMHA recognized the need for a national dialog on matters critical to the field. Managed care, the most recent paradigm shift in the behavioral health arena, along with other changes, was challenging the value, clinical and economic bases of mental health practice. In this environment there was a paucity of interdisciplinary problem solving or support for the open exchange of ideas and finding of shared solutions for the field. Many stakeholders felt that they had little ability to act constructively in what seemed to be an increasingly adversarial milieu.

The expectation of quantifiable, demonstrable and improved outcomes had become a major concern. With ever less money to provide services, requirements for self-assessment and accreditation were continuing to mount. This trend was reinforced by consumer and purchaser demands for demonstrated clinical results. Those on the front line of clinical service and administration often felt that the expectations of government, accreditation organizations, consumer advocacy groups, and large purchasers of managed behavioral health services were in conflict. Increasingly, providers were facing duplicative if not at times competing demands which threatened to drain resources away from the essential services.

In response to these problems, the American College of Mental Health Administration, a unique and energetic interdisciplinary leadership group, began a dialogue with a wide cross-section of stakeholders. Representatives of purchasers, providers, consumers, governmental and accreditation organizations came together in March 1997 to attend the first Santa Fe Summit. Proceeds of this meeting, Preserving Quality and Value in the Managed Care Equation, were published in 1998. The report reflected a year's effort in trying to reach broad stakeholder consensus about values in the field and an agreement on a "core" set of indicators and measures.

At the same time, the national accrediting organizations in mental health and substance abuse services were themselves each struggling with these same issues and concerns. They saw the ACMHA report as a starting point

towards reaching broader agreement and accepted an invitation to partner with ACMHA in an effort to further build consensus. The accrediting organizations acknowledged that there was a real need for general agreement. The lack of consensus about what to measure for evaluating quality and performance and addressing consumer concerns was increasingly problematic. They also recognized the benefit of having an independent group facilitate a dialogue amongst them. Thus, the ACMHA Accreditation Organization Workgroup was born.

The accrediting organizations are leadership bodies, each serving a different constituency within the very diverse behavioral health environment. Providers and programs range from therapeutic foster care and child welfare services at one end of the continuum, to hospital-based psychiatric units at the other. Yet, all of the accreditors share a common vision: to help health plans, agencies, providers and payers deliver services consistent with accepted standards and to promote the best possible outcomes for consumers. None of the accreditors is a licensing or regulatory body. Each is constituted as a not-for-profit organization with an independent Board of Directors. Each utilizes a consensus-building process involving professional and consumer leaders organized into advisory and technical work groups to help shape their accreditation programs.

The accrediting organizations dedicated themselves to a very thorough and rigorous consideration of the original ACMHA work. It is our belief that this gleaning and refinement process has resulted in a generally applicable set of principles. This report attempts to distill the current state of knowledge into a fair consensus about the essentials of quality and outcomes in behavioral health services.

The accreditors are, in a sense, competing organizations within their own markets. Each is under increasing scrutiny and pressure from a variety of interest groups, governmental regulators, as well as appointed and elected officials and legislators. True dialogue required a safe environment. For this reason, membership to the Workgroup was limited to the participating accrediting organizations' appointed representatives. In the process, a variety of groups and individuals felt rebuffed, left out of the process, and concerned that their issues and perspectives might not be represented.

Efforts have been made throughout this process to gain input from the field and to assure that the work remains relevant to stakeholder concerns. Some of these efforts included:

- Working drafts were widely available at every stage of the process, and the Workgroup received and considered many comments.

- Members of our work group spoke widely to professional and consumer groups at national and regional meetings.
- A national consumer forum was telecast in April 2000 to specifically assure consumer input.

Only a reading of this report can answer whether we have been open-minded, fair, constructive and responsive.

This report reflects the commitment of the American College of Mental Health Administration, and each of the accreditation organizations participating in the Workgroup, to advance the partnership between consumers, purchasers, providers, and others in quality measurement and improvement. Behavioral healthcare is not really a free market enterprise—most consumers cannot knowledgeably choose the best provider, and various surrogates (government, managed care companies, families, courts, and primary care physicians) often preempt their ability to choose. We cannot simply say, “let the buyer beware,” and trust the market to ensure the best and most efficacious services. Advocacy and organized consumer groups have done much to represent the interests of individuals and families. Hopefully, our work will further advance the ability of consumers to be knowledgeable and active.

We present this work with the belief that efforts towards improving quality and increasing accountability in the behavioral health field will continue. We hope our legacy and contribution will be:

- A clear explanation of the elements of quality assessment.
- A substantial step forward in consensus and convergence on quality measurement within the mental health and substance abuse fields.
- An ongoing relationship between the accrediting organizations that will carry forward into the future.
- An advance in the goals of compassionate care enlightened and empowered by science.
- The availability of information to support consumers in making informed decisions about quality and care.

There is clearly more work yet to be done. We have dealt with the *why* and *what* questions about quality measurement. The very difficult challenges in the *how* remain to be addressed. The technical issues about data, measurement and implementation need to be resolved. Our work is immediately relevant to the world of adult mental health services, but its applicability to children’s services and to substance abuse services requires further consideration.

This paper is presented as part report, part invitation. The American College of Mental Health Administration and the Accreditation Organization Workgroup cannot alone complete this process and make it viable in the day-to-day world of managing systems and providing care. It is time for the field at-large to review this work and to join in the next steps.

The American College of Mental Health Administration has considered it an honor to serve as the convener of this effort. The College's Board of Directors proudly endorses the final product of the ACMHA Accreditation Organization Workgroup.

# History and Participants

As noted in the Introduction, this report grows out of an initiative of the American College of Mental Health Administration (ACMHA) that began in 1996. The ACMHA Board, meeting in New Orleans at the close of its annual meeting that year, sought to redefine the role of the College. Traditionally a member-focused group, the Board of Directors recognized that the College held a unique niche in the behavioral health field: an organization not tied to any specific profession or interests, with members reflecting the public and private sectors, researchers and teachers, and all of the clinical disciplines.

The Board, with the leadership of successive Presidents HG Whittington MD and Beverly Abbott LCSW, committed to a series of “summits”. The objective was to build on ACMHA’s status as a ‘non-aligned nation’ and work towards consensus in the field on important but vexing issues. One of the most critical and pressing issues facing the field in 1996-97 continues unresolved today: the need for agreement on a ‘core set’ of indicators and measures for mental health and substance abuse services.

The first of this series, now known as The Santa Fe Summit on Behavioral Health, was held in March 1997. This very successful meeting, underwritten by an unrestricted educational grant from Eli Lilly and Company, focused on performance indicators and led to the publication of a monograph entitled Preserving Quality and Value in the Managed Care Equation<sup>1</sup>. The report received widespread dissemination and generally positive reaction, with concurrence on the values and principles expressed.

In March 1998, ACMHA hosted a follow-up meeting or ‘mini-summit’ in Santa Fe. Some 40 key leaders in the field gathered to review the 1997 work and release of the monograph. During this meeting, Dr. Mary Jane England, co-chair of the mini-Summit, along with John Morris, MSW, 1997 Program Chair and monograph editor, challenged the accreditation organizations present. They proposed that the accreditation organizations take a leadership role in building upon the ACMHA work and moving forward with a consensus on indicators and measures for the field. Representatives of three accrediting organizations: Dr. Donald Galvin and Deborah Wilkerson from CARF...The Rehabilitation Commission; Dr. Mary Cesare-Murphy from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); and Claire Sharda from the National Committee for Quality Assurance (NCQA), all accepted the invitation to work with ACMHA.

The ACMHA Board agreed to establish a special project, the Accreditation Organization Workgroup, to assist the accreditors in working towards further agreement on a consensus set of indicators and measures. Dr. Neal Adams

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<sup>1</sup>Production and distribution of the report has been supported by the Office of Managed Care at SAMHSA

was asked to serve as Project Director and Principal Investigator and John Morris, then ACMHA President-elect, agreed to serve as co-PI/co-director; Dr. H. G. Whittington, Dr. Sheila Baler, and Dr. Eric Goplerud and Dr. Mary Jane England rounded out the ACMHA representatives.

During the initial planning for the project, it was decided that additional organizations needed to be involved, and invitations were made to American Accreditation HealthCare/Commission (URAC), the Council on Accreditation of Services for Children and Families (COA), and the Council on Quality and Leadership for Persons with Disabilities (The Council). COA and The Council agreed to join the Workgroup. Initially, the group also included Dr. Frank Sullivan as a representative from the Health Care Financing Administration (HCFA), but after an initial meeting in June 1998, it was mutually agreed that the work should focus on those organizations that actually conduct accreditation. Since that time, HCFA has maintained a liaison to the Workgroup but has not been an ongoing participant.

Given the special and unique role of accreditation in quality and accountability, the history of independence and autonomy of the accrediting organizations, their tradition of leadership, and their collective broad influence over the entire field of mental health and substance abuse services, the accreditors were an ideal group to carry forward the work initiated by ACMHA. Ranging from complex health care delivery systems to small local out-patient service providers, and every level of service in between, there are few aspects of our current healthcare system that are not in some way impacted by the accreditation process. Each of the accrediting organizations themselves has had some expectation of measurement activity by accredited organizations. Together they were interested in the possibility of reaching some agreement upon essential and common data gathering and measurement activities to address the needs and concerns of their multiple stakeholders and constituencies.

The ACMHA Board of Directors acknowledged that the resources to successfully bring such a project to fruition were beyond its own budget. A consortium of funding sources was designed to support the work while ensuring that the initiative reflected the College's commitment to broad participation of the behavioral health field. The final funding came from these sources: the partnering accrediting organizations themselves, the John D. and Catherine T. MacArthur Foundation, the Robert Wood Johnson Foundation, Eli Lilly and Company, the Office of Managed Care of SAMHSA and the Center for Mental Health Services, along with the American College of Mental Health Administration.

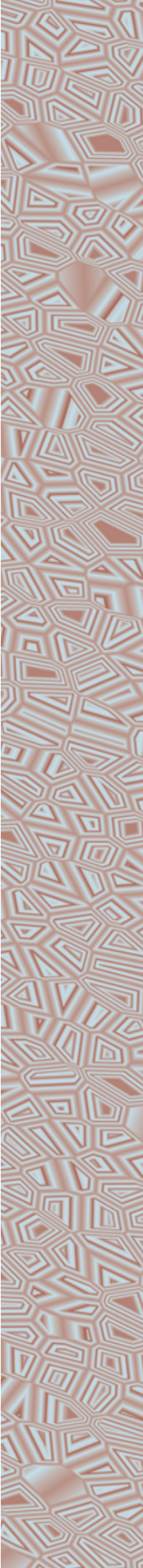
The Workgroup has met every 2-3 months since June 1998. The collaborative nature of the work has been reflected in the process of the meetings. Each of the partner organizations has taken a turn hosting the meeting in its locale. The group established early on a commitment to a cooperative, informal and

collegial atmosphere for the work, which enabled the group to benefit from its diversity of perspectives in seeking common ground.

At several points in process, ACMHA and the Workgroup have attempted to present their work to key stakeholder groups for comment and review. This has greatly enriched the process and the final product is hopefully responsive to the feedback received. Perhaps the most significant effort in this regard was a national video teleconference for consumers held in April 2000. This not only provided valuable input but also clearly demonstrated the feasibility of using technology to reach out and engage consumers in a dialogue about key issues in the field.

The workgroup has generated a series of work products that are detailed in the following sections of this document. Time will be the final arbiter of the success of this initiative. Regardless, this effort provides a model for the field demonstrating the importance and value of a collaborative approach to solving the complex problems that confront behavioral health today.

# Desirable Attributes for Performance Indicators



One of the first challenges for the ACMHA Accreditation Organization Workgroup was to agree upon a common language by which to conduct the discussion about measurement. It quickly became obvious that there were a number of common terms used by all of the organizations but with each organization ascribing its own interpretation to the words. Clearly a common taxonomy was needed to prevent the entire process from becoming a virtual Tower of Babel.



The following table was created to make the differences and similarities in language clear to all and to foster agreement on a common taxonomy for the Workgroup.

### Workgroup Taxonomy

COMMON TAXONOMY	CARF	COA	JCAHO	NCQA	The Council
	PERFORMANCE INDICATORS VERSION 1.1		ORYX	HEDIS 3.0	PERSONAL OUTCOME MEASURES
<i>Domain</i>	Domain	Domain	Domains of Performance	Domain	Factors
<i>Concept or Concern</i>	Concern	Concern			
<i>Indicator Definition</i>	Indicator	Outcome Indicators	Performance Measurement	Measure/ Indicator	Performance
<i>Measure</i>	Measure	Measure		Data Element	Measure
<i>Specification</i>	Data Element	Data Element	Date Element		Data Element
<i>Benchmark</i>	Benchmark	Benchmark	Benchmark	Benchmark	Benchmark

In addition to needing a common taxonomy, the Workgroup also needed a paradigm by which to organize the various ideas and views. After much deliberation, it became clear that there was a hierarchy of concepts and an inter-relationship between them. The table below became an essential tool for the Workgroup and helped to structure the discussion and organize the tasks.

## Workgroup Hierarchy of Measurement

<b>CONCEPTUAL</b>  <i>What</i>	<b>1. DOMAIN</b>	the most global category (access, process/performance, etc.)
	<b>2. CONCEPT OR CONCERN</b>	the most salient issues to be addressed by measurement strategies
	<b>3. INDICATOR DEFINITION</b>	something important to measure-the markers that could identify an outcome target
<b>TECHNICAL</b>  <i>How</i>	<b>4. MEASURE</b>	mechanisms used or data elements identified to support a judgment on the indicator
	<b>5. SPECIFICATION</b>	details pertaining to the collection of data for measures, e.g., sampling, frequency, instrumentation, etc.
	<b>6. BENCHMARK</b>	industry standards based on data derived from studies using the mechanisms above

The dark line between Indicator Definition and Measure warrants special attention. This line divides the conceptual and the technical, the difference between questions about *what to measure* as compared to questions about *how to measure it*. This came to be called the ‘Goplerud Line’ in honor of Dr. Eric Goplerud, a Workgroup member from ACMHA and also the Director of the Office of Managed Care at SAMHSA, who urged the group to move quickly to address all of the elements in the hierarchy.

However, the Workgroup decided that initially its work needed to stay above this line. There were more than sufficient challenges in resolving the questions about Domains, Concepts and Concerns, and Indicator Definitions. Going ‘below the line’ was always viewed as an essential but difficult set of technical next steps which would, of necessity, follow reaching consensus about the concepts and details about what is important to measure.

Additionally, it was essential for the Workgroup to agree upon some criteria to guide choices and decisions in the selection of indicator definitions from among all the possible candidates. The Workgroup built upon the accomplishments of the Performance Measurement Coordinating Council

(PMCC) and adapted a set of desirable attributes of performance measures to channel the process. The PMCC, now dissolved, was a collaborative venture which included the American Medical Accreditation, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the National Committee for Quality Assurance (NCQA) in an effort to coordinate these three organizations' performance measures across the continuum of care.

Performance measurement is often described as the quantitative assessment of health and human service processes and outcomes. Performance measures may be used to assess health care quality given by individual practitioners, provider organizations, or systems of care. A performance indicator is something measurable that describes whether a process or outcome occurs. Desirable attributes are the characteristics that define appropriate and useful measures. In agreeing upon attributes, the five accrediting organizations sought to promote consistency in performance indicator measurement.

It is important to recognize that selecting appropriate measures depends on the purpose of assessing performance. For example, one purpose would be for determining quality improvement needed and another purpose is to hold providers accountable for the care being given. The corresponding definitions distinguish when an attribute is more critical for one measurement purpose than another.

While achieving agreement on a set of desirable attributes, each of the accrediting organizations participating in the Workgroup maintained its own perspective regarding the application of these or other attributes to its measurement initiatives and accreditation programs. These individual perspectives are summarized below:

- **CARF...The Rehabilitation Accreditation Commission** has been working to identify key performance indicators and associated measures for a wide array of programs. The purpose of CARF's work on indicators, which is still under development, is to provide assistance to organizations that want to gather and report uniform information to consumers and payers and to use in internal quality improvement. Because indicators may have different applications for CARF-accredited organizations, each of the attributes is important to consider, though some attributes may be more important than others.
- **The Council on Accreditation** endorses these principles and attributes as they relate to COA-accredited organizations that provide behavioral healthcare services to children and families. However, COA accredits multi-service organizations that offer a diverse range of programs and services that do not fall under the

exclusive domain of behavioral healthcare. As a result, many COA-accredited organizations may find that the endorsed attributes are not relevant to their operations. COA also recognizes that its accredited organizations may lack the technical resources to implement performance measures at the same level of scientific rigor and sophistication reflected in the listed attributes.

- **The Council on Quality and Leadership in Support of Persons with Disabilities** supports these attributes as they pertain to measures that focus on providers and emphasize specific health conditions or areas of health. However, with its publication of the *Personal Outcome Measures System*<sup>®2</sup>, The Council remains strongly committed to measurement efforts that support a holistic approach to outcomes in behavioral healthcare and human services.
- **The Joint Commission on Accreditation of Healthcare Organizations**, through the ORYX<sup>™3</sup> initiative, is incorporating sets of standardized measures into its accreditation process to generate both cross-sectional comparisons and longitudinal analysis. Cross sectional comparisons are utilized for external and internal accountability, and for establishing benchmarks of excellence, while longitudinal analyses monitor and support ongoing quality improvement efforts within the individual health care organizations. Consequently, the attributes will be applied as appropriate to measures intended for use by the Joint Commission.
- The **National Committee for Quality Assurance's** Health Plan Employer Data and Information Set (HEDIS<sup>®4</sup>) is a set of standardized performance measures designed to enable purchasers and consumers to reliably compare the performance of managed care plans. Because the measures are designed to distinguish performance among managed care plans, and because the processes and outcomes of care can be affected by confounding factors over which plans may have little control, some attributes may be more important than others.

Agreement on these desirable attributes has been an important step towards reaching consensus on a set of indicators and measures. The five accrediting organizations have used the attributes in their efforts to decide what to include in the final set. It is important to recognize that not every indicator included in the consensus set fully addresses or satisfies the concerns raised by each attribute. However, each included indicator definition has been examined and found to be, on the whole, consistent with the attributes.

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<sup>2</sup>*Personal Outcome Measures System*<sup>®</sup> is a registered service mark of The Council.

<sup>3</sup>ORYX<sup>™</sup> is a registered trademark of JCAHO.

<sup>4</sup>HEDIS<sup>®</sup> is a registered service mark of NCQA.

The agreed upon attributes are detailed in the tables below.

ATTRIBUTE	DEFINITION
<b>1. Importance of Topic Area Addressed by the Measure</b>	
A. High priority for maximizing the health of persons or populations	The measure addresses a process or outcome that is important in maximizing the health and well being of persons or populations. Highest priority is given to those concerns that are defined by high prevalence, incidence, mortality, morbidity, or disability.
B. Financially important	The measure addresses an area of health or well being that either involves high per-person burden or affects a large number of people.
C. Demonstrated variation in care and/or potential for improvement	The measure addresses an aspect of health or functioning for which there is a reasonable expectation of wide variation in service delivery and/or potential for improvement.  If the purpose of the measure is internal quality improvement and professional accountability, then wide variation in service delivery across practitioners or settings is not necessary.
D. Strategically important	The measure addresses an area with a high level of expressed consumer and community concern.
<b>2. Usefulness in Improving Individual Outcomes</b>	
A. Based on established service or clinical recommendations	For process measures, there is good evidence that the process improves health or well-being outcomes. For outcome measures, there is good evidence that there are processes or actions that providers can take to improve the outcome.
B. Potentially actionable by user	The measure addresses an area of health or human service that potentially is under the control of the practitioner, health care or human service organization or system.

ATTRIBUTE	DEFINITION
C. Meaningful and interpretable to user	The results of the measure are reportable in a manner interpretable and meaningful to the intended user. For example, practitioners must be able to use the information generated by the measure to improve direct services. Health or human service organizations must find the information useful for decision-making purposes. When measures are used to compare health or human service systems, users should be able to understand the service delivery and economic significance of differences in how well systems perform on the measure.
<b>3. Measure Design</b>	
A. Well defined specifications	The following aspects of the measure are to be well defined: numerator, denominator, sampling methodology, data sources, allowable values, methods of measurement, and method of reporting.
B. Documented reliability	The measure will produce the same results when repeated in the same population and setting (low random error). Tests of reliability include (a) test-retest (reproducibility): test-retest reliability is evaluated by repeating administration of the measure in a short time frame and calculating agreement among the repetitions; (b) inter-rater: agreement between raters is measured and reported using the kappa statistic; (c) data accuracy: data are audited for accuracy; and (d) internal consistency for multi-item measures: analyses are performed to ensure that items are internally consistent.
C. Documented validity	The measure has face validity it should appear to a knowledgeable observer to measure what is intended. The measure also should correlate well with other measures or the same aspects of care (construct validity) and capture meaningful aspects of this care (content validity).

ATTRIBUTE	DEFINITION
D. Allowance for risk	<p>The degree to which data collected on the measure is risk adjusted or risk stratified depends on the purpose of the measure.</p> <p>If the purpose of the measure is for internal continuous quality improvement and professional accountability, then requirements for risk adjustment or risk stratification are not stringent.</p> <p>If the purpose of the measure is comparison and accountability, then either the measure should not be appreciably affected by any variables that are beyond the users control (covariates), or to the extent possible any extraneous factors should be known and measurable. If case-mix and/or risk adjustment is required, there should be well-described methods for either controlling through risk stratification or for using validated models for calculating an adjusted result that corrects for the effects of covariates. (In some cases, risk stratification may be preferable to risk adjustment because it will identify quality issues of importance to different subgroups.)</p>
E. Proven feasibility	<p>The data required for the measure can be obtained by practitioners, health or human service organizations or systems with reasonable effort and within the period allowed for data collection.</p> <p>The cost of data collection and reporting is justified by the potential improvements in service delivery and outcomes.</p> <p>The measure should not be susceptible to cultural or other barriers that might make data collection infeasible</p>
F. Confidentiality	<p>The collection of data for the measures should not violate any accepted standards of confidentiality.</p>
G. Public availability	<p>The measure specifications are publicly available.</p>



# Proposed Consensus Set of Indicators

The centerpieces of this report are the indicator definitions detailed in the tables that follow in this section.

There are three tables, one for each of the domains identified by the Workgroup: ACCESS...getting in to services, PROCESS...what happens during services, and OUTCOME...results of services. Within each domain, there are topics, concepts or concerns and indicators definitions or *things to count*.

In seeking consensus, the Workgroup members struggled with a number of issues that warrant some discussion in presentation of the proposed set. For the most part, broad if not universal applicability across populations, levels of care and systems was a primary consideration in selecting indicator definitions for inclusion.

Most, but not all, of the proposed indicator definitions satisfy this criteria. However there are several concepts or concerns that, although not as broadly applicable as others, were included because of their vital importance. There are also many exceptions to this in the OUTCOME domain. Here an effort was made to identify concerns and indicator definitions that were specific to the special needs of adults and children.

This consensus set is by no means intended to establish the entirety of performance evaluation in mental health and substance abuse services. The consensus set attempts to establish a first level of agreement. If anything it is the floor or minimum in measurement; it is not intended to be the ceiling. There are several caveats that need to be considered in review of the proposed consensus set.

- While the included concepts/concerns are intended to be broadly applicable and universal, important issues for children's services and substance abuse services may not be adequately represented or addressed.
- The accrediting organizations members of the Workgroup agree on the value, appropriateness and utility of these indicator definitions. However, this agreement should not be construed as reflecting a specific endorsement or requirement by any accreditor for data collection, reporting and/or accreditation.
- The inclusion of an indicator should not be construed as an endorsement of any particular measure or specification.

A corollary to the idea of broad applicability is the notion that some indicator definitions will support *quality comparison*. These indicator definitions are listed in **boldface type** in the tables. The Workgroup felt that for these indicator definitions, measures and specifications could be readily developed and provide sufficiently valid and reliable quantification such that comparison across providers and system could be made.

Those indicator definitions not in boldface fall in to the category of *quality improvement*. There was sufficient concern about the problems in developing measures and specifications for these indicator definitions that comparison was not seen as feasible in the near future. Rather, these indicator definitions lend themselves more to internal monitoring of performance and local accountability.

The Workgroup concluded that many of the concepts and concerns could be addressed by evaluating the perception of the experience of care by persons served. Indicator definitions based upon the report of persons served are highlighted in the tables with *italics*. For many concerns there are multiple parallel indicator definitions that are based upon a more objective approach and imply the availability of administrative and clinical data for measures and specifications.

Indicator definitions in the OUTCOME domain make reference to measurement intervals. Many specify evaluation at the initiation of treatment, the termination of treatment and at an interval following the termination of treatment. This is noteworthy because of the implied need to conduct some routine follow-up. For persons served requiring extended treatment, consideration should be given for evaluation at regular intervals.

In many respects the information included in the tables is simple and straightforward. In other ways the tables are rich with detail and complexity. Together they represent a substantial step forward for the field in agreement on what is important to count and measure about performance and outcomes in mental health and substance abuse services.

ACCESS... getting into services

TOPIC	CONCEPT OR CONCERN	THINGS TO COUNT
<b>1. Services are available</b>	Persons served perceive and experience services as available.	<ul style="list-style-type: none"> <li>a. <b>The rate of persons served reporting that they receive services they need</b></li> <li>b. The rates of utilization of services as compared to the identified needs of the community.</li> </ul>
<b>2. Services are convenient</b>	Persons served perceive and experience services as convenient (i.e., available services are well located, offered at convenient hours, etc.)	<ul style="list-style-type: none"> <li>a. <b>The rate of persons served reporting that transportation is not a barrier to recovery</b></li> <li>b. Geographic analysis of population-to-provider rates and travel times for behavioral health professionals</li> </ul>
<b>3. Services are timely</b>	Persons served perceive and experience services as timely.	<ul style="list-style-type: none"> <li>a. <b>The rate of persons reporting timely response from first request for service to first face-to-face meeting with a mental health professional</b></li> <li>b. <b>The rate of persons reporting timeliness from a first appointment to a second appointment</b></li> <li>c. The average number of days from first request for service to first face-to-face meeting with a behavioral health professional</li> <li>d. The average number of days from a first appointment to a second appointment</li> </ul>
<b>4. Services are provided</b>	Services are available and provided to people like me.	<ul style="list-style-type: none"> <li>a. <b>The rate of utilization of services at each available level of care described by meaningful groupings of persons served</b></li> </ul>

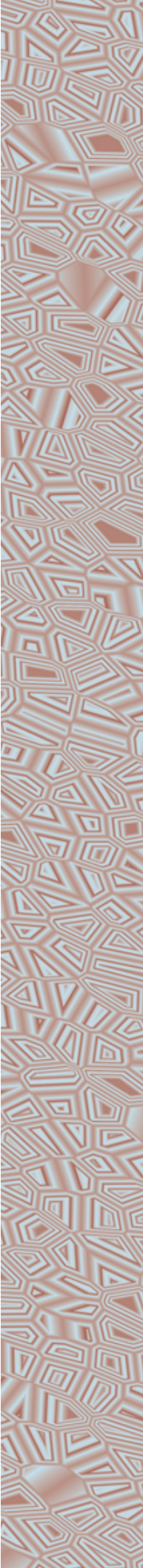
PROCESS... what happens during services

TOPIC	CONCEPT OR CONCERN	THINGS TO COUNT
<b>1. Treatment decisions</b>	Persons served (and families of children and adolescents) participate meaningfully in treatment decisions.	<ul style="list-style-type: none"> <li>a. <b>The rate at which <i>persons served report they received useful information to make informed choices about their treatment</i></b></li> <li>b. The rate of participation in decisions regarding treatment by persons served</li> <li>c. The rate of participation in decisions regarding treatment by families of children and adolescents when indicated</li> </ul>
<b>2. Responsiveness</b>	Services are responsive to the clinical status of the person served.	<ul style="list-style-type: none"> <li>a. <b>The rate of persons served who receive timely face-to-face follow up care after leaving a 24 hour care setting</b></li> <li>b. The rate of persons served who receive a timely course of treatment following diagnosis of a behavioral health disorder</li> </ul>
<b>3. Non-coercive treatment</b>	Whenever possible, treatment should be voluntary and non-coercive.	<ul style="list-style-type: none"> <li>a. <b>The rate of <i>persons served who report experiencing treatment as non-coercive</i></b></li> <li>b. The rate of involuntary treatments</li> <li>c. The rate of seclusion and restraint</li> </ul>
<b>4. Experience of care</b>	Persons served perceive and experience service providers as responsive and sensitive.	<ul style="list-style-type: none"> <li>a. <b>The rate at which <i>persons served report they were treated with politeness, respect, and dignity by staff</i></b></li> <li>b. <b>The rate at which <i>persons served report feeling hopeful about their recovery</i></b></li> <li>c. <b>The rate at which <i>persons served report they were treated with sensitivity to their gender, age, sexual orientation, culture, religious, ethnic, and linguistic background</i></b></li> </ul>
<b>5. Co-occurring illness</b>	Co-occurring mental illness and substance abuse is recognized and treated.	<ul style="list-style-type: none"> <li>a. <b>The rate of persons served diagnosed with co-occurring mental illness and substance abuse disorders</b></li> </ul>
<b>6. Safe treatment</b>	Persons served are safe in treatment.	<ul style="list-style-type: none"> <li>a. <b>The rate at which <i>person served report that they feel safe in treatment</i></b></li> <li>b. <b>The rate at which <i>persons served report that they feel safe in the community</i></b></li> <li>c. The rate of suicide, homicide and unexpected deaths</li> </ul>

OUTCOME... results of services

TOPIC	CONCEPT OR CONCERN	THINGS TO COUNT
1. <i>Well being</i>	Persons served experience an improvement in health and psychological well being as a result of treatment	<p>a. The rate of persons served who are better, worse or unchanged at the termination of treatment compared to the initiation of treatment</p> <p>b. The rate of persons served who are better, worse or unchanged at a standard interval following the termination of treatment compared to the termination of treatment</p>
2. <i>Work and school</i>	Persons served are productively involved in work and school.	<p>a. <i>For adults:</i> the rate of employed/unemployed adults counted at the termination of treatment and at a standard interval following the termination of treatment</p> <p>b. <i>For employed adults:</i> the average number of days not worked counted at a standard interval following the termination of treatment</p> <p>c. <i>For children:</i> the average number of missed class days counted at a standard interval following the termination of treatment</p>
3. <i>Safety</i>	Treatment improves the safety of persons served.	<p>a. The rate of episodes of victimization reported at a standard interval following the termination of treatment</p> <p>b. <i>For persons served who identify victimization or vulnerability as a concern at the initiation of treatment: the rate of perceived vulnerability reported at the termination of treatment and at a standard interval following the termination of treatment</i></p>
4. <i>Legal involvement</i>	Persons served should be out of trouble with the law.	<p>a. <i>For persons served who identify problems with the law as a concern at the initiation of treatment: the rate of arrests, detentions and/or incarcerations counted at a standard interval following the termination of treatment</i></p>
5. <i>Housing</i>	Housing needs are resolved.	<p>a. The rate of domiciled/homeless persons at the termination of treatment and at a standard interval following the termination of treatment</p> <p>b. <i>For adults who identify housing as a concern at the initiation of treatment: the rate who report improvement, worsening or no change in their satisfaction with housing at the termination of treatment and at a standard interval following the termination of treatment</i></p> <p>c. <i>For children:</i> the rate of children at home at the termination of treatment and at a standard interval following the termination of treatment</p>

# Consumer and Stakeholder Perspectives



The American College of Mental Health Administration and the Accreditation Organization Workgroup have been concerned about assuring the relevance and utility of their work with stakeholders throughout the effort towards consensus. In March 1999 a one-day invitational meeting was held in Santa Fe to receive feedback after the first year of work. In the Spring of 2000 the final draft of the consensus set was ready for further review and comment before preparation of this report.

Perhaps the most significant review occurred in April 2000 with a national video teleconference and virtual town hall meeting for consumers. The purpose of the teleconference was to familiarize consumers with the ACMHA Accreditation Organization Workgroup's proposed set of indicator definitions and to obtain feedback about the perceived utility of the information for consumers. The Workgroup retained two consumer consultants, Paul Weaver PhD from *Mental Health America* and Wilma Townsend MSW from the Office Support Agency to coordinate the event and to evaluate consumer input.

The teleconference was broadcast in front of a live audience from South Carolina Educational Television. In addition, consumers from forty-six sites in twenty-two states participated in the teleconference that included a call-in for questions and answers. Over four hundred and seventy-five consumers provided written feedback through completion of a survey that allowed for scoring the utility of the proposed indicator definitions.

The respondents reflected the diversity of consumers in the field according to the following analysis:

<b>Gender</b>	<b>%</b>	<b>Ethnicity</b>	<b>%</b>	<b>Type of Service Provider</b>	<b>%</b>
male	46	Caucasian	62	<b>Public</b>	
female	52	African Americans	19	mental health	68
		Native Americans	8	substance abuse	39
<b>Age</b>		Hispanic/Latino	6	<b>Private</b>	
18-30	12	Asian/Pacific Islander	2	mental health	73
31-50	57	Other	9	substance abuse	14
51-70	27				
<b>Years as a Consumer</b>				<b>Years Since Last Services</b>	
0-3	19			less than 2	62
4-10	27			more than 2	27
11-19	23				
20+	21				

Approximately two-thirds of the survey respondents ranked the three domains of ACCESS, PROCESS and OUTCOME as having significant utility for making decisions about care. At the same time, over forty percent (41.1%) reported that the ACMHA Accreditation Organization Workgroup consensus set of performance indicators omitted factors that were important to them in comparing service providers or health plans. However, there was not a significant response in the specific identification of other domains.

In general, survey respondents also found the specific concepts and concerns to be useful. Using a five-point Likert scale (a score of 5 indicating “most useful” and a score of 1 indicating “least useful”), most items were ranked 4 or 5 at least 60 to 70% of the time.

There were however a few notable exceptions:

- Receiving services at an acceptable place received a score of 4 or 5 from only 12% of respondents
- Receiving coordinated care for mental illness and substance abuse problems received a score of 4 or 5 from only 47% of respondents
- Knowing that decreased criminal justice involvement was a direct result of services received a score of 4 or 5 from only 49% of respondents

In addition to the teleconference, twenty-one consumer researchers and leaders from 17 states participated in a focus group designed to solicit feedback on the ACMHA Accreditation Organization Workgroup’s proposed consensus set. The focus group, convened in June 2000, offered the following comments:

- Questions concerning capacity, hours, and transportation should be included in the ACCESS domain
- An item addressing the core competencies of mental health professionals should be included in the PROCESS domain
- The term “during treatment” should be substituted for “result of treatment” in the OUTCOME domain indicator definitions
- Additional variables other than services might influence outcomes.

The consumer focus group also argued for more emphasis on:

- Recovery as a domain or a specific topic under each of the three domains

- Staff providing a sense of hope, understanding, and education about illness and alternative resources
- Involving consumers in the accreditation process
- Consumer choice, including the option to choose medication providers, or to choose no services
- The extent to which many aspects of service are driven by cost
- Transportation as a major variable in getting to, and maintaining services
- Trauma, cultural competence, peer support groups, and rights

On the whole, the consumer feedback, from both the survey and the focus group served to confirm the usefulness and the importance of the information included in the proposed consensus set. The Workgroup felt that the comments concerning issues of transportation and the value of respect, dignity, recovery, and hope were especially meaningful. In response to this input, several changes were made in the final consensus set. PROCESS item 4.b was added and ACCESS item 2.b was substituted for an indicator definition about the location of services.

In addition to the review by consumers the Workgroup's products were reviewed in September 2000 by members of the Washington DC based Mental Health Liaison Group. This group includes representatives of the major national professional, trade and advocacy organizations in mental health and substance abuse. The work was well received with positive comments and a general interest in joining with the Workgroup to explore next steps in development and implementation. There has also been some interest expressed by members of the Liaison Group to explore the applicability of the proposed indicator definitions to children's services.

The Workgroup also presented their recommendations to the Board of the American Behavioral Healthcare Association (AMBHA) in October 2000. Again the work was well received with general support and the recommendations were viewed as a positive step forward. Here too, the possibility of collaboration in further development was a consideration.

As stated in the introduction, this document is an interim report about a work in progress. The Workgroup has reached an important level of agreement and initial feedback from key stakeholders has been generally in accord. The purpose of this report is to share the work more broadly with the field and to promote further dialogue.

A form for comment is included in the final pages. Feedback may be provided through the ACMHA website at [www.acmha.org](http://www.acmha.org). Readers are encouraged to share their perspectives on the issues and proposed solutions.

# Data Sources and Related Issues

This section presents a brief general overview of data collection issues and challenges. In addition, a list of possible data collection sources for each measure is presented along with specific data collection questions that need to be addressed.

While the ACMHA Accreditation Organization Workgroup was able to reach agreement about what is *important to measure*, agreement about *how to measure* was more difficult to achieve. Data collection for performance measures presents several unique challenges, including the identification of specific data sources for each measure, ensuring comparability if multiple sources are used and minimizing the costs associated with the data collection effort.

The intended use of any specific performance measure will have a profound impact on determination of the optimal data collection methodology. For example, performance measures that are used for quality improvement activities within a system of behavioral health care need only be consistent within that particular system. Quality evaluation that uses internal quality improvement as a basis necessitates consistent data collection methodologies for each individual quality improvement activity. Different data collection methodologies are possible among the different performance measurement activities within an individual behavioral health system; again the desired consistency is within a specific measurement activity.

However, when behavioral health systems are compared among each other, the data collection methodology must be comparable for each performance measure. Quality evaluation that supports comparing one system or provider with another must specify a specific data collection protocol for each performance measure. While the ACMHA Accreditation Organization Workgroup has always supported the value of quality measurement for comparison, solving the technical issues required to specify a single measure and data collection strategy, or to calibrate across several options, is an enormously challenging task.

Data are available from three primary sources:

- *Person served self-reported data*
  - information collected directly from the person served, including consumer surveys, focus groups, questionnaires, etc.

- *Clinical records*
  - clinical information that resides in permanent paper records, which may be at multiple provider or practitioner locations
- *Automated data systems*
  - clinical, claims, and encounter information that resides on computerized retrieval systems, which may involve multiple provider or practitioner locations and formats

Each of these data sources possesses unique data collection advantages and challenges that need to be addressed. There are many caveats to consider in making decisions about measure specifications.

#### *PATIENT SELF-REPORTED DATA*

Many performance measures rely on the individual person served to report about experiences and outcomes of care. This source of data is often viewed as the most reliable for measures relating to the experience the person served has with the behavioral health system, such as satisfaction with providers, practitioners, and plans. The person served is also viewed as a reliable source of information for reporting about some of the outcomes resulting from the care they receive. These outcomes might include improvements in health or psychological well being or being able to function at work or school. Self-reported data can serve to validate or corroborate other measures of process and outcome. Many argue that it is the person served's perception of the process and impact of their behavioral health treatment that should be the gold standard of quality.

Patient self-reported data can take on many forms and complexities. Simple questionnaires filled out in a practitioner's office prior to a visit can serve to evaluate access and availability of services. Computerized outcomes assessments can be used to evaluate pre- and post-treatment efficacy. Interviews of the person served by trained staff can help to evaluate the quality of a new treatment method or change in protocol. Standardized surveys that are administered by third-party (independent) vendors can be used to assess the quality of care, access to services, patient satisfaction, and perceived outcomes.

Many types of patient self-reported data can be inexpensive to administer and score. As computerized systems become more common in practitioner offices, the time and cost of administering patient surveys for a variety of reasons (e.g., perceived outcomes, satisfaction, access) becomes more manageable. Especially when used for quality improvement activities, these inexpensive data collection methodologies for administering patient self-reported instruments can be quite cost effective.

However, when self-reported data from the person served are desired for comparing behavioral health systems among peer organizations or levels, then more standardization is required to minimize bias in the results. This will allow for fair and accurate comparisons to be made. Many in the field believe

that the most rigorous standardization requires surveys to be administered using contracted survey vendors who independently survey patients and report results.

Cost can be a significant factor in the collection of self-reported data. As survey administration protocols become more complex and involve multiple parties, the costs increase. Ultimately, the cost of administering a data collection effort must be weighed against the needs of the data and its intended uses. Holding systems accountable for their quality performance requires a delicate balance of the cost for determining quality and the desired impacts of the quality measurements.

Another challenge to self-reported data is the ability of the person served to accurately recall information. Survey items that require extensive recall periods may produce unreliable results. Instruments used for collecting self-reported data must also be thoroughly tested to ensure that cultural differences in the results are not the primary measurement and that language barriers do not bias results. Furthermore, surveys intended to evaluate the cultural competency of a provider or practitioner should be designed to maximize cultural differences.

#### *CLINICAL RECORDS*

Clinical records are formal documents that should include a complete record of the care process. There are a variety of standards for clinical records that can be followed to provide an adequate representation of behavioral health services. The clinical record is often viewed as the 'gold standard' in terms of a reliable source of clinical information about an individual. This viewpoint assumes that the person served is forthcoming with all pertinent information to each provider and that a complete record is available for review. The clinical record typically include a history, diagnoses, treatment plans, a record of services provided, medications, referrals to other treatment settings, and a discharge summary along with other documents.

However, clinical records have their limitations as a data source for quality evaluation and measurement. Records are often an expensive source of data for performance measurement because of the work required to extract data.. Complete records must be located for each patient to be measured for the specific time period of the measurement. This step may involve multiple practitioners, providers, and plans. A standardized data collection tool, often called an abstraction tool, must be developed to ensure data comparability

and completeness. Data collectors should be trained on the use of the collection tool and tested to ensure that all data collected by the different data collectors is reliable (inter-rater reliability). Once trained, the data collectors are sent to practitioner offices to locate clinical records and abstract the information. Sometimes clinical records are photocopied and sent to a single location for abstraction. Both abstraction methods require considerable resources and time.

The protection of confidentiality is a concern when clinical records are used. The accuracy and completeness of clinical records can also be a problem. Some providers do not chart correctly or completely, and as a result clinical records are not a true reflection of the care given. Multiple practitioners may serve one individual and the integration of data from multiple sources can also be problematic and some or all of the data may be unavailable.

Most clinical records are considered to be paper records, i.e., not automated in a computer retrieval form. Many examples of computerized clinical records are becoming available, but a standard and complete record is typically not available. Computerized clinical records that include searchable and standardized data fields will lead to increased efficiency in the care of the person served and make performance measurement using this data source more feasible.

#### *ADMINISTRATIVE DATA SYSTEMS*

Automated data systems, or administrative data, use standardized codes to identify events, diagnoses, treatments, and other aspects of care. Coding systems such as the Current Procedural Terminology (CPT) or the International Classification of Diseases, 9<sup>th</sup> Revision, Clinical Modification (ICD-9-CM) offer standardized methods for coding of clinical encounters. There are many other automated data systems used for clinical and behavioral health care. Many of these standardized systems were established to automate claims and billing, which often limits their usefulness in performance measurement.

The potential benefits of administrative data are the ease and low cost in retrieving information for quality performance measurement. Several studies have found that administrative data can be sufficiently accurate for performance measurement when used within a particular health care system. When complete administrative systems, which include comprehensive electronic clinical records, become more widely available, performance measurement can be better integrated into the process of care.

While administrative data systems offer the advantage of lower cost, they often lack the detail, completeness and accuracy needed for performance

measurement. Claims and encounter data often do not have the specificity required to make detailed assessments of care. Unless diagnoses are tied to claims, the amount of information is limited.

Over the past few years, several studies have examined the differences between clinical records and administrative systems for quality measurement. Most conclude that there are striking differences between the two. This makes comparability of clinical records and administrative systems difficult. Without carefully designed studies to evaluate the comparability of data for a specific performance measure, using both to report performance measures is problematic.

Another limit of data available in administrative data systems include the lack of coordination of laboratory, pharmacy, and clinical information. Often these data are available on separate platforms that were not designed to be compatible with other data systems. Miscoding is also a significant problem in administrative data systems. Miscoding may result from incorrect data entry, coding mistakes, or even fraudulent coding. For example, some providers may miscode under the guise of protecting confidentiality, helping individuals to receive services that are denied, and to enable providers to bill at higher rates. Regardless of the source, miscoding presents a serious problem for performance measurement.

Most administrative data systems also lack demographic information about the persons served that is essential for risk/case-mix adjustment. The most common available demographic data in administrative data systems includes age and sex. Other characteristics such as race/ethnicity, comorbidities, education or employment, which are necessary for risk/case-mix adjustment of many performance measures, are not available.

Despite these issues and caveats, the Workgroup did give some consideration to possible data sources for specific measures included in the consensus set. The following tables parallel the tables in Section Five. Here, however, the column of *Concepts or Concerns* has been deleted and a column of *Possible Data Sources* has been added. The same **boldface** emphasis for those indicator definitions that the Workgroup believes can be relatively easily implemented for quality comparison purposes is included.

ACCESS... getting into services

TOPIC	THINGS TO COUNT	POSSIBLE DATA SOURCES
<b>1. Services are available</b>	a. <b>The rate of persons served reporting that they receive services they need</b>	a. <b>consumer survey; focus groups; individual interviews</b>
	b. The rates of utilization of services as compared to the identified needs of the community.	b. encounter data; enrollment data; billing records; clinical records
<b>2. Services are convenient</b>	a. <b>The rate of persons served reporting that transportation is not a barrier to recovery</b>	a. <b>consumer survey; focus groups; individual interviews</b>
	b. Geographic analysis of population-to-provider rates and travel times for behavioral health professionals	b. encounter data; enrollment data; billing records; clinical records; mailing labels; provider data bases; mapping software
<b>3. Services are timely</b>	a. <b>The rate of persons reporting timely response from first request for service to first face-to-face meeting with a mental health professional</b>	a. <b>consumer survey; focus groups; individual interviews</b>
	b. <b>The rate of persons reporting timeliness from a first appointment to a second appointment</b>	b. <b>consumer survey; focus groups; individual interviews consumer/clinician report</b>
	c. The average number of days from first request for service to first face-to-face meeting with a behavioral health professional	c. clinic appointment books and phone logs; administrative records; billing records; encounter data
	d. The average number of days from a first appointment to a second appointment	d. clinic appointment books and phone logs; administrative records; billing records; encounter data; consumer/clinician report
<b>4. Services are provided</b>	a. <b>The rate of utilization of services at each available level of care described by meaningful groupings of persons served</b>	a. <b>encounter data; billing records; patient report; patient demographic information</b>

PROCESS... what happens during services

TOPIC	THINGS TO COUNT	POSSIBLE DATA SOURCES
<b>1. Treatment decisions</b>	<b>a. The rate at which <i>persons served</i> report they received useful information to make informed choices about their treatment</b>	<b>a. consumer survey; focus group; individual interview</b>
	b. The rate of participation in decisions regarding treatment by persons served	b. clinical records; consumer survey; clinician report
	c. The rate of participation in decisions regarding treatment by families of children and adolescents when indicated	c. clinical records; consumer survey; clinician report
<b>2. Responsiveness</b>	<b>a. The rate of persons served who receive timely face-to-face follow up care after leaving a 24 hour care setting</b>	<b>a. encounter data; billing records; consumer report; clinical records; discharge documents</b>
	b. The rate of persons served who receive a timely course of treatment following diagnosis of a behavioral health disorder	b. encounter data; billing records; clinical records; consumer report
<b>3. Non-coercive treatment</b>	<b>a. The rate of <i>persons served</i> who report experiencing treatment as non-coercive</b>	<b>a. consumer survey</b>
	b. The rate of involuntary treatments	b. clinical records; critical incident reports; encounter data
	c. The rate of seclusion and restraint	c. clinical records; critical incident reports; encounter data

PROCESS... what happens during services *continued*

TOPIC	THINGS TO COUNT	POSSIBLE DATA SOURCES
<b>4. Experience of care</b>	a. The rate at which <i>persons served report</i> they were treated with politeness, respect, and dignity by staff	a. consumer survey; complaints; focus groups
	b. The rate at which <i>persons served report</i> feeling hopeful about their recovery	b. consumer survey; focus groups
	c. The rate at which <i>persons served report</i> they were treated with sensitivity to their gender, age, sexual orientation, culture, religious, ethnic, and linguistic background	c. encounter data; billing records; clinical records
<b>5. Co-occurring illness</b>	a. The rate of persons served diagnosed with co-occurring mental illness and substance abuse disorders	a. encounter data; billing records; clinical records
<b>6. Safe treatment</b>	a. The rate at which <i>person served report</i> that they feel safe in treatment	a. consumer survey; complaints; focus groups
	b. The rate at which <i>persons served report</i> that they feel safe in the community	b. consumer survey; complaints; focus groups
	c. The rate of suicide, homicide and unexpected deaths	c. clinical records; critical incident reports, public health records

OUTCOME... results of services

TOPIC	THINGS TO COUNT	POSSIBLE DATA SOURCES
<p><b>1. Well being</b></p>	<p>a. The rate of persons served who are better, worse or unchanged at the termination of treatment compared to the initiation of treatment</p>	<p>a. consumer survey; clinical records; encounter data; billing records</p>
	<p>b. The rate of persons served who are better, worse or unchanged at a standard interval following the termination of treatment compared to the termination of treatment</p>	<p>b. consumer survey; clinical records; encounter data; billing records</p>
<p><b>2. Work and school</b></p>	<p>a. <i>For adults:</i> the rate of employed/unemployed adults counted at the termination of treatment and at a standard interval following the termination of treatment</p>	<p>a. consumer report; tax/employment records; clinical records; collateral report</p>
	<p>b. <i>For employed adults:</i> the average number of days not worked counted at a standard interval following the termination of treatment</p>	<p>b. consumer report; tax/employment records; clinical records; collateral report</p>
	<p>c. <i>For children:</i> the average number of missed class days counted at a standard interval following the termination of treatment</p>	<p>c. consumer/family report; school records; clinical records; collateral report</p>

OUTCOME... results of services *continued*

TOPIC	THINGS TO COUNT	POSSIBLE DATA SOURCES
3. <b>Safety</b>	a. The rate of episodes of victimization reported at a standard interval following the termination of treatment	a. consumer/family report; law enforcement records; clinical records; collateral report
	b. <i>For persons served who identify victimization or vulnerability as a concern at the initiation of treatment: <b>the rate of perceived vulnerability reported at the termination of treatment and at a standard interval following the termination of treatment</b></i>	b. <b>consumer/family survey; clinical records</b>
4. <b>Legal involvement</b>	a. <i>For persons served who identify problems with the law as a concern at the initiation of treatment: the rate of arrests, detentions and/or incarcerations counted at a standard interval following the termination of treatment</i>	a. consumer/family report; law enforcement records; clinical records; collateral report
5. <b>Housing</b>	a. The rate of domiciled/homeless persons at the termination of treatment and at a standard interval following the termination of treatment	a. consumer/family report; housing authority records; welfare records; clinical records; collateral report
	b. <i>For adults who identify housing as a concern at the initiation of treatment: <b>the rate who report improvement, worsening or no change in their satisfaction with housing at the termination of treatment and at a standard interval following the termination of treatment</b></i>	b. <b>consumer/family survey; clinical records</b>
	c. <i>For children: the rate of children at home at the termination of treatment and at a standard interval following the termination of treatment</i>	c. consumer/family report; welfare records; clinical records; collateral report



# Next Steps

From its inception, a primary goal of the ACMHA Accreditation Organization Workgroup has been to improve the availability and utility of performance information for mental health and substance abuse services consumers. Each of the accrediting organizations participating in the Workgroup expects accredited programs and providers to be involved in some level of data collection and analysis for quality management. There is also an expectation that at least some of this information is available to consumers. However, issues of validity and comparability have oftentimes limited the value of such information. Any notion of next steps for the Workgroup, and the field, must address the need to better inform consumers and other stakeholders in their decisions and choices about services.

The agreement reached to date by the Workgroup is an important step forward in pursuit of this goal. Consumers and other stakeholders need information that allows them to compare and to choose. Agreement on *what to measure* sets the stage for reaching broad agreement on *how to measure* in order to meet the expectations of consumers. But the challenges involved in reaching agreement on the technical issues are substantial.

The work is unfinished at this point. While agreement on what is important to measure has been reached, the problems of data collection, measurement, implementation and reporting have yet to be addressed. There are several tasks that remain. This consensus process has identified concerns and indicators that could be considered universal and relevant to virtually all consumers, but the work to date does not address other concerns of special populations. This is of particular importance in the realm of children's as well as substance abuse services.

The Workgroup intentionally limited its work to the process of reaching consensus on a conceptual level. The more difficult, detailed and controversial work of developing or specifying measures is viewed as a next step to follow after substantial consensus on the indicator set is reached. The reasons for this are several:

- Some indicators do not have clearly established or accepted valid, reliable and methodologically sound measures.
- In other cases, the diversity of available measurement strategies requires choosing amongst them and recommending a single measure—a task that is fraught with political and practical difficulty. It is not clear that endorsing measures is an appropriate role for ACMHA or of the accrediting bodies. There is substantial work to be done in measure evaluation before considering such an endorsement.

- If a single measure cannot be specified, or if a choice among measures is recommended, the possibility of calibrating several comparable measures needs to be considered.
- Strategies and techniques for case-mix adjustment need to be developed.
- The resources—time, expertise, and money—required to accomplish these tasks exceeded what was immediately available to the Workgroup.

There are also questions of leadership that need to be addressed. Until this point, it has been valuable for the accrediting organizations to work amongst themselves to reach some level of agreement. Now it is important to open the process and to actively engage other stakeholders in the effort. ACMHA and the accreditation organizations are willing to consider taking the lead, but clearly the tasks ahead require an alliance with others. The Workgroup believes that a national dialog and forum in the field is essential in order to set such a course.

Some of the specific issues that need to be addressed include the following:

#### *CHILDREN'S SERVICES*

The concerns included in the consensus set are hopefully germane to the questions surrounding care for children and their families. In addition, some of the indicators are subdivided into adult and children's components. Nonetheless, the inclusion of indicators and measures that are focused on and appropriate for services to children needs to be considered. The Workgroup acknowledges that children are not simply small adults, and special concerns and measurement issues apply to performance of children's programs.

In this arena, next steps will entail targeted development work to identify appropriate indicators for behavioral health services for children and adolescents.

#### *SUBSTANCE ABUSE SERVICES*

The work to date has not focused specifically on the issues of substance use services and outcomes. Again, the consensus set addresses universal concerns that are likely relevant to substance abuse services, and there are some indicators that specifically address substance abuse issues. However, this is a critical area of service delivery with specific values and concerns

that must be addressed. The ACMHA Accreditation Organization Workgroup recognizes that another like group, the Washington Circle Group, has been working to identify indicators for substance use programs. Next steps for the ACMHA Accreditation Organization Workgroup should include a collaborative review of the work of the Washington Circle Group, with an eye towards better coordination of the two efforts.

#### *DATA COLLECTION*

Many of the proposed indicators rely upon the consumer's perception of the experience of care or the outcomes achieved. The most likely source of this information is a consumer survey. The challenge will be to identify a survey that could be appropriate and feasible for administration across the diversity of systems, programs, and populations in the field.

One promising effort to create a broadly applicable consumer survey instrument is already underway. The ECHO survey is currently under development in a collaborative effort involving NCQA, Harvard University and SAMHSA. This new survey is built upon the widely used Consumer Assessment of Health Plans (CAHPS) and its behavioral health counterpart the Consumer Assessment of Behavioral Health Services (CABHS). The ECHO survey also includes items and concepts from the well-accepted Mental Health Statistics Improvement Program's (MHSIP) Consumer Survey that is now widely used by States and other public providers.

This new survey tool shows much promise; continuing to monitor and evaluate developments in this arena is critically important. One possibility, based in item response theory, is to identify a set of essential questions to be included in *any* survey thus creating a potentially "universal" survey tool. Whether or not the ECHO, or perhaps some subset of items, will prove to be a universally applicable survey instrument remains to be seen. Regardless, there are also many questions about survey administration, sampling, data analysis, case-mix adjustment, etc. which will need to be resolved.

#### *EPIDEMIOLOGICAL MEASURES*

Included in the consensus set are indicators that are population-based epidemiological measures. These data require a different level of analysis than those dealing with aggregating consumer views and measures of clinical change or administrative efficiency. A specific review of these measures, and strategies for case-mix adjustment based upon such data requires substantial attention.

## *INCIDENT AND ERROR REPORTING*

Several of the proposed indicators address issues of safety and so-called “sentinel events,” such as seclusion, restraint, suicide rates and safety in treatment. The Federal government and others have recently implemented new practice and reporting requirements related to these concerns. These requirements are likely to affect virtually all of the accrediting bodies as well as providers. The Workgroup is concerned about proposing any measures in this arena that are not in concert with government and regulatory requirements. Next steps should include close monitoring of government guidelines for incident and error reporting and an effort to coordinate data collection with government requirements.

## *REVIEW OF AVAILABLE MEASURES AND INSTRUMENTS*

Before developing measure specifications, a thorough review of available and applicable measures, tools, instruments and/or data elements should be conducted. Only those measures with evidence of validity, reliability, and feasibility should receive further consideration. Several reviews and compilations of instruments already exist and these should be among the first to be considered.

This process should also include a review of ongoing demonstrations and applications of performance indicator/ measurement systems. These projects include demonstrations of the MHSIP Consumer Oriented Report Card, The National Association of State Mental Health Program Director’s (NASMHPD) 16-state study, the American Behavioral Healthcare Association’s (AMBHA) PERMS project and others.

Other than field-testing, the review of available measures is likely to be the most resource-intensive next step. The Workgroup recognizes that substantial resources will be needed to accomplish such a review. Seeking resources to support such an effort is also an essential next step.

## *FIELD TESTING*

Sound measure development or data collection requires field-testing that should be conducted to evaluate the validity, reliability, usefulness, and feasibility of the proposed indicators and measures. This is a second order task, given the substantial amount of work to be done in identifying measures, data elements, and other specifications for the indicators.

If a uniform consumer survey, such as the ECHO, proves to be generally applicable to the Workgroup's concerns and indicators, the utility of specific items or scales will need to be assessed. In addition, the use of such an instrument in a wide range of settings and populations will also need to be considered. Here, too, substantial resources to properly field test instruments and data collection strategies will be required.

The accreditation organizations participating in the Workgroup are continuing their own efforts to develop and implement performance indicators and measures within the context of their individual accreditation program. Each of the accrediting organizations view themselves as responsive to both a shared as well as a unique array of constituents which includes consumers, providers, payers, government, researchers, policymakers.

From the start, each accreditation organization agreed to work towards consensus about what is important to measure. They also agreed to bring that consensus forward within their respective organizations consistent with their own policies, strategies and operations. Specifically, they agreed to consider the Workgroup's conclusions in their own performance measurement development process and to take into account the Workgroup's recommendations for inclusion in each organization's accreditation requirements or expectations.

Clearly this internal process will be a critical next step for the Workgroup members. No doubt there will be much dialog and debate within each organization about the merits and pitfalls of moving forward; the risks of standing still will also need to be considered. The accreditation organizations are leadership organizations, but they do not exist in a vacuum. They are responsive to the field and cannot make decisions that exceed or are contrary to the concerns of their constituents.

The Accreditation Organization Workgroup and ACMHA believe that this work- to-date is an important step forward in the advocacy, development and implementation of a uniform set of key performance indicators for behavioral health. Perhaps the most important next step is a renewed national dialogue on performance measurement in response to this effort and recommendations. Such a dialog must also include some consideration of the resources needed to move on and address the issues detailed above in order to further agreement and the development of specifications.

Each of the accreditation organizations and ACMHA are interested and willing to continue the process. The Workgroup members themselves have found great benefit in participating in the process, in learning from each other's perspectives, and achieving a more robust and inclusive set of recommendations than any one organization could have achieved in isolation from the others. The accreditation organizations are well positioned to influence the field and to move towards greater uniformity in measurement, but even they cannot accomplish this alone. Finding ways to broaden the participation and ownership of this effort is central to any further development.

# Editor's Notes and Acknowledgments

## Editor's Notes and Acknowledgments

This report and the work it represents is the product of several years of labor, travel, meetings, conference calls, assignments, and the like. Inevitably, such a project is dependent on the hard work and contributions of many people—many of whom can go unrecognized without taking an important moment to acknowledge their efforts.

The ACMHA Accreditation Organization Workgroup is deeply indebted to the many organizations that provided financial support for the project. This includes The John T. and Catherine D. MacArthur Foundation, The Robert Wood Johnson Foundation, Eli Lilly and Company, and the Office of Managed Care at SAMHSA and the Center for Mental Health Services at SAMHSA. In addition, the American College of Mental Health Administration and each of the five accreditation organizations made a substantial commitment of time, money and other resources to this effort. The Board of ACMHA has been especially supportive as have been the individual Boards and administrations of the Accreditation Organizations.

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Last but not least, the many different people working in the mental health and substance abuse fields deserve their own recognition. To the many professionals, administrators, organizations, delivery systems, corporations, government agencies, etc. who dedicate themselves daily to providing services and promoting quality, your work is ultimately what this report is about. Without your commitment and efforts to provide quality care for consumers, concerns about measurement and accountability are meaningless.

*Neal Adams MD*

Editor

# Review and Feedback Form



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