Summit 1997

Preserving Quality And Value In the Managed Care Equation

FUTURE DEVELOPMENT
ACMHA MEASURES REVIEWED &CONSIDERED BUT NOT ADOPTED

SECTION V: KEY MEASURES

This section will include the proposed measures for each of the indicators selected for the core set. This was the part of the SUMMIT's work that proved the most difficult for participants. There is considerable debate in the field about the efficacy of different measurement instruments, the burden of collecting data, data comparability, etc. ACMHA welcomes the work of our colleagues in refining and improving these recommendations. We propose that as the field accepts the VALUES and INDICATORS proposed in this document, that there will be a new consensus to tackle the methodological disputes in these targeted areas. The measures will follow the same order as the indicators.

In reviewing our work, HSRI offered some observations about issues that are cross-cutting for measurement:

1. **For indicators/measures relying on survey data , what is an appropriate sample size?** Consensus needs to be reach about the size of differences that are sought, so that power analyses can be conducted and sample size determined.
2. **How should the sample be drawn? Before an indicator requiring a survet could be fully implemented, guidelines would need to be agreed upon regarding the survey administration (i.e., mailed? Phone? in-person?), minimum acceptable completion rates, and the larger sampling frame (i.e., all enrollees? All enrollees with at least one encounter? Etc.).**
3. **How will risk-adjusting and benchmarking be handled?** All measurement instruments will need to have demonstrable validity if they are to have utility across plans, populations and settings. (Dr. Joe Thompson of NCQA highlights the ditinction between measures that are useful for internal quality improvement (QI) versus those that have reliability for quality comparison (QC), the latter having to meet a higher standard of scientific validity.

There are tables in the appendix which give further detail. Measures have been selected based upon the judgement that they are **measurable, manageable** and **meaningful**.

Manageability reflects the relative ease/burden of collecting and analyzing the data collected.

Measurability refers to the extent to which a measure can give quantifiable and comparable expression of the domain being studied--the scientific dimension.

Meaningfulness refers to the relative utility of the measure to the mental health and substance abuse fields: Can the resulting information be useful to consumers and purchasers in making decisions? Can the information help providers manage better?

A: OUTCOME MEASURES

INDICATOR ONE. (O-I-1). ***Adults [including those with serious and persistent mental or chemical dependency disorders] reside in their own homes or living arrangements of their own choosing.***

PROPOSED MEASURES:

O-M-1. Consider categories from the Lehman Quality of Life Inventory (Brief version): (a) What is your current living arrangement, and (b) How much choice did you have in selecting the place where you live. There is a rating scale from "Total" to "None." [Note: Use of these questions without checking for copyright and validity concerns is NOT recommended.]

O-I-2. ***Adults [including those with serious and persistent mental or chemical dependency disorders] are working***.

RECOMMENDED MEASURE:

O-M-2: For the risk-adjusted population of persons with severe and persistent mental illnesses, consider two items: (1) from the Lehman Quality of Life Scale (Brief version): (a) "What kind of work do you do at the present time? "; (2) from the International Association of Pyschosocial Rehabilitation (IAPSRS) Programs "Toolkit for PsychoSocial Rehabilitation Outcomes: (b) "How many hours a week do you usually work?" [Note: Use of these questions without checking for copyright and validity concerns is NOT recommended.]

O-I-3. ***Adults [including those with serious and persistent mental or chemical dependency disorders] have good physical health and report good mental health***.

RECOMMENDED MEASURE:

O-M-3: Consider selected scales from the SF-12 (physical and mental component scales), BASIS 32 (depression and anxiety, psychosis, and impulsive addictive behavior scales), or MHSIP Report Card (symptoms, medications, and side effects questions). [Note: Use of these questions without checking for copyright and validity concerns is NOT recommended.]

O-I-4. ***Adults with serious and persistent mental or chemical dependency disorders report feeling safe.***

RECOMMENDED MEASURES:

Consider modified items from Lehman Quality of Life Inventory: (a) In the past <year> have you been a victim of a violent or non-violent crime?; (b) How safe do you feel where you live?

[Note: Use of these questions without checking for copyright and validity concerns is NOT recommended.]

O-I-5. ***Adults with serious and persistent mental or chemical dependency disorders can avoid trouble with the law.***

RECOMMENDED MEASURE: Consider adaptation from Lehman QOLI: In the past <year> have you been arrested or picked up for any crime? [Note: Use of these questions without checking for copyright and validity concerns is NOT recommended.]

O-I-6. ***Adults with serious and persistent mental or chemical dependency disorders maintain a social support network.***

RECOMMENDED MEASURE: Consider multiple items from the Lehman QOLI: (a) In the past <year> how often did you: visit with a friend not living with you? Telephone a friend? Make a plan ahead of time to do something with a friend? Spend time with someone like a girlfriend or boyfriend? Talk with a member of your family on telephone? Get together with member of family? [Note: Use of these questions without checking for copyright and validity concerns is NOT recommended.]

O-I-7. ***Adults with serious and persistent mental or addictive disorders are able to manage their daily lives.***

RECOMMENDED MEASURE: Consider selected items from the MHSIP Consumer Report Card Survey, specifically those relating to: "I deal more effectively with daily problems (Q26); "I am better able to control my life." (Q28); "I do better in my leisure time." (Q34); "I have become more independent." (Q37); "I am more effective in getting what I ‘want’ [note: word is ‘need’ in MHSIP questionnaire]. (Q39); "I am better able to deal with crises: (modified from language in Q40: Original language: "I can deal better with people and situations that used to be a problem for me.")

O-I-8. ***Adults with serious and persistent mental or addictive disorders report a positive quality of life.***

RECOMMENDED MEASURES: Consider single item from Lehman QOLI:"How do you feel about life in general? ";

B: PROCESS/PERFORMANCE MEASURES

P-I-1. ***Consumers actively participate in decisions concerning their treatment.***

RECOMMENDED MEASURES: Consider two questions from MHSIP consumer survey: (a) I, not the staff, decide my treatment goals (Q19) ; (b) I felt comfortable asking questions about my treatment and medications (Q12). [Note: Use of these questions without checking for copyright and validity concerns is NOT recommended.]

P-I-2. ***Consumers who receive inpatient care* receive face-to-face follow up care within seven days of discharge. [*@Inpatient care@ is defined as A24-hour, medically supervised care for a primary mental or substance abuse diagnosis.]***

RECOMMENDED MEASURE: The total number of discharges from 24-hour, medically supervised care for a mental health or substance abuse diagnosis that were followed by at least one non-emergency, face-to-face mental health or substance abuse treatment visit within seven days, divided by all discharges from such settings, during a 12 month period.

P-I-3. ***Consumers with mental health and addictive disorders are engaged in treatment.***

RECOMMENDED MEASURE: The total number of enrollees receiving one and only one mental health or substance abuse service in the past year, divided by the total number of enrollees receiving more than one mental health or substance abuse service in the same year.

P-I-4. ***Consumers receive adequate information to make informed choices.***

RECOMMENDED MEASURE: Consider three questions from MHSIP survey: (a) I felt comfortable asking questions about my treatment and medication (Q12); (b) I was given information about my rights (modified from Q14); (c) I was told what side effects to watch for (modified from Q17). [Note: Use of these questions without checking for copyright and validity concerns is NOT recommended.]

P-I-5. ***Consumers receive mental health inpatient services in a voluntary, non-coercive manner.***

RECOMMENDED MEASURE: Total number of admissions to 24-hour, medically supervised residential mental health and substance abuse treatment to which consumers are admitted (committed) involuntarily, divided by the total number of 24 hour, medically supervised admissions in a 12 month period.

[Note: ACMHA acknowledges significant problems with data collection of this data because of variability in plan design, methodology for coding encounters by individual versus family, variability in location of services, including primary care settings, etc.]

P-I-6. ***Consumers are satisfied with the services they receive.***

RECOMMENDED MEASURE: Consider selected questions from the MHSIP Consumer Survey: (a) I like the services I receive from my mental health or substance abuse provider

(modified from Q01); (b) I would recommend my mental health or substance abuse provider to a family member or friend (modified from Q03); (c) I feel that I was helped by the services I received; (d) I feel that I was treated with dignity and respect (modified from Q20-n, Q14); (e) I feel that I was free to ask questions about my mental health and substance abuse treatment (modified from Q12); (f) I feel that my provider is sensitive to my cultural and ethnic background (Q20-n). [Note: Use of these questions without checking for copyright and validity concerns is NOT recommended.]

P-I-7. ***The system of care assumes responsibility for continuous and integrated care appropriate to the needs of children and families. [Also see Section IV, special section on children.]***

RECOMMENDED MEASURE: See special section on children, Section III.

C. ACCESS MEASURES

A-I-1. ***Consumer experiences of treatment (both positive and negative) are assessed on dimensions of appropriateness, timeliness and sensitivity of services delivered.***

RECOMMENDED MEASURES:

(a) Consider customer satisfaction with initial access measure from AMBHA PERMS: Was the amount of time you had to wait for your first appointment <not a problem>, <a small problem>, <a big problem>, <don=t know>. [Note: Use of these questions without checking for copyright and validity concerns is NOT recommended.]

(b) Consider selected questions from MHSIP Consumer Survey: "I was unable to get the services I thought I needed" (Q09-n); "I was able to see a psychiatrist when I wanted to" (Q10); "Staff were willing to see me as often as I felt it was necessary" (Q06); "Staff were not sensitive to my cultural/ethnic background" (Q 20-n) ; "The location of services was convenient" (Q05) ; "Services were available at a times that were good for me" (Q08); "I was unable to get some services I wanted because I could not pay for them."(Q04-n). [Note: Use of these questions without checking for copyright and validity concerns is NOT recommended.]

A-I-2. ***Service denials, terminations, or refusals are assessed.***

RECOMMENDED MEASURES: NO MEASURE IDENTIFIED. There are definitional, data source, and other problems with this indicator and its measurement. Considerable attention is being given to external review of this indicator.

A-I-3. ***Penetration rates demonstrate benchmarked levels of service delivery to like populations.***

RECOMMENDED MEASURE: AMBHA PERMS 1.0 .

A-I-4. ***Access to a full range of services is demonstrable.***

RECOMMENDED MEASURES: (a) MHSIP Report card measure of ready availability; requires more than one question; (b) review of contract provisions/external review protocols; (c) utilization rates by service type per administrative data base.

A-I-5. ***Children and families receive the appropriate services the need, when they need them.***

RECOMMENDED MEASURES: The potential sources for this information include CAHPS, FSQ-R/YSQ-R, MHSIP Report Card, AMBHA PERMS, and YRBS. (a) Self/Family Report/Survey, which includes consideration of culture, geographic spread, clinical use and timeliness; and (b) information through service and administrative data bases retrieved through queries such as:

Length of time from first appointment to second appointment by: (1) frequency distribution of % initial contact to first appointment; (2) % persons who show for first appointment within 30 days of initial contact.

Length of time from first to second appointment by: (1) frequency distribution of % of initial appointment to second; (2) % of persons appearing for second appointment within 30 days of first.

Percent of consumers identified via Geo-mapping to be within 30 mile radius of provider.

(c) Information gathered through accreditation processes such as NCQA, CARF or JCAHO. An important variable accessible through this mechanism might be cultural competence/sensitivity as measured by provider offering translation or multi-lingual services if >10% are identified as non-English speaking.

A-I-6. ***Children and the families are being assessed for and offered services at appropriate levels.***

RECOMMENDED MEASURES: These measures could be gathered through service or administrative data base queries:

a. penetration rate by age, sex, and population for services to clients with mental health and substance abuse primary diagnoses, as benchmarked against epidemiologically based predicted rates.
b. Penetration rate in the primary health care system of clients by age, sex and population as compared to predicted rates;
c. Follow-up and transition data monitoring the intervals of time between providers on referral; #days/referral, benchmarked against mean days for the system.

D: STRUCTURE MEASURES

As noted in the introduction, the structure measures tend to be the more traditional accreditation measures. In keeping with the ACMHA concept of not duplicating efforts of existing bodies, our recommendation in this area is that systems use those elements of existing accreditation surveys that address these indicators. CARF, NCQA, JCAHO, HCFA and others all have instruments or survey questions to assess these indicators.

It is the ACMHA position on these measures, that the standard should be: **A benchmarked or nationally accepted measure or survey that adequately supports a finding on the indicator in question.**

ACMHA believes that no survey system is adequate unless **all of the ACMHA indicators are covered.**

SECTION VI: ISSUES CONSIDERED BUT NOT RECOMMENDED AT THIS TIME

Performance Indicator: P-I-5. ***Psychotherapeutic medications are used appropriately.***

The misuse of psychotherapeutic agents is a source of grave concern for consumers, professionals and purchasers alike. The implications for ineffective (or worse, counter therapeutic or dangerous) treatments are significant.

Corresponding Measure: P-I-5. ***Psychotherapeutic medications are used appropriately.***

RECOMMENDED MEASURE: None. Discussion: This is an important measure, which has face validity and is seen as an important quality of care indicator. However, an existing/established instrument for this indicator could not be found. Moreover, while the concept of Aappropriateness of pharmacotherapy@ is easy to appreciate, there are actually few, if any, established criteria for best practices and there is a wide range of Aacceptable practices. HEDIS 3.0 included a test measure regarding the use of antidepressant medications, but a concern of the workgroup was that this measure was narrow and addressed the issue of unnecessary prescription of medications, not the broader focus of use or lack of use of appropriate medications.

The workgroup is committed to the notion of monitoring and evaluation pharmacotherapy practice. Of special interest was the work of Lantz, Giambanco, and Buchalter in a recent issue of *Psychiatric Services* (47:9, 951-55). The process work group recommends development of a measure based on this work, including a matrix of drug utilization sorted by major diagnostic categories. Other data variables (gender, ethnicity, age) were also proposed. This measure is seen as dependent on the existence of pharmacy data bases and electronic patient record technologies.