

Improving Montana’s Mental Health System – Final Report

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Montana Department of Public Health and Human
Services – Addictive and Mental Disorders Division

*Improving Montana's Mental Health
System – Final Report*

EXECUTIVE SUMMARY

Prepared by The Technical Assistance Collaborative, Inc.
January 15, 2001

I. INTRODUCTION

In the Spring of 2000, the Montana Department of Public Health and Human Services (DPHHS), Addiction and Mental Disorders Division (AMDD), Mental Health Services Bureau (MHSB) selected The Technical Assistance Collaborative, Inc. to evaluate the strengths and weaknesses of the Medicaid Mental Health Program and the Mental Health Services Plan and to offer recommendations for the future. Both the Mental Health Services Bureau and TAC see this project as a parallel effort to supplement the work of the Mental Health Oversight and Advisory Council's (MHOAC) efforts to make recommendations about Montana's mental health system. This report constitutes TAC's final deliverable and incorporates reports completed for each of the three identified task as well as a report describing the conditions necessary to accomplish the system improvements recommended in these reports.

The three tasks included an independent review and assessment of the Mental Health Services Program (MHSP) and the Medicaid Mental Health Plan (MMHP), recommendations regarding outcome and performance measures for the future, and an evaluation of the service delivery system in Montana along with findings recommendations for system and service changes. The information in this Final Report comes from a variety of sources, namely:

- Interviews and program observations conducted by TAC senior staff during several on-site visits (see Appendix B);
- Review of numerous documents, reports, and database descriptions provided by AMDD (see Appendix A);
- Reviews of reports and managed behavioral health contracts from numerous states and national organizations containing information on outcome and

- performance indicators used in other jurisdictions and/or recommended by national organizations (see Appendix C for a summary of these);
- Review and analysis of paid claims and other utilization data provided from MHSB, AMDD, and the DPHHS paid claims vendor, Consultec (see the Task One report);
 - The input of system stakeholders provided during two sessions of the Performance Measurement Advisory Group (PMAG) and three different meetings with the MHOAC; and
 - The knowledge of and experience of the TAC team with other state and local mental health systems.

A summary of the three task reports and the report on necessary conditions is presented below.

It is important to note that this evaluation and planning project was *not* an evaluation of the quality of current services or providers, a set of recommendations to correct current budgetary problems, nor a specific response to specific AMDD or constituent identified concerns. The recommendations from this project, if implemented, will address many of those issues indirectly by providing a blueprint for the improvement of Montana's mental health system in the future.

II. TASK ONE: ASSESSMENT OF THE MENTAL HEALTH SERVICES PLAN (MHSP) AND THE MEDICAID MENTAL HEALTH PROGRAM (MMHP)

The assessment of the MHSP and the MMHP consisted primarily of an analysis of two existing datasets, i.e., the Consultec Medicaid MHSP paid claims file, and the Montana State Hospital database maintained by AMDD. These two datasets have extensive data on multiple variables. However, the paid claims data covers only ten months of FY 2000 and therefore does not contain sufficient history to make reliable judgments about future trends. However, some analysis is possible from these datasets as well as additional data provided by AMDD and other sources (see Appendix A).

The purpose of Task One was to:

1. Assess the existing datasets and data systems available to the Addictive and Mental Disorders Division (AMDD) to see if they contain accurate and consistent information that can be used to describe the characteristics and track the performance of the public mental health system in Montana;
2. To the extent possible, use existing datasets to describe components of the public mental health system and assess performance on certain key indicators; and

3. Make recommendations to AMDD relative to the use of existing datasets for on going monitoring of the system, on new data to be designed and collected, and on certain service system improvements identified as being needed through the current analysis.

The Tables and Charts for the Task One Report lead to the following conclusions:

1. Medicaid enrollment is up 7.62% while growth in users of services is up over 30%. Regions 4 and 5 had the highest enrollment growth while Regions 1 and 2 had the highest growth in the proportion of users of services (penetration rates).
2. MHSP enrollment has remained fairly level at about 4,300, but the number of users has increased by 17.6% and the percentage of users has increased by 22.64%.
3. Forty-six percent (46%) of total expenditures go to facility-based or out-of-home services.
4. Less than 8% of all service users use 66% of total mental health dollars, 63% of these being children.
5. Montana State Hospital (MSH) admissions are increasing, averaging 45 per month for the last six months of FY 2000 as opposed to an average of 34 per month in FY 1999.
6. Lengths of stay at MSH have dropped, from an average of 96 days in FY 1999 to 59 days in FY 2000, although this is still very high. (The average stay in psychiatric units of Montana general hospitals is 4-7 days.)
7. Over 80% of admissions to MSH are civil commitments and less than 10% are forensic commitments.
8. Of the 2000 heaviest users (i.e., persons who utilized the most amount of service dollars), 1,256 were youth under 21 years of age. These youth utilized 52% of *all* expenditures for all users (child and adult). These youth utilized 99% of all out-of-home care, 99% of all outpatient hospital resources, and 30% of all community inpatient care, while receiving less than 45% of the resources for intensive case management and less than 25% of all Community Mental Health Center resources.

The conclusions to be drawn from these data are that AMDD has some good data (although more is needed) and it should be analyzed and used for performance analysis and planning. There is a need to design new systems for additional outcome and performance data, e.g., consumer self-report (see Task Two and

Three reports). The data documents mental health system issues that were also identified in interviews and document review, i.e., there is too much out-of-home care and too little community support and wrap around services for both children and adults, and hospital utilization is too high. Targeting the highest users of services for these changes would be a good place to start. A change in system design, service technologies, and oversight processes could result in better outcomes for people and more efficient use of limited resources.

III. TASK TWO: OUTCOMES AND PERFORMANCE MEASUREMENT

The goal of Task Two was to review Montana's past efforts and the efforts around the country regarding outcome and performance measurement to identify both the process and the measures Montana should utilize in the future to track the system performance and outcomes for consumers and their families. Due to the unique history of Montana's mental health system, TAC recommended a developmental process beginning with stakeholder input and buy-in followed by a specific implementation strategy for the Montana AMDD related to developing and implementing outcome and performance measurement for the Montana public mental health system. The purpose of the stakeholder input process – the Performance Management Advisory Group (PMAG) – was to achieve consensus about and commitment to the overall strategy for outcome and performance measurement as well as initial outcome and performance indicators that should drive Montana's initial data collection and reporting activities.

TAC recommends a process for continuing input by system stakeholders, whether members of the initial PMAG or others interested in and affected by the outcome and performance measurement process. The objectives of the on-going stakeholder input process are the following:

1. Continually reinforce the original policy goals and system performance expectations of the Mental Health Access Plan (MHAP), link these to a quality management and quality improvement strategy, and adopt these principles as the overall context for outcome and performance measurement;
2. Continue to work with stakeholders to develop a common understanding of terms, concepts, technologies, and experiences from other states.
3. Forge an organizational and service system culture that supports data collection and analysis and the use of information for management and service improvements;
4. Refine the outcome and performance indicators and measures to reflect policy priorities, agree on instrumentation or data sources (either existing

or to be developed) to collect data about these measures, and assure effective implementation of data collection and reporting activities; and

5. Provide input into reporting formats, discuss reports and their implications, and provide input to the actions that should or will be taken as a result of the reports received.

As part of the Task Two effort, TAC reviewed Montana's history regarding outcome and performance measurement and discussed with PMAG the reasons why these efforts had not come to fruition. TAC identified a need to begin slowly and take incremental steps to collect and report data but to do *something* to get started, to engage system stakeholders in developing both the indicators and the reporting processes for measurement processes, and to put outcome and performance measurement and reporting in the context of a broader more comprehensive quality management and improvement process. Detailed recommendations and timeframes regarding how to begin with regional profiling and move into outcome and performance reporting are included in the Task Two report. Likewise, recommendations regarding how to conceive of common terms and definitions, how to assure outcome and performance measurement does not end with reporting but rather moves into action are also included. Elements of a comprehensive quality management and improvement process are described in the Task Three report.

It is critical for Montana's system to develop a culture of collecting, reporting, and using data. Both provider and state capacity to do so will need to be developed and supported. In the first instance, data should not be used to punish providers or individual practitioners for performance or outcomes below expectations. Rather, data should be used to identify system concerns that need to be addressed to improve both the process and the outcomes of care. Provider consequences should come only after attempts to improve have failed or been rejected. A delicate balance between provider partnership and provider accountability needs to be achieved for these efforts to be successful.

Both Montana's history and a synthesis of other state's and national organizations experiences and efforts at outcome and performance measurement (see Appendix C) suggest the following domains and areas of concern for Montana's future efforts.

DOMAIN	CONCERNS
ACCESS – Individuals can easily access AMDD-funded services quickly and easily.	<ul style="list-style-type: none"> • Network Adequacy • Penetration (User) Rates • Timeliness of Services
APPROPRIATENESS – Services are appropriate to the individual’s needs and goals, and consistent with professional standards.	<ul style="list-style-type: none"> • Consumers Being in Right Level of Care • Consumer/Family Satisfaction • Consumer/Family Involvement in Treatment Planning
ADMINISTRATION – Programs and services are operated in an efficient and accountable manner.	<ul style="list-style-type: none"> • QM/I System Effectiveness • Adequacy of Human Resources • Data Reporting and Use
VALUE/COST – Services provided and outcomes achieved are at the least cost possible or are within acceptable cost ranges.	<ul style="list-style-type: none"> • Case Management’s Link to Outcomes • Cost for Services • Cost Shifting
CONSUMER OUTCOMES -- Individuals experience positive outcomes as a result of services received.	<ul style="list-style-type: none"> • Consumer Functioning in “Real” Life • Community Tenure • Social Goals (Jail, Housing, Work, School)

The indicators developed by PMAG for these areas of concern are included in the Task Two report. Measures or ways of counting data for these indicators will need to be developed as will methods and tools for collecting this data. This process will need to be developmental and incremental. The key is to begin.

IV. TASK THREE: FINDINGS

The purpose of the Task Three report was to identify current issues within the Montana Mental Health System and to make system recommendations to address these issues. This report builds on the Task Two and Three reports and provides specific recommendations for future system changes. All the information sources used for this Final Report were used to develop these findings and recommendations. These recommendations have been informed by meetings and input with MHOAC. Their input and those of AMDD were invaluable. However, the findings and recommendations are TAC’s alone.

A. *Service System Culture and Capacity*

The Montana Mental Health system does not currently have a culture and capacity that lends itself to maximization of resources or services to assure the most benefit is provided for eligible persons. This culture and capacity issue is evident in the system’s lack of a consistent, coherent service philosophy, inadequate service array, and insufficient involvement of consumers and families in service development, implementation, and evaluation.

The service array is generally over reliant proportionately on facility or bed based services, out-of-home placements, traditional outpatient therapies, and relatively long term day treatment and partial hospitalization. Services that are rehabilitative, supportive or recovery oriented are underdeveloped. In-home, wrap around, psychosocial rehabilitation, supported housing, employment services, mobile crisis, intensive or assertive community treatment (ACT) case management, and peer operated alternatives are either unavailable or under utilized in many parts of the state.

B. Service System Organization

The organization of Montana's service delivery system for adults with serious and persistent mental illness and children with serious emotional disturbances is more a creature of recent history than a planned approach to the organization and financing of quality mental health care for a state's population. The current state of affairs is a result of efforts to correct the failed implementation a major system change, i.e., managed care. The history and goals of these changes; the current nature of the system and its lack of a single point of accountability for both client care and resources; and the state's attempts to manage the system with limited structural tools are all important factors in service system organizational issues that need to be addressed in order for the system to be most effective in service Montanans and in being accountable for limited resources.

C. Infrastructure and Leadership

The leaders of Montana's system have managed incredible changes and course adjustments with very limited human resources and in the face of multiple expectations in a very short period of time with pretty successful results. They are to be commended for quick and bold action, attention to the priority issues at hand, creative solutions for both immediate and longer term issues, and lack of defensiveness as they are viewed under the microscope by advocates, elected officials, system constituents, Montana taxpayers and communities, outside consultants, and national observers. Montana's system leaders have been reactive to the overwhelming issues confronting them partly out of necessity. The advisory processes in existence results in multiple recommendations too numerous and sometimes too general to have a meaningful impact. It is now time for the system's leaders to complete a strategic planning process that will give the system a vision and direction for the future. In order to plan and implement such a vision, they will need adequate staff and resources, data capacity, and quality management and improvement capabilities system wide.

D. Resources and Rates

Any system of publicly funded services must analyze the needs of persons for whom it is required or for whom it chooses to fund care and determine whether the funds it has available are sufficient to meet those needs. If not, the system has three options: (a) the expenditure of funds must be adjusted either to encourage the utilization of lower cost services or to prioritize services for higher need clients; (b) system leaders must seek additional funds; or (c) difficult decisions about cutting services or excluding populations must be made. Montana's system does not have a systematic way to determine which option is most efficacious and which resources to adjust and how. The system needs additional resources. AMDD needs to lead a process to determine the amount of resources needed. Additionally, AMDD needs to seek the effective utilization of resources outside the mental health system that are available for system clients.

V. TASK THREE: RECOMMENDATIONS AND PRIORITIES

The following recommendations are summarized from the complete Task Three report. The designation of priorities recognizes that not everything can be done at once and that there is a logical order to the work that will need to be undertaken to accomplish these recommendations. The prioritization of the recommendations indicates the order in which each of these recommendations should begin rather than the relative importance of the recommendation substantively. Therefore, the words "immediate," "soon," and "later" are used to denote this order of implementation. These words should not be taken literally, but rather should indicate that some things need to begin as soon as possible, some should begin shortly thereafter, and others depend on the beginning of the first two or come more logically after the first two priorities are begun (not necessarily completed).

A. Planning

1. *Strategic Planning Process and Document (Immediate)* – AMDD should complete its strategic planning process setting a single vision for the system's future, with input from multiple constituencies and endorsement by the MHOAC. This plan should then guide future funding and system development activities as well as MHOAC's advisory work.
2. *Advisory Input Process (Immediate)* – The system's advisory multiple processes, including MHOAC, should be more focused. The multitude of disconnected recommendations coming from a number of quarters results in frustrations for all. MHOAC should assist the AMDD and the Mental Health Services Bureau (MHSB) in setting priorities based on the strategic plan. Then, advisory process

and recommendations should be focused on the implementation of those priorities before moving on to additional priorities or recommendations. AMDD and MHSB should work more closely with the MHOAC to set those priorities and common direction.

3. *Assessing System and Service Needs (Later)* – A needs assessment or gap analysis should be conducted to identify unmet or inadequately met service needs and the costs associated with meeting those needs. This process should occur after the system has stabilized further and after the infrastructure changes have begun in the regions.

B. Structural Changes

1. *Regional Structures (Single Points of Clinical and Fiscal Accountability) (Planning – Immediate; Implementation – Soon)* – A single point of financial and clinical care accountability should be created in each of the five regions of Montana. These regional structures should be developed from existing providers acting in networks to the extent that they are interested in doing so or procured if no existing provider network is interested in developing such a regional structure. The regional structure should be developed over a multi-year period and should be responsible initially for managing service planning, then care management both within the mental health system and with other service systems, and later the limited available funding (including state hospital resources) available to the region, in conjunction with regional planning and advisory bodies. These regional structures should include consumers, families, and community members as part of their governing bodies. Serious consideration should be given to including addiction services and funding within the responsibility of these structures to create an integrated regional behavioral healthcare system serving both persons with mental illness, persons with addictions and persons with co-occurring disorders.
2. *Regional Planning and Advisory Councils (Immediate)* – There should be a single state appointed regional planning and advisory body for each of the state's five regions. This body should be comprised of a majority of consumers and families and should relate directly to MHOAC by way of appointments and representation. These bodies should be responsible for specific input and advice on regional and state issues as identified by the regional structures and the MHOAC.
3. *Roles and Responsibilities within the System (Soon)* – The roles and responsibilities of the state, the regional structures, the providers, and the regional planning and advisory committees should be clearly defined as recommended in the body of the Task Three report. Generally, the state should provide leadership, direction, regulation, funding, and oversight while the regional structures should be responsible for regional planning and administration of both care management for clients and funding and credentialing of service providers

to meet the identified needs within the region within the limited funding available. Data needs should be addressed by reporting from providers to a single data system managed by the state either directly or through the regional structures. These roles and responsibilities should be clarified as the regional structure system is developed with input from stakeholders.

4. *Roles of Consumers and Families (Soon)* – The experiences and expertise of consumers and their families should be utilized at all levels of the system as decision-makers on governing and advisory bodies, as trainers, as employees, as peer and alternative service providers, and as system and program evaluators. It will take support and special efforts to recruit, retain, and support consumers and their families in all these roles.

C. Service Delivery Changes

1. *Defining Levels of Care and Eligible and Priority Populations (Soon)* – AMDD, with input from system stakeholders, should identify priority populations for services within those eligible for care as an alternative to setting slot limits on those served. The services needed by these priority populations should be translated into levels of care that could be pre-authorized depending on the priority of the person presenting for services and the needs associated with that level of care. This would keep all current persons eligible for services, but assure that persons with higher needs or who are higher priorities get services first. It would also assist the system in identifying unmet or inadequately met needs for the gap analysis process recommended above.
2. *Core Services Array (Immediate)* – A core services array that must be available in all regions of the state and within reasonable time and geographic distances should be identified and implemented. These core services should focus on basic psychiatric care along with in-home and wrap around services as well as rehabilitative and supportive services along with housing and family care options more than on facility-based or out-of-home care.
3. *Service Array for Children and Youth (Soon)* – Additional services for children should be focused on in-home and wrap around services, including therapeutic foster care homes and services. A voluntary or mandatory moratorium on the development of new facility-based treatment settings for children and on out-of-state placement for children should be implemented. Partial hospitalization and inpatient services should be minimized. A statewide dialogue about the best way to approach behavioral needs of children in schools needs to occur. The interagency agreement dealing with multi-system children should be revised and reactivated both at the state level and at the local level through the regional structures described above.

4. *Service Array for Adults (Soon)* – Additional services needed for adults include psychosocial rehabilitation, peer oriented services, employment, and housing and supportive living options. Crisis services that are mobile, respite, and peer in nature are also needed. The link between crisis and admission to inpatient services should be strengthened through the regional structure development described above. Day treatment services should be shortened and focused on employment and recovery. Partial hospitalization should be used only for short-term crisis services to prevent hospitalization. Pre and post booking jail diversion should be available in all significant population centers.

[NOTE: The additional services for both children and youth and for adults need to be developed as soon as possible. However, there are so many system issues preventing this development that this may not be possible quickly. It will be important for the system to address the planning and structural issues as well as to identify the core service array and address some financial issues first before implementing new services. However, the unfolding of this service development needs to be a considered part of the strategic planning process described above. In the meantime, adjusting rates for rehabilitative and in-home services and halting development of bed-based services are places to start in encouraging the development and expansion of appropriate service alternatives.]

5. *Utilization Management (Soon)* – The current UM contract (with either the current or a different vendor, depending on performance) should be continued until the regional structures are in place. Then, consideration should be given to what UM activities should be statewide and which should be the responsibility of regional structures. Care management and utilization management should be designed together into a rational system for controlling service utilization and assuring persons in need get the right services in the right amounts at the right time. Retrospective reviews of all services on a spot check basis should be built into the system as it is redesigned. The levels of care and associated clinical criteria described earlier should guide both these retrospective reviews and the prior and concurrent reviews conducted by the UM vendor or the regional structures. Data from prior and concurrent reviews should be reviewed regularly by state officials.

D. Financial Changes

1. *Resource Needs (Soon)* – Additional resources are needed both for service development and for state and local infrastructure. The amount of these resources should come from the strategic plan setting priorities, timelines, and approaches to maximizing current resources. Missing core services should be developed and/or funded for each region before additional services beyond the core services are addressed.
2. *Service Rates (Immediate)* – Rates paid for services should be analyzed and revised to encourage the development of additional or enhanced services in the

core service array for children and youth and for adults. Specifically, rates for partial hospitalization should be reduced. Rates for in-home and supportive services should be increased. Rates for day treatment for adults should be for a service that is time limited and subject to concurrent review beyond that period of time. Rates for services should be revisited once the regional structures described above are in place.

3. *Financing Mechanisms (Later)* – The funding of the system should be reexamined in light of the development of regional structures described above. Once their development has begun, a 1915(6) waiver of federal Medicaid rules or a Medicaid plan amendment should be considered to allow the state and the regional structures flexibility in funding and limitations on provider development to focus on the services the state and regional structures want to fund rather than the services providers are interested in providing. This waiver should be designed carefully to prevent the problems with the last Medicaid waiver implementation. The combining of all financial resources, including those at the state hospital and state nursing home facility, should be the goal. The latter resources can be managed by regional structures either through direct transfer of funds with purchased services from the state as a provider, or through an allocation of bed days for each region to access. While the financing mechanisms are critical to the system’s success, they cannot be accomplished quickly and therefore must develop as the system design unfolds.
4. *Resource Management Plan (Soon)* – All the resources potentially available for meeting the needs of adults and children and their families need to be identified and a plan for maximizing these resources developed, along with identification of the roles of various system players in seeking these resources. These resources include but are not limited to housing, public benefits, healthcare, employment, and educational, and business development services.

E. Functional Changes

1. *Quality Management and Improvement (Performance and Outcome Reporting – Immediate; Additional Activities – Later)* – MHSB should develop and begin implementing a quality management and improvement plan that includes the elements described in the report. Performance and outcome reporting and improvements based on these data should be a priority. (See Task Two report). A human resource development plan should be part of the fully developed QM/I plan. Best practice development, including work to identify and implement practice guidelines and models consistent with either evidence or with consensus about promising practices should be an affirmative part of the QM/I system. Agreements about the role of regional structures, providers, advisory bodies, and others should be reached during the regional structure development process. The Board of Visitors should be reconstituted to operate as a consumer quality

review team (CQRT) and should be responsible for reviewing all services funded and provided, not just those provided by the state and the CMHCs.

2. *Management Information Systems (Analysis of Current Data – Immediate; Fully developed MIS – Later)* – Management information system development should focus first on analysis and development of reports from existing data sources to develop a data-using culture throughout the system of care. The regional report card described in TAC’s Task Two report should begin to be developed and disseminated as soon as possible, with changes to the reporting items or format as discussion of the data occur and additional data are available. Data currently available from Consultec, the State Hospital reporting data, the UM vendor, and any other currently collected data set routinely available should be integrated through some form of common identifiers and analyzed for trends and system performance. (See for example, TAC’s Task One report). A long-range goal should be to develop a single MIS with single unique client identifiers to which all information about a client’s care, costs, and outcomes is reported and from which all financial and all clinical performance and outcome reporting is done.
3. *State Functions and Staff (Data Analyst and Services System Planner – Immediate; QM/I – Soon; Others – Later)* – Staff should be added to MHSB specifically to address the data analysis, service system planning, and QM/I issues. Later, a contracts specialist/regional structure liaison, a human resource development specialist, and clerical staff should be added to assure the state structure is sufficient to oversee the performance of the Montana system of care and assure high quality outcomes for clients with the most efficient utilization of resources possible.

A table depicting all these recommendations by timeframe is set forth below.

IMMEDIATE	SOON	LATER
<ul style="list-style-type: none"> • Strategic Planning Process and Document • Advisory Input Process Revisions • Regional Planning and Advisory Councils • Regional Structures – Planning • Core Services Array – Decision, Inventory, and Plan for Implementation • Selected Service Rate Increases and Finances for System Stabilization • QM/I – Performance and Outcome Reporting • MIS – Data Analysis • State Infrastructure/Staff – Data Analyst and Service System Planner 	<ul style="list-style-type: none"> • Clarification of Roles and Responsibilities in System • Regional Structures – Implementation (Including Necessary Infrastructure) • Increased Consumer and Family Role • Defining Levels of Care and Eligibility and Priority Populations • Additional Services for Children (beginning with Core Services) • Additional Services for Adults (beginning with Core Services) • Additional Funding for Services and Regional and State Infrastructure • Expansion of Utilization Management, Including Establishment of Criteria • Resource Management Plan – Housing, Vocational, Education, etc. • State Infrastructure/Staff – QM/I Specialist 	<ul style="list-style-type: none"> • QM/I Activities Including Human Resource Development Plan, Practice Guidelines Development and Dissemination, Structure for Taking Action • Introduction of Incentive Based Financing Mechanisms; Consideration of a limited Medicaid Waiver or State Plan Amendment • System Wide Needs Assessment/Gap Analysis • State Infrastructure/Staff – Human Resource Development Specialist, Contracts Specialist (Regional Structure Liaison), Clerical/ Administrative Support • Additional Resources for Additional Services • MIS – Development Single Comprehensive Data System

VI. NECESSARY CONDITIONS

In order to accomplish the goals set out by the Montana mental health system leaders and to implement the recommendations in this report, several conditions are necessary. *First*, there must be collaboration, both with the system and externally with other critical systems. This internal collaboration must come from a desire on all stakeholders to move beyond the difficulties of the last few years and move beyond the mistrust and fatigue that have developed because of these difficulties. Everyone, from state officials to providers to consumers and families, must be willing to step up to the plate and work once more to take steps to improve the system of care. Externally, there must be collaborations either initiated or reinstated with other critical systems such as schools, child welfare systems, juvenile courts, jails and corrections (both state and locally), vocational rehabilitation and employment systems, and housing systems. Both Medicaid and the primary health care systems are also important collaborators if services for Montanans with mental health needs

are to improve. The Necessary Conditions report describes these necessary collaborations in some detail.

Second, there must be additional financial resources available for system stabilization, infrastructure development at both state and regional levels, core services enhancements, and ultimately additional services development. These additional resources should be provided in the appropriate order and should be augmented by the system changes described in the TAC reports in order to assure the efficient use of limited resources and the appropriate system development and oversight for the future. These resource needs are described in more detail in the Necessary Conditions report.

Third, there will need to be legislative action in the form of budget decisions and in the form of supportive or directive legislation to authorize and provide the resources for many of the system changes described. These legislative actions also must be taken in the appropriate order and will require further analysis of existing legislation to identify the exact wording of bills and amendments to existing Montana law. Additionally, further work and decisions about the roles of regional structures and the desired legal status of these structures will be necessary before legislative language either authorizing selection or establishing authorities can occur. These issues are discussed in the Necessary Conditions report.

Fourth, there must be a willingness to act (or political will). This requires that state officials, stakeholders, politicians, and other systems all step up to the plate and act in concert to improve the system of care for mentally ill and emotionally disturbed Montanans. This, too, is discussed further in the Necessary Conditions report.

VII. CONCLUSION

The findings and recommendations described above are explained in more detail in the complete Final Report following this Executive Summary. The implementation of these recommendations will assist Montana in improving its system of care for adults and children with mental health needs and in utilizing limited public dollars in the most efficient way possible.

Task One: Assessment of the Mental Health Services Plan (MHSP) and the Medicaid Mental Health Program (MMHP)

I. INTRODUCTION

The purpose of Task One, and the Task One report, was to complete three objectives. These are:

1. Assess the existing datasets and data systems available to the Addictive and Mental Disorders Division (AMDD) to see if they contain accurate and consistent information that can be used to describe the characteristics and track the performance of the public mental health system in Montana;
2. To the extent possible, use existing datasets to describe components of the public mental health system and assess performance on certain key indicators; and
3. Make recommendations to AMDD relative to the use of existing datasets for on going monitoring of the system, on new data to be designed and collected, and on certain service system improvements identified as being needed through the current analysis.

In the following sections TAC addresses these three objectives. TAC relied primarily on two existing datasets; the Consultec Medicaid/MHSP claims file, and the Montana State Hospital database maintained by the Division. These are the two datasets that have extensive data on multiple variables. In the case of the Consultec dataset, the extraction and analysis also required the skill and experience of a health care economist familiar with Medicaid databases.

II. ASSESSMENT OF THE AVAILABILITY, RELIABILITY, AND CONSISTENCY OF DATA AVAILABLE FOR SYSTEM EFFECTIVENESS MEASUREMENT

This section of the Task One report addresses the first objective in Task One: to assess the availability and reliability of existing data sources and databases for evaluating the current public mental health system in Montana. The questions to be answered include:

1. Can existing datasets be used to objectively evaluate some of the key measures of performance recommended for the public mental health system?
2. How accessible, reliable, and valid are the various datasets for this purpose?
3. What cautions or caveats should be used when using existing datasets to assess the performance of the current public mental health system?

TAC has acquired and evaluated several existing sources of data to address these questions. The following is a summary of our findings.

A. Medicaid Paid Claims Files

Medicaid paid claims data was obtained from Consultec, with the extract containing data as follows:

- Final transaction paid claims with begin service dates on or after 7/1/99
- Claims paid through 8/28/00
- Mental health claims for Medicaid recipients were included using the claim allowed indicator (value=7).
- Mental health claims were identified for MHSP recipients by claim allowed indicator (3 or 6) and deprivation code (X1 or S7).

TAC analyzed data for the year with service dates beginning 7/1/99 and ending 6/30/00. A very significant limitation of this data is that claims run-out is not complete. Montana Medicaid allows a 365-day window for claims submission. Since the claims file contained claims paid through August 2000, none of the quarters during this year can be considered fully complete. That is, analyzing the raw paid claims data without adjusting for completion of the claims run out will under-estimate paid claims for the any period within this year. In order to estimate the eventual claims experience for the year, completion factors were developed for each month of service and each category of service. Using these factors, TAC was able to produce reasonable estimates of the eventual final claims experience by month and aggregate service category, which provide a reasonably accurate high-level view of the service use during the year analyzed.

The lack of maturity in the claims data does introduce limitations that prevent the presentation of some detailed analyses that would be otherwise useful to examine. The completion factors allow adjustment to aggregate dollar estimates for aggregated service categories, but they do not allow us to predict actual use of services by individuals or individual services. As a result, any analysis examining the experience of individuals (e.g., average time between services) or specific service codes could produce misleading and inaccurate results. For certain analyses, the data were restricted to the period July 1, 1999 to March 31, 2000, which allowed for some additional detailed estimates.

The Consultec claims file contains detailed information on every encounter by every enrolled individual that used Medicaid and/or MHSP mental health services during the time period.¹ The Medicaid eligibility category is included², as well as the age and primary diagnosis of individuals served. All service types and providers are coded as well, so that individual service types and provider types can be analyzed by location, clients served, and services provided. The amount paid for each encounter is also in the database, so total costs for services, high user analyses, and other cost analyses can be conducted.

TAC was able to calculate completion factors, so that for some aspects of the analysis it was possible to estimate a year's worth of activity rather than just the nine months covered by the actual claims data.³ Providers report submitting claims promptly, and also getting paid promptly. Consultec agrees that this is occurring. TAC's own analysis concurs – the completion factors seem reliable and relatively uniform and predictable. For the future, if the completion factors prove to have accurately predicted the fourth quarter claims paid, then they can be used with some confidence⁴ by AMDD for much more accurate forecasting of annual expenditures compared to budget.⁵ As will be seen in some of the analysis presented below, there has been quite rapid growth in both utilization and costs over the past year. While this is obviously no surprise to AMDD, earlier use of the data to forecast expenditures may have permitted the Division to intervene earlier to correct the situation.

Again, TAC cautions that nine months of paid claims data, however statistically reliable, is really insufficient for many types of analyses. Most analysts would prefer to have at least two years of clean claims data prior to the current period to assure that the analyses are feasible and correct. With nine months of data, it is difficult to drill down into smaller data categories, or cells, and still be assured of reliability. For example, TAC had planned to analyze elapsed times between service events and average numbers of encounters per episode of care for certain services. These analyses are currently impossible, because there are too few observations in each cell, and the time frame for the analysis is too brief for statistical reliability. In future years, once sufficient data has been collected, AMDD will be able to generate or receive these reports on a regular basis.

For this reason, most of the indicators extracted from the paid claims data and discussed below are carried out at relatively high levels of analysis (i.e., state and

¹ A total of 25,998 unique individual service users are included in the dataset.

² There are no discrete eligibility categories for MHSP enrollees, but all other types of claim information are included for MHSP as well as Medicaid.

³ Note: the completion factors work to predict monthly paid claims, but do not work to predict monthly eligibles and users. Thus, for the analyses of people as opposed to dollars TAC has used the nine months of hard data available on eligibles and users available in the claims file.

⁴ However, two complete years of data are usually necessary to calculate completion factors by service and provider type that can be used reliably for forecasting.

⁵ TAC will submit information on the completion factors to AMDD in a separate memorandum.

region, Medicaid and MHSP, adult and child) but not at the level of providers and service types or distinct eligibility groupings or age sub-categories.

B. Hospital Utilization Data

TAC was supplied with two full years of Montana State Hospital data covering the period 1998 – 2000. The annual inpatient service databases are linked by unique client number, so inpatient events can be traced across fiscal years. As with the Medicaid claims data, there were some initial bugs in transmitting and reading the data. However, Mary Letang of AMDD was extremely patient and helpful in correcting certain formulae and report formats, and the data is now in very good condition for analysis. The Montana State Hospital database includes admission and discharge date, length of stay, discharge status, admission type, indication of first admission versus re-admission, the committing county, and certain demographics such as age, gender, race, and religious preference.

AMDD maintains similar data on the Montana State Nursing Home. TAC did not analyze that data because it is assumed to be a stable population that would rarely move back and forth between community services and inpatient status. However, the database looks to be in as good condition as the Montana State Hospital database.

Some issues common to public inpatient care patterns frequently complicate analysis of state hospital databases. For example, average length of stay is one indicator of how well the hospital is preparing people for discharge, and how well the community system is working to get people out of the hospital, so it is important that the average length of stay be calculated correctly. Individuals who are discharged after a very long length of stay skew the average length of stay calculation. In addition, individuals who have been admitted during a period but not yet discharged also skew the average length of stay calculation, since they show zero days of stay. To correct for these factors, TAC reconfigured the database into 24 monthly admission cohorts, and calculated length of stay for each cohort. In this way, all individuals who were admitted before the 24-month period of the dataset were excluded from the analysis, and all individuals admitted but not yet discharged were also excluded.

Montana state hospital, like many public psychiatric facilities, has a tri-modal distribution of hospital episodes. The first group, or mode, includes a substantial number of admissions that are discharged within three days. These are typically individuals who are inappropriate for inpatient care and are discharged or leave on their own volition.^{6 7} The second group is the typical admission cohort, in which

⁶ It should be noted that the FY '99 – 2000 hospital dataset does not list anyone as having been discharged because they were inappropriate for the facility.

⁷ TAC believes that further assessment of this very short stay group is important. They may use few hospital days, but they use a lot of resources to process the admission, conduct the admission

individuals have relatively average acute care lengths of stay.⁸ The third group is the very long stay cohort. These individuals frequently stay for over 200 days, and a number have not yet been discharged after almost two years in the hospital. This group may be evidencing an “institutional syndrome,” in which the hospital become a place to live rather than a place for treatment. Several studies have shown that after three months stay it becomes very difficult to effectuate a community placement.

TAC recommends further analysis of the length of stay phenomenon in Montana State Hospital. One methodology for this analysis is a life table analysis. This is basically an actuarial approach that can be used to predict the probability of an individual being discharged based on how long they have already stayed. In a Massachusetts example, Individuals were found to have very high probabilities of discharge from day five to day 10 of a hospital stay. From day ten to day 15 the probabilities of discharge flattened out, and after day 15 the probability of being discharged started going down. After 30 days in the hospital, individuals were found to have a greater than 90 percent probability of staying a year in the hospital. This type of analysis is important because it can show at what point in an episode of inpatient care it is necessary to effectuate a discharge, lest the individual be at risk for a very long stay. This methodology can also be used to develop very reliable forecasts of the number of hospital days needed for a given admission rate per month or week.

TAC has also been supplied with some general hospital inpatient psychiatric care data, which was assembled by the Montana Hospital Association. Not all Montana hospitals participate in supplying data to the Hospital Association, so the dataset is not complete. Data from out of state hospitals is also not included. Finally, the data covers only people over 17 years of age, and thus does not provide a good picture of general hospital psychiatric inpatient care for children and younger adolescents.

TAC did not have access to the hospital database, only the hard copy reports. However, the information appears useful, and can be compared in some instances with Montana State Hospital data. It is hoped that the Montana Hospital Association will continue to provide this useful information.

C. Mountain Pacific Quality Health Foundation Service Authorization Data

TAC did not use Mountain Pacific Quality Health Foundation’s data as part of this study. In some jurisdictions it is useful to analyze the frequency with which certain services are requested for authorization, and the denial rates. High denial rates could be an indicator of restricted consumer access to certain service types, or could

assessment, etc. In addition, some of the very short stay group might become long stay upon their next admission. TAC has identified at least four situations in which that occurred during FY 2000.

⁸ However, as will be described below, Montana State Hospital has very long average lengths of stay for acute care.

be an indicator of some service gaps in the community that results in inappropriate requests for services. An organization's quality management and improvement team frequently reviews service authorization and denial rates. However, in the case of Mountain Pacific Quality Health Foundation the initial information provided indicated that denial rates were usually less than one percent. With denial rates that low it would be fruitless to try to reach any conclusions about either restricted service access or gaps in services in the mental health system in Montana. Additional information requested about these denial rates and the reason for them was not provided by Mountain Pacific Quality Health Foundation's representative.

It is hoped that the new utilization management contractor, First Mental Health, will have a somewhat greater effect on utilization patterns, and also will provide AMDD with regular reports of service authorization request and denial rates.

D. Child Residential Care Placement Data

Staff of AMDD maintain a manual database of youth in out-of-home and out of state placements. Admissions to such programs can be tracked through the service authorization process, and lengths of stay can ultimately be tracked through the paid claims file. However, it would typically be three months after a discharge from residential care before the episode of care would be completely recorded in the claims file. There is no system or set of systems currently in use in Montana that could reliably track the number of youth in out of home or out of state placements on any given day or week.

However, for data this specialized, and covering a very small number of individuals (± 70 when TAC last reviewed the report), a simple manual database (i.e., Excel or ACCESS manually maintained as opposed to electronically populated with data from other systems) is probably sufficient. Because AMDD staff already maintain and analyze this data, there was no reason for TAC to conduct further analyses of the data.

E. Other Data Sources

Provider-specific data

TAC surveyed several of the larger mental health center and youth serving agencies in Montana to see if they collect any information in a consistent manner that could be useful to AMDD in assessing consumer outcomes and/or system performance. The responses were consistent: agencies collect and report the data necessary to track consumers and service encounters, and to produce the necessary billing forms to get paid (UB 92 and HCFA 1500). They do not routinely or consistently collect or analyze information on consumer outcomes or provider performance. Nor do they routinely or consistently collect or analyze information on level of functioning and acuity (i.e., Multnomah scale, Basis 32, CAFAS, etc.)

The providers surveyed stated that prior to the implementation of managed care they were working on implementing the Mental Health Statistics Improvement Project (MHSIP) report card data. However, since the end of managed care they have not returned to that effort. As the stakeholder input process recommended in the Task Two report continues, data for the consumer outcome and system performance measures, will have to be built into all providers' data collection and reporting systems.

Consumer and family satisfaction reports

AMDD has conducted periodic consumer and family satisfaction surveys. These have been helpful, even though the responses have been somewhat predictable. In the final Task Two and Task Three reports, TAC recommends some improved approaches for consumer, family, and provider input and some additional types of information to be collected through consumer and family self-report.

Qualitative information from key informant interviews, focus groups, and program site observations

AMDD staff typically use a variety of qualitative sources of information as well as any available quantitative data to monitor and oversee public mental health activities in the field. TAC used a similar approach when assessing the Montana public mental health system for this report and for the Task Two and Three reports. Because of its direct link to many of TAC's recommendations, most of the qualitative data collected and used for the analysis is summarized in the TASK Three report. The importance of qualitative information should not be underestimated. In fact, quantitative data at best provides indicators of factors that should be studied further. It is the qualitative information that supplies informed judgments about how to interpret the quantitative data. This is the essence of the continuous quality improvement process, in which a variety of quantitative and qualitative types of data and information are brought together to provide a complete picture of the events, activities, or results under consideration.

III. FINDINGS FROM THE DATA COLLECTION AND ANALYSIS

In this section of the report, some of the findings and observations are presented about current mental health system characteristics and performance. These are examples of how existing datasets can be used to assess the current system and to identify areas for improvement, gap filling, etc. Producing such analyses also helps to identify further analyses that could be conducted from existing data, and also identify new types of data that are important but not currently available.

A. Indicators from the Consultec Paid Claims File

As is well known in Montana, the Medicaid and MHSP programs have grown significantly since the end of managed care. This is true for many variables, including eligibles, users, and paid claims for services.

In Table 1 TAC displays the growth in Medicaid eligibles and users per month. For example, monthly eligibility has grown by 7.62 percent in the nine-month period from July 1999 to March 2000. Monthly total users (those receiving at least one service encounter) increased 30.18 percent in the same time period. Eligibility as a percentage of total population went up by 7.62 percent, while users as a percent of eligibles went up by 26.09 percent.

Similar information about the MHSP eligible population is displayed in Table 1 A. MHSP eligible enrollment levels have stayed relatively constant, averaging about 4,300 per month for the period July 1999 to June 2000. MHSP enrollment as a proportion of the total Montana population has also remained constant, at about one half of one percent. However, as with the Medicaid population, both the absolute number and the percentage of users have gone up. For MHSP, the number of users has grown by over 17 percent, and the percent of eligibles that use services has increased by 22.64 percent.

MHSP eligibility does not have the same meaning as Medicaid eligibility. For Medicaid, eligibility is based on financial eligibility for categorical assistance (i.e., SSI, TANF, Medically Needy Spend-Down, etc.) and not on any specific diagnosis or level of functioning. As shown in Table 3 below, between eight percent and 16 percent of Medicaid eligibles actually use mental health services. For MHSP, eligibility is based on financial need (income less than 150 percent of the federal poverty level) *and* on meeting the clinical criteria for serious emotional disability or serious mental illness. Thus, MHSP eligibles by definition are in need of mental health services as a condition of eligibility.

Given the eligibility requirements for MHSP, one might expect utilization to exceed the current level of slightly less than 60 percent. This is an issue that could receive further study through the quality management/improvement process. Additional analysis of MHSP data is possible, but will require some additional data extracts and linkage between the MHSP enrollment database and the Consultec paid claims files.

Table 2 displays the same information by region by month. This shows that while Medicaid eligibility has grown the fastest in Northwestern Montana (Region 5), use rates have grown the fastest in Eastern (Region 1) and North Central Montana (Region 2.) This is an example of a situation in which data provides an indicator of something that varies across the state, but does not provide an explanation of why that is happening. Further analysis will have to be conducted to see why these differences occur, and whether they make any difference.

Table 3 shows the growth of Medicaid eligibles and users by age. It is interesting, but perhaps not significant, that most of the growth in eligibles has been accounted for by youth (15.83 percent growth for under 19, less than ½ percent for the 19 – 21 age group, and shrinkage of over 2 percent on the 22 and over group) while at the same time the growth in users was higher for the 22 and over group (34.66 percent growth for the 22 and over group, and 24.75 percent growth for the under 19 group.) Table 3 also shows penetration rates, or users as a percent of eligibles. Penetration rates of 8.4% percent for youth are about consistent with national patterns. The penetration rates for adults of almost 16 percent are quite high when compared to national averages. High penetration rates are usually an indicator of good outreach and facilitated access to services. However, as with above, it may be an indicator of access that is *too* easy because of the addition of new mental health centers to the provider community or some other reasons.

Table 4 shows the growth in spending per capita and per user for the 12 month time period. Per capita expenditures have increased by 28.9 percent, and per user expenditures have increased by 24 percent. Table 5 shows the same information by Medicaid and MHSP and by Region. Table 5 shows that South Central Montana (Region 3) and Southwestern Montana (Region 4) have the highest overall per capita spending, the highest per capita MHSP spending, and the highest Medicaid spending per eligible and per user. As with the regional variations noted above, additional analysis will have to be completed to understand why these variations occur and whether they matter to the system.

The obvious conclusion from the above data is that access and use rates for services have increased much more quickly than have eligibility rates. This may be an expression of pent up demand for services from the managed care era. It may also be an indication of much easier access to newly certified mental health center providers. In either case, it goes a long way towards explaining why service costs have exceeded the budget during the current fiscal period.

Charts A and B show the monthly rates of growth in Medicaid and MHSP expenditures for the current fiscal year. Table 6 provides the detailed back-up data for these charts. In the period from last July until June 2000, total monthly expenses increased by almost 29 percent. As can be seen in Chart B, Medicaid expenditures grew by 25.94 percent, while MHSP expenditures grew by 41.67 percent. In Medicaid, the growth rate for facility⁹ expenditures was 16.4 percent, and for medical¹⁰ expenditures was 30.52 percent. In MHSP (which does not cover inpatient facility services) the growth in medical expenditures was 43.2 percent, while the growth in drug expenditures was 36.3 percent. It should be noted that although the growth rates in MHSP were higher, MHSP represents just over 16 percent of total expenditures, while Medicaid comprises just under 84 percent of the expenditures.

⁹ See Table 3 – “Facility” refers to UB 92 claims, which include inpatient and hospital-based outpatient services plus residential treatment services.

¹⁰ See Table 3 – “Medical” refers to HCFA 1500 claims, which include mental health center claims therapeutic group homes and therapeutic foster care.

Thus, the smaller growth rates in Medicaid actually account for a much higher proportion of overall expenditure increases.

Given the limitations of the Medicaid/MHSP dataset, it is not possible to conduct valid analyses at a greater level of detail than the above. When more data is available, and when the data covers a longer time period, it will be possible to isolate discrete factors (i.e., growth in MHSP child/adolescent service costs) that may have a significant effect on the patterns of growth in expenditures. This is the type of specialized analysis that AMDD should be able to accomplish with ease in the future.

The only clear pattern shown in the expenditure analyses is that monthly expenditures are going up. As noted above, this is likely to reflect pent up demand from when the system was under managed care, and also the entrance of new providers into the system. Other factors may include the effect of moving from a system in which inpatient services were tightly managed to a system in which virtually all admissions are approved, and the fact that there are no current incentives to either prevent admissions or to get people out of the hospital. These issues are discussed in more detail in the Task Three report and clearly are issues that AMDD should continue to track while a more cohesive community based system of care is developed, and First Health begins to manage utilization more closely.

Perhaps the most important analysis from this Table is the proportion of funds paid for out-of-home services as opposed to community-based services. Forty-six percent of the total annual expenditures are for four out- of- home type service categories: residential treatment, inpatient hospital, therapeutic group homes, and therapeutic foster care. This is a very high proportion of overall expenditures for facility-based services.

Table 7 shows expenditures for both UB 92 facility claims and for HCFA 1500 medical claims. As can be seen from the data, several inpatient and facility-based or out- of- home residential services are among the top providers. In fact, 46 percent of the total expenditures go for facility-based or out- of- home services. This is a relatively high percentage, and reflects the need to develop more community-based alternatives. Additional information on this topic is included in the Task Three report.

Table 8 shows a ranking of expenditures by procedure code for medical claims (UB 92 facilities do not use the same procedure codes, and were reported in Table 3), and substantiates the analysis of provider type expenditures in Table 7. First on the list is therapeutic group home-intensive, with 8.24 percent of the expenditures. Intensive case management for adults and youth are the next two, followed closely by insight-oriented treatment. Day treatment for youth and adults rank 8th and 9th, respectively. Community-based psychiatric rehabilitation is ranked number 12, with 1.41 percent of the total resources. These rankings may be indicators of some misalignment of service resources in the community. For example, in a preferred

model community service system one would hope to see greater expenditures for intensive case management than for residential treatment services. In a similar manner, the expenditures for community psychiatric rehabilitation services would be substantially higher than expenditures for insight oriented therapy. These indicators, in combination with the high expenditures for facility-based services highlighted above, point to a relatively traditional public mental health service system that has gaps in preferred models such as family centered systems of care for youth and in recovery oriented approaches for adults. The Task Three report emphasizes this point, and adds a substantial amount of detail about the services and system changes needed to implement these changes.

TAC has received additional data analyses that will support more detailed analysis of heavy users of services in the Montana public mental health system. A first cut of the data shows that less than 8 percent of all service users (2,000 of 25,998) use 66 percent, or over \$51 million of the total dollars spent for mental health services. 63 percent of these heavy users are children, and 37 percent are adults.¹¹ Of the 2,000 heavy users, the lowest total paid claims is \$8,000, and the highest is over \$115,000. Hospital and out of home placements account for over 62 percent of the heavy user expenditures.

TAC conducted a separate analysis of the 1,256 youth (21 and under) of the 2,000 total heavy users of Medicaid/MHSP resources. These youth in one year have used an estimated \$41 million of combined Medicaid and MHSP expenditures, or 52 percent of the total estimated expenditures for all Medicaid MHSP enrollees or \$79 million. Youth in this group have used 99% of therapeutic group home care, 99% of residential treatment and 99% of therapeutic group home expenditures. Clearly, if Montana is to control costs and re-deploy resources in these high cost service areas, the group of 1,256 youth would have to be targeted for alternative services. These 1,256 youth also use 97% of the total outpatient hospital resources, most likely for partial hospital services. Almost 30% of all inpatient hospital (excluding Montana State Hospital) expenditures are for these youth.

It is interesting to note that these heavy user youth comprise less than 45% of intensive case management resources for youth, and less than 25% of all Community Mental Health Center resources. These data need much further study. However, they suggest that more expensive and less community integrated service models (i.e., group home and partial hospital) are being overused, while intensive case management and Community Mental Health Services provided in more normal community settings may be underused.

Tables 10, 11, and 12 contain summaries of the data for this special study. This type of focused study of subsets of consumers or services is an example of the type of studies that could be conducted by AMDD on a regular basis if the data were made available in appropriate formats, and if AMDD has staff to conduct the analyses.

¹¹ Reminder: youth 21 and under comprise about 42% of total Medicaid MHSP enrollment.

B. Montana State Hospital Data

In the 24-month period from July 1998 through June 2000, Montana State Hospital has admitted 872 individuals, and discharged 805 of those individuals.¹² The average number of admissions per month has been 36.33, and the average discharges per month of the admission cohort have been 33.38. One issue related to management of state hospital beds is a phenomenon known as “silting up.” TAC strongly dislikes this term, but it does describe common experience that over time hospital beds get filled with people who don’t leave, resulting in fewer and fewer beds for acute care. Over the past two years it appears that Montana state hospital has been de facto converting about three beds per month to long term residential care. This phenomenon is ironic, because even when admissions and average lengths of stay go down, beds available for acute care can still be reduced over time.

In the '98 – '99 time period, 50 of the admissions, or 9.9 percent of all admissions, were readmissions during the same year time period. In the '99 – 2000 time frame there were 54 re-admissions, or 11.66 percent of all admissions. This is not a particularly high readmission rate for either year. Some of the readmissions came within 30 days of the previous discharge, but this is not the typical pattern. Readmissions are always a concern, and should be monitored closely.

Admissions to Montana State Hospital have been going up somewhat, averaging 34 per month during '98 – '99, and now averaging 45 per month for the last six months of FY '99 – 2000. However, the average length of stay on admission has been reduced from an average of 96 days during FY '98 – '99 to an average of 59 days in FY '99 – 2000. These are still very long lengths of stay. For example, in the private hospital data supplied by the Montana Hospital Association, the average lengths of stay are in the four to seven day range. This is very consistent with national general hospital lengths of stay for psychiatric inpatient care. In most states, the expected length of stay for an individual involuntarily committed to a public mental hospital is 10 to 15 days. Montana’s average length of stay is more than four times higher than that. Clearly, this is another factor that explains the high bed days and high census now being experienced in Montana State Hospital.

From the hospital data supplied to TAC, just fewer than 80 percent of the admissions were routine civil commitments, and under 10 percent were for all types of forensic commitments. Thus, it does not appear that forensic admissions are causing the long lengths of stay. As noted earlier, TAC has adjusted the data to exclude very long stay individuals from the calculations, so there is not a mathematical skewing effect from those types of lengths of stay. Also from the data it appears that over 50 percent of the discharges are general discharges to the community as opposed to group homes, etc. Thus, for more than half of the discharges waiting for a group

¹² As discussed in Section II, TAC has created admission cohorts for each of the 24 months represented in this analysis. Individuals admitted before July 1, 1998 is not included in the analysis, even if they were discharged during the '98 – '00 time frame.

home or other type of facility does not appear to be slowing down the discharge process. TAC also notes that only a small number are discharged on conditional release (seven of 463 discharges in '99 - 2000.) Some participants in Montana have suggested that conditional release would be a useful mechanism to get more people out of the hospital sooner.

Chart C, D, and E show the monthly trends in admissions, lengths of stay, and bed days used for the 24 admission cohorts. Table 9 provides the numerical detail for these Charts. Monthly average bed days have gone from 3,087.27 in the '98 – '99 period to 1,997 in the '99 – 2000 period. The 37,045 bed days used by the 12 admission cohorts in the '98 – '99 period amounts to just over 101 beds, while the 23,964 bed days used by the '99 – 2000 admission cohorts amounts to just under 66 beds.¹³ This is more evidence that beds are likely to be slowly and inadvertently being converted from acute to long stay. If this were not the case, the census of the hospital would be able to be much lower than it currently is.

In general, the Montana State Hospital data confirm the general conclusions reached from the Medicaid/MHSP claims data: that Montana has a relatively traditional public mental health system with long hospital lengths of stay and few community resources that are specifically designed to prevent crises and hospitalizations, and to get people out of the hospital as quickly and effectively as possible. Further, as noted in this report and in the Task Three report, there are currently no real incentives for community providers to keep people out of the hospital, or to get them out quickly if they are admitted. In addition, the lack of a single point of accountability for individuals in the system makes it both easy and likely that people will fall through the cracks and end up in crisis and on a pathway to being hospitalized.

IV. CONCLUSIONS AND RECOMMENDATIONS

A. Usefulness of the Data

The first question is: are the existing datasets useful for describing system characteristics and for tracking certain performance indicators. The answer is a qualified yes. The Montana State Hospital database appears to be complete and accurate, and is useful for tracking key indicators such as admissions, readmissions, lengths of stay, and bed day utilization. The admitting County is included in the dataset, so regional comparisons of admissions and bed day utilization can be accomplished, and the state hospital data can be arrayed with other types of data to develop regional profiles and related analyses.

¹³ Note: the '99 – 2000 period should be re-examined in the near future. Many of the individuals in the admission cohorts for that time period who had not yet been discharged at the time of the study will be discharged by now or soon, and thus the bed day calculations for their individual stays can be added to the overall bed day analysis.

The Consultec claims data also appears to be complete and accurate, and is useful for a variety of analyses of performance factors, such as penetration rates, elapsed times between service encounters, resource allocation, and patterns of service delivery. These data will become more useful for specialized analyses and financial forecasting over time.

There are naturally a number of key data elements that are currently missing from any system currently available to AMDD. These include level of functioning and acuity, consumer focused outcome measures (see the Task Two report) and consumer self-report of satisfaction, choice, quality of life, and health and mental health status. Capacity to collect and report these types of data will have to be developed, and will have to be integrated as much as possible into existing data systems. In the Task Two report, TAC makes specific recommendations about data for regional profiles and for outcome and performance measures. In the Task Three report, TAC recommends specific actions regarding analysis of data and development of a single integrated data system. These recommendations will affect provider data collection and reporting as well as that of the Division.

TAC also notes, as has been more fully described in the Task Three report, that AMDD has certain issues with regard to data collection and analysis. The first is that there are inadequate links between the various databases, which makes analysis and interpretation more difficult. Second, AMDD lacks sufficient skilled personnel to integrate data from many different sources, analyze and interpret the data, produce routine reports for management decision support, and conduct special studies when necessary. Correcting both of these issues will significantly improve the Division's capabilities to conduct quality management and quality improvement functions, and to provide information to oversight agencies, the Legislature, and the general public.

Finally, TAC hopes that AMDD will now use the two major datasets addressed in this report for on-going system monitoring and decision support. It seems particularly important to assure that the Medicaid/MHSP claims database continue to be updated and used, now that the initial work of preparing the database for analysis has been completed. Once a baseline of indicators from that data has been established, it will be both possible and productive to track those indicators over time.

B. Identification of Service System Issues and Recommendations for Change

TAC has noted a number of key issues to be addressed in the current service system. The most important of these initially will be (a) to develop practice guidelines for services for youth and adults in the community, and to convert more traditional models and the resources associated with them to new community service approaches, as described in the Task Three report; and (b) to address the

high utilization and census of Montana State Hospital. The First Health pre-admission screening and authorization function should assist somewhat in this latter effort, but there is much work to be done in the community to provide viable alternatives to hospitalization, to prevent crises from occurring in the first place, and to get people out of the hospital quickly before they become “new long stay” residents of the facility. The Task Three report provides a number of recommendations for implementing strategies to address both (a) and (b) above and for addressing the data analysis and management information system issues.

Task Two: Outcome and Performance Measurement

I. INTRODUCTION

This report constitutes the first deliverable from the Technical Assistance Collaborative, Inc. (TAC) to the Montana Addictive and Mental Disorders Division (AMDD) of the Department of Public Health and Human Services (DPHHS) under the current mental health system evaluation and planning project. This report is the final product for Task Two of this project. The report is based on the following primary sources of information:

- Interviews and program observations conducted by TAC senior staff during several on-site visits;
- Review of numerous documents, reports, and database descriptions provided by AMDD;
- Reviews of reports and managed behavioral health contracts from numerous states and national organizations containing information on outcome and performance indicators used in other jurisdictions and/or recommended by national organizations (see Appendix A for a summary of these);
- The knowledge of and experience of the TAC team with other state and local mental health systems; and the input of system stakeholders provided during two sessions of the Performance Measurement Advisory Group (PMAG), convened by the Mental Health Services Bureau at TAC's request for this purpose. The minutes of these two meetings are available from MHSB; and
- The Mental Health Oversight and Advisory Council (MHOAC) recommendations and input at three of their meetings at which TAC was present and presented information about this project.

In its initial Task Two report, TAC recommended a developmental process beginning with stakeholder input and buy-in followed by a specific implementation strategy for the Montana AMDD related to developing and implementing outcome and performance measurement for the Montana public mental health system. The purpose of the stakeholder input process – the PMAG – was to achieve consensus about and commitment to the overall strategy for outcome and performance measurement as well as initial outcome and performance indicators that should drive Montana's initial data collection and reporting activities.

TAC recommends a process for continuing input by system stakeholders, whether members of the initial PMAG or others interested in and affected by the outcome and performance measurement process. The objectives of the on-going stakeholder input process are the following:

1. Continually reinforce the original policy goals and system performance expectations of the Mental Health Access Plan (MHAP), link these to a quality management and quality improvement strategy, and adopt these principles as the overall context for outcome and performance measurement;
2. Continue to work with stakeholders to develop a common understanding of terms, concepts, technologies, and experiences from other states.
3. Forge an organizational and service system culture that supports data collection and analysis and the use of information for management and service improvements;
4. Refine the outcome and performance indicators and measures to reflect policy priorities, agree on instrumentation or data sources (either existing or to be developed) to collect data about these measures, and assure effective implementation of data collection and reporting activities; and
5. Provide input into reporting formats, discuss reports and their implications, and provide input to the actions that should or will be taken as a result of the reports received.

This recommended developmental and stakeholder input process is based on TAC's assessment of the status of outcome measurement in Montana. Although there have been several efforts over the past several years to develop outcome and performance measures, there has been no consistent implementation or follow through on these efforts. The actual indicators and measures proposed under the various efforts are quite consistent with those proposed and/or implemented in many other jurisdictions. The fact that these efforts have not been implemented are evidence that: (a) there is not a common understanding among all stakeholders about the technology and process of outcome and performance measurement; (b) there is not consensus about what should be measured and how measurement and reporting should occur; (c) there is not yet a real commitment to the value of measuring performance and outcomes compared to the effort required to accomplish it; and/or (d) there are concerns among stakeholders, particularly providers, about how outcome and performance information will be used.

Despite AMDD's efforts over the past eight to ten years to implement reliable and consistent data collection and reporting in support of outcome and performance measurement, it is clear that there is not a well-developed culture of using data for management or data for quality improvement in the Montana public mental health field. Given this lack of culture and experience with the use of consistently collected and analyzed data for management, TAC does not believe that any strategy for measuring outcomes and performance among providers should be imposed immediately and from above. Further, given that AMDD has made a serious effort to improve relations and maintain communications with stakeholders since the end of the Montana Community Partners (MCP) contract, it would be inconsistent and

disruptive at this point to take any unilateral action to implement outcome and performance measurement requirements before stakeholder input is heard and considered.

This is particularly true because the state-of-the-art in outcome and performance measurement in the public mental health field remains in the developmental stages. Managed mental health care continues to evolve rapidly in both the public and private sector. States and other purchasing organizations continue to refine their delivery systems and models of care, and data processing, claims payment, and outcome and performance measurement tools are rapidly becoming more sophisticated. Even established systems such as Massachusetts and Iowa continue to amend and modify their outcome and performance indicators and targets with the managed care organizations and with their provider network. These developments are taking place at the same time as provider organizations and networks, especially the providers serving public sector clients, struggle with budget constraints; staff recruitment and turnover; mounting demands from managed care organizations and state regulators; and minimal rate increases. Similarly, Montana should see this effort as a developmental process to begin now and continue as the regional structures and other recommendations discussed in TAC's Task Three report are designed and implemented.

Although the technology of outcome and performance measurement and related management systems has improved significantly in recent years, there is still little empirical evidence about the effectiveness of either managed care approaches (other than to decrease costs and inpatient utilization while increasing access, crisis services and sometimes rehabilitative and in-home services, if systems are designed with these specific goals) or about the tools and measures employed to assess these initiatives. Thus, each state embarking on the course of managing care and measuring outcomes does so with limited experience from other jurisdictions on which to build, and no "pat answer" about the best way to proceed. This lack of empirical evidence is compounded by the fact that each state's mental health system is unique, and comparisons among state systems are difficult and unreliable. Much can be learned from current practices and experiences in the field, especially the work of the MHSIP, NASMHPD and ACMHA efforts (see Appendix A), but these still must be tailored to Montana values, resources, and priorities.

Thus, the stakeholder input and buy-in strategy, and the implementation process begun and recommended to be continued is intended to link the best of what has been learned about outcome and performance measurement in the public mental health field with the unique history, values, and priorities of the public mental health system in Montana. What is important is to begin, and to begin with a commitment to continue the developmental process, including the changes and incentives (and if necessary sanctions) needed to collect and analyze data and use it to improve the system of care toward agreed upon goals and expectations.

II. MONTANA'S PREVIOUS EFFORTS

Montana's Department of Public Health and Human Services and the Addictive and Mental Disorders Division and Mental Health Services Bureau have emphasized the importance of outcome and performance measurement for many years. For example, prior to the implementation of the Mental Health Access Plan (MHAP), AMDD published *Principles for Practice for Community Service Providers*. This document includes 22 outcome statements related to individual consumer outcomes, and an additional nine agency functions defined as supporting individual outcomes. Categories of outcomes defined for consumers include:

- Community membership;
- Relationships;
- Dignity, self-worth, and individual rights;
- Individual choice and decision-making;
- Health and safety; and
- Promoting well-being, comfort, and security.

Provider agency administrative categories include:

- Promoting sound management and good practice;
- Assuring the integrity of the public mental health delivery system; and
- Assuring Medicaid compliance.

In addition, a number of provider and system performance indicators are listed, including:¹⁴

- Access to services;
- Waiting times;
- 24-hour availability;
- Inpatient admissions;
- Service penetration rates; and
- Stakeholder participation.

More recently, as part of the implementation of the MHAP, AMDD prepared a report on Quality Assurance Measurement. This report specifies that the performance of Montana Community Partners, the managed care contractor, will be measured in five categories:

- Access to services;
- Appropriateness of services;
- Clinical indicators and member outcomes;
- Stakeholder satisfaction; and

¹⁴ Note: the following is a representative sample of the total number of indicators listed.

- Program administration.

As part of this quality management effort, Montana contracted with Health Management Associates (HMA) to independently administer consumer satisfaction assessments.

The above information provides positive examples of Montana's commitment to outcome and performance measurement. They are also fully consistent with the state of the art in consumer outcome and performance measurement as part of a larger quality management and improvement process. In fact, the consumer outcome categories included in the *Principles for Practice* report are consumer driven and recovery oriented in a manner consistent with the Mental Health Statistics Improvement Project (MHSIP) Report Card and with modern recovery principles. Further, the performance indicators adopted for the MHAP quality monitoring process are very similar to those used by many states and recommended by national organizations for performance measurement in managed systems of care (see Appendix A.)

Recently, AMDD leadership has been outlining a new strategic *Mental Health Plan: Directing Public Mental Health Services into the 21st Century*. AMDD intends to use this plan to further emphasize the importance of specific outcome and performance measurement activities linked with quality management and quality improvement practices. In fact, one function of this report is to stimulate stakeholder input and consensus building related to outcome and performance measures to be included in that strategic plan. The completion of this strategic plan, with input from system stakeholders and endorsement by the Mental Health Oversight and Advisory Committee (MHOAC), is a key recommendation in TAC's Task Three report.

III. TAC'S STRATEGIC RECOMMENDATIONS

A. *Adopt a Montana-Specific Policy and Quality Management/Quality Improvement Context as a Basis for Outcome and Performance Measurement*

As noted above, AMDD and MHSB and the Addictive and Mental Disorders Division defined some specific goals and objectives for the original Mental Health Access Plan that became the basis for the MCP managed care initiative. These include:

1. Have a system in which rational treatment decisions are made according to the needs of the individual being treated and which is adaptable, taking into account the changing needs of the individual and the full range of available treatments.

2. Offer a prospect of a more complete continuum of care with rapid development of alternative and innovative treatment settings and modalities as new needs and opportunities are identified and as scientific knowledge progresses.
3. Allow the state to predict expenditures and demonstrate that tax money is being spent on effective services.
4. Produce an integrated service system across the state, with timely access to a coherent continuum of services for all Montanans who are eligible for and in need of mental health services.
5. Offer continuity of services across settings, and those services must be of known, high, uniform, and improving quality.
6. Include meaningful dialogue with and participation by consumers, family members, advocacy groups, and providers in design, implementation, evaluation, and monitoring.

These goals and objectives for the Montana public mental health system are important because they provide a policy context for measuring consumer outcomes and provider and system performance. There is a well-known adage in the field that states: “What you measure is what you get.”¹⁵ This means that whatever outcome and performance indicators are adopted and measured should be consistent with the policies, objectives, and values of the state leadership and system stakeholders. The outcome and performance measures recommended by the PMAG and recommended in this report by TAC do reflect these policies, objectives and values.

Second, it is important for all stakeholders to know and understand how indicators of outcomes and performance will be used. What does a certain level of performance on a given indicator mean? How can levels of performance be compared across providers that may be serving consumers with different levels of need? Will the information be used to sanction some providers and reward others, or will it be used to make all components of the system more effective? These are legitimate questions, and they arise in every jurisdiction that starts to move away from process measurement and towards outcome and performance measurement. This is why TAC so strongly emphasizes the role of quality management (QM) and quality improvement (QI). The policies and priorities of Montana officials and stakeholders answer the question of what to measure; the QM/I process defines how the information collected will be used to constantly improve the quality and effectiveness of the Montana public mental health system. The QM/I functions are described in detail in the next section of this Report, and a comprehensive QM/I plan and system is recommended by TAC in its Task Three report.

¹⁵ It is also a complementary adage that “What you report is what you get with enthusiasm.” Hence, the suggested regional profiling and outcome and performance indicator reporting recommended later in this paper.

Third, it is important for Montana to adopt some clear principles for selecting the first few outcome and performance measures to be used. Discussions among stakeholders about outcome and performance measures can become infinitely complicated in a very short period of time. What a system and its stakeholders want to measure and the technology and capacity to do so often quickly diverge. Clear selection and implementation principles and criteria can assist AMDD to keep the stakeholder discussion process focused and limited in its scope and the implementation process as effective as possible, with the likelihood of early success upon which to build later.

Such criteria could include:

- The measures selected should be uni-dimensional – that is, they will measure one and only one variable at a time, and the variable is not dependent on or significantly modified by any other variables.
- The measurement activity should require a minimum of extra work from stakeholders, especially providers. That is, no one should immediately have to conduct special studies, carry out discrete surveys, or do manual searches of medical records or other files to produce a report without the time to incorporate these requirements into daily operations and data collection activities.
- Once outcome and performance indicators and measures are selected and tested, with assistance for providers to meet the reporting requirements, accurate and timely data collection and reporting should be a condition of receipt of public funding for mental health services.
- Experience in other jurisdictions indicates that outcome and performance measurement will be developmental. Therefore, the process should be on-going and will result in continuing refinements in definitions, measurement tools, and assessment of the validity and reliability of the specific data collected and reported.
- The selected indicators and measures should be directly related to priorities identified by Montana officials and other stakeholders as being relevant to policy objectives and Montana values and resources.
- The selected measures should reflect some of the key concerns in the Montana landscape, such as access to services in rural areas, placement of children in 24-hour programs and/or out-of-state programs, and/or use of alternative programs enabled by the flexibility in Medicaid rehabilitation option and/or waivers.
- The reporting of data about outcome and performance measures should be utilized first to identify system issues and take system wide actions to improve system performance and system impacts on client outcomes. Eventually, when

outcome and performance indicators are refined and measurement processes are satisfactory, and with plenty of notice and time for preparation, data reporting by providers or by practitioners should be considered to assist providers and practitioners to compare their performance to that of others similarly situated and to improve their performance to the benefit of consumer outcomes.

- Reporting by regions should occur immediately and continue as the recommended regional structures are developed. Eventually, regional reporting should be the basis for decisions about regional funding and other system opportunities.

B. Use Consistent Definitions of Terms

One barrier to successful implementation of outcome and performance measurement and improvement activities has been the lack of common understanding about the meanings of terms. Because of the proliferation of the Continuous Quality Improvement (CQI) or Total Quality Management (TQM) programs, the accompanying terms can carry very different meanings in different settings. Therefore, selecting terms and definitions to be used consistently in Montana will enhance the stakeholder dialogue and the usefulness of the outcome and performance measurement process.

Another reason to clarify the terms is that consistent application and use of the terms are important building blocks to the establishment of a working “culture” in which all stakeholders become increasingly comfortable with data in the evaluation of service delivery systems. When all parties speak from the same understanding of key concepts such as performance indicators, measures of effectiveness and access, the level of discussion about important issues can be raised to a higher level beyond the anecdotal accounts and generalized criticism that often occur in public debate about behavioral health care.

In order to fulfill its statutory mandates, AMDD must assure the following:

- That services are minimally adequate so that persons served are not harmed (***quality assurance***);
- That services produce expected good results for individuals and communities (***consumer outcomes***);
- That the system performs in expected effective ways (***quality management***); and
- That services, administrative processes and staff are constantly improving and learning new and better ways to do business and deliver services (***quality improvement***).

While **quality assurance** is absolutely critical, it is not sufficient. **Quality assurance (QA)** relates to the establishment of minimum requirements, monitoring processes of the delivery of care, identification of problems, and investigation of those problems or incidents. **Quality assurance** includes activities such as licensure and certification of providers (both individual and organizations), accreditation of providers, and investigations of allegations of fraud, abuse, and neglect.

Establishing and managing to expected performance standards (including but not limited to contract compliance) is crucial but is also not sufficient. The activities of **quality management** include identification of required performance and confirmation that the delivery system is performing at or above the required levels. **Quality management (QM)** includes, but is not limited to, **quality assurance** activities. Helping providers and the service delivery system as a whole manage to identify expected results is the goal of **quality management**. Activities associated with **quality management** include measuring, reporting and acting on identified **outcome and performance indicators**.

Recognizing that human endeavors can always improve, the State of Montana should take the lead in setting a tone of learning, trying new approaches, and providing leadership to work in partnership with all parts of the system to constantly find ways to get better – both clinically and administratively. These characteristics make up the “culture” in which care is delivered. These activities form the cornerstone of a true high quality system. To accomplish this, therefore, the State of Montana must be committed to **quality management** processes and activities (including **quality assurance**) and to constant **quality improvement (QI)** throughout the state-funded system of care. Activities that promote **quality improvement** include, but are not limited to:

- Forming teams to retrieve data on program operations and consumer outcomes, analyze it, and use the information to improve the ways in which the system performs;
- Development, implementation and refinement of practice guidelines or “best practices” in the delivery and administration of behavioral health care;
- Conducting targeted studies aimed at determining why outcomes or performance is at the level it is and what it would take to make it better.

In some systems, the term **performance improvement (PI)** is used to describe the process of measuring and improving system performance. This term will be used synonymously with **quality improvement (QI)** in TAC’s reports about the Montana MHSP and Medicaid mental health system. Other terms were defined during the PMAG meetings and will be defined throughout this report in the context in which they are used.

C. Implement All Five Steps of a Quality Management and Improvement Process

There are five basic steps that make up the Quality Management and Improvement (QM/I) cycle. These steps include **design, data collection, feedback, actions, and redesign**.

The first step is **designing** the QM/I system. This step involves the determination of what is important (values), what defines quality (factors that are critical to quality or concerns), what needs to be monitored, what uses will be made of information learned through monitoring, what needs to be improved, and what data systems will be needed to gather and analyze the information to complete these tasks. The PMAG representing many constituents began this **design** process for the Montana mental health system.

The second step is **data collection**. This step requires identification of data sources and collection methodologies. Collecting data and assuring accuracy of data are the actual tasks involved. Data can be quantitative (for example, utilization or financial data) or qualitative (for example, observations of staff interactions with individuals in homes or other service delivery settings). Sometimes, **design** will be impacted by what is feasible and fundable in terms of **data collection** capacity and costs. While this report recommends some initial outcome and performance indicators, the actual measures and the data sources for these measures have yet to be developed. Developing these with the input of a stakeholder group will not only make the measures and data sources more workable, but will also add to the system buy in and culture development process.

The third step is providing **feedback or reporting**. This means analyzing data and reporting it to decision-makers, stakeholders (individuals, families, providers, advocates, staff, legislators), and other interested parties in ways it can be utilized to take action. This reporting and feedback will be difficult without additional staff to conduct data analysis and additional quality management and improvement staff to conduct special studies and assist in reporting the analyzed data to decision-makers as well as working with other MHSB and AMDD staff and system stakeholders to recommend changes or actions to decision-makers. (See recommended staffing additions in TAC's Task Three report.)

Data reports and **feedback** methods should be driven by the original design and decisions about what is important to be tracked and improved. The **feedback** should relate to the original values and priorities of the stakeholders. Wide reporting of the information gained from data collection is critical. Reporting on anecdotes and non-representative samples may lead to inaccurate conclusions and judgements about cause and effect. Without aggregate data on the full scope of a program, service, or region (and eventually, but not initially provider or practitioner specific reporting) the resources of all parties may be wasted or inefficient.

The fourth step is **taking action** based on the data. Monitoring data or system/provider performance is not enough. Knowing what is happening is not enough. Once performance is known, decisions must be made to take action to improve the system. Options include but are not limited to:

- Increasing expectations;
- Rewarding high performers;
- Changing the management of delivery systems to address deficiencies documented in the data;
- Clarifying standards or expectations;
- Expanding or decreasing the provider network;
- Undertaking new or additional training;
- Changing provider licensure, endorsement, or credentialing requirements;
- Developing corrective action plans with providers including sanctions or incentives;
- Increasing monitoring or data collection activities;
- Choosing different system managers (especially once regional structures are implemented – see TAC’s Task Three report); and
- Undertaking special studies to determine why certain events or data are occurring.

Once the appropriate action is determined, efforts must be made to make sure these actions are implemented. Reporting that does not result in **action** is wasted effort and inefficient use of limited resources.

Fifth is the process of determining whether the actions taken had any impact on desired performance and **redesigning** the QM/I and/or the service delivery systems to expand the scope of system improvements. This critical process is not often accomplished. Even when the managers of a system know what they want (step one); measure and monitor what is occurring (step two); provide information to decision-makers and constituents (step three); and determine and implement appropriate action (step four); they frequently will not take the final step to see if those actions made any difference and make the necessary changes. This fifth step completes the process and will allow Montana’s service delivery system to know and publish that it has improved; determine whether different or additional actions need to be taken; and/or identify whether expectations can be raised or new areas for improvement can now be addressed.

All five of these steps must be addressed in Montana’s quality management and improvement system. Without any one of them, the QM/I plan/system will not only be incomplete; it will be ineffective. Each of these steps is subject to evaluation and quality improvement itself.

D. Implement the Collection of Data on as Many as Possible of the Outcome and Performance Indicators Developed by the PMAG as an Initial Step Toward a Larger Outcome and Performance Measurement Process.

Part of a good QM/I system is determining how the system is performing and setting goals for both clinical and administrative performance. Through the initial stakeholder input process, a number of **concerns** (a value statement about an aspect of a system that should be objectively measured in order to judge performance of that system or outcomes for consumers of that system) were identified (see minutes from the first meeting of the PMAG held August 9, 2000. The PMAG also agreed on the use of a limited number of initial **indicators** (specific evidence that the concern is being addressed) for which measures and data sources need to be identified and tracked. This process occurred at the second PMAG meeting on October 4, 2000. It was agreed that **outcomes** would refer to the results for clients while **performance** would refer to system behaviors or activities to assure good clinical care and administrative efficiencies and accountability.

Measures (the methodology used for deriving and calculating performance indicators) still need to be developed for each **indicator** in order to determine the specific data to be collected. This process should be done with the input of the PMAG or another stakeholder group to assure measures are appropriate to the indicator recommended and workable for the system at this time. Some of the indicators discussed by the PMAG will not be easy to measure. Some will need simplification in order to find a workable measure. Conceptually, they make sense as a place to start. In conjunction with the regional profiles discussed later in this report, they will begin to assist the system in addressing the concerns identified. It will be important for AMDD to select some of these indicators, specifically those that can be measured with existing data sets, and begin the measurement, data analysis and reporting process. Others can follow or may be refined as the system and its stakeholders get used to the difficult process of identifying measures, selecting data sources, and testing data collection and reporting processes.

Targets (the actual performance sought in any given timeframe) for each of the indicators must be established, but should be done after measures are selected and baselines are established. **Targets** should be specific (for example, 90 percent of consumers presenting in crisis will receive a face-to-face assessment within one hour of the first contact; the number of youth in out-of-state residential placements will be reduced by 25 percent per year for the next three years, etc.) These **targets** can be based on **benchmarks** (the desired performance or outcome based on the performance or outcomes of similar systems or agreed upon goals for the system under review), but must also be realistic based upon the **baseline** (actual level of performance at a given recent point in the past) for that **indicator**.

Benchmarks are not currently available for many indicators selected in the sense of expected performance given certain conditions. However, in some cases, national information is beginning to be available for certain types of indicators for systems to use to set their own **targets**. In other words, while TAC could suggest that a certain indicator ought to approach a particular number or goal, the reality of the Montana system may make that unrealistic or not feasible. It is more critical that Montana establish **baselines** for each indicator/measure, once the actual measure is developed for each indicator selected, and that a reasonable and doable amount of improvement is sought in reasonable periods of time.

Another term – **standards** – is often used in a **quality improvement** system. **Standards** are often broad but require a person or organization to take a specific action (for example, a provider must have an up-to-date policy and procedure on reporting) or may be more specific and can include elements of (for example, aftercare will be provided within 3 business days of discharge from a 24-hour care program). For clarity, TAC suggests that AMDD consider using the term **standard** to mean the requirements of licensing, certifying, accrediting, or funding bodies that providers must follow in order to obtain and retain the license, certification, accreditation, or contract. Usually, all **standards** must be met or most **standards** must be substantially met in order for a contract, a license, certification, or accreditation to continue. In this way, the system can distinguish between **standards** expected of each provider, and the **performance or outcomes** expected of the service delivery system as a whole. At some point in the future, the specific performance or outcome expectations may be incorporated into the standards or requirements of providers within the system, once experience with indicators, measures and targets is achieved.

Outcome and performance concerns, indicators, targets and measures utilized by the State of Montana should be categorized into five areas or **domains**. These are:

- *Access* – Individuals can access AMDD funded services quickly and easily.
- *Quality/Appropriateness* - Services are appropriate to the individual's needs and goals, and consistent with professional standards.
- *Individual (Consumer) Outcomes* – Individuals experience positive outcomes as a result of services received.
- *Administration* – Programs and services are operated in an efficient and accountable manner.
- *Value/Cost* – Services provided and outcomes achieved are at the least cost possible or are within acceptable cost ranges. (For example, the service system inputs – dollars, staff, and other resources – and outputs – units of services, episodes of care – result in positive outcomes for consumers; high satisfaction for consumers and families; and system efficiencies such as

reduced inpatient and residential treatment facility utilization, reduced administrative costs, and could not likely be achieved for less cost).

The domain called Consumer Outcomes will be referred to as the Outcome Domain while the other four domains will be considered and referred to as the Performance Domains.

These categories, or **domains** have been used by TAC to organize examples of indicators from other jurisdictions and national organizations (see Appendix A). TAC has also used these **domains** to organize the synthesis of indicators recommended by TAC to be the initial indicators for Montana's system after discussion with the PMAG at its second meeting on October 4, 2000. These recommendations are displayed in the chart in Recommendation 6 below.

E. Select Appropriate Methods and Tools for Collecting Data and Reporting on the Initial Indicators Selected to Monitor and Improve the Performance and Outcomes of Montana's Mental Health System.

There are a number of methods or tools for utilizing the information and data available from the various data sources. **Methods** of information and data collection might include:

- Analysis of paid claims;
- Analysis of utilization management reports;
- Review of policies and procedures or other written materials;
- Review of accrediting, licensing, certifying and/or oversight bodies' reports;
- Surveys of relevant parties (for example, individuals, families, staff, providers);
- Self-assessments;
- Interviews of involved individuals (for example, peer-to-peer consumer interviews to collect self-report information on satisfaction, quality of life, etc.) and;
- Surveys of outside observers about their impressions (for example, the community or other service delivery systems).

Tools used in these methods might include the standard AMDD consumer enrollment and assessment forms, an existing instrument validated and in the public domain, a checklist of qualitative information to be collected, a written set of questions to ask, a form to fill out, or a list of issues to address. They might also include electronic data elements required to be submitted to a centralized management information system. Evidence or **documentation** of the use of these tools and methods might include written summaries and/or findings; copies of written materials, policies or procedures; tapes or transcriptions of interviews, quantitative

reports of aggregated numbers, and filled out forms or checklists. Collectively, the use of methods and tools and the documentation of their use are called **monitoring**. For each indicator, AMDD should work with its stakeholder group to identify the tool, method, or data source it will use to find the information it seeks regarding that indicator. These data should be combined with other QM/I activities described below and in TAC's Task Three report to complete a total picture of how a provider, a region, or the system as a whole is performing. **Monitoring**, and then taking action on the findings will be critical functions of the regional structures recommended in the Task Three report.

Monitoring is critical, but not sufficient for Montana's QM/I system to be effective. Without **monitoring**, there would be inadequate information about how the services or administrative systems are performing. However, simply knowing how they are performing is insufficient to effect change or improvement. Once data and information is developed through a variety of **monitoring methods, tools, and documentation**, it is incumbent upon AMDD or the regional structures it creates to be responsible for system administration in each region (see TAC's Task Three report) to review, report, study, analyze, and then act on this data and information. Such data and information may be collected for purposes of comparison with past or future data and information may be collected for historical or archival purposes.

However, AMDD (and its regional structures once created) should ask careful questions about why data and information are being collected and how it will be reported and used before limited resources are expended in preparing, collecting, and storing it. **Reporting** the information obtained helps system actors and external bodies be aware and make recommendations or decisions about how those systems should perform in the future (either differently or the same) and how to make them do so. Without these necessary steps of **reporting** and **acting** on the information, **monitoring** can be simply an empty activity without teeth or merit.

These activities complete the feedback loop described earlier in this report and allow the service delivery and administrative systems to be self-correcting and constantly improving to the benefit of individuals, their families and communities, and the general public.

F. Select a Small Number of Outcome and Performance Indicators for Initial Work on Measures and Data Sources, then Implementation of Data Collection and Reporting, with Refinement and Expansion of These Indicators as the System's Experience with Outcome and Performance Measurement Increases.

Appendix C contains a matrix that summarizes selected indicators and/or measures of effectiveness from other states and organizations engaged in the management of

behavioral health care. This extensive listing of indicators and measures is provided: (a) as background information for Montana decision-makers and stakeholders about what is being measured or proposed to be measured in other jurisdictions; (b) as examples of the variation of both indicators and approaches to measurement that are currently being used or proposed in other jurisdictions; (c) as evidence that, despite the variation, there are many commonalities among the various jurisdictions with regard to many of the measures currently used; and d) as a way for Montana officials and stakeholders to see how Montana's previous efforts and the currently favored MHSIP report card compare to other jurisdictions' and organizations' indicators and measures.

From the large matrix of examples from other sources, TAC has extracted some key performance indicators and/or measures for each of the domains that represent both the most commonly used performance indicators and/or measures and those that appear particularly relevant to Montana. These are included in Table A below for purposes of comparison to those indicators discussed by the PMAG and recommended by TAC for initial implementation in Montana.

**TABLE A: SUMMARY AND SYNTHESIS OF PERFORMANCE INDICATORS AND MEASURES
FROM OTHER JURISDICTIONS AND NATIONAL ORGANIZATIONS**

Access	Individual (Consumer) Outcomes	Quality/Appropriateness of Care	Administration	Value/Cost
Penetration/Utilization Rates by age, region, and eligibility category (Medicaid or MHSP).	% of Adults who are employed, in training, in school, or who are active volunteers. % of consumers who retain employment during the course of treatment.	% consumers who actively participate in decision making regarding treatment.	# of consumers and family members serving on governing boards, planning committees and other decision-making bodies, participate in QI activities, or hold paid staff positions.	Average per capita resources expended on mental health services for each age/eligibility category.
Consumer self report of convenience and timeliness of access to desired and culturally relevant services.	% of youth attending school or other age appropriate educational experience; days in school.	% consumers linked to physical health services.	Monthly, quarterly and annual reports submitted within required timeframes.	Administrative expenses as a % of overall costs of care.
Timeliness of access for urgent, emergent, and routine services.	The % of adults living in independent housing they own or lease.	Hospital or residential treatment facility re-admissions within 90 days of previous discharge.	Timely payment of clean claims, and timely resolution of denied claims.	Days of inpatient and RTC care per 1,000 enrollees.
Timeliness of access to on-going services following intake, and timeliness of access to psychiatric assessment and medication monitoring.	% of youth living in their own family or a selected surrogate family as opposed to out-of-home placements.	# of grievances and appeals submitted, and % resolved within defined timeframes.		Lengths of stay for inpatient and residential treatment services.
Individuals discharged from inpatient or intensive care facilities or from crisis stabilization services receive a follow up service within defined timelines.	Consumer self-report that quality of life has improved and the independent functioning has increased as a result of their treatment experience.	Family reports satisfaction with the degree of involvement in treatment of their children.	Contract with a consumer advocacy group to conduct satisfaction surveys and provide analysis and feedback on providers.	Inpatient and outpatient cost per episode by age and eligibility category.

After examination of all the previous Montana efforts, the national information available, and a synthesis of commonalities in these efforts, as well as the results of the Montana PMAG meetings, TAC recommends the initial indicators set forth in Table B below. These indicators will allow the State and stakeholders to begin judging Montana's system performance and consumer outcomes achieved. Many of these indicators are the same as previous efforts or national experience, but they are grouped by the concerns discussed and prioritized by the PMAG.

Every jurisdiction and organization that has tried to implement outcome and performance measurement has found the technicalities of measurement somewhat daunting. Likewise, in Montana, the ability to identify measures and begin to collect information about each indicator will be difficult, even for relatively simple measures such as satisfaction on standardized instruments. Not all the recommended indicators in Table B can or should be tackled at once and not all will be easy to measure. TAC recommends that the indicators that can be relatively easily measured with existing data sets be the ones that AMDD begins with, and that the PMAG or a similar group assist AMDD with the deliberation about what measures and what data sources will work to collect the information needed for the other indicators. If an indicator cannot be easily measured after this discussion, a different indicator should be chosen to represent the group's concern.

These indicators should be combined with and/or tempered by the regional profiles described in Recommendation G below to create a total picture of system performance and consumer outcomes throughout Montana's mental healthcare system.

TABLE B: RECOMMENDED INITIAL OUTCOME AND PERFORMANCE INDICATORS FOR MONTANA’S MENTAL HEALTH SYSTEM

DOMAIN	PMAG CONCERNS	ADULT INDICATORS	CHILD/ADOLESCENT INDICATORS
ACCESS	Network Adequacy	<ul style="list-style-type: none"> • # of units of each service provided (eventually compared to a gap or needs analysis or compared to users by level of care) • # of practitioners per eligible, esp. psychiatrists, nurses, and licensed therapists • distance and/or time to services by service type and urgency • # and distribution of practitioners with culturally specific experiences or skills 	<ul style="list-style-type: none"> • # of units of each service provided (eventually compared to a needs analysis or compared to users by level of care) • # of practitioners per eligible, esp. child psychiatrists, and licensed therapists specializing in children’s mental health • distance and/or time to child specific services by service type and urgency • # and distribution of practitioners with culturally specific experiences or skills
	Penetration Rate (number of persons potentially eligible who receive care)	<ul style="list-style-type: none"> • Medicaid % served compared to eligible and to expected utilization based on epidemiology and public presentation rates • Non-Medicaid individuals served compared to # in Montana under 150% of poverty and compared to those under 150% of poverty expected to utilize services 	<ul style="list-style-type: none"> • Medicaid % served compared to eligible and to expected utilization based on epidemiology and public presentation rates • Non-Medicaid individuals served compared to # of families in Montana under 150% of poverty and compared to those under 150% of poverty expected to utilize services
	Timeliness of Services	<ul style="list-style-type: none"> • Time between discharge from inpatient, crisis, or residential care to next face-to-face service • Time between request for service and first face-to-face service by urgency of need • Time between request for service and first face-to-face appointment with a practitioner who can prescribe medications, by urgency of need 	<ul style="list-style-type: none"> • Time between discharge from inpatient, partial hospitalization, or out-of-home placement to next service • Time between family request for service or identification of being at risk and assessment by a practitioner experienced with children’s mental health issues • Time between assessment and first service by a practitioner specializing in children’s mental health

DOMAIN	PMAG CONCERNS	ADULT INDICATORS	CHILD/ADOLESCENT INDICATORS
APPROPRIATE-NESS	Consumers Being in the Right Level of Care	<ul style="list-style-type: none"> • # of avoidable hospital days due to lack of community alternatives • % of adults served who meet criteria for level of care to which they are assigned • # and types of post denial services received 	<ul style="list-style-type: none"> • # of out-of-home placements due to lack of in-home or wrap around services • % of children/adolescents served who meet criteria for level of care to which they are assigned • # and types of post denial services received
	Consumer/Family Satisfaction	<ul style="list-style-type: none"> • % of adults expressing satisfaction on a standardized tool, both during an episode of care and at a specified time after the episode is concluded • % of family members of SMDI adults expressing satisfaction with services and with their involvement in their family member's service planning 	<ul style="list-style-type: none"> • % of families expressing satisfaction on a standardized tool tailored to the issues experienced by families of SED children, during an episode of care and at a specified time after the episode is concluded • % of children/adolescents expressing satisfaction on a standardized tool specifically for children/adolescents
	Consumer/Family Involvement in Treatment Planning	<ul style="list-style-type: none"> • % of adults meaningfully involved in their treatment planning • % of adults whose treatment plans show the consumer's signature • % of adults expressing satisfaction with the level of their involvement in treatment planning • % of adults experiencing choice of post-discharge services, living setting and service provider during discharge planning from inpatient services 	<ul style="list-style-type: none"> • % of families meaningfully involved in their child's treatment planning • % of families expressing satisfaction with their level of involvement in their child's treatment planning • % of families expressing that they had a choice in their child's services and practitioner after return from an out-of-home placement

DOMAIN	PMAG CONCERNS	ADULT INDICATORS	CHILD/ADOLESCENT INDICATORS
ADMINISTRATION	QM/I System Effectiveness	<ul style="list-style-type: none"> • % of adult service providers with an approved QM/I plan meeting MHSB/AMDD standards • % of adult service providers expressing satisfaction on a standardized tool • # of adult service providers terminating their involvement as a publicly funded mental health provider • % of QM/I concerns identified about which action is taken to remedy or improve within a reasonable period of time • # of consumers and families on governing and advisory bodies and in QM/I activities 	<ul style="list-style-type: none"> • % of child/adolescent providers with an approved QM/I plan meeting MHSB/AMDD standards • % of child/adolescent providers expressing satisfaction on a standardized tool • # of child/adolescent service providers terminating involvement as a publicly funded mental health provider • % of QM/I concerns identified about which action is taken to remedy or improve within a reasonable period of time • # of families on governing and advisory bodies and in QM/I activities
	Adequacy and Quality of Human Resources	<ul style="list-style-type: none"> • job tenure in the system by job type • # of vacancies not filled within 60 days • # of staff who are or meet the criteria to be consumers 	<ul style="list-style-type: none"> • job tenure in the system by job type • # of vacancies not filled within 60 days
	Data Reporting and Use	<ul style="list-style-type: none"> • % of required data elements reported accurately and completely by provider • % of claims submitted within a specified period of time by provider • % of clean claims paid within a specified period of time 	<ul style="list-style-type: none"> • % of required data elements reported accurately and completely by provider • % of claims submitted within a specified period of time by provider • % of clean claims paid within a specified period of time

DOMAIN	PMAG CONCERNS	ADULT INDICATORS	CHILD/ADOLESCENT INDICATORS
COST/VALUE	Case Management's Link to Outcomes	<ul style="list-style-type: none"> • comparison of case management services amount and intensity to consumer outcomes • cost by provider by type of case management 	<ul style="list-style-type: none"> • comparison of in-home and wrap around services amount and intensity to child and family outcomes
	Costs for Services	<ul style="list-style-type: none"> • rate for services by unit compared to actual cost analysis • costs and types of services utilized by consumers in identified cost bands, compared to outcomes within those groups • costs per capita by eligibility category • percentage of administrative cost compared to direct service cost (adults and children) • days of inpatient and residential services per 1000 enrollees 	<ul style="list-style-type: none"> • rate for services by unit compared to actual cost analysis • comparison of costs for school based services using bundled rates versus unbundled rates • costs per capita by eligibility category • costs and types of services utilized by consumers in identified cost bands, compared to outcomes within those group • days of out-of-home care per 1000 enrollees
	Cost Shifting ¹⁶	<ul style="list-style-type: none"> • costs spent by criminal justice on mental health services for prisoners and persons in jail compared to number served and outcomes achieved • total cost for specific individuals across multiple systems 	<ul style="list-style-type: none"> • costs spent by education, child welfare and juvenile justice, compared to number served and outcomes achieved • total cost for specific children/adolescents and their families across multiple systems

¹⁶ Both PMAG and TAC recognize that these measures would be difficult to do and would be more of a research effort than a performance measure. Both believe it would be an interesting challenge at some point in the future to determine whether there is cost shifting and if so, in what direction.

DOMAIN	PMAG CONCERNS	ADULT INDICATORS	CHILD/ADOLESCENT INDICATORS
CONSUMER OUTCOMES	Consumer Functioning in “Real” Community Life	<ul style="list-style-type: none"> • % of SMDI adults competitively employed • improvement in daily living skills or functioning on a standardized tool before and after services • satisfaction with quality of life on a standardized instrument 	<ul style="list-style-type: none"> • % of SED children/adolescents in regular school attendance with no more than a routine number of absences or disciplinary actions • % of SED children/adolescents with acceptable performance at school as identified by their parents, teachers and providers
	Community Tenure	<ul style="list-style-type: none"> • average number of days in the community per year by consumer diagnosis, functioning, age, and race • # of days between admission to an inpatient facility and readmission • % of adults readmitted within 30 days of discharge • lengths of stay in inpatient and residential treatment 	<ul style="list-style-type: none"> • # of days in a permanent family placement (natural or adoptive) • # of children/adolescents in out-of-home and out-of-state placements at any given time • # of children/adolescents returned to out-of-home placement within 30 days of returning home • lengths of stay in out-of-home placements
	Social Goals	<ul style="list-style-type: none"> • # of interactions with the criminal justice system while in community settings • % SMDI adults in stable housing of their choice • % SMDI adults with an adequate number and array of persons in their social networks 	<ul style="list-style-type: none"> • # of interactions with the juvenile justice system in a given time period (e.g., after 6 months of services) • % of children/adolescents rated as having age appropriate social skills

G. Design and Implement Regional Profiles for Key System Indicators

Pending the completion of the stakeholder process and the selection of priority indicators and associated measures and data sources, TAC recommends that some limited data analysis and reporting be initiated immediately by AMDD. TAC envisions this as a form of regional profiling, similar to that done in a number of other states. Regional profiles typically contain comparative information of regional population, socio-demographic, and geographic characteristics, plus some indicators of system activity such as penetration rates; inpatient and residential treatment admissions; and days used, etc. These data are intended to be extracted from existing data sources, with no special studies or data collection activities required. The information in the profiles is considered to be background information that may help to identify issue areas, service gaps, or other local priorities, and may also be useful later in explaining variations among regional performance levels. However, it must be clear that the information in the regional profiles cannot be considered to be true outcome and performance information until all the stakeholder input and related design activities described in this report are completed.

There are two motivations for beginning to collect regional profile information quickly. First, it will be concrete evidence of AMDD's efforts to use objective data to address management issues in the system following the termination of the MCP initiative. Second, it will initiate all stakeholders to the process of interpreting and comparing information on a regional basis. In TAC's experience, this can be somewhat traumatic at first, but quickly leads to an improved culture of using data for quality management and improvement. It can also lead to some friendly competition among regions related to certain indicators. Finally, it will begin to shape the actual outcome and performance measures attached to the indicators discussed by the PMAG as identified above.

The following Table C is a proposed format and data that might be included in a quarterly Montana regional profile report.

TABLE C: RECOMMENDED MONTANA AMDD REGIONAL¹⁷ PROFILES

Indicator	Region 1	Region 2	Region 3	Region 4	Region 5	State Average/Median
Total Population						
% < 18						
% 18 – 64						
% 65+						
% Native American						
% African American						
% Hispanic						
% other cultural or linguistic minority						
% below 100%, 150% and 200% of federal poverty level						
Size of area in square miles						
Population per square mile						
# communities with > 5,000 population						

¹⁷ Regional data are determined by residence of service recipient or geographic area, as appropriate to the context of each indicator.

Indicator	Region 1	Region 2	Region 3	Region 4	Region 5	State Average/Median
# Medicaid enrollees						
% of total population of state						
% of total Medicaid population of state						
% SSI ¹⁸						
% TANF						
Monthly average # Medicaid persons served ¹⁹						
Monthly average % Medicaid enrollees served						
Monthly average # MHSP served						
Monthly average % MHSP served						
# adult inpatient admits per 1,000						
# youth inpatient admits per 1,000 population						

¹⁸ AMDD may want to use age breakdowns as well as or instead of eligibility categories.

¹⁹ In this context, number served refers to those individuals receiving an actual service encounter during the month, not those individuals enrolled as active cases.

Indicator	Region 1	Region 2	Region 3	Region 4	Region 5	State Average/Median
Adult hospital bed days per 1,000 population						
Youth hospital bed days per 1,000 population						
Youth RTC bed days per 1,000						
# youth currently in residential treatment						
% youth in out-of-state residential treatment						
# providers in Region ²⁰						
Average cost per active consumer for the quarter						
MA \$ per enrollee for the quarter						
MHSP \$ per capita for the quarter						

²⁰ Defined by the number of providers certified as Medicaid providers and invoicing for at least one eligible encounter per month.

Indicator	Region 1	Region 2	Region 3	Region 4	Region 5	State Average/Median
Paid claims for quarter for: <ul style="list-style-type: none"> • Inpatient • RTC • Partial Hospital • Day Services • Psychosocial rehab services • Individual Tx • Group Tx • Medication Management 						
# grievances or appeals this quarter						
# complaints to Ombudsperson for quarter ²¹						
% service authorization requests denied for: <ul style="list-style-type: none"> • Inpatient • RTC • Partial Hospital 						

²¹ When these data are available. Conversations with the Ombudsperson indicate that the office is just beginning to track this information in a fashion that would make it available on a quarterly basis.

IV. DESCRIPTION OF AND TIMELINES FOR RECOMMENDED PROCESS

The next steps in this process were discussed by the PMAG at its October 4, 2000 meeting. Generally, these steps include but are not limited to copying this report for all interested system stakeholders, creating a task force of stakeholders to advise in the selection of priority indicators and development of measures and data sources for each indicator, analyzing the MHSIP data and data collection that currently exists to determine its usefulness going forward or for comparisons looking back, and whether the current MHSIP outcome and performance indicators and data sources would be adequate to address the concerns and the desired indicators discussed by the original PMAG, educating providers regarding the need for data, inventorying the data currently available, and beginning to collect and report on data to stakeholders, legislators, media, and others.

These actions should be quick and decisive to assure momentum does not die regarding the implementation of collection and reporting of outcome and performance information. The recommended steps and proposed timelines are as follows:

1. Discuss this report at the December meeting of MHOAC.²² (December 2000)
2. Appoint a time limited stakeholder advisory work group (PMAG or another group) consisting of providers, members of MHOAC, consumers and family members, other interested state systems/functions, and AMDD staff as desired. (January 2001)
3. Develop and distribute the first regional profile report with the data available covering the last quarter of FY 2000, April to June 2000. (January 2001)
4. Convene the Outcome and Performance Measurement Advisory Group (OPMAG) approximately monthly to review the first regional profile reports and discuss priority indicators and related measures and data sources. (January – June 2001)
5. Begin data collection on additional indicators and measures and continue regional profile reports. (April to June 2001)
6. Develop and distribute quarterly regional profile reports for first and second quarters of FY 2001 covering July to December 2000. (April 2001)
7. Combine regional profile data and additional indicators into recommended domains for quarterly AMDD Quarterly Performance Report beginning third quarter of FY 2001 covering January to March 2001. (July 2001)
8. Set targets for FY 2002 for regional profile indicators and/or for additional indicators for AMDD Quarterly Performance Report for first quarter of FY 2002 covering July to September 2001. (June 2001)

²² It should be noted that a brief discussion of this and the other TAC reports did occur at the December 2000 MHOAC meeting.

9. Develop and distribute first AMDD Quarterly Performance Report including both regional profile data and additional indicators in five domains for third and fourth quarters of FY 2001 covering January to June 2001. (July and October 2001)
10. Develop and begin distributing AMDD Quarterly Performance Reports compared to expected targets for FY 2002 quarters with the first one covering July to September 2001. (January 2002)
11. Refine and expand indicators, measures, data sources, and expected targets for FY 2003 covering July 2002 to June 2003. (May 2002)

Throughout this process, the OPMAG and the MHOAC should be utilized to discuss outcome and performance reports, provide additional input, and assist in making refinements and working out operational issues that may arise. It is important that the timelines associated with this process not be allowed to slip in order to keep the process moving and not become just one more attempt at developing performance indicators to measure that does not materialize.

V. CONCLUSION

This report describes a framework and a process for beginning a quality management/improvement and outcome and performance measurement process for Montana's mental health system. It does not propose at this time exactly how to measure the indicators or the tools or data sources that should ultimately be used. Rather, these should come from the stakeholder group and the AMDD staff working together over the next several months. These decisions will be made ultimately by AMDD after beginning regional profiles and after considering stakeholder input and data capacity. However, the proposed process should be accomplished quickly and decisively and action taken without further deliberation. Refinements can and should occur later, but delay because consensus cannot be achieved or because data collection is difficult should not be allowed. Consensus will emerge and data collection will get easier as practice with outcome and performance measurement increases.

No outcome and performance measurement process will be without problems or provide perfect information to satisfy all stakeholders or AMDD. The development and refinement of measures will continue over time. The important concept is to decide and begin with what is doable and agreed upon and continue to improve the system's ability to capture information about performance and outcomes as dialogue continues and experience grows.

Task Three: Findings and System Recommendations

I. INTRODUCTION

This report constitutes the third deliverable from the Technical Assistance Collaborative, Inc. (TAC) to the Montana Addictive and Mental Disorders Division (AMDD) of the Department of Public Health and Human Services (DPHHS) under the current mental health system evaluation and planning project. This report is a narrative description of TAC's findings and observations from a variety of information sources, namely:

- Interviews with system stakeholders including providers, consumers, families, advocates, legislators, and advisors, as well as staff various divisions of DPHHS and other state departments;
- Observations of programs and services during three on-site visits;
- Review of numerous documents, clinical criteria, reports, regulations, and database descriptions provided by AMDD;
- Review of recommendations and materials from, as well as discussions with, the Mental Health Oversight Advisory Committee (MHOAC), the Mental Health Ombudsman, the HJR 35 Subcommittee on Mental Health, the Montana Protection and Advocacy Agency, Mountain Pacific Quality Health Foundation (the utilization management vendor) and other interested parties and organizations in Montana;
- Reviews of reports and materials from numerous states and national organizations regarding mental health services and delivery systems; and
- The knowledge of and experience of the TAC team with other state and local mental health systems.

A list of documents reviewed and persons interviewed for this review of Montana's mental health system are included in Appendices A and B.

It is important to acknowledge the particular work done by the MHOAC on a number of critical system and service issues in Montana. TAC has been provided with a copy of MHOAC's minutes and recommendations. TAC agrees with a number of these recommendations while others are either too general or need additional detail to be more understandable. There are a few recommendations that TAC either did not agree with, or has some questions about as they are stated. Some MHOAC recommendations will add important detail and action steps as the recommendations in this report are considered and acted upon (for example, some of the recommendations about training and services may be important parts of the strategic plan or the needs assessment recommended by TAC, if these recommendations are pursued). The MHOAC material and other system stakeholder input was especially valuable to TAC as we did our review and formulated findings and system recommendations.

This report should be read in conjunction with the first task (Task One) deliverable from TAC that described and evaluated the current mental health system in Montana through analysis of data available from a variety of sources including – but not limited to – paid claims, state hospital data, out-of-state placement of children, and private hospital psychiatric utilization data. These data helped to inform TAC regarding some of the observations and findings described in this report. TAC’s second deliverable (Task Two) should also be considered when reading this report. In fact, that report and the process that helped shape the recommendations in that report regarding what outcome and performance measures to utilize to begin a quality management and improvement system for Montana’s mental health system, are referenced in this report.

All three reports produced by TAC are about the way Montana’s system is organized, managed, and funded. Part of TAC’s review was about the adequacy of services either in terms of amount or in terms of clinical approach. However, the observations made in this report are not about specific programs, specific providers, or even really about specific services. Rather, these reports discuss the infrastructure issues that prevent services from being as adequate or as effective as they could be and that prevent outcomes and performance from being what consumers and the Montana community expect.

These recommendations will require that certain conditions exist or are created if they are to be successfully implemented. These necessary conditions are referenced in general in this draft. However, a more specific discussion of what it will take to implement these recommendations will be included in the final Task Three report once this draft has been reviewed by AMDD and by system stakeholders.

TAC acknowledges from the outset that all these recommendations cannot be accomplished or at least not all at once. However, this report will hopefully provide readers with a blueprint for moving Montana’s system forward, one step at a time.

II. FINDINGS

A. Service System Culture and Capacity

The Montana Mental Health system does not currently have a culture and capacity that lends itself to maximization of resources or services to assure the most benefit is provided for eligible persons. This culture and capacity issue is evident in the system’s lack of a consistent, coherent service philosophy, inadequate service array, and insufficient involvement of consumers and families in service development, implementation, and evaluation.

Service philosophy and system culture

The Montana mental health system for children and adults does not have a consistent philosophy about what the results should be when the services are delivered and the

client²³ is no longer in need of the services provided. This decision or judgment is left largely to each individual service provider or practitioner. Likewise, the system is focused currently on the payment structures and amounts or the licensure or authorization requirements for each type of care or service covered by the Montana Medicaid and MHSP plan. As a result, there is not an evident culture supporting recovery or symptom reduction and return to normal living, or a culture of long term supports in the least restrictive and most normalized settings possible. Rather, the system culture and philosophy of care varies geographically and is focused on providing, funding, and advocating for new or expanded services rather than on the results desired or expected from the system's activities.

This culture is a more typical healthcare or Medicaid culture than a mental health or disabilities services culture. While there are good values expressed by the leaders and advocates within Montana's mental health system²⁴, and while there were laudable goals involved in Montana's efforts to develop a single managed care approach to its service delivery system whether for Medicaid or non-Medicaid eligible persons, the focus on and challenges of this effort for the last several years has occurred at the expense of a focus on service guidance and coherent service system development.

The understanding and infusion of new service technologies has also been left to individual providers or practitioners. System leaders have not had time to address these issues in the face of the move from a franchised regional grant-based system to a managed care capitated system and then back to a semi-managed fee for service environment with any provider able to meet licensure standards allowed to provide care and bill for services. The system is growing haphazardly in a sort of free market kind of mentality and without planned attempts to assure services are available and adequate throughout all parts of Montana for all eligible populations, with the most likelihood of positive results.

The need to pay attention to the philosophy or culture of Montana's service delivery system is critical. The inattention to these issues will result in continued inadequacy of services, as described below.

Inadequate service array

While no state and few communities have adequate services to meet the needs of residents with mental health problems, Montana's mental health services for children and adults are not meeting the needs of Montana's citizens. The services available through both Medicaid and MHSP are disproportionately facility based, do not always make use of the most recent service technology innovations, and are not driven by a common agreement about what each community needs to adequately address the

²³ The word "client" and the word "consumer" are used interchangeably throughout this report. They mean individuals (both adults or children) or their families who currently, or in the past, received or requested services from mental health agencies or practitioners.

²⁴ The core values identified in the Mental Health Services Bureau's draft plan include: respect, choice, quality, community, flexibility, participation, awareness, stewardship, safety, access and recovery. These values are excellent and have been a consistent theme throughout Montana's mental health system efforts over the last several years.

needs of even adults with serious and persistent mental illness and children/adolescents with serious emotional disturbance. There are important service types missing in most geographic areas, and insufficient amounts or inadequate coordination of the services that do exist in many areas of the state.

For example, the array and amount of *crisis services* throughout the state are generally not adequate to meet the needs of most communities and most individuals in the eligible populations. Crisis services often involve police, hospital emergency rooms, and high intensity service interventions. While CMHCs are funded to provide an array of crisis services, there are no particular requirements or incentives for establishing mobile crisis teams, in-home crisis respite, on-going or immediate access crisis groups, or peer support crisis or crisis prevention services. CMHC crisis residential beds are available only in the most populated geographic areas and are not always fully utilized. At the same time, CMHCs are not always made aware of persons entering other service providers in crisis. CMHC crisis workers are not available 24 hours per day in all regions. Emergency services are provided by different systems and different practitioners, depending on what system first encounters the individual or family in crisis. Specialized mobile services for children and families in crisis that would respond to schools or to home environments are sparse or non-existent in most areas.

There is currently no systemic way statewide for CMHCs or other primary service providers to know when persons in their care enter into a crisis state or emergency services setting. Communication among hospital emergency rooms and other crisis intervention providers is variable, depending on the community resources and the leaders of the respective service providers and agencies. In some areas, adults and children are ending up in community hospital settings, the state hospital, intensive residential settings, local jails, or other high cost, high intensity settings when they could be diverted or served more effectively in less intensive ways and connected or reconnected more quickly to on-going community-based care.

There are few *jail diversion* projects or services that work to keep adults or children out of correctional institutions at the local level. To the extent that services are available for these populations, they are focused on services while in adult jail or juvenile corrections facilities or while they are in the court process. Both pre- and post-booking diversion for adults and coordinated efforts to get juvenile offenders out of juvenile justice settings and back into supportive services to the child/adolescent and the family are necessary. These services require significant interaction with other systems such as courts, corrections, police, and schools.

Residential services for children represent a significantly high proportion of dollars and children served in Montana's system. [See TAC's Task One report, Assessment of the Mental Health Services Plan and the Medicaid Mental Health Plan, regarding the proportion of dollars and persons served in residential or facility based settings.] At the same time, the amount of wrap around services for children and in-home family supports provided for the families of SED children is significantly small. Most persons TAC interviewed as well as the Task One data analysis indicated a relatively complete

array of outpatient services for children and for adults, while little “in between” community supports are available to prevent children and adults who need more service than an outpatient service can provide are available to keep individuals from progressing to higher intensity facility based services.

Only a few *PACT* teams exist for adults throughout the state, and these are relatively recent additions to the service array. *Case management* for adults and children short of the adult *PACT* model appears to be primarily supportive or broker service models rather than an intensive case management model available 24 hours per day 7 days per week. There does not appear to be a philosophical understanding of the different roles and expectations of different levels of case management for different service intensity needs.

Few *daytime activities* or *services* for adults and children exist beyond day treatment, partial hospitalization, and clubhouses. Day treatment appears to be largely long term therapeutic models, even though such models have been shown to create dependence on formal systems rather than supporting adults in recovering from their mental illness and developing skills to cope with and manage their own illness and their own lives. Few vocational opportunities exist for adults, and even Montana’s *clubhouses*, which are excellent in some parts of the state, are viewed by workers in them as “a stable end-point in clients’ lives” rather than as a model for assisting clients to achieve self-empowerment and social and vocational skills to help them recover and move toward competitive employment and normalized (or “natural”) community recreational opportunities.

While adult clubhouses do provide some opportunities for client run enterprises or activities, there is neither a culture within the system nor specialty funding to support *consumer operated alternative services* or *consumer-operated vocational services* or *businesses*.

Partial hospitalization is provided for both children and adults in disproportionately high numbers and for longer lengths of time than should be necessary. This service is expensive and is currently provided by anyone who meets the program criteria for anyone who meets the service criteria rather than being reserved for only short-term crisis, diversion or step-down needs and only in specified and limited settings.

Housing and supportive living arrangements for adults are not widely available throughout Montana. Supported apartments and adult family or foster care are either not available or are in insufficient numbers except in a few geographic areas.

A high number of SED children are either in *residential* settings or are in school-based programs that do not follow-up with children and their families once they return home or during the summer months. Many children in the last year have been sent out of state for residential placements. An insufficient number of *therapeutic foster care* homes exist while relatively high amounts of dollars are being spent on a variety of different kinds of out-of-home, facility based settings and providers.

Physician or *psychiatric services*, especially medication prescribing and management for both adults and children are hampered by the lack of psychiatrists who will work in rural Montana or who will accept Medicaid or MHSP funded clients. Private psychiatrists, community hospitals, and mental health care providers are not well coordinated in many parts of the state. Primary care physicians are not being well utilized for this purpose, and it may be difficult to do so given the nature of the services system structure and the lack of information available to primary care physicians about mental health diagnostic techniques and appropriate service system linkages. The use of advanced practice nurses for this purpose is also not well developed throughout the state. Other mental health specialists such as counselors, psychologists and social workers are also in short supply in many parts of the state.

Outpatient services for adults and for children and their families appear to be relatively traditional without attention to new approaches to multi-systemic or family based interventions for children or to cognitive behavioral therapies for adults that are proving useful for certain types of individuals with identified needs or clinical pathways. Nor is there any significant attention to integrated service approaches for adults with co-occurring disorders of mental illness and addictions or for children/adolescents who are abusing substances and are at risk of addiction who are also exhibiting symptoms of behavioral or mental disorders. Outpatient services are provided for relatively long periods of time without any retrospective review from utilization managers either inside or outside most agencies TAC talked with to determine whether clinical improvements are continuing to be experienced by these therapies.

Finally, *multi-system coordination* of services for children and for adults is less than adequate to meet the needs of Montanans with mental health needs as well as service needs from or within other systems. For children, the collaboration between schools and juvenile justice systems as well as with child welfare appears spotty and inconsistent. The ties to police, courts, jails, and other correctional facilities for adults is primarily concentrated on identification of needs and appropriate referrals. The collaboration with state or local housing planners, vocational rehabilitation service funding bodies, elder services authorities, and adult recreational and educational resources seems either to be non-existent or an afterthought rather than a specific strategy for increasing resources available for adults with mental healthcare needs or for supporting adults in their recovery. Some of these coordination activities probably seem like a luxury given the few available human and financial resources available for mental health services. However, without this explicit planning and coordination, mental health care resources will either be tapped for the wrong reasons or will not be as effective as they could be in helping Montanans with mental health needs.

It is important to note that there are probably positive exceptions to all these findings in various places within Montana, and that there may, in fact, be other examples of inadequacy of services than those described here. These examples are given to make the point that Montana's service array is neither sufficient nor even throughout the state. Part of the solution to this problem lays in concerted leadership efforts to assure a

variety of service types are available, are being used for the right persons in the right amounts, and are being provided with the most recent service technologies. However, some of these service adequacy issues will require either additional or redirected funding to address unmet service needs, and/or will require attention to other sources of funding and collaboration with other service funding systems to assure limited dollars are used as effectively as possible. In some cases, the solution to this problem may be difficult to achieve because of the unique nature of Montana's rural and frontier communities. However, more can be done with current capacities and more could be done with relatively little new or redirected resources.

Utilization management

Until recently, the *utilization management* (UM) vendor employed by the Mental Health Services Bureau routinely authorized placement of individuals into higher levels of care than were found to be necessary if no other less restrictive setting was available according to the provider requesting the authorization. This vendor rarely denied authorization for payment for a requested service. It is difficult to know with the data available whether the criteria were too loose, the criteria were simply well known and utilized by clinicians, or the in-state peer review of denials resulted unfairly in denials being rejected. While large numbers of denials are not the goal, if the prior authorization system is not denying any or relatively few service authorization requests, then the question has to be asked whether the expenditure of funds for this function is necessary.

The system had few ways of systemically knowing whether other settings or other less intensive services could actually be found or be developed, therefore whether any of the services authorized could have been provided in a less restrictive or less expensive way. The current (and new) UM vendor has been given both resources and a mandate to utilize care managers in each region to assure that the least restrictive environment is identified before high-end services are authorized. However, the UM vendor has no authority or ability to create service alternatives where none currently exist. The vendor has no ability to redirect service dollars to new or unique services to meet the needs of individuals in a less restrictive or less costly manner. [See section below regarding the UM issues within the Montana system.]

While the new UM system vendor's contract does include an expected number of limited targeted retrospective reviews and concurrent reviews of all prior authorized services expect inpatient,²⁵ these reviews may not be sufficient alone to assure continuing services are appropriate or that services not required to be authorized are appropriately provided. This effort needs to be combined with a clear set of definitions about what populations and what services are eligible and what populations are priorities for receiving which services and in what intensity. A thoughtful set of clinical criteria and defined levels of care are needed to be used not only by clinicians to make judgments about who should get what kinds of services, but by utilization managers to

²⁵ The payment methodology for inpatient services is based on diagnostic related groups (DRGs) which limits payment to a set amount per diagnostic category thereby precluding the need for extensive concurrent reviews by someone outside the hospital itself.

review these decisions in a standardized and objective way. Currently, few practice guidelines or program descriptions are available beyond licensure criteria upon which to judge whether clinical decisions are being made appropriately and with the most likelihood of positive results for clients and their families.

Involvement of consumers and families

Consumer and family advocates are quite prominently visible in the discussions witnessed and the documents reviewed by TAC regarding the current issues in Montana's mental health delivery system. However, consumer and family voices appear to be loudest in local arenas or in areas where advocacy and advice are concentrated at the state level, namely, in the Mental Health Oversight and Advisory Committee. TAC had an opportunity to watch the MHOAC and some of its subcommittees in action. TAC also reviewed many of the MHOAC materials and recommendations. Consumers and families were also among the individuals TAC interviewed both in the state offices and in some of the site visits. Additionally, TAC interviewed the Ombudsman and staff and learned about the consumers and families who receive assistance through that office.

These voices are important and, in fact, critical in the continuing evolution of Montana's mental health system for adults and children. The structured opportunities for consumers and families to provide input through local advisory groups, service design work groups, satisfaction surveys, quality management and improvement reviews, data collection and analysis, and financial and strategic planning need to be thought out deliberately and strategically. Currently, there are a number of ways that consumers and families make their voices heard, but no consistent way for those voices to be incorporated into actual decision-making. A number of discordant or inconsistent voices will only result in no clear voice at all. Montana has a stated value of consumer and family involvement with no specific plan for consumer and family voice and choice that incorporates system and service planning, development, implementation, evaluation and redesign. Multiple types of consumer and family perspectives need to be included in a way that truly guides the system's development. Consumers (including both adults and at least adolescents, if not younger children) and families need to have a clear role in the various aspects of Montana's system with clear and stated expectations about what the results of their input and work will be.

B. Service System Organization

The organization of Montana's service delivery system for adults with serious and persistent mental illness and children with serious emotional disturbances is more a creature of recent history than a planned approach to the organization and financing of quality mental health care for a state's population. The current state of affairs is a result of efforts to correct the failed implementation a major system change, i.e., managed care. The history and goals of these changes; the current nature of the system and its lack of a single point of accountability for both client care and resources; and the state's attempts to manage the system with limited structural tools are all important factors in

service system organizational issues that need to be addressed in order for the system to be most effective in service Montanans and in being accountable for limited resources.

From franchise to control to semi-managed: history of Montana’s system of care

Prior to 1997, Montana’s mental health services for both adults and children – and the management of those services – were concentrated in five regional community mental health centers (CMHCs) as contemplated by Montana’s statutes. These CMHCs essentially had a franchise, either in actuality or in practice, to provide publicly funded non-Medicaid services and specific Medicaid services such as day treatment and targeted case management for eligible populations in their geographic region of the state. The CMHCs also brought in other local funding sources that they added to state and federal funding to make available the most services possible for SMDI adults and SED children, as well as other persons with mental health needs in Montana’s communities. While the CMHCs did not offer choice for consumers, they did provide a single point of accountability for service delivery efforts within their geographic region. However, because they were often “the only game in town” and because there were few financing mechanisms in place to create incentives to change service delivery in specific ways desired by the state or by system advocates, they did not change easily or quickly and were often considered intractable on some issues by both advocates and state leaders.

CMHCs were funded by grants and by fee-for-service arrangements that were largely driven by contracts with AMDD and its predecessors, which memorialized the expectations between the state and these providers. Quality and accountability was largely in the hands of the CMHCs and their boards (both governing and advisory) and in the hands of DPHHS’ contracting function. State regulations in addition to the contracts with CMHCs were the only sources of provider quality controls. Few providers other than CMHCs were interested in providing services to the populations they served for the funds they were willing to use and with the regulations they had to live by. CMHCs did relate to these providers in their areas either as subcontractors or as colleagues. To the extent that CMHCs were willing and able to collaborate with other service delivery or needs identification systems such as corrections, juvenile justice, courts, schools, child welfare, etc., the interactions around populations touched by multiple systems were good and helpful. To the extent that CMHCs were not willing to work collaboratively, or were not able to be accountable, the state, consumers, and advocates had little recourse.

CMHCs during this time kept a certain amount of data about utilization and expenditures that are not in the same format or system as the data produced during later years under the managed care vendor, or currently by the DPHHS claims payment vendor. Some CMHCs assisted AMDD/MH Services Bureau in its initial efforts to implement the national MHSIP data set for client satisfaction and outcomes. However, this data is no longer routinely collected by some CMHCs and other providers or has been changed such that a common data set for outcomes and performance does not currently exist.

The state executive and legislative branches were interested in creating incentives for CMHCs to behave differently, for other providers to come into the system, and for new approaches to quality controls to be implemented. They were interested in:

- Developing a managed mental health care system in which rational treatment decisions are made according to the needs of individuals;
- Expanding the continuum of care with alternative programs for the unmet needs of populations who are underserved in the current MHSP and MMHP programs;
- Developing data gathering mechanisms to measure key processes and outcomes of care so that gaps in service can be identified and costs of care can be accurately predicted;
- Increasing access to services including continuity of care from one service to another;
- Identifying, measuring and improving quality; and
- Encouraging and promoting meaningful dialogue and participation with consumers, family members, advocacy groups, and providers throughout the process.

In order to meet these goals, Montana sought and received a waiver of certain Medicaid rules that introduced managed care technologies, opened up the system for new providers, and capitated the competitively procured managed care vendor (Magellan) to live within the limits of funding imposed by the HCFA waiver. At the same time, Montana blended the service delivery systems and services for non-Medicaid eligible SMDI adults and SED children (the Mental Health Services Plan or MHSP) and the service delivery system for Medicaid eligible children and adults. This action was a laudable attempt to meet the needs of Montana's priority children and adults regardless of funding stream.

The result of this activity was to move from five regional franchises to a single statewide managed care vendor with similar definitions, rules, and protocols for authorization and payment for services regardless of geographic area, population, eligibility status, etc. The implementation of this move to managed care was flawed in many respects, some of which had nothing to do with the individuals involved either in the state's or Magellan's leadership. As a result, claims to providers were not paid promptly; providers began to suffer; promised new services were not forthcoming, consumers and families did not feel heard; authorizations for services were cumbersome to access and inconsistently applied; and the vendor lost significant amounts of money (according to Magellan, \$12-15 million per year, approximately the amount of the administrative portion of the contract capitation amount). The non-Medicaid population utilized additional services beyond what was anticipated. And, the data about what actually happened during this time period at a system level was either slow in coming, not provided at all, or was considered inaccurate for purposes of doing systemic analysis of studies regarding the system's performance. Performance and outcome requirements were never implemented in a way that could track what occurred before and after this move to managed care.

Montana's managed care experience got so bad that the legislature seriously considered terminating the contract with the vendor. In response, Magellan gave notice that they would not continue the contract beyond April 30, 1999. Magellan continued until June 30, 1999 in an administrative services capacity to assist in a smooth transition.

The months between April and July saw the state cancel the waiver program, and the AMDD staff quickly moved back to a semi-managed fee-for-service environment in which a DPHHS vendor processed claims, a separate DPHHS vendor authorized certain high end/high cost services, and AMDD staff tried for over a year to put order back into a chaotic system that has seen tremendous changes without much in the way of perceived gain. Moving from CMHC-controlled regional services to a single statewide tightly controlled risk-based managed system of care and back to a now relatively unmanaged fee-for-service system, all within a few short years, has left the state with additional providers creating more choice for clients, but at the expense of a system that has little clarity about its goals or its methods of achieving those goals, and without the data and information it needs to manage its current activities and future directions. It has also left a system that has been focused on trying to right itself in terms of management structures and financial performance rather than a system that is growing or systematically changing toward identified and articulated improvements necessary to meet Montanans' mental health needs.

In this environment, state leaders have been focused on controlling system growth and expenditures. Advocates have been focused on addressing the unmet needs they believe the system has always had or have been created by the changing times in Montana's mental healthcare system. Providers were originally focused on getting paid so that they could maintain any services as well as survive in the changing environment. CMHCs were focused on getting paid, restabilizing services and workforces, and regaining a sense of control in the regions for which they felt responsible. Few voices have emerged that are in concert and few have said that continuing change is a necessary thing. And, little attention to new service technologies or to creating systemic approaches to service delivery, financial management, and performance and outcomes accountability and management has occurred.

Accountability for client care and system resources

Over a year after the change from a tightly controlled statewide managed care environment to a state administered semi-managed fee-for-service environment, stabilization has returned to the system in the form of providers being paid in a timely fashion and increased communication between the state and the service delivery system for problem-solving purposes. However, state officials have been preoccupied with this return to stability; trying to manage the system with only rules and regulations; and trying to both explain and stop the continuing expenditures that exceed anticipated or budgeted amounts. State officials now have a variety of providers to contend with (instead of five primary CMHCs or a single managed care vendor) all of which have no particular incentive to control costs or to provide only the care that is needed for the time necessary to achieve identified outcomes for clients. CMHCs now have no

particular responsibility for the total mental health needs of a client, and all providers are responsible only for those parts of the client's care that they are being reimbursed for at any given moment. In a fee-for-service system, without any additional controls beyond prior authorizations for high end services, providers get more by providing more services – period – until they reach the limit of what the utilization management criteria are for high end services, or they reach the limit of the service definitions (which are loosely enforced), or they can send the client to another service (e.g., the state hospital) for which they do not have to pay.

An alarming recent phenomenon is the increase in school-based services for children provided directly by schools. At least one school has been successful in seeking licensure to provide services as a mental health center, thus allowing them to bill directly for in-school mental health services for children. One other school has terminated a longstanding relationship with a CMHC in an apparent decision to become a certified provider in its own right. Other schools are talking about the possibility and see the DPHHS/AMDD Medicaid and non-Medicaid funding as a source of payment for behaviorally and medically related services they believe children in their schools need but which have not been provided by traditional mental health providers. This phenomenon in both Montana and in other states has resulted in runaway costs and in services being funded by mental health systems that were either previously funded through school IDEA and other funds or not provided at all. The issue of whether these additional services are needed aside, the drain on Montana's mental health resources when many of these services were not contemplated by the original design or budget of DPHHS is a critical issue for state legislators and state executive leaders.

Most providers that TAC talked with indicated a personal and professional commitment to making sure clients (whether children or adults) got the services they need, connecting them appropriately with other service providers, staying within the criteria established by the state and/or by professional practice standards, and stretching limited resources to serve the most clients possible for the limited dollars available. However, the data regarding service provision during the last year suggests that in general, services are not provided in a way that will maximize resources, and that additional services are being created in order to stop the use of additional resources, but without a careful financial or programmatic analysis of how these new services will perform and whether they will in fact simply serve additional people or create new demand.

At this point, no single entity is responsible for any one client's care and the resources available for that client or that population. DPHHS/AMDD is the single point of accountability for system resources, and yet the system is set up to prevent DPHHS/AMDD from refusing to pay so long as a provider is certified to deliver the service being provided, even if the need for the service for a specific client cannot be justified. Other than the Montana State Hospital and the Montana State Nursing Home, DPHHS/AMDD has no other direct authority over a specific person's or population's care. DPHHS has introduced additional capacity to review high-end services prior to authorization of payment for those services through the new UM vendor (see below),

and has introduced care management capacity to that vendor to assist in finding alternatives for the consumer, should authorization be denied. However, this vendor and its care managers do not have authority to change providers or shift funding to create more appropriate services for that consumer or a population of consumers' needs.

CMHCs and other key providers have certain responsibilities for care and case management for specified populations. However, if clients enter non-CMHC provided services such as community hospitals, residential treatment settings, or private psychiatrists, the coordination and communication regarding these services is largely dependent on the relationships among these providers and practitioners. In many cases, TAC was told that consumers entering the hospital or being transferred to Montana State Hospital in Warm Springs could occur without the knowledge of the CMHC that has been treating him/her. This could also lead to questions regarding to whom he/she will return for treatment when hospital services are no longer needed.

A system of coordination of services for children (MRM) that emanated from a state interdepartmental agreement among state child-serving agencies, and was required of local child-serving entities, was disrupted with the advent of the managed care vendor's role. While not universally liked by all the people TAC interviewed, there was common agreement that this process and requirement for coordination did help in most of the state's five regions to identify multi-need children and adolescents and collaborate on their care and the payment for needed services. Child and adolescent use of out-of-home residential placements, especially those out of state, was apparently significantly lower under both the pre-managed care and during managed care environments in Montana. In the last year, an alarmingly high number of children and adolescents are being transported out of state for residential placement while in-state facility based service settings (beds) have increased, as has use of these high cost, high intensity services.

Systems should have a single point of accountability for client care as well as for the relevant resources related to that care if they are to be accountable, efficient and effective. The state's role should be to:

- Describe populations to be served;
- Define the mental health needs of those populations and the services that will meet those needs;
- Design a service delivery system;
- Select and/or certify the providers of those services;
- Monitor and oversee the delivery of those services to assure accountability and good system performance and client outcomes; and
- Pay for eligible services for eligible populations while staying within budgets allocated by the state legislature.

Currently in Montana, the state is cast in all those roles and in addition, is attempting to be responsible for client care. The state's infrastructure is only a small portion of what the managed care vendor brought to this enterprise and yet it is trying to do all those managed care tasks in addition to state roles.

Montana's system has not adequately lined up the roles: of each player, the incentives for service provision, service outcomes, and financial accountability in a way that will assure the best services for the highest priority people in the most efficient and effective way. DPHHS staff are insufficient in numbers, skills, and experiences to perform all the duties it has in front of it and has limited tools to conduct the kind of oversight and management needed in Montana's system. Organizational and financial structures need to be redesigned to attend to Montana's system's needs and to make the most out of limited dollars for eligible individuals.

Provider licensure as a means of system control

For any system to be successful, a variety of controls are needed for both clinical and system management. Prior to managed care, Montana used its licensure process, its contracts with CMHCs, and its grant-based payment mechanisms as the primary vehicles for system control. These vehicles proved insufficient for assuring quality, allowing choice, and encouraging innovation and increased access for more individuals and families.

During the move to managed care, Montana introduced the following as vehicles for system control: eligibility criteria and service definitions; competition for the role of managed care vendor and the vendor contract; encounter data; provider credentialing; extensive utilization management; quality management; performance and outcome requirements; provider contracts with the vendor; and risk based payment mechanisms along with other managed care technologies. These vehicles were either poorly implemented or never got off the ground due to forces partly in everyone's and partly in no one's control. In some cases, control was exercised forcefully and in excruciating detail (e.g., prior authorization of payment for services, refusal to pay for services not documented in the data system) and in other cases, control was never exercised at all (e.g., performance and outcomes management).

Now, DPHHS/AMDD has no contracts with providers – except for a few grant-based ones – contracts for key availability services such as telephone crisis services, and has only the prior authorization of payment for high-end services and limited encounter data as managed care technologies. It has eligibility requirements and licensure rules and regulations as its primary tool for system control. As a consequence, when system problems occur, regulation changes and/or eligibility changes are the primary tools the state has to adjust in order to get spending under control. AMDD is beginning, as part of this system planning effort, to introduce performance and outcomes measurement. This tool is critical and should be a primary role of AMDD, but will not be sufficient without other means to make adjustments based on the results of this measurement process. These tools are insufficient to control the system in an effort to assure

adequate services and care and to manage limited resources for which multiple competing demands continue to grow.

Montana needs a way to appropriately align the role of the state; providers; system managers; and consumers, families, and advocates, to assure the system is carefully constructed and managed with sufficient restraints to make system adjustments without choking the system's ability to go forward with appropriate speed and direction. Montana also needs a way to reintroduce regional system leadership without going back to the days of franchised CMHCs with limited choice for consumers and limited ability to hold franchisees accountable. Montana needs system gatekeepers that assure that the right services are available for the right persons and are received only for as long as needed without prohibiting the ability of providers to address the immediate clinical needs of clients and without creating a situation that destabilizes provider finances and workforces.

C. Infrastructure and Leadership

The leaders of Montana's system have managed incredible changes and course adjustments with very limited human resources and in the face of multiple expectations in a very short period of time with pretty successful results. They are to be commended for quick and bold action, attention to the priority issues at hand, creative solutions for both immediate and longer term issues, and lack of defensiveness as they are viewed under the microscope by advocates, elected officials, system constituents, Montana taxpayers and communities, outside consultants, and national observers. Montana's system leaders have been reactive to the overwhelming issues confronting them partly out of necessity. It is now time for these same leaders to complete a strategic planning process that will give the system a vision and direction for the future. In order to plan and implement such a vision, they will need adequate resources, data capacity, and quality management and improvement capabilities system wide.

Strategic planning

Montana was changed to a managed care system based on a planned evaluation of what was desired and needed. The process of developing the Medicaid waiver request to HCFA required that Montana create a planning process and strategic vision based on values and goals to be accomplished (see Section B above).

Since the implementation of the managed care plan – in order to stay solvent and operational, and to assure even minimal access to priority populations – it was necessary for the values and goals that were originally articulated to take a back seat to the exigencies of what was immediately confronting the system. The system is spending more than was budgeted by a projected \$20 million annually (including both state and federal funds), somewhat more than the amount reported as a loss by the managed care vendor. Now, state leaders are continuing to respond to immediate pressures for changes that will assure access while controlling costs. These cost containment mechanisms have been based on the immediate problem and the available vehicle for solving that problem rather than on an analytical approach to a long term

solution that will not only solve the immediate problem, but also continue to move the system toward its strategic goals.

In this current environment, different voices are heard on different issues often without a coordinated theme. Some voices are directed toward decreasing what is viewed as over expenditures. Some are directed toward increased resources. Some voices talk about service needs for children and youth, while others talk about the critical needs for adults in jails and prisons. Some talk about the need for training while others discuss the need for additional advocacy or ombudsman services. Some talk about needed legislative changes while others talk about the performance of providers or the lack of practitioners in frontier areas of the state. Few talk about system needs and few talk about how to bring resources and care management together to assure the system as a whole is adequately performing. Some express frustration with lack of data and information, but few seem willing to invest the time or money in the infrastructure to support that data for management and quality improvement purposes. Some talk most about why system leaders are making the decisions they are making and why they are not listening to constituents or are not making the changes believed to make a difference for Montanans with mental healthcare needs. All of these issues may be relevant, but not all can be priorities.

Currently, Montana AMDD does not have a single strategic vision and plan for Montana's mental health system. The Division, along with its constituents, has been too focused on immediate issues at hand rather than on what the system should look like in the future and how will it need to move and change to get there. Some constituents describe this current state of affairs as lack of leadership. Others describe it as lack of a strategic vision. It may be more a lack of time and energy rather than lack of vision or desire for a common direction. The Mental Health Services Bureau has begun the process of developing a strategic plan. This activity will help create a single vision for the future to guide actions of all parts of the system and to explain the need for new resources at certain periods of time for certain perceived gain. Leadership from all parts of the system will be necessary to create this plan and have it adopted as the system's direction rather than to use it as one more opportunity upon which to disagree.

State advisory processes

As indicated earlier in this report, the Mental Health Oversight and Advisory Committee (MHOAC) is doing good work that should not be ignored. However, at the current time, the MHOAC recommendations are multiple and without prioritization. They address many different aspects of the system and are presented at varying levels of generality or detail. MHOAC appears to act more in an advocacy role vis a' vis the Division and DPHHS as well as vis a' vis the legislature and other decision makers. While that role is appropriate at some level, especially when MHOAC believes the Division's and Department's direction is fundamentally incorrect, MHOAC must begin to see its role as helping AMDD and DPHHS to accomplish jointly established priorities for the system as a whole. MHOAC should help AMDD and DPHHS establish major goals and priorities, the assist and advise in implementing those goals and priorities before recommending other actions or priorities. Likewise, AMDD and DPHHS must see MHOAC as more

than just another voice coming at them. They should find ways to engage collaboratively with MHOAC regarding common statement of problems and goals, jointly established priorities, and an agreed upon vision of the system for the future.

The Board of Visitors is a concept of community involvement in the oversight of state or CMHC-operated programs and services needs to be reconsidered. This very well may be one viable approach to outside evaluation of service effectiveness and a valuable source of advice to both the state and CMHCs about changes that could improve care. However, currently, the Board of Visitors is limited to only certain types of providers and only to the services within the program or service reviewed. This limited view makes this process at best less relevant and useful than it could be and at worst, contentious for those who see it as an unfair review that others do not have to undergo. This process needs to be re-conceptualized as part of the quality management and improvement process and as part of the consumer and family involvement strategy. The Board of Visitors should be comprised of at least half consumers and families and should be responsible for on site reviews of all providers in an organized rotating fashion. The process of review and the use of the review findings should be clearly defined as part of the AMDD quality management and improvement process. Examples of effective consumer quality review teams can be found in Philadelphia, Ohio, and Washington State.

State and regional staff

The fact that Montana's system is as stable and as functioning as it is given its recent history is particularly amazing considering the small amount of staff in AMDD and in the Mental Health Services Bureau prior to and during managed care. With only a limited number of professional and clerical staff [the Bureau currently consists of only seven professionals (two of which are new within the last year) and one clerical staff dedicated to its business] and with limited assistance from other key DPHHS staff and two major vendors (one for utilization management and one for claims payment) they have managed to not only stabilize and keep the system afloat, but to communicate with constituents and legislators; begin planning and stakeholder input processes for the future; and account for system budget and expenditure issues for executive and legislative action. When compared to the budget and infrastructure Magellan had for managing the system of care, it is clear that resources alone are not the only key to successful management of a statewide system.

However, the state is now in the position of being so under resourced in its management infrastructure that it will likely make mistakes rather than continue to lead. AMDD and the Mental Health Services Bureau need additional resources to begin to implement additional system controls as described in the preceding section. Contract management; quality management and improvement; and financial and data analysis are functions critically lacking for the future. Additionally, human resource development throughout the system of care will be important and necessary for future system changes. Planning resources will also be important as Montana moves to the next stage of its development.

These resources may be needed at the state level and/or at regional levels depending on how Montana decides to pursue its structural issues in the future. Without some of these resources at the state level, either directly within the Mental Health Services Bureau or appropriately assigned to these Bureau functions from AMDD or DPHHS staff, the state will not be able to assure that its future directions are sound and will likely continue to be reactive rather than proactive in its planning and commitment to a single strategic vision.

Data analysis capacity

Each decision or idea that AMDD makes or has today about system problem solving is based in part on its assumptions about what system impacts a particular decision or idea will have. For example, the decision to change the definition of SED children assumed that this would limit expenditures to those children most in need. It was assumed that the development of additional residential facilities or beds would reduce the need for hospital beds. Unbundling school based services rates is assumed to result in less expenditure of dollars for only those services provided, rather than for a higher bundled cost to cover the general or average costs of a child's care. It is also assumed to make it less attractive for schools to get into the direct delivery of mental health services rather than to partner with a child-serving agency that is already certified to bill for services.

Likewise, utilizing CHIP resources first for children's mental health needs is assumed to cost less to the state than continuing to provide this care through the non-Medicaid mental health care system (MHSP). Reducing the rate paid for partial hospitalization services and changing the location in which these services can be delivered is assumed to reduce the expenditure of dollars for this service after making assumptions about the cost of alternative services that might be used. Setting a limit on the number of persons who could be served by the MHSP system at any one time while allowing exceptions for crisis services and for persons coming out of the state hospital is assumed to result in a capping of or slowing down in the expenditures for the MHSP part of the system. Paying higher rates for psychiatric care is assumed to increase the number of private practitioners who will be willing to serve state funded individuals, hence increasing the availability of and access to psychiatric care. Paying higher rates for the use of crisis beds for persons coming out of the state hospital is assumed to result in a lower census at the state hospital without increased costs to the system as a whole. Increasing the co-pay for certain key medications because the manufacturers are not willing to give the state bulk discounts is assumed to have an impact on the manufacturer worth the impact on the clients themselves and their ability or willingness to utilize the lower cost medications (which may result in increased service utilization or increased impact on other systems from clients not complying with prescribed medication regimens).

All of these assumptions may prove to be correct. However, there has been little time for state leaders to analyze data or consider alternative scenarios before suggesting or implementing these suggestions. Data for such analyses are not always available, and even with good data, there is no guarantee that decisions will be without problems. However, AMDD decisions would be more rational and justifiable and more likely to

produce the desired results if AMDD had staff time and capacity to analyze data and alternative scenarios before implementing decisions.

There is currently little analytic data capacity within MHSB or even within AMDD to make sure the assumptions upon which decisions are made actually occur rather than unintended consequences occurring. These unintended consequences could include an increase in hospital use, creation of new demand, continuation of rising expenditures, expenditures in fact increasing faster than anticipated, or decrease in access for those most in need while expenditures for lower priority clients or services actually rise. Most of these assumptions are aimed at reducing the budgetary impact of services without a drastic impact on access. However, few assumptions have been analyzed about how to structure systems to introduce assumptions and incentives for clearly defined priority services and populations.

Finally, the system as a whole, down to the provider level, does not have a culture of data-driven decision making. By and large, providers and practitioners interviewed by TAC did not have data for decision-making or had only data relative to the operation of their own agency or practice. While some have client outcome data that they have created and use for their own purposes and while many providers as well as consumers and families express a need for data upon which to make system decisions, a fair amount of skepticism was expressed about the system's ability or true desire to produce such data and about providers' willingness to collect and report data that might reflect on their performance.

There are a number of reasons why AMDD needs consistent, timely, and accurate data to carry out its functions as governance, leadership, and central point of accountability for the entire Montana public mental health system. First, good data is needed to monitor system performance and behavior, and to institute corrective action when needed. The recent budget issues are a clear example of why ready access to information on a much more timely basis is necessary for proper management. Second, good data will support the quality management and quality improvement process, by adding quantitative access, utilization, and cost data to other quantitative and qualitative information to provide a multi-dimensional analytic capacity to the process. Third, good data is needed to make the division's case to its oversight agencies, the legislature, and the general public. Outside entities and individuals cannot understand why the division might need more money or need to change current service delivery patterns without seeing data about the costs and effects of the current system.

As has been documented in the Task One report, the AMDD has access to a variety of sources of information, the most important of which is claims data produced by Consultec and transmitted to MedStat for use by Montana State government. AMDD also has good current and historical State Hospital data, which can be used to track high-risk inpatient users and to assess the success of regions or providers in reducing hospital admissions and lengths of stay. In the future, it is assumed that AMDD will

receive regular reports from First Health (the current utilization management vendor) on service authorization requests and denial rates.

There are several major deficiencies in the data available to the division for planning, forecasting, and decision-making. The first problem is that the databases that could be used for detailed analysis are not effectively linked. For example, State Hospital admission and length of stay data are collected and available, but those data are not joined with the Medicaid claims data to analyze crossover transfers between general hospital units and the State Hospital, or to generate a high user analysis that includes both State Hospital use with general hospital and community service use patterns. First Health will likely forward authorization and re-authorization data to AMDD or to Consultec, but it is not clear how that data may be integrated with claims data in regular reporting. For example, it is customary for service providers and/or consumers to use less services than are contained in service authorizations. However, unless the actual paid claims are routinely reconciled with service authorizations, the ratios between actual service utilization and authorized service utilization will not be known. If this occurs, it will not be possible for AMDD to forecast the actual costs of service authorizations over time, and thus will be less able to manage the appropriation(s) as effectively as may be desired.

The second problem is that none of the various sources of data or current databases contain information vital to managing the quality and performance of the public mental health system. Consistent measurement of consumer-focused outcomes and provider performance are essential to both system accountability and to continuous quality improvement. TAC's Task Two report specifies certain consumer-focused outcome and related performance measures to be tracked and reported in a consistent manner throughout the system. These outcome and performance measures should be designed into the routine reports submitted by providers and the regional structures. Other related indicators, such as consumer level of functioning and acuity measures, should be reported in a similar manner and made available for analysis. Incentives for providers to collect and report such data may need to be considered either directly or through the regional structures proposed in this report. If these incentives do not work, sanctions may need to be considered.

Other data related to consumer outcomes and provider performance will not be routinely available through the claims data, and thus must be assembled, entered, and analyzed in parallel to the Consultec, First Health, and Montana State Hospital databases. Most of this data will originate in consumer and family self-reports of satisfaction, quality of life, health status, choice, etc. Although this data will be in a separate database, it must be capable of being linked with data from all other sources. For example, self-report information about mental health status, quality of life, and satisfaction with choice will need to be correlated with data on acuity and level of functioning, utilization patterns, and costs of service patterns or episodes of care. This is the only way AMDD will be able to answer questions of cost-effectiveness and value for the public dollar spent. It is also the best way to provide consistent, objective, and reliable data to the quality management and improvement processes.

This last example points out the third problem with AMDD's current information management and analysis capacity. That is, even with carefully designed and linked data collection and reporting systems, there will always be a need to access data electronically from a variety of sources, bring the data together into a central file, and conduct special analyses to respond to: (a) pre-defined management reports that cannot be produced from existing databases; and/or (b) special analyses of specific issues to support quality improvement and decision-making. AMDD does have some in-house capacity to download and tabulate data from various sources, and to create reports of use to managers for system management and problem solving. However, that capacity is very limited, and the limitations inhibit regular use of what little capacity does exist.

Quality management and improvement capability

AMDD has recently added a person to the Mental Health Services Bureau to be responsible for the Bureau's quality management and improvement efforts. This is a critical function of the state and of any part of the structure for system management. Quality management and improvement was one of the functions Montana hoped to gain from the managed care vendor, but which never got implemented due to other administrative crises regarding provider payments and data collection and reporting.

This staff person has been a victim of the same phenomenon experienced by other AMDD and Bureau staff. That is, she has been pulled to lead or do projects and other activities that were immediately needed to deal with system crisis and system expenditure issues rather than being able to focus on the development of a quality management and improvement system.

Montana's mental health care system does not have a consistent and coherent quality management and improvement effort at this point in time. The system relies largely on licensure processes, complaint resolutions, and individual provider efforts to ensure quality in the services and systems funded by DPHHS. AMDD/MH Services Bureau has made several attempts over the last few years to introduced performance and outcome indicators and measurements. (See TAC's Task Two report on Outcome and Performance Measurement). None of these efforts has reached fruition although each has identified things the system and its constituents believe are important and want to track and see improved.

AMDD has committed to beginning an outcome and performance measurement process with input from constituents that began during the development of and reaction to TAC's Task Two report. Some of the recommendations in that report regarding regional profiles are in process now. However, AMDD does not have adequate resources to sustain this process at this time, and it does not yet have an identified way to put outcome and performance measurement within the context of an overall quality management and improvement system that will operate consistently at all levels (providers, system managers, and state departments), and will include ways to analyze data collected and take action based on that data.

D. Resources and Rates

Any system of publicly funded services must analyze the needs of persons for whom it is required or for whom it chooses to fund care and determine whether the funds it has available are sufficient to meet those needs. If not, the system has three options: (a) the expenditure of funds must be adjusted either to encourage the utilization of lower cost services or to prioritize services for higher need clients; (b) system leaders must seek additional funds; or (c) difficult decisions about cutting services or excluding populations must be made. Montana's system does not have a systematic way to determine which option is most efficacious and which resources to adjust and how.

Resources to meet needs

Montana's system of care clearly does not have sufficient resources to adequately meet the needs of Montana's residents with mental health problems, nor even the needs of adults and children with the most serious disability-related mental illnesses and emotional disturbances. Montana's expenditures per capita are not out of line when compared to other states. Montana's system is neither a severely under funded nor a particularly generously funded system. The rural nature of Montana's system suggests additional resources may be needed to serve individuals in large, highly dispersed geographic areas where costs increase due to distance and inability to attract and retain licensed clinical professionals for mental health services. In FY 2001, Montana's current expenditures do not provide sufficient funds to serve all Medicaid clients well including, all persons with incomes up to 200 percent of the federal poverty level, as originally desired when the managed care vendor was selected in 1996.

Montana has since reduced its non-Medicaid eligibility guidelines for full payment for services to those with incomes up to 150 percent of poverty, and additional cuts to this guideline have been proposed but not enacted. Rather, a system of limiting services to a set number of slots unless a person is in crisis or is returning to the community from the State Hospital has been imposed recently to try to address a projected annual budget deficit of \$20 million. Other measures have been taken to reduce costs and other measures have been proposed that would potentially reduce costs further.

It should be noted that the so-called "savings" realized in the initial managed care years is masked by the loss experienced by the managed care vendor. If the \$12-15 million annual loss "eaten" by Magellan is added to reported expenditures of the system during the managed care years, then the expenditure patterns of Montana's mental health system are fairly consistent over the pre, during, and post managed care era. In other words, the savings were not "real" and the trend accounting for the real costs during that time is a relatively straight line of growth from pre-managed care to today. The fact that both current system leaders and a large national managed care company experienced a similar inability to manage within available resources and by approximately the same amount, suggests that resources to meet the needs of currently identified priority populations are simply insufficient, at least as currently distributed and managed. While

some redirection of dollars can result in a more efficient use of existing resources, there is no doubt that Montana's system will likely continue to experience a similar if not accelerated growth trend, unless populations covered are reduced, services covered are reduced or limited, or additional dollars are made available to the system for necessary services for the populations and services currently covered.

At a legislative finance committee hearing held on October 3, 2000, DPHHS presented its projections and its proposals for reducing costs as well as its request for an \$11 million supplemental appropriation (state general funds) to cover costs beyond budget that the Department did not feel it could handle by cost reduction or containment actions. The staff for this joint legislative committee expressed skepticism that the budget overage would be that little and that the supplemental appropriation would potentially need to be more than the amount requested by DPHHS.

In the meantime, the discussions of providers and advocates have been about unmet service needs while the efforts of state leadership have been to identify ways to cut current service costs, redirect service needs to other systems for payment (e.g., CHIP), or take regulatory actions to assure costs do not continue to grow uncontrolled. To date only two actual regulatory changes have been implemented. One is the redefinition of eligible children to mandate that children eligible for CHIP sign up and be served with those funds first before unmet service needs are paid for by the mental health system's non-Medicaid funds. The second is the limits on the number of individuals who can be served in the non-Medicaid part of the system. The only rate change implemented to date is an increase in the rate paid for psychiatric services. In addition, efforts to reduce the high cost of pharmaceuticals have been implemented that will result in additional costs to clients for those medications manufactured by companies that refuse to provide the state with bulk discounts as provided for the healthcare system in Montana. This latter change may in fact save money on pharmaceuticals, but may result in higher costs for other services or systems due to either clients' unwillingness or inability to pay for needed medications or to clients' unwillingness to stay on less effective medications that have side effects that are more difficult to manage and tolerate.

Regulations have been proposed to change the definition of SED children as well as the definition of SMDI adults, reduce the use of partial hospitalization services, provide increased rates for use of crisis residential beds for persons leaving Montana State Hospital, and increase rates for case management for a limited period of time for those persons about to be or just released from Montana State Hospital. Also proposed are requirements for billing of school based services directly rather than through a bundled rate and increased requirements for mental health centers so that they would have to meet criteria closer to those required of CMHCs in order to bill directly for care provided to children in schools.

While these options for cost containment are important to analyze and debate, it is also critical to look at the total resources available to determine whether they are sufficient to meet the needs of identified populations for identified services. Currently, no plan, needs assessment, or gap analysis exists or has been conducted recently to guide

decision makers to determine what it would cost to serve what kind of populations in what kind of manner with what kind of result. Without such an analysis driven by the populations determined to be the priority for Montana's system of care, system constituents' advocacy for additional resources are hard to justify as being more important than some other request for resources, either within the mental health system or in the larger state funded human services arena.

Service rates

The rates Montana pays its providers for covered services are not appallingly low, but neither do they adequately reflect the difficulties in providing services in large, rural, and frontier areas. The rates as currently structured also do not work to provide incentives for lower cost community based or in-home services that might meet the needs of some adults with serious mental illnesses or children with severe emotional disturbances short of more expensive out-of-home or high-end services. Rather, the rates work largely to encourage current and traditional services, often in facility based rather than in community or home based settings. It should be acknowledged that Medicaid rules and regulations as well as the reality of the costs of certain types of practitioners work to drive rates at times (e.g., the rate for a physician visit will be more usually than the rate for a visiting nurse simply because physicians are generally paid more even if the function they are performing – prescribing and medication management – is essentially the same). However, if Montana wants to encourage the utilization of lower cost services and services more likely to result in recovery and subsequent lower utilization of services, it needs to examine its rate structure accordingly.

Additionally, it needs to align financial incentives with care management and quality management authority and responsibility. A method and structure to do this to maximize the use of limited resources is recommended below.

Future issues affecting costs

There are a number of issues on the horizon that may affect the cost of Montana's publicly funded mental health services. These include but are not limited to: the increasing numbers of providers eligible to bill for services (especially schools); the increasing cost of psychotropic and anti-depressant medications; the increasing medicalization and diagnosis of children's behavioral issues, the increasing public desire to keep certain types of offenders "in treatment" and off the streets even after the time period for which they could have been imprisoned expires; and the increasing costs of recruiting and maintaining high quality staff for mental health services, especially in rural and frontier areas.

These issues must be acknowledged, analyzed, planned for, and managed in order to assure Montana's system of mental health services continues to provide access and quality care for eligible Montanans. The funding of these services and increased costs is a policy issue that must be debated and decided before system leaders and managers can produce the results for system users that are desired and at the same time are possible within limited resources.

III. RECOMMENDATIONS AND PRIORITIES

The recommendations listed below are made to respond to the observations and findings described in this report and to assist the Montana mental health system improve and meet its goals. Many of these recommendations are consistent with those made by advisory groups and stakeholders. Some are already being implemented by AMDD. Others will require more discussion, analysis and planning to determine the best approach to implementation and to involve the appropriate constituents in their development.

Because so many processes and groups are making recommendations for Montana's system and because not all recommendations can be implemented at once, TAC has indicated the relative priority of these recommendations (high, medium, or low). Some of these recommendations can be implemented relatively quickly and some will take several years. Some require relatively little resources or effort and some will not be able to be implemented without considerable commitment of human and financial resources. The priority rating noted here do not take into account these relative difficulties, but only the importance of getting started soon as opposed to beginning on these recommendations later. Starting sooner rather than later is also a reflection of how long a recommendation might take or how critical it is for the improvement of Montana's capacity to serve its residents and stretch limited resources in the most effective manner possible.

The recommendations below are grouped in sections covering planning, structural changes, service delivery changes, financial changes, and functional changes. While some of these recommendations are specific to services, the overall focus of these recommendations is the system as a whole. TAC's responsibility is to provide advice and recommendations regarding needed system changes to assure improvements to and overall effectiveness of the system as a whole for eligible populations as a whole.

A. Planning

Strategic planning process and document

It is time for system leaders to rise above the fray about cost containment or savings methods and the multiple advice and recommendations coming from different sources within the system. These are necessary activities and will no doubt continue. However, AMDD and the Mental Health Services Bureau needs to focus now on its plan for the future that will set clear values, directions, and goals; identify priorities and actions to reach those goals along with the responsible parties and appropriate timelines. It will be necessary for all system constituents – from advocates and advisors on the MHOAC to legislators dealing with budget and legislative language to providers, consumers and families – to get behind a single view of Montana's mental health system's future. After sufficient time for input, debate and refinement, a plan should be finalized by AMDD and

endorsed by MHOAC to guide the system's future development. All decisions, budget requests, legislative changes, and other efforts and recommendations should be judged in light of those system goals and actions.

The plan begun by the Mental Health Services Bureau is a good start on this planning effort. It is important that this effort is finalized with the recommendations in this report in mind, and that a public process be pursued to get public input and buy-in to this final plan. The plan must address system structure and management issues, resource issues and service delivery needs and issues.

It is imperative that AMDD and MHOAC sit down together and prioritize the MHOAC recommendations and identify which ones can be done and which cannot given current resources and given the direction the state needs to set before going forward. These priorities must be connected to the Mental Health Services Bureau's strategic plan. If the Montana mental health system is to be effective, it must speak with one voice and it must push with one hand. AMDD needs to work with MHOAC as if it were both a policy and advocacy board. AMDD needs to develop the draft strategic plan that is action-oriented but in a visionary framework. The framework should describe the system as it should look in three to five years. This framework should be concrete regarding structure, services, finances, human resource needs, quality management/improvement and administration. Action plans should accompany the visionary framework. The action plan objectives could be for a time frame of up to two years, but the individual concrete action steps should have no more than a two-year time frame in which to be accomplished. This will help to force both MHOAC and AMDD thinking about what is actually doable in any particular year.

AMDD should work with a subcommittee or the full MHOAC to address any concerns MHOAC has with the draft plan, and then agree on the few doable priority objectives toward which both MHOAC and AMDD will work for the next one to two years, bringing resource requests and decisions, legislative changes, system structure changes, and policy and regulatory changes to bear to meet those priority areas. Then MHOAC should focus its advisory and advocacy activities, and AMDD should focus its decision-making and actions on those priorities. There should be regular dialogue about the progress on those areas and about the next set of priorities to be established jointly during this one to two year period.

If these two groups can work collaboratively in this manner, all recommendations can ultimately be addressed, whether in exactly the same form or not depends on the collaborative process. Actions may not be taken within the time frame that all constituents would like, but a lot more action toward a single vision for the future is likely to be the result.

Advisory and input process

It should be noted that the MHOAC seems to be the appropriate body to provide public input and assist in obtaining statewide buy in to the strategic plan. However, to be a truly effective oversight and advisory committee, MHOAC needs to think of itself as

advising AMDD in the priorities and issues before AMDD rather than advising the state as a whole via AMDD and the system regardless of what is the currently the priority facing AMDD. This recommendation does not negate MHOAC's current role or efforts. However, AMDD needs to actively participate ex officio on this Committee (including the head of the MHSB or another AMDD representative sitting at the table rather than simply being available to respond to questions), assist in agenda setting, and help direct MHOAC's activities (not its advice, just its activities) to assure that the energy and advice MHOAC creates is not falling on deaf ears. MHOAC can and should continue to provide uncensored input to budget and legislative processes, as well as to AMDD and the Mental Health Services Bureau. However, a prioritization of recommendations focused on AMDD's priorities and the jointly adopted strategic plan described above rather than simply what MHOAC determines to be an issue somewhere in the system will likely result in more effective communication and more likelihood of action being taken on the recommendations made. This should also allow both AMDD and MHOAC to concentrate on adding detail to recommendations made and accepted for implementation, rather than just adding more recommendations.

It should be noted that MHOAC should not become a tool of AMDD such that it has no independent voice or no ability to affect priorities. MHOAC should be a partner in selecting these priorities and in some cases should actually set these priorities. However, once set, MHOAC's work for a given period of time should concentrate on those priorities, not on creating additional recommendations or requests for AMDD to react to, or unfortunately ignore due to lack of ability to do everything at once. In this way, MHOAC will be more effective and the system will speak with a more forceful and a single voice. It will also have a more clearly defined advisory structure to assist AMDD and the state as a whole in improving Montana's mental health system.

Assessing system and service needs

It is critical both for the service results of consumers and for the strategy of bringing stakeholders together around a common vision, that AMDD lead an effort to identify the mental health needs of priority and other eligible populations and the gaps between those service needs and what currently exists in Montana. These needs should include both traditional mental health services funded by the state with state and federal resources and by related systems for which AMDD will take the lead in identifying practice guidelines, clinical criteria, and quality standards. They should also include services that are not traditional mental health services and will not be paid for directly by DPHHS, but are necessary for adults and children with mental health needs. These include but may not be limited to housing, family based prevention, vocational, public benefits, and other services and benefits that help persons with disabilities to achieve success in community living.

This needs assessment or gaps analysis process can occur in a relatively informal but systematic manner using current information in the system and agreements among constituents about needs and priorities. Or it can occur formally in a relatively traditional manner as a needs assessment process. Finally, there is a new scientifically validated process of needs assessment and gaps analysis to determine the needs and gaps for

adults with serious mental illness that could be used. This process is more labor intensive and costly, but is more defensible in the process of explaining why resources are needed for what purposes. A similar process for children and adolescents might be developed to be equally valid and defensible for these purposes.

Whatever process and technology is used, AMDD should include this needs assessment process in its plan. Doing so will help bring stakeholders and funders together around the needs and the priorities for funding. It should be noted that this process of needs and priority setting for resources cannot be done just once. It is an on-going process and will be impacted by system structure changes as well as service technology changes occurring in Montana and in the country.

B. Structural Changes

Single point of regional accountability for client care and system resources (regional structures)

Montana's system needs to recreate some of the regional responsibility that existed prior to the managed care era without returning to the franchise or control of CMHCs and without losing some of the managed care techniques that have been implemented as a result of managed care and the post-managed care era. TAC recommends the development of five regional authorities with both responsibility and accountability for client care and for managing limited resources for both adults and children. While TAC does not recommend separate adult and children's authorities, TAC does urge AMDD to assure that the players involved and the structure developed be adequately knowledgeable and skilled to address and manage both children's and adult's service delivery systems and issues.

For purposes of this report, TAC will refer to these regional points of accountability as regional structures. It is important to note that a fundamental issue to be decided is whether these structures should be a regional authority authorized in Montana statute and if so, whether they should be governmental entities or selected non-governmental entities. If these regional structures are to be non-governmental, they should be developed rather than formally procured, at least initially. Whether formal procurement will be required later, may depend on whether a Medicaid waiver is sought to make some of the implementation of these and related issues easier and more effective. If procurement is later required or deemed prudent, these homegrown regional structures will have sufficient time and opportunity to develop capacity to compete fairly and openly with any outside profit-making entity that might be interested in doing this work.

The purpose of these regional structures will ultimately be to manage and be responsible for care and services, funding available to the region, and quality improvement in a given geographic area, with increasing financial risk for care and services, while having a limit to the risk a particular entity must bear (see financial recommendations below). In other words, once the regional structures have developed sufficient capacity they will be asked to manage within limited and defined resources while being responsible for a set population of eligible and priority persons who may not

be rejected or ejected from care except on the basis of clinical criteria indicating care is no longer needed or beneficial. These structures should also be given performance and outcome expectations to assure that the care delivered is timely, good, and produces results. This is a modified managed care approach in that the mechanisms for regional structures to share this financial risk with the state may be more traditional for mental health systems than the capitation or case rate approach of managed care. This approach will allow regional structures some flexibility to meet consumers' needs and produce outcomes while encouraging innovation and creativity to stretch limited resources.

It is important for AMDD to consider the use of these structures for the management of substance abuse and addictions funding and services as well as mental health services to create a single regional behavioral healthcare system. The number of individuals who are mentally ill who abuse or are addicted to drugs and/or alcohol and the number of abusers/addicts who have mental health needs is high, especially in publicly funded systems. The need to develop integrated treatment options for persons with co-occurring disorders is adamant. The national debate over the best way to fund these types of services is resulting in new national funding sources for testing or implementing integrated services. And, a large number of the individuals who need to be diverted from justice and correctional facilities are persons with co-occurring disorders. Planning and overseeing these services through a single regional system could help to address multiple service delivery concerns in Montana's system of care.

Additionally, managing these funds together may result in increased efficiencies and clearer policy directions. While TAC did not specifically review the funding or management of Montana's addictions services system, the need in a rural state such as Montana for tight management structures and for unique regional approaches for all services is clear. Having addictions and mental health services managed through the same regional structures could help to focus the management resources while also providing other systems a clearer partner with which to interact and plan for local community services approaches. This integration of management should not result in a complete blending of addictions and mental health services resources at the provider level. In many cases, the funding should be utilized for clearly distinct programs and must be accounted for in distinct fashions. However, the administration of these dollars through the same regional structure should help to enhance efficiency and coordination of care while offering an increased likelihood of appropriate integration of services for those persons with co-occurring disorders.

TAC recommends five regions to correspond with the regions utilized by several other state agencies and consistent with the five regions AMDD still relates to for data management issues. It is possible that a single entity could be the regional structure for more than one of these regions. However, no one entity should be allowed to develop and propose to be the regional structure for more than two regions.

Initially, these regional structures should be developed and nurtured from within current providers who are interested in developing capacity themselves or procuring an

administrative partner while they build capacity to manage services, finances, and quality improvement. The legal structure utilized should be optional for the provider network to choose. It could be a new non-profit entity, a single current provider serving as a fiscal agent for a provider network, or a managed care organization hired by or in collaboration with a group of providers. However, whatever the structure, significant representation of consumers and families as established by the AMDD regional structure application process should be included in planning processes and on the ultimately designed governing body.

The development of these regional structures should begin slowly and should proceed in incremental steps over the course of two to five years. Each region could develop a structure on different time frames, with an outside timeline beyond which AMDD should proceed to procure an entity to be the regional structure if a local provider group has not been able to meet criteria for being the regional structure, or if more than one organization expresses interest in being the regional structure. With the proviso that this recommendation will be refined by public input and the actual steps may vary depending on the region, the steps in this developmental process should begin during the current fiscal year (FY 2001) and should proceed approximately as follows:

Year One (FY 2001) – Develop criteria and process for initial regional structure plans, including issues such as single access process (client flow and assessment process), single care management process, communication among providers in the region, referrals into and out of inpatient care and residential treatment and living settings, crisis services, and consumer and family involvement. Also, develop, appoint, and train the Regional Planning and Advisory Councils described below.

Year Two (FY 2002) – Allow provider groups to organize and identify their intention to enter into planning to become a regional structure for a declared region. Providers should be told that they are encouraged, but do not have to participate in this planning process. However, if they do not, there is no guarantee that resources and funds will continue to be available for that provider and eventually this regional structure will be determining what providers are given contracts or credentials to provide services in this region. Any provider that wishes to participate in this process should be offered an opportunity to do so. This year should also include the development of criteria for the governance and administrative infrastructure needed to enter the final stage of this process, but provider groups should be required to develop the initial services plan before moving into governance planning. It should also include performance and outcome requirements driven from the early data gathering and benchmarking discussed in TAC's second deliverable (Task Two report on Outcome and Performance Measures).

Year Three (FY2003) – Any provider group that is ready to actually establish or procure the administrative and legal structure necessary to begin acting as a regional structure should submit an application to show capacity to become a regional structure, beginning July 1, 2002. This application should be written similar to an openly procured application to be a managed care entity and should include a proposed contract that

includes populations and services, incentives and rewards, and expected performance and outcomes. This process will assist AMDD to be clear about its needs and expectations and will serve to be the criteria against which a regional structure proposal will be judged. Once a regional structure has been approved based on written application, an on-site readiness review should occur before the contract for funds, care, and quality management should be conducted.

NOTE: By July 1, 2002, the waiver discussed later in this report could be approved and able to be implemented through these regional structures, although such a waiver could be planned to be implemented July 1, 2003, giving these structures a year to operate before beginning to manage in a waiver environment. Develop the financing mechanism(s) for these regional structures that will maximize incentives for providing effective and efficient services in non-facility based settings to the extent possible. Mechanisms to consider include global budgets, case rates, capitation, or other incentive based financing.

Year Four (FY 2004) – All regions should have a fully functioning regional structure that has met criteria in the application. If a region has no provider group willing or able to function as a regional structure, multiple provider groups interested in being such a regional structure, or HCFA requires procurement under an approved waiver request, then DPHHS should issue a request for proposals to select an entity to perform the regional structure roles. By the end of this year, all regional structures should be ready to enter into a contract with AMDD that includes managing all the services, care processes, quality improvement processes, and finances available to the region for mental health (and potentially addictions) services for children and adults.

Year Five (FY 2005) – Regional structures should be making adjustments and reporting to AMDD on quality management and improvement efforts consistent with AMDD regulations or guidelines.

The roles and responsibilities of these regional structures should also be phased in incrementally. These roles and responsibilities should be distinctly different from the roles and responsibilities of the state or of providers. While these regional structures should be developed or selected by provider networks or groups, they should be focused primarily on planning for, managing, and accounting for mental health (and potentially other services) dollars, assuring client care is appropriate to meet their needs, and being responsible for reporting and increasing the quality of services in their region. The regional structures should *not* be a provider of direct services other than perhaps, at their option, care and case management services. If the legal structure chosen is a fiscal agent model, the provider serving as the fiscal agent should have a clear organizational separation between its role as provider and its role as the fiscal agent for the regional structure. In this case, the decision-making body should be a group of providers, consumers, and families operating as a board separate from the fiscal agent's board.

The functions of the state once these regional structures are in place is to set policies, procedures, and criteria; account for funds and services; assure services are of high quality and are producing good outcomes; and oversee the activities of the regional structures. The regional structures will be responsible for assuring the care of each eligible client is planned and provided and to assure that limited dollars are utilized in the most effective manner. Quality management and improvement activities will be shared by the state; regional structures; regional planning and advisory councils; and direct service providers.

Regional planning and advisory councils

These regional structures should be partnered with and advised by regional planning and advisory councils (RPACs) appointed by AMDD and structurally connected to the MHOAC. In other words, the five regional planning and advisory councils (RPACs) should be composed of individuals from that region representing a majority of consumers and families (both children and adults) but with additional members who are local government officials, community members at large, and other key system players who can contribute to the responsibilities of these planning bodies. These members should have clear terms and term limits. RPACs should be governed by written bylaws, the framework for which should be developed and provided by AMDD with input from MHOAC. The RPACs should be chaired by a consumer or family member selected on a rotating basis from and by the members. That person, plus two other members of these regional bodies selected by AMDD, (to assure at least one person representing children's issues and one person representing adult issues) will represent that region on the MHOAC. In this way, local issues and state issues can be coordinated and communication can travel clearly in both directions. To the extent that the state MHOAC begins to operate as a planning and advisory body to AMDD, with active participation with and by AMDD staff, and focused on issues jointly developed by MHOAC and AMDD, the advice and input of both regional councils and MHOAC will be more meaningful and more likely to be implemented.

Other existing regional, local, or provider specific advisory bodies may continue or be disbanded depending on whether there is a need for them to continue to advise other aspects of the system. The goal, however, is to have a clear advisory structure that mirrors and corresponds to the developing infrastructure of the system to assure that issues and communications are clear and that a single voice can emerge from stakeholder dialogue and debate at both regional and state levels.

Roles and responsibilities within the new system

The relative functions of the state, the regional structures, the regional planning and advisory bodies, and local and statewide providers are described in Table D below. The staffing pattern for the state functions is discussed in another section of this report. The staffing patterns needed for the regional structures depend on the legal structure and the plan that is proposed and approved for each regional structure. While the cost of these structures can be estimated in a general or average sense, the actual costs will have to be determined as implementation proceeds.

TABLE D: ROLES AND RESPONSIBILITIES

TOPIC	STATE	REGIONAL STRUCTURES	PROVIDERS	RPACS
Planning and Policy	Set strategic plans, policies and procedures for system as a whole	Develop and submit regional plans for services and financial management	Participate in state and local planning efforts	Advise and approve regional structure plans for services and financial management
Eligibility and Service Array	Define populations, services, and statewide priorities, including core services that must be available in each region and in each community	Contract for and/or provide core and optional services utilizing multiple providers throughout the region; assure eligible individuals are served according to their needs and AMDD guidelines	Provide contracted services for eligible clients and their families	Identify unmet needs in eligible populations and needs in currently ineligible populations
Contracting and Management/Administration	Develop/select/support regional structures; contract with them for management and over-sight of funds and services	Develop and manage regional infrastructures	Participate in development of regional structures	Advise regional structures on operations and implementation
Funding	Seek and account for financial resources from federal and state sources	Seek and account for local and other non-DPHHS funds	Account for local and DPHHS funding for mental health services; seek and collect client fees and charitable contributions/grants where appropriate	Review and advise on budgets; assist with local fundraising efforts
Quality Management and Improvement	Develop quality management and improvement process and requirements; set performance and outcome measures	Develop and implement quality management and improvement plans and activities pursuant to AMDD guidelines and requirements; report on regional performance and outcomes	Implement and report on quality management and improvement activities and performance and outcome measures as required by contract; assure that performance and outcome targets are met in the region	Conduct quality oversight activities in conjunction with regional structures quality management and improvement plans and activities
Data Collection and Management	Collect, analyze, and report statewide data regarding expenditures, service utilization, system performance, and client outcomes	Collect and/or assure reporting of accurate data within the region regarding expenditures, service utilization, and system performance and client outcomes	Maintain and report accurate records and data in electronic or other formats as required by regional structures	Review reports; ask questions about expenditures, budgets, revenues, performance and outcomes; identify concerns to regional structures and to the MHOAC

TOPIC	STATE	REGIONAL STRUCTURES	PROVIDERS	RPACS
Provider Credentialing and Qualifications	Establish provider licensure and/or qualifications and license and/or certify providers as meeting minimum qualifications	Credential and recredential providers and individual practitioners, including primary care physicians and independent nurse practitioners who are willing and qualified to provide mental health services	Maintain licensure and credentials required to provide contracted services	Review and advise regional structure on credentialing criteria and process; assist in conducting credentialing and recredentialing reviews as appropriate; receive reports about credentialing and recredentialing results
Practice Guidelines	Establish practice guidelines for programs and services, including but not limited to cultural competence concerns	Assure AMDD practice guidelines are implemented and cultural competence requirements are met	Implement practice guidelines required by AMDD and regional structures; participate in development and refinement of practice guidelines	Advise and comment on practice guidelines and recommend needed refinements to regional structures
Best Practices and Training	Maintain and disseminate information about administrative and clinical best practices	Develop and implement a regional training/ technical assistance plan to guide providers in implementing administrative and clinical best practices	Assure staff receive the training and technical assistance required by the regional training plan	Receive, suggest, and assist in dissemination of practice guidelines and best practice information
Human Resource Development	Develop, provide and/or fund human resource development efforts, including but not limited to efforts with Montana higher education and others to develop practitioners for frontier areas	Assist in recruitment and retention of key professionals for the region, including shared professionals, and technology assistance (e.g., telemedicine approaches)	Participate in joint regional recruitment and human resource technology efforts	Advise and assist in regional recruitment and retention activities
Inpatient Service Delivery	Provide inpatient services for individuals meeting criteria who cannot be served in community hospitals	Arrange for assessment and diversion activities for persons referred for community inpatient or state hospital admission or continued stay and for out-of-home placement	Provide assessments and services to prevent or divert individuals from unnecessary hospitalizations, out-of-home placements, and jail or juvenile justice interactions	Receive and review reports and information on inpatient and diversion activities; visit and report on issues in hospitals, jails, and out-of-home residential placements

TOPIC	STATE	REGIONAL STRUCTURES	PROVIDERS	RPACS
Utilization Management	Provide or contract for utilization review for high end services such as inpatient, residential, partial hospitalization; establish utilization management criteria and levels of care	Conduct or contract for retrospective utilization management activities for low end services and conduct utilization review of high end services if contracted to do so by the state; develop and implement utilization management mechanisms to assure level of care criteria are being followed	Follow AMDD and regionally established levels of care and utilization management criteria and processes in making treatment decisions with consumers; participate in refinement of criteria and processes	Receive reports, review and comment on utilization management activities and information; advise and participate in utilization management criteria and process development and refinement
Complaint, Grievance and Appeals	Establish a common consumer complaint, grievance, and appeal process; hear and resolve consumer appeals	Ensure implementation of the consumer complaint, grievance and appeal process; resolve grievances that cannot be resolved by providers	Maintain and implement consumer complaint and grievance process according to state and regional requirements	Receive and review reports and comment on consumer complaint, grievance and appeals data; report to MHOAC
Consumer Participation	Support and provide a forum for consumer and family voices; establish and work with stakeholder work and advisory groups	Include consumers and families on governing and advisory bodies in significant numbers; assure consumers are involved in evaluations of programs and services	Include consumers and families on governing and advisory bodies, in quality management and improvement activities, and as employees	Recruit, train, and support consumers and families who want to serve on governing and advisory bodies and participate in quality management/program evaluation activities
Child and Adolescent Service Systems	Enter into and implement interagency memorandum of agreement with child-serving agencies	Enter into and lead local consortia for multi-agency and high need children and adolescents to prevent out-of-home and out-of-state placements	Participate in local consortia for high need and multi-agency children and adolescents	Review, comment and advise on interagency and intersystem issues for children and adults
Intersystem Resource Management Planning	Develop resource management plan to identify and work to maximize public benefits and resources for adults (e.g., housing, vocational and employment services, adult education services, small business services, SSI and Ticket to Work Resources, etc.)	Collaborate with local systems that provide services for or interface with children, adolescents or adults with mental health needs	Assure consumers and their families are aware of and assisted in obtaining eligibility for public benefits and services	Contribute to resource identification and management plans; advise regional structures on clients' resource needs and ways to increase those resources

Role of Consumers and Families

In the redesigned service delivery structure, the role of consumers and their families should be considered explicitly. At both the state and regional levels, consumers and their families should be clearly represented on governing and decision making bodies and on advisory and planning bodies. They should have clear and visible roles in program development and policy development efforts. No working group or system management discussion should occur without their presence.

Consumers and their families should be critical players in quality management planning and implementation activities. Montana should either convert its Board of Visitors system into a Consumer Quality Review Team (CQRT) approach such as exists in Ohio, Washington and Philadelphia, or such a CQRT should be developed to augment the Board of Visitors' role. The results of CQRT visits and findings should be overtly incorporated into any system changes or any provider corrective actions.

Consumers and their families should also be included in the system as paid or volunteer trainers for staff. Their perspectives are invaluable both for pre- and in-training educational experiences. Consumers and their families should also be included as service providers, either as peers, as deliverer of alternative services, or as direct providers of traditional services (e.g., case management, family education, etc.). Consumers and their families should also be employees of state systems, of local regional structures and of providers. The positions they can fill are the same as for any other person, i.e., policy maker, clinician, administrator, advocate. Consumers and families should not be relegated to only advocacy positions.

Finally, while not the only position consumers and families should hold, their role as paid advocates and ombudspersons cannot be underestimated. Their experiences offer other consumers and families a helping hand that understands both the system and the experience of being a mental health consumer or family. Likewise, their role as decision-makers in grievance and appeal processes should be considered, either in their role as employee or in their role as outside advocate or ombudsperson. These roles can include either final decisions or can include recommendations for resolution or mediation of disputes to prevent the need for more formal grievance and appeal processes.

In order to accomplish the true involvement of consumers and their families at all levels of the system, a plan for recruitment and support of individuals entering the system in these capacities needs to be developed. This plan should include help and support for both consumers and their families as well as for other staff and organizations adapting to the idea that consumers and their families are valuable partners not just service recipients. Such a plan is in development in Missouri with the input of a variety of consumers, families, advocates and providers, and includes identification, training, supports, and mentoring for consumers and their families who want to be involved in system issues at all levels and in all capacities.

C. Service Delivery Changes

Defining levels of care and eligible and priority populations

Montana is in need of clarification and delineation of the populations it wishes to serve and within those populations, who is a priority both in terms of urgency and in terms of intensity of care. AMDD has recently undertaken a regulation change to redefine SED children and SMDI adults and is beginning to do case file reviews to determine what criteria and documentation are being used to designate a child as meeting this definition. This process is a good start in making better definitions and distinctions between eligible populations and priority populations for certain types of services.

AMDD has also recently adopted an interim “slot” approach to controlling the number of children and adults who can receive services at any given time in the MHSP or non-Medicaid program. It is not yet clear whether this approach will also result in a reduction of expenditures for those services. In adopting this approach, AMDD has had to, of necessity, create exceptions to this slot limitation for persons who are in crisis or who are returning to the community from the Montana State Hospital. It is not yet clear whether this approach will result in a chilling effect on the number of individuals seeking or being referred for services, an increase in the number of persons designated as being in crisis, or other attempts by consumers, families, referral sources, and providers to get around or cope with the slot limitations.

The difficulties with this approach to controlling or prioritizing services are many. This process could result in Medicaid eligible persons with less intense needs receiving services while persons with high intensity needs – but who are not in crisis and are not Medicaid eligible – being placed on a waiting list. The same is true for persons currently in care who may be more stable, or no longer need a particular service while a person who has significant and immediate (but not crisis) needs may be waiting for access to a “slot.” This situation also can result in services for some individuals being put off until a crisis occurs. This slot and waiting list process also generally is a first come, first serve approach to allocating limited resources. Persons who are first on the waiting list are not necessarily the most in need at any given time. As a result, AMDD has implemented a triage approach to the decision making process about who gets access to these “slots” and who must wait for services.

AMDD has considered developing a work group of stakeholders to discuss alternatives to this approach. It is critical that consumers and their families have a voice and a role in this discussion. It is also critical that this process, or some other process, initiated by AMDD and the Mental Health Services Bureau result in: a renewed or revised definition of clinical eligibility for children/adolescents and adults; the development of criteria within those eligibility categories for access to what kinds of services (typically a level of care process); and a definition of urgency, emergency, and routine service needs to determine who gets what services under what conditions for what period of time and how quickly.

This approach assumes that while all SED children may be eligible, some SED children will need more intensive services at a given time than another SED child. Likewise, not all SMDI adults are alike in their service needs and therefore in the cost of the necessary services. In addition, a person with severe or intense service needs may not need so much later when the person's life or clinical situation changes.

In addition to the level of care needed for a particular individual at a particular time, persons who are clinically and financially eligible for services but needing a lower level of care may still find themselves in crisis and therefore need services more urgently. For both client care and system management it is important to distinguish between higher levels of need or need for care more quickly from the simple fact of asking or presenting for services first as a way to ration limited resources. Montana needs to identify not only clinical eligibility but also levels of care based on criteria, expected outcomes, and service menus within those levels of care. Montana also needs to define what it means to have an urgent need, an emergent need, and a routine need, all in clinical criteria terms. These definitions and criteria should drive who gets services first and who gets what services that others do not, as well as who get the most services or the most intense service package at what time and for how long. The development of these criteria will not only provide more rational decisions for prioritizing utilization of limited resources, but it will also provide the basis for both retrospective and prospective utilization management processes and analysis. Likewise, it will assist the process of needs assessment or gap analysis described earlier in this report.

Generally, services should not be limited to a set number of people as a way to control costs. Rather, decisions regarding access to services for all who are eligible should be made based on needs of individuals, differentiating rationally between those who need more or quicker services and those who need less or more routine services.

In addition to levels of care and definitions of gradations of urgency, AMDD should set priority populations rather than just limit the number of slots available in general. For example, while all SED children may be eligible, AMDD may want to prioritize SED children and youth in the custody of the state or involved in a juvenile justice process. SMDI adults may be eligible (so long as they meet the income limits), but AMDD may want to prioritize SMDI adults with co-occurring mental health and substance abuse disorders, or SMDI adults. These priorities will, of necessity, mean that some individuals get access to limited services sooner than others, but at least there is rationality to the decision-making. Since the setting of priorities will be controversial, this should be proposed in the Mental Health Services Bureau's strategic plan and stakeholders given a chance to react and provide input regarding their view of priority populations.

Core services array

Not every community can have every type of service it might like to have in sufficient numbers to meet the needs of its residents in their home community, especially in rural or frontier areas. However, AMDD needs to establish a set of core services that should be available in each region along with capacity guidelines, requirements, or targets by

which to measure when “enough” services are available (for example, supportive case management at a ratio of 1.0 FTE to 40 clients; a telemedicine videoconferencing site within an hour drive for the attending psychiatrist and for the client; mobile crisis face-to-face intervention with a one-hour drive for the mobile crisis team or worker; a psychiatrist within 50 miles with a case load of no more than 500 clients). These services should then be developed or expanded as resources become available until the capacity targets are met. These services and capacity targets should be the priority for any new resources and each regional structure’s plan should be required to include how these core services will be developed or expanded and over what time period.

It should be noted that core services should be the same for all regions. However, the capacity targets and the model for service delivery may have to vary based on the rural and frontier natures of some of Montana’s regions. For example, while TAC would recommend that a PACT type case management model be available in every region, it may not be possible for this intensive case management model to be implemented in exactly the same way as is described in the research literature about this model. Even though fidelity to the model is crucial for good outcomes, it is possible to make adjustments and be creative in the ways in which these core services are implemented to take into account the unique geography, history, culture, residents, and characteristics of each region.

It also should be noted that unique cultural issues might make certain types of services and certain provider types critical for some communities or some populations (e.g., traditional or natural healers in some Native American communities or populations). These are absolutely necessary as are core services. The need for these specialized services and providers should be addressed in the plans created by each regional structure.

Core services for each region should include:

- outpatient individual and group or family counseling;
- medical/medication management (psychiatric, APN, or primary care physician);
- inpatient;
- 24/7 crisis services, including telephone triage and screening, face-to-face walk-in, mobile, and crisis and planned respite (both in and out-of-home);
- case management (at least two and preferably three levels of intensity);
- therapeutic foster homes (children);
- short term residential treatment (children);
- short term foster care homes (adults)
- family care homes and other supportive living alternatives (adults);
- benefits and housing assistance (adults and families of SED children);
- vocational and employment services (adults);
- clubhouse and/or other peer run services (adults);
- therapeutic day treatment (children);
- wrap around and in-school supports(children);
- community supports (adults);

- jail and juvenile justice diversion;
- peer and/or family supports;
- family and consumer education; and
- transportation sufficient to assure core services are available within appropriate access timeframes.

These core services are designed not only to provide an array of services that will meet the needs of each region's eligible populations, but to prevent the unnecessary expenditure of dollars for services that are of higher cost because lower cost and lower intensity services that are often more effective are not available. These services should exist within each region and often within geographic sub-regions. Beyond core services, each region should be able to identify and plan for additional optional services it wants to see funded or provide or have available even if this service is outside the regional boundaries. To the extent possible, service dollars should allow for this regional flexibility, while still requiring accurate and timely encounter data to be captured as a condition of payment or funding.

In addition to establishing core services that each region should work to make available, AMDD, in conjunction with system stakeholders, should develop practice guidelines for each service type that go beyond licensure standards or endorsement criteria and incorporates all available information on what is evidence-based practices and what is likely or expected to produce positive outcomes but is not yet scientifically proven. This process will not be easy and will take significant time. AMDD may want to consider establishing a Practice Guidelines Task Force composed of providers, practitioners, consumers, families, and academic researchers to head up this effort over the next couple of years. On-going refinements to these practice guidelines will be necessary as the mental health field's knowledge about best practices continues to evolve.

These practice guidelines will be useful in holding regional structures and providers to a standard of care with regard to each type of service provided. More importantly, these practice guidelines can be a vehicle for system stakeholders to discuss, debate, and reach agreement on what constitutes high quality care in Montana and what are the criteria by which that will be judged.

In order to implement these core services in each region, AMDD will need to work with system stakeholders to agree on core services, inventory and map where current services are located and the capacity of each, establish access standards in terms of timeframes and distances, and then set forth a plan for prioritizing which services should be established or expanded in which region and on what time frame. Some of this planning should occur as part of the regional structure development described earlier in this report.

Service array for children and youth

As indicated in the Findings section of this report, the service array for both children and adults is inadequate and is preventing the wisest use of available resources. The exact services needed and the amount of those services will vary from region to region and

will depend on the definitions, criteria, and priorities discussed above. Generally, Montana needs to develop an array of children's services focusing on community-based, family support and wrap around services designed explicitly to keep children in the community and with their families rather than taking children out of their homes for care. Additional services needed or that need to be enhanced or expanded include, but may not be limited to: in-home supports, family-based interventions, mobile crisis services specifically for children and adolescents, in-home and out-of-home respite (e.g., a summer camp for behaviorally involved children), behavioral therapy aides in home and in school, therapeutic foster homes, and family education and support services.

These additional services should be part of the goals for regional structures once core services are in place. Consistent with Medicaid rules and regulations, AMDD should consider a moratorium on the development of any further bed-based or facility-based service development for children and youth until some of these other services are more fully developed and available. Such a moratorium may be difficult absent a Medicaid plan amendment or waiver for Medicaid funded services. However, a voluntary moratorium may be an approach to consider in the interim. Such a moratorium could be strengthened by support from the MHOAC based on the fact that the system is over utilizing facility based services and needs to focus on development of regional strategies to control this utilization and develop home and community based alternatives.

A service array for children cannot be adequately addressed without a clear multi-system strategy for addressing their multiple needs, especially for children with the most severe needs. AMDD should take the lead to reenergize the interdepartmental working group that used to be active. This group should cross departments and divisions and bring together all agencies with responsibility for serving children to discuss how children with behavioral healthcare needs are being addressed in each system. A new memorandum of agreement needs to be drafted to reconfirm the state's commitment as a whole to serving children in a united and holistic way. If possible, the Governor should lend support to this effort through an Executive Order asking all local entities to work with the state level children's cross-system groups to identify policy and resource issues preventing the adequate delivery of services for children.

State education leaders and local school leaders need to be a part of this strategy. One of the first issues that should be discussed (with a facilitator if necessary) is the issue of behavioral healthcare services in school. A dispassionate analysis of what is needed and why and what it would take to fund those needs is needed. This analysis should include a review that addresses why utilizing mental health funds to solve the problem will not work if it so disrupts the system and so decimates the resources that other children and even adults and their families cannot receive the services they need. The analysis should also consider how to convince legislators to fund such a large new need that may seem endless. This analysis should help guide a direct approach for the state to take on the issue of children's in-school behavioral issues that are not directly in the mission of a publicly funded mental health system.

This cross-system work group for children should have a counterpart at the regional structure level to assure children's issues are addressed and multi-system kids are served with the most efficient use of all systems' resources.

Service array for adults

The service array for adults, like the service array for children, is equally concentrated on the high end and the low end of the intensity spectrum with a lot of long term day treatment in the middle. Missing or in short supply are those services designed to assist a consumer in his or her own recovery. Such services include vocational and employment services, consumer-operated and peer support services, a variety of housing options, and in-community case management (intensive or PACT model). Also missing is adequate mobile crisis and crisis respite services for adults, along with housing options such as supportive apartments, supported group living, and family care homes. At the same time, the over reliance on long term involvement in day treatment and clubhouse recreational activities keep adults with severe and persistent mental illness in the role of patient or client. Additional attention to making opportunities and assisting clients in utilizing community recreational resources and other natural supports would benefit both clients and the limited budgets of mental health providers.

Utilization management

Utilization management is a critical function for Montana's system to do and do well. It is important to include all the components of utilization management, i.e.,

- *pre-authorization* of services that are low end/low cost or are built into service packages for which providers do not need prior authorization;
- *prior authorization* of services that are high cost, high intensity, frequently under or over utilized, or which the system wants to decrease or hold to a minimum;
- *concurrent review and/or authorization* of either of the first two types of services to assure continuing need or benefit from the service;
- *retrospective review*(usually through case file reviews of a sample or targeted types of services) to assure providers are making and documenting clinical decisions based on pre-established criteria; and
- *analysis of utilization management data* to identify trends and make system adjustments when services are being under or over utilized or are not being provided to the right persons or for the right amount of time.

Currently, Montana's system primarily uses the prior authorization and concurrent review (or continuing stay authorization) of high end services components only. As the regional structures are developed (see section earlier in this report), the other components of utilization management (UM) should be included in the planning and responsibility of the regional structures. The current vendor (or whatever vendor is doing UM for AMDD when the regional structures begin to develop their own UM capacity) should continue to do the prior authorizations of high-end services until regional structures are capable of taking on this function. The state may want to continue this limited UM function as a centralized statewide vendor indefinitely to assure

a check point on other UM functions and decisions being made at the regional structure level. However, the regional structures should be expected to take on the regional care management function when they are fully developed, and the funding for that portion of the vendor's activities should be shifted to regional structures.

D. Financial Changes

Resource needs

In order to accomplish many of these changes, additional resources will be needed. Certainly, as indicated earlier in this report, additional resources will be needed to address the service gaps for both children and adults. There are four priorities for any new resources short term, i.e., (a) system stabilization; (b) missing core services; (c) infrastructure development for regional structures and the Mental Health Services Bureau; and (d) rate increases for critical services.

The resources necessary to meet the current needs should be provided to stabilize the system and allow system leaders and stakeholders to concentrate on the planning, gaps analysis, and structural and functional changes that will be needed to improve the system clinically and administratively. However, any additional resources available short term beyond what is needed to stabilize the system should go toward either services that are in the core services list and that are missing in the array for children or adults or for infrastructure development described in this report so that current resources can be used more effectively. Until additional capacity is built to manage the resources that are available in a way that will work to improve services and outcomes for clients, further investment in resources will only solidify those processes that are not working well now.

Service rates

In the meantime, since service utilization is what drives where money is expended in Montana's system rather than a planful utilization of limited dollars toward identified goals, the primary way to influence service delivery is through regulatory change or through rate changes. AMDD has proposed a regulation change that would place the fee schedule outside the regulatory process thereby allowing changes in that schedule on a more strategic basis. As of early October 2000 the only actual rate change made was an increase in rates for psychiatric services. In order to encourage the utilization of in-home and other non-facility based services, the rates for these services need to be increased. Specifically, rates for respite care and psychiatric rehabilitation and support need to be increased. Likewise, rates for some of the services that ought to be discouraged should be reduced. For example, partial hospitalization rates should be reduced. Day treatment rates should not be reduced, but there should be strict and relatively short time limits with concurrent review for services beyond a set period of time. This service, when necessary for a client, should be directed toward helping the client get ready for a clubhouse, the use of natural community resources, or vocational services rather than as a long term way to occupy an individual's day in a structured setting.

This use of rates to drive system reform is quite cumbersome and inadequate. The rate structure should be revisited once the regional structures are in place. The financing mechanisms for these structures may eliminate the use of state established rates altogether or may suggest a different approach to funding providers to offer incentives to produce outcomes rather than to simply provide services.

Financing mechanisms

With the introduction of regional structures, Montana has an opportunity to align finances, quality, and care management in a single structure. It is imperative that the way regional structures are funded and are required and/or allowed to fund services are sufficiently flexible to allow creativity and sufficiently lined up with the system's clinical and quality outcome goals to assure that incentives to perform are present. In order to utilize regional structures to create organized systems of care, it is almost a necessity to seek a Medicaid waiver to allow limitations on who can be providers, to allow services to grow differently in different regions, and to pay for services with mechanisms that allow incentives for efficiency as well as good clinical and client outcomes. While a Medicaid state plan amendment would be an approach to consider for adult services, an actual waiver would probably be necessary for children's services.

TAC recommends that AMDD explore the possibility of a relatively straightforward 1915 (b) waiver to allow these regional structures to be funded with Medicaid dollars and to manage the provider network and the service delivery process. It will be necessary to work carefully with HCFA in requesting such a waiver to prevent requirements for multiple structures, disruption to the system, or extended procurement processes. Therefore, the waiver development process should be done carefully and deliberately to address these issues before deciding whether a waiver is the right approach.

While TAC believes that a waiver may be necessary to accomplish the goals of an organized regional structure with responsibility and authority to control both resources and care management and to have the incentives to create new services with existing dollars, TAC is also mindful of Montana's recent history with a Medicaid waiver. This history may make state leaders and system stakeholders gun shy about this process and its potential result. However, Montana needs flexibility to move its system forward, and it needs control of runaway costs in areas that are not priorities or in areas that are already overdeveloped relative to other services. In order to provide better care for people and stretch limited existing and future resources, a waiver of Medicaid rules may be a necessity.

The actual funding of the regional structures bears some further consideration before proposing a method in a waiver application. With a Medicaid waiver, different regional structures might be funded through different mechanisms or at least on different time frames, depending on demonstrated capacities and on regional needs. It is important that regional structures bear some risk along with the state. Yet, when financial risk is introduced, one has to ask, "What is the alternative if this organization fails?" and "What financial requirements will need to be made before the organization goes at risk?" Once

these questions arise about regional provider networks, the answers get complicated. Additionally, when traditional risk approaches are considered (e.g., capitation), the numbers of eligible persons and the current experience level of Montana providers as managed care entities are too low to suggest that this might be a viable approach. To avoid these unnecessary complexities, TAC recommends that Montana enter this development stage with the understanding that risk will be shared in some fashion and there will be financial incentives for regional structures to perform well, and that this risk mechanism and the financial incentives will be developed over time with regional structure input. In all likelihood, starting with a global budget to regional structures with some kind of shared risk pool and risk corridors may be the best approach that would also be a proposal to be discussed with HCFA.

The funding for the operations of the regional structures will need to be addressed. The providers and other stakeholders developing the initial plans for these structures will probably need a minimal amount of planning money. As these structures become operational, they will need operating dollars. The source of these dollars should be some combination of the regional structures commitment to find efficiencies resulting in freed up resources to bring to the table and direct funding from AMDD with either state, federal or foundation dollars. The savings from any other efficiency, to the extent they are found, should be directed toward the missing core services. If some of the high end or over utilized services can be reduced, these dollars should be redirected to these needed services rather than going back into the department or general state fund streams.

It should be noted that one significant resource is the dollars being spent in state facilities, both the Montana State Hospital and the Montana State Nursing Home. While TAC is not suggesting at this time that there are significant amounts of dollars that could be redirected from these sources, these funds should not automatically be off the table for discussion. Once the regional structures are established and other funds are flowing through them, the regional structures need to plan for and propose a way to utilize their share of state facility resources for their region. The regional structures also need to have clinical responsibility and financial incentives to “own” the clients in those facilities who come from (or to) their region. One approach might be to assign a number of beds per region that can then be traded with each other like commodities, but for which the regional structures will have to pay if they exceed their own bed limits. Some portion of these hospital resources might be paid out to the regional structures if the five regions as a whole hold down the number of beds used to a number that allows ward closures or other significant savings.

While forensic clients in Montana State Hospital offer a challenge in terms of their resource use, they should not be excluded from the discussion about when and how the regional structures begin to manage this resource. Forensic clients also come from and usually return to the community. They often have the same service needs as SMDI clients of mental health systems. They cost inordinately high numbers of dollars (compared to their clinical needs) because of security needs or concerns. These dollars can be spent for diversion services and for appropriate community based services that

will assist in managing limited resources in the best way possible for both consumers and the communities in which they live and/or will return. In some cases where states have left forensic clients out of regional planning and management responsibilities, the resources for these clients within state hospital or facility based settings has grown to far outstrip their proportionate numbers in the system. Additionally, local systems of care can become less involved and less interested in diversion or in taking responsibility for these individuals' release and subsequent care in the community when the funding for their care is not the responsibility of these local systems from the beginning.

In order to provide incentives for the development of local options for forensic clients either to prevent them from becoming forensic clients in the first place or from languishing in state facilities far beyond the time when they clinically need to be there, local systems need to be responsible for the identification of such individuals and for service development to meet their needs, including advocacy with local courts to return individuals to appropriately supervised local services. This local responsibility must take into account the increased costs of serving such persons, not because their clinical needs are greater but because the requirements for security and supervision and the administrative responsibilities of interacting with courts are higher than for non-court involved clients.

Resource management plan

A final recommendation regarding financing mechanisms and strategies is that AMDD and the Mental Health Services Bureau create a client resource plan and strategy for identifying all the resources available to SED children and their families and to SMDI adults and determine clear actions that the state can play in helping clients access these services. A good example of both the need and the value of this kind of strategy is the housing resources available for both adults and families. However, to access these resources either by consumers or by providers, there must be evidence and identification of the need in the state's comprehensive housing plan. If that action is not taken, the federal resources available for local entities and for consumers may be restricted. Housing resources are critical for adults and for families of children with mental health needs.

Another critically important resource is the recently passed Ticket to Work and Work Incentive Improvement Act of 1999. Under this new federal law, consumers will be given a paper document or ticket to pay for the cost of his/her vocational rehabilitation services. The entity to which the ticket will be given is known as an employment network. Providers can be the recipients of this ticket on behalf of or as part of the network. Reimbursement methods are optional for the employment network, i.e., reimbursements for expenses paid on a milestone system or as a lump sum spread out over 60 months following the consumer's ninth month on the job. Due to these long reimbursement timeframes, many providers may not be able to "float" the funding needed to provide services while waiting for reimbursement. Montana needs to prioritize becoming an employment network and determine how it will structure that network in light of the recommendations in this report. It should consider making the regional structures an employment network once they have established the capacity to

do so. The state should consider setting up the network(s) so that regional structures can accept the tickets on behalf of the network for that region and then assist the consumer in making the choice of providers available to provide the rehabilitation services. Alternatively, if providers accept the tickets on behalf of the network, the collaboration and coordination of services should occur through the regional structures.

This recommendation may be difficult to pursue without additional staff assistance. Yet, there are opportunities for resources for consumers and providers that will not be as likely to be marshaled without AMDD support.

E. Functional Changes

AMDD needs to address three issues within its own organization in order to have the capacity to manage the system for the future. These include the development of a statewide quality management and improvement system, the development of a more functional and single integrated MIS system, and the addition of key staff to central office.

Quality management and improvement

AMDD and specifically the Mental Health Services Bureau must be able to identify the elements of a quality management and improvement (QM/I) process and structure and must create a plan to systematically address these elements. QM/I is critical and perhaps will be the central function of the Mental Health Services Bureau in the future. The elements of a QM/I system include, but are not limited to, the development of outcome and performance measures and the data sources and analyses necessary to know how the system is performing, and be able to do something about it. TAC's Task Two report discusses proposed outcome and performance measures for Montana's mental health system and proposes a way to get started. TAC recommends that AMDD go through the process of developing a written QM/I plan addressing all the elements to identify where its ability to manage and improve the quality of services and systems is lacking and to identify ways to begin addressing these issues.

The 10 elements that should be addressed in a written plan include:

1. Guiding Principles;
2. Definitions of Concepts and Terms;
3. Structure and Roles (at both state and regional structure levels), explicitly including consumer and family member active participation at all levels;
4. Written Annual QM/I Plan of Action, including the activities, responsible parties/entities, and timeframes that describe the processes of QM/I, i.e.,
 - Design
 - Data collection
 - Feedback (reporting)
 - Actions (including incentives, corrections, sanctions, special studies, training, etc.)
 - Redesign;

5. Outcome and Performance Measures, Indicators, and Targets;
6. Information/Data Sources and Uses (including methods for collecting this information and data) based on the performance measures, indicators and standards chosen;
7. Regional Structures contract compliance reviews and provider credentialing process;
8. Human Resource Development, especially recruitment, training and supervision of staff;
9. Human Rights and Safety Mechanisms, including but not limited to complaint processes; incident reporting and investigations (especially for allegations of abuse and neglect); seclusion and restraint tracking, management and prevention; and risk management activities including corrective actions to prevent risk to consumers, staff and organizations; and
10. Best Practices/Practice Guidelines development, dissemination, and implementation.

It should be noted that no single individual or even a whole unit within the Mental Health Services Bureau or within AMDD can *do* all the above elements. However, the QM/I function and position within the Mental Health Services Bureau must take responsibility to lead this QM/I effort, and it must include all of the Mental Health Services Bureau staff, other AMDD and DPHHS staff as needed, and system stakeholders.

The Board of Visitors process should be reconsidered and reconstructed as an active and useful part of the quality management and improvement process. The Board of Visitors should be comprised primarily of consumers and families, with some community members and other system representatives. Their visitation process should be equally applicable to all programs, services, and providers throughout the system of care. The content and structure of their visits, their reports, and the follow-up to the issues raised in their reports should be analyzed and revised to correspond with the quality management and improvement plan structure, focus, and goals and should be included as a vital piece of information to be analyzed and reported along with other data on system or provider performance and consumer outcomes.

Management information systems (MIS)

TAC is not suggesting that AMDD build a fancy new information system, or hire a lot of new programmers and system analysts. Rather, we recommend a two-part strategy for AMDD to enhance its capacity to receive, analyze, and interpret information from a variety of sources for use in holding the system accountable for outcome and performance expectations, and for planning, forecasting, and decision support.

This capacity would have three additional objectives:

- To assure that AMDD system managers have sufficient information for both routine and ad hoc decision support and quality management and quality improvement activities;

- To provide direct and timely feedback and locally-useful information to regional structures, providers and any other parties that supply data to AMDD or its agents about the performance of their own components of the mental health system, and about their performance relative to other components of the system; and
- To generate regular reports to oversight agencies and the legislature about the quality, performance, cost-effectiveness, and unmet needs of the public mental health system and its constituents (consumers, families, providers, etc.).

The first part of the strategy has already been anticipated in TAC's Task Two report. That is to pre-define certain management reports that contain data on priority management performance issues, which can be produced through data extracts from existing databases. Such reports could include regular analyses of penetration rates, utilization patterns and costs, and elapsed times between service events from the Consultec Medicaid/MHSP claims file. They could also include monthly reports of Montana State Hospital admission and lengths of stay by region combined with general hospital admission and length of stay data.

The second part of the strategy is to develop a capacity to collect and analyze specialized data not routinely included in pre-defined data extracts, to combine that data with existing data from other sources, and to produce interpretive analyses to address priority management problems or external information requests.

To accomplish the above two-part strategy, TAC recommends that AMDD hire for the Mental Health Services Bureau a senior-level information analyst with expertise to design routine reports and data extracts and define management report contents, analytic frameworks and timeframes. This expertise should also specify what internal hardware and software is necessary to collect, data enter, and analyzed data from other sources in combination with the pre-defined sources. This data analysis capacity and expertise does not provide management information systems or information technology functions, although knowledge of both is essential. Rather, the capacity and expertise serves management – assisting managers (in the field as well as in AMDD) to specify: (a) what information and interpretation (as opposed to data) is essential to their management functions and accountabilities; (b) how that information can be most reliably collected and reported with minimal cost and disruption to other system functions; and (c) how all the various data sources can be efficiently brought together for more in-depth analyses and special reports.

The hardware and software necessary to support the above strategies is readily available and increasingly inexpensive. We believe only a relatively minor investment in equipment, processing capacity, or software tools will be necessary. What is more critical is to have a staff capacity to perform the above functions, and to also be available to assist managers to formulate the appropriate questions and interpret the available information in a manner that is valid and reliable, and that actually informs the decision-making process.

The longer term MIS strategy for Montana's mental health system is to create a single system data management capacity with a unique client identifier used throughout the system and into which all relevant data about a client's use of services and payment for those services and client outcomes are reported and analyzable on line in real time. However, this is not realistic for this system at this time. After the regional structures have begun to develop their capacities, implementation of this long term MIS goal should be considered.

State functions and staff

The functions that the state AMDD and Mental Health Services Bureau should be able to perform and the existing staff in the Mental Health Services Bureau are described earlier in this paper. The current Mental Health Services Bureau staff needs to be augmented to manage what is now in front of them with the departure of the managed care vendor over a year ago. The staff needed reflects the recommendations in this report about what activities need to occur to improve Montana's mental health system. Recommended staff additions to the Mental Health Services Bureau include:

- Senior level data analyst;
- System and services planner (with service system experience, to augment existing staff and to focus on the interface with non-mental health resources such as housing, employment, education, etc.);
- Quality management and improvement specialist (to augment existing staff);
- Senior human resource development specialist (familiar with rural and frontier mental health issues);
- Contracts specialist/regional structure liaison; and
- Additional clerical/administrative support.

The priorities for staff additions are the data analyst, the system and services planner, and the QM/I specialist. The exact personnel titles for these positions will depend on Montana's state personnel system. However, the functions are critical if Montana wants a high quality, accountable, and effective mental healthcare system.

IV. CONCLUSION

Montana's mental health system has been through tremendous changes over the last several years. The result is a system that has been through chaos and is now settling into an organized and operational system that has institutionalized some of the chaos that brought it to this point. Before that chaos erupts again, it is important for DPHHS and its Addictions and Mental Disorders Division and Mental Health Services Bureau to refocus on its values and goals, create a clear plan and vision for the future, and begin to actively work with system stakeholders to get there. This report offers a number of recommendations to address some of the system issues that affect consumers and the services AMDD provides for them. Some of these recommendations stand alone and some are interrelated so that doing one will not be possible without doing another.

Whether singly or as a whole, these recommendations will not come easily. There will be individuals and groups with their own ideas about how the system should evolve. There will be significant sentiment to stay in the calm of the eye of the storm rather than venture out toward the shore. There will be others who want change faster than the system can reasonably accommodate. It is critical that all these voices have an opportunity to review and dialogue about these issues and recommendations and provide input and perspective to DPHHS, AMDD and the Mental Health Services Bureau as they review this report.

TAC's final and perhaps most important recommendation, is ultimately – and before the passage of too much time – DPHHS, AMDD, and the Mental Health Services Bureau needs to make a strategic decision and take strategic action. There are too many voices all saying good, but disconnected things. State leaders have to take the leadership that this opportunity affords to articulate the vision and steer the ship in one clear direction, with all actions taken calculated to get it there. This kind of action can help the voices unite.

Montana's system has a unique history and is doing good things for consumers. It can be better, and use resources more wisely, as well as communicate more clearly what the value is to all Montanans of a healthy comprehensive mental health system for children and adults. The recommendations in this report should help accomplish these system objectives.

Necessary Conditions for Implementation of Recommendations

I. INTRODUCTION

This report constitutes the final product of the Montana Mental Health Services Plan Consultation by the Technical Assistance Collaborative, Inc. (TAC). This report succinctly identifies the conditions necessary to assure the implementation of the recommendations in the reports from Task One (Assessment of the Mental Health Services Plan and the Medicaid Mental Health Plan – Data Analysis), Task Two (Outcomes and Performance Measurement), and Task Three (Findings and System Recommendations).

The necessary conditions discussed in this report are a summary of issues and actions identified by TAC throughout this seven (7) month project and discussed with a variety of state officials and system stakeholders in meetings and interviews. Hence, this report is simply a way to capture these discussions and in many cases agreements about what must happen for this consultation and the recommendations coming from it to make a difference for the Montana mental health system and its decision-makers, consumers, families, providers, allied systems, advocates, and other constituents.

The necessary conditions described here will be grouped into four areas: collaborations, finances, legislative action, and willingness to act. The conditions described in each of these areas are mutually dependent on those described in other areas. Satisfying one condition will not necessarily cause others to happen or recommendations to be implemented. Rather, all these conditions must be present in a synergistic fashion over the next several months and even years in order for Montana's system to achieve the goals it has set for itself and for it to improve in its ability to assist consumers in their recovery and resiliency processes. Montana needs to consider whether these conditions can be achieved in order for system improvements to occur.

II. COLLABORATIONS

There are two necessary types of collaborations that must be present for Montana's system to succeed. One is external, i.e., collaborations with other systems or organizations that are critical to the mental health system's or its consumers' success. The other is internal, i.e., those alliances and collaborations necessary within the mental health system to move forward collectively and positively.

A. External Collaborations

Any system that serves the public with public dollars must collaborate with other publicly and privately funded systems that affect either the system or its clients. While all of those systems are important, there are some at different points in a system's history that are critical to the next set of improvements or the next set of actions that positions the system for future success. There are seven (7) critical systems outside the mental health system that Montana's mental health system must collaborate with in order to achieve future success for itself and its consumers. Three (3) other systems are mentioned for purposes of Montana's system planning regarding current and future collaboration needs.

The first three systems are child-serving systems, i.e., the Montana educational system, the Montana child welfare system, and the Montana juvenile justice system. Each of these systems is a critical player in the lives of children with severe emotional disturbance (SED) and the state and local mental health system for children. While there are other systems that also impact children's lives, these three touch SED children's lives or affect the funding or services for SED children more than others. It is imperative that Montana state, provider, consumer, advocate, and family leadership find ways to engage these three systems and to do so with common goals, common expected outcomes, and common agreements about how to operate and fund services and activities to achieve the goals for Montana's SED children. The mental health system may find itself needing to revise service definitions, revise payment methodologies, revise eligibility or population priorities, or revise provider requirements in order to collaborate effectively with these three systems. These other systems may also have to adapt and change to accommodate the needs and goals of the mental health system for SED children. It is critical that a single dialogue with these systems begin immediately with the state players providing the leadership, but including the other constituency representatives as appropriate at the statewide or regional level.

An effective memorandum of agreement among these four agencies at the state level needs to be developed with the support of the Executive and the Legislative branches. From this, common messages and direction to local entities (e.g., courts, schools, child welfare offices, regional structures, providers, etc.) of these four agencies regarding goals, expected performance and outcomes for children, and a clear problem-resolution process required in at least each region if not each local area.

The second set of four systems affects adults. Again, while there are many other systems with which collaboration is critical, these four currently have a profound impact on the successful recovery of adults with serious and persistent mental illness (SPMI) in Montana. These four systems are the addictions services system, the correctional system (especially local jails), the housing development and support system, and the vocational rehabilitation system. As with children, there needs to be a working agreement with each of these systems (a single collective agreement among these five systems would be good) regarding the SPMI adults for which these systems need to work collaboratively. These agreements also need to establish common goals,

common outcomes, and common expectations of both state and local players to maximize resources for SMI adults and to assure that SPMI adults with needs for jail diversion, addictions treatment, affordable and supportive housing, and/or jobs, do not lose out to the many other demands on these various publicly funded systems. These agreements also need to find ways to take advantage of changing federal and state opportunities for adults, such as new affordable housing opportunities (for families, as well), new “ticket to work” opportunities, and new integrated mental health and addictions treatments for adults that could help SPMI adults who interact with jails and those who do not.

As with children, the Executive and Legislative branches need to be leaders together in addressing cross system issues and problem resolution methods. Local leaders also need to be informed and given assistance or have barriers removed from efforts to take advantage of local collaborations that could improve the system of care for adults with SPMI.

Another adult system that will become more and more important over time is the system serving aging adults. As the population in general ages, more and more adults will be eligible for services available for other older adults. These systems may need help adapting to serving persons with SPMI histories and SPMI adults may need help accessing senior services.

Two other systems that affect both adults and children are the health care delivery system and specifically the Medicaid system within Montana. The health care delivery system is largely private rather than governmental and is organized and funded in a completely different way than mental health or addictions services systems usually are. Yet, in a state such as Montana, the need for health care practitioners to be engaged in the care of persons with mental illness and emotional disturbance is critical. Health care providers and practitioners need to be aware of and interested in serving both the additional health care needs and the primary medication needs of SPMI and SED persons. Likewise, the mental health care system needs to know how to collaborate with health care practitioners and identify health care needs of its clients to make it as easy as possible for practitioners to serve SED children and SPMI adults.

State and stakeholder leaders need to develop a plan to tackle collaboration issues with healthcare practitioners and agencies. Specifically, methods for identifying, referring and tracking health care needs and methods for informing and supporting health care professionals need to be addressed. Also, plans need to be developed that identify incentives for health care professionals to provide needed medication and psychiatric care for children and adults, while assuring that health care professionals have the latest information and are practicing the best techniques for identifying and treating behavioral health issues as well as are making the right referrals for more extensive behavioral health care assessment and services as appropriate. The state’s EPSDT program will be a critical element in the success of this process for children.

Medicaid is of course a key player in both physical and mental health care for eligible children and adults in Montana. Continuing efforts will be needed on the part of both the mental health and the Medicaid leaders in Montana to assure that Medicaid resources are maximized and that the design of the Medicaid program for mental health services maximizes the community and home based supportive and rehabilitative services that SED children and SPMI adults need. This includes working jointly to consider a waiver in light of the regional structures recommended in TAC's Task 3 report.

B. Internal Collaborations

In the idea of internal collaborations, TAC includes all those persons and agencies interested in the Montana mental health system's success for the persons it serves. The Task 3 report discusses the need for leadership, a common direction, and one clear voice. This means that advisors must be clear about their role and the need to collaborate with system decision-makers even while advocating for further changes. System decision-makers must define a vision and direction informed by the desires of system advisors and actors. Providers must put the goals of the system and the desired outcomes for consumers above their own needs as organizations or practitioners. Persons responsible for service delivery must be supported, paid, and empowered even while the direction and vision and expected performance and outcomes are clear.

The system as a whole is tired. TAC observed and was told time and again that providers are tired and untrusting and no longer willing to collaborate or work together to develop regional structures or protocols. Advisors and advocates are feeling as though their advice falls on deaf ears and do not want to come to meetings just for the sake of meeting. Legislators are tired of being asked to fill in financial holes with tax dollars that are needed for other things, especially when the efficiency of the system or the outcomes it produces cannot be assured or described and when multiple voices and priorities are put forth by a divided mental health constituency. And, state officials are tired of working constantly to assure providers are paid, supervisors and legislators are answered, consumers are served, and budgets are managed, all the while being asked to do more or being asked to explain why something else is not being done.

The system must come together and remember the past but get beyond it. There must be a renewed sense of the whole and a renewed sense of commitment. Critical players must renew their trust of each other and of the system's capabilities. It is not enough to say that one is tired and that certain key players are not likely or not willing to come to the table again. Rather, everyone must acknowledge how much has been accomplished, how well Montana has rebounded and learned from its recent experiences, and how important it is for everyone to work through the fatigue, much like an athlete, to get a second wind.

Providers must come to the table with each other and with other systems, as well as with the state and consumers to design the next phase of the system's development. A state official, likely the head of the Mental Health Service Bureau, must sit as a colleague of advisors on the MHOAC, not as simply an observer or passive participant. Consumers and family members must collaborate with the state and providers to encourage all of them to work harder and try again, so that recovery and resiliency can be accomplished. No one can afford to say "it's time for a breather" or "things are okay now as they are so let's not start something new." Providers being paid on time is not the only performance indicator that should matter. Consumers being satisfied, or too tired to complain any longer, is not a sufficient outcome. Children being returned to Montana from out-of-state but still being out-of-home is not a good enough gain. Even the budget being supplemented so that cuts do not need to occur this year is not an adequate measure of the system's success.

System stakeholders must recommit to collaboration within, to develop a strategic plan and direction that everyone will get behind and work toward (not just to naysay others' ideas), to agree on common clinical criteria and common expected performance and outcomes, and to plan and implement a joint advocacy agenda that will sing the system's praises while asking for a few targeted legislative changes or increases that everyone supports affirmatively and consistently. This kind of collaboration will lead to successes for the system, for consumers and their families, and for individual providers and other stakeholders as well.

III. FINANCES

The Montana mental health system needs additional resources to stabilize and to meet the unmet or inadequately met needs of current system users as well as those who are in need but not yet a part of the system of care. These additional financial resources should be very strategic and should assist in building infrastructure that was lost or stressed during the managed care vendor time period, and should address the needs for core services in each of five regions of the state before addressing additional service needs. These financial resources should be considered an investment and will need to be accompanied by a clear strategic plan, and structural and service changes that will help Montana make the most out of limited tax dollars. Additionally, work with other systems to maximize resources available for persons with mental health needs is crucial. In addition to those collaborations described above, the state should consider a new Medicaid waiver or state plan amendment to provide the flexibility needed to accomplish the goals identified by both state officials and system stakeholders. These changes and actions are described at length in TAC's Task Three Report – Findings and System Recommendations.

The financial investments needed fall into the following categories and in the order indicated below in terms of strategic system and service development. Some of these investments may be gained by redirecting current state or federal dollars, by seeking additional federal resources or grants, by partnering with other systems, or by additional

appropriations. Each of these sources should be actively sought. The Montana state legislature should consider requests for additional appropriations in light of the order of these needs and with knowledge of other resources sought or directed to these activities. These additional resources will not be gained in one year, but rather should proceed based on the strategic plan and incremental regional infrastructure development described in the Task Three Report.

1. System Stabilization: The first and foremost priority for additional resources is funding to supplement the existing budget to deal with expenditures that are currently exceeding revenues and to establish a realistic base from which to proceed in the future. Future funding may result in redirection of these funds into different services or activities, but for now, stabilization of the system is paramount to allow attention to longer term solutions.
2. Planning: Local planning councils and provider networks will need small amounts of funds to get organized and to carry out required planning activities to create regional structures and planning bodies. The state may need additional planning funds, but these funds may be available from existing resources.
3. State Infrastructure: Small amounts will be needed for the additional staff identified in the Task One, Two, and Three Reports (initially, a data analyst and services system planner with others in future budget years).
4. Rate Increases: Provider rate increases and adjustments to encourage home and community based services for both children and adults, to attain and retain key clinical professionals, and to decrease the use of partial hospitalization and long-term day treatment without focus on vocational skills or other forms of recovery.
5. Collaboration Assistance: To the extent that collaborations with any of the systems identified above need additional resources for training, planning, service planning and coordination, and match or good faith funding, these funds should be sought or appropriated. These funds might also include funding required to accomplish some of the changes recommended to increase the involvement of consumers and their families and to redirect the activities of the Board of Visitors.
6. Regional Infrastructure: As planning for regional structures and planning and advisory councils proceeds, these provider networks and councils will identify needed resources to make the infrastructure work. These resources should be sought from within available dollars to the extent possible, but may need the infusion of small amounts or funds or one-time monies to create structures and processes for managing care and resources that should then result in the maximization of other service or infrastructure resources. (For example, state or community inpatient costs may be reduced or not grow as much as they otherwise would, or the statewide utilization management contract may be terminated or reduced as regional structures pick up some of these activities.)

7. Core Services: As described in the Task Three report, a short list of core services (not all desired services can be on this list or the services are no longer “core”) should be the priority for available resources. Once the list of core services is defined, an inventory should be taken and missing or inadequate services identified for each region. (In some cases, services will have to be in each population center or several locations in a region to be meaningful. For example, a clubhouse that is many miles away and is therefore essentially unreachable for some SPMI adults, cannot be considered to be in existence for those SPMI adults even if it is technically available in the region in which they live). Once the inventory is completed, a prioritization of the services to be funded over what period of time should be undertaken. These services should also be a part of the planning of regional structures to assure that the structures are focusing on service development and maximization of scarce resources and not just on administrative or infrastructure development.
8. Additional State Infrastructure: These costs would include minimal costs for additional state staff as described in the Task Three Report (a QM/I specialist, a contract specialist, a human resource development specialist, and administrative/clerical support), and perhaps more extensive costs for a more fully developed single management information system to support claims processing and budgeting, but also outcome and performance reporting. Additional quality management and improvement activities may also require additional resources at a later point in time.
9. Additional Services: Once the needs assessment described in the Task Three Report is completed, the costs of additional services will be identified and decisions can be made about the priorities and the order for additional resources in the context of a system that has created the infrastructure and services needed to sustain a quality system of care.

IV. LEGISLATIVE ACTION

Obviously, the Montana State Legislature is key to the success of the Montana mental health system. Two legislators serve in key roles on the Mental Health Oversight and Advisory Committee (MHOAC), while other legislators serve on the HJR 35 Subcommittee on Mental Health. These legislators along with other interested individuals on the Finance Committee will be pivotal in both asking appropriate questions and educating legislative colleagues on issues in and the progress of Montana’s mental health system.

Legislative action will be required for both conceptual support as well as specific changes to laws and budgets. Legislative actions needed to implement the recommendations for system improvements identified by the TAC evaluation of the mental health system include:

1. Initial Planning for Regional Structures and Regional Planning and Advisory Councils: During the legislative session beginning in early 2001, the legislature should hear and consider the findings and recommendations from the three reports produced as part of this consultation. Legislation supporting or requiring the initiation of planning for regional structures and regional planning bodies would strengthen AMDD's ability to redirect resources and begin this regional planning process. Legislation creating regional planning and advisory councils either in this session or soon thereafter would "kickstart" the process with support from the legislature for a common direction for the system's future.
2. Budget: Obviously, the legislature will consider budget items for the mental health system in this and future sessions. The priorities identified above should help guide these budget decisions.
3. Clean-up of Language Prohibiting the Recommended Future Direction: To the extent that legislation exists that was time limited or that prohibits movement toward the recommended directions, this legislation should be changed or eliminated. This language could be replaced by language suggested in the first legislative action described above.
4. Nurse Practitioner Authority: Any language prohibiting appropriately trained advance practice nurses from providing needed psychiatric assessment and medication prescribing and monitoring should be examined and changed. Montana has a scarcity of psychiatrists available or willing to work in publicly funded settings for publicly funded clients. To the extent that advanced practice nurses can fill this gap safely, they should be authorized to do so, and rates paid by DPHHS and other state agencies for behavioral healthcare services provided by these practitioners should encourage their use to help fill this human resource gap. Such nurses can be invaluable not only to other mental health practitioners but also to health care workers (including primary care physicians) in identifying and appropriately treating persons with psychiatric disorders. Special consideration regarding both adults and children should be discussed in the process of making these legislative changes.
5. Establishment and Authorization of Regional Structures: After the first planning year, AMDD and MHOAC may want to recommend that legislative authority for the establishment of regional structures be put into place. The scope and type of this authority will depend on whether these structures are to be governmental in nature or simply legislated authorities selected from the private (non-profit or otherwise) sector. Likewise, there could be authority given to DPHHS to create, select, or appoint regional structures or authorities or to pass regulations creating such entities. Each of these approaches has pros and cons. The exact legislation to be passed depends on how the system develops, the cooperation experienced by the state from CMHCs and other providers in developing these regional structures, and the desired attributes of these structures for both clinical

and fiscal management and for external purposes (for example, federal Medicaid review). Current statutory language governing the CMHCs should be examined and changed or eliminated in light of this new authorizing statutory language.

6. Board of Visitors Authority: It may be important to provide statutory authorization for the Board of Visitors to be constituted as a consumer quality review team and to have access to all providers, not just those operated by the state or those that have been traditionally subject to this review. This possible statutory language should be considered in the context of a comprehensive quality management and improvement system developed by AMDD and including the role of the regional structures and the regional planning and advisory councils. This Board of Visitors should be independent of service providers but should report to the right body(ies) – probably the regional structures and regional councils – in order for those regional bodies to have both the information and the responsibility to act on issues identified by the Board of Visitors. Both the AMDD and the regional structures, as well as the Board of Visitors in each region, should have a role in identifying the process and protocols to be used by this group in evaluating programs, agencies and services as well as in hearing and reporting on consumer concerns and input. An analysis needs to occur to determine if authorizing language is necessary for AMDD to establish guidance about this effort and requiring all providers receiving state or federal monies to be subject to these visits.
7. Medicaid Waiver Legislation: To the extent that a Medicaid waiver is considered and determined necessary, and to the extent that legislation authorizing or implementing such a waiver request is needed, this legislation should be developed and passed at the appropriate time.
8. State Hospital Language: Language regarding admission and discharge as well as administration and funding of the Montana State Hospital may need to be changed once the regional structures are developed and the responsibility for utilization management and care coordination are assigned to the appropriate structure. The legislature is encouraged NOT to change the criteria for civil commitment or for outpatient commitment of mentally ill adults or children outside this larger context. Changing these criteria usually only serves to backlog clients in the state hospital or other facility based settings, or to distract attention from the underlying need to provide adequate community and home based services, adequate financial and care management, and appropriate quality management and improvement activities.
9. Mental Health and Addictions Collaborations: At some point, the legislature may want to consider the mental health system and the addictions system together. Clients served by these two systems frequently have service needs from the other system, either because of an adjunctive diagnosis to a primary illness or addiction or two co-occurring and equal disorders that need to be treated in an integrated fashion. The research and technology about treating these issues

together, and often in an integrated manner, is increasing rapidly. Montana currently manages both fields from one division in DPHHS. However, the providers and structures to support those providers are often separate and do not collaborate in ways beneficial to service recipients. While TAC did not explicitly review the addictions service system in Montana, we heard and observed enough to suggest that there might be both service and collaboration gains as well as financial gains if these two systems were consciously more integrated at the regional or service delivery level. To the extent that legislation is needed to encourage, support, or require a study of this issue and potential actions emanating from such a study, this kind of legislative action would be worthwhile.

V. WILLINGNESS TO ACT

Much has been done in the 18 months to reestablish a sense of stability and to identify what needs to happen next for the Montana mental health system and the persons it serves. TAC heard over and over again about the damage done psychologically to the providers, employees, advocates and other stakeholders, not to mention the consumers, from the move to a single statewide managed care vendor and back to a fee-for-service system. Many persons described this as being tired – tired of meetings, tired of trying, tired of fighting to make things right, and tired of change. Changing, or at least going forward in spite of these feelings may well be the single biggest necessary condition for Montana’s mental health system to move on in a positive way.

Now that the system is less turbulent, it would be easy for system leaders and key actors to rest and wait for wounds to heal and anger to be forgotten before doing anything other than the activities needed to bring financial stability to the system. However, now is the time for everyone involved to look toward the future rather than toward the past or even at the present. Today is not good enough for the residents of Montana. The system can be better, and there is significant energy still in the system to take a step into the future. So long as this is done slowly, incrementally, and with clear firm direction yet with system stakeholders at the table, this can be a positive time rather than simply a time to rest and regroup.

It is not just an axiom that if a system is not moving forward, it will move backwards. That will, no doubt, be true in Montana. If stakeholders cannot marshal the strength to move forward, it is likely that the system will stagnate or in fact recede in its ability to care for persons with mental illness and emotional disturbances. Ironically, the “tiredness” may be experienced as significant energy put forth in attempting to stop any forward movement for fear that future changes will mean loss of current gains or stability. Or, it may be experienced as “passive aggressive” refusal to participate.

Either of these responses will be destructive. It is important for everyone to pull together and establish a “political will” to act in concert and toward the good of the whole. Compromise and change can be positive if done with trust and a common

desire to improve and see the system grow on behalf of the Montanans it is there to serve.

Planning without action will be wasted, and action without planning will be for naught. Planning that is simply avoided or fought against will result in a constituency, a public, and a legislature unwilling to support necessary services and providers needed for the mental health of Montana's citizens.

VI. CONCLUSION

When the conditions described above are met, Montana's system can implement system improvements. Whether these improvements are exactly the ones described in the three reports produced as part of this consultation is not the most important thing. It *is* important, however, that a general strategic direction be set with clear action steps incorporating all the elements discussed in those reports and in this final chapter. These actions will result in a system that the whole country will watch with as much interest as it watched the move to managed care and back to a state controlled fee-for-service system in Montana. Being on the front page will again be a thing to be desired rather than to be avoided.

APPENDIX A

**DOCUMENTS REVIEWED BY THE TECHNICAL
ASSISTANCE COLLABORATIVE, INC. FOR
CONSULTATION WITH THE MONTANA MENTAL
HEALTH SYSTEM**

APPENDIX A

DOCUMENTS REVIEWED BY THE TECHNICAL ASSISTANCE COLLABORATIVE, INC.

State AMDD Documents

Medicaid and Mental Health Services Plan (DRAFT) (6/30/1999)

DPHHS Administrative Rules affecting Mental Health Services

Memos and Administrative Rules of Montana (46.12.1940-46.12.1942 & 46.12.1921-22)
re: SED Children (9/30/99)

Administrative Rules for Montana 16.32.601 – 16.32.651 (3/31/98)

Administrative Rules of Montana Table of Contents

Administrative Rules of Montana 46.12.1940 – 46.12.1944B & 46.12.1470 – 46.12.1473
re: SED Children's Services, Mental Health Services, and Case Management Rates
(6/30/99)

Administrative Rules of Montana 53.21.701-53.21.704 re: Managed Care

Health Care Facilities, Subchapter 6, Minimum Standards for Mental Health Centers,
Rule 16.32.601-16.32.602, 16.32.607-16.32.610, 16.32.615-16.32.617, 16.32.621-
16.32.624, 16.32.627, 16.32.630, 16.32.640, 16.32.644-16.32.646, 16.32.650-
16.32.651

Notice of Public Hearing on Proposed Amendment of ARM 46.20.106 and Adoption of
the Temporary Emergency Amendment of ARM 46.20.106 pertaining to mental health
services plan eligibility (8/14/00 & 9/5/00, respectively)

Draft Notice of Public Hearing on Proposed Amendment of ARM 37.86.102, 37.86.2206,
37.86.2207, 37.86.2801, 37.86.3001, 37.86.3005, 37.86.3502, 37.86.3702, 37.88.901,
37.88.905, 37.88.906, 37.88.907, 37.88.1106, 37.88.1116, 46.20.103, 46.20.106,
46.20.114, 46.20.117 pertaining to Mental Health Services

PATH – Contract between AMDD and Golden Triangle Community MH Center;
(11/9/99)

PATH Automated Report Program Provider Agency User Guide (CMHS) (10/30/98)

CRISIS PHONE – Contract between AMDD and the Mental Health Center (July 31,
1999-June 30, 2000)

PACT – Contract between AMDD and Golden Triangle Community MH Center (12/8/99)

PACT Program Standards (11/19/99); Note: adapted from document by Deborah Allness, MSSW & William Knoedler, MD

Definitions for PACT Outcome Indicators

Billings PACT Program Monthly Report February 2000

Helena PACT Program Monthly Report, February 2000

DROP IN – Contract between AMDD and the Mental Health Center (July 31, 1999-June 30, 2000)

ADULT FOSTER CARE – Contract between AMDD and HJK, Inc. (Hawthorne House) for the provision of Adult Foster Care; Contract #00-331-74061-0 (8/7/99)

PASSAR – Contract between the Montana DPHHS, Addictive & Mental Disorders Division and Golden Triangle Community Mental Health Center Contract #00-331-74021-0 (8/11/99)

Process for Screening of Applications for Voluntary Admission to Montana State Hospital

Application for Voluntary Admissions form

Various other admissions forms

Recommended Maximum Authorization Spans (3/21/00)

Clinical Management Guidelines: Montana Medicaid and Montana Mental Health Service Plan (rev. 1999)

Policy, Procedures and Protocols: Managing Resources Montana for Children and Adolescents with Severe Emotional Disturbances – Department of Corrections and Human Services (1/20/94)

Memorandum of Understanding between the Department of Family Services, Department of Social and Rehab Services, Department of Health and Environment Services, Office of Public Instruction, Montana Board of Crime Control, and Department of Corrections and Human Services (7/1/93)

Role of Managing Resources Montana Regional Managing Resources Specialists (10/12/93)

Needs Assessment: Social Indicators Model for Montana (2/13/98)

Overview of Mental Health Services Bureau Evaluation of MHSP and MMHP (5/21/00)
Provider Enrollment Requirements for MMHP/MHSP
MH Budget Reduction Plan 2000-2001
Montana Mental Health Program Budget Control Options

May 2000 Budget Summary

Fee Schedules for Mental Health Providers (5/15/00)

Montana Mental Health Evaluation: Report on Satisfaction and Functional Level of Long-Term Clients, Health Management Associates, January 1999

Suggested Outcomes Measures for Montana MHAP; Compiled from recommendations of the DPHHS Staff QA Workgroup and the MHMC Advisory Group Subcommittee on Quality Assurance

CHIP Benefit Plan and Eligibility Plan (June 2000)

Montana Prevention Needs Assessment Student Survey Guidelines; Chemical Dependency Bureau of Montana (1/18/99)

Department of Public Health and Human Services MCP/MBC Program Improvement Plan (PIP) – Accomplishments (1/5/98)

Clinical Management Guidelines: Montana Medicaid and Montana Mental Health Services Plan (re: MHAP) (7/99)

Montana Medicaid/Mental Health Service Plan – Mental Health Center Questions & Answers – Version 3.1, Version 2.1, Version 1.1 (10/28/99; 8/30/99; 8/4/99; respectively)

Medicaid Mental Health and Mental Health Services Plan Services Array and Montana DPHHS, Available Practitioner Procedures (6/16/99 & 7/15/99, respectively) – MHSP Covered Diagnoses and Crosswalk

MHSP – Eligibility Determination Process, Policies, and Procedures (Undated)

Montana Medicaid and MHSP – Mental Health Manual (Undated)

Corrections and Clarifications to the Mental Health Manual (Undated)

MHMC QA Staff Workgroup Notes (1/19/96)

Proposed Variables for Evaluating MCO Performance – Draft for discussion

MRM Interagency Agreement (10/25/94)

Montana Mental Health Services Plan – An Introductory Guide; DPHHS (11/99)

Adult Case Management Services, p. 19-20; Excerpted document

Principles for Practice for Community Service Providers – Operations Manual (Draft 10/93)

Notes – MHMC QA Staff Workgroup (1/19/96)

Suggested Outcomes Measures for Montana MHAP (Undated)

Mental Health Bulletins – DPHHS (Selected Issues from 4/9/99 – 5/00 and monthly from 5/00 to 12/22/00)

MHAP Evaluation – Client Satisfaction Survey; (3/98/00)

Performance Measurement Input from PMAG Members

Performance Measurement Advisory Group Meeting Notes (August 9, and October 4, 2000)

Montana Mental Health Plan – Directing Public Mental Health Services into the 21st Century (Draft Outline 5/22/00)

Excerpt from the Draft Montana Mental Health Strategic Plan – Vision Statement, Values, Key Issues and Related Goals

Maps Showing Boundaries and CMHC Responsibilities for Five Regions Before and After Fifth CMHC Went Out of Business

Documents from State Utilization Management Vendor Prior to Fall 2000 (Mountain Pacific Quality Health Foundation)

Certificate of Need (CON) Requirements Form

Adult Services Forms (Preadmission and Continued Stay)

Youth/Adolescent forms (Preadmission and Continued Stay)

Residential Psychiatric Care for Individuals under 21 (RTC) (Preadmission and Continued Stay)

Clinical Assessment Not Needed for Re-Enrollment Clinical Eligibility for MHSP Applicants

Discharge Form

Materials Supplied by CMHCs and Other Providers

Presentation Materials/Overheads from the Golden Triangle Community MH Center (6/5/00)

Needs Assessment in the West: A Report on a Workshop and Subsequent Analysis/Western States Decision Support Group (3/9/98)

Sample Data from Western Montana Mental Health Center (Crisis Stabilization Facilities: Jan 98-Mar 00 – April 12, 2000)

River House, Missoula Newsletter (May-June, 2000) and Schedule (5/00)

Minimum Standards of Care for SBMHS; Recommendations by the State Provider Group on Intensive Outpatient Services (6/28/00)

Intensive Outpatient Services Provider Task Force's Final Report: A Partnership in Building an Intensive Outpatient Services Continuum For Children and Adolescents; Jani McCall, Consulting with Communities; (9/25/00)

Responses to TAC's Information Request re: Indicators of Quality, Consumer Outcomes, and Organizational Performance -- Responses provided by Bob Ross of the Mental Health Center, Connie Worl of the Montana State Hospital, Larry Noonan of A.W.A.R.E., inc., Janet Vestre of the Golden Triangle Community Mental Health Center, Candace Powell of the Kalispell Adult Mental Health Services, Stepping Stones and the Western Montana Mental Health Center (7/25/00)

Rainbow House Weekly Treatment Options Form (3/00)

Day Treatment Attendance Summary Form; RBHDTS (4/00)

Table of Organization for South Central Montana Regional Mental Health Center (8/21/98)

Golden Triangle Community Mental Health Center brochure and list of services (3/7/00)

Golden Triangle CMHC Clients Previously in Montana State Hospital Served Subsequently in Adult Foster Care; Data and Summary (August 2000)

Documents from and to the Montana Legislature

1999 Montana Legislature-House Joint Resolution No. 35

Legislative Information re: the Mentally Ill (Chapter 21, Part 1, 53-21-101 through 53-21-603)

Mental Health Inpatient Facilities, Subchapter 3, Voluntary Admissions To Montana State Hospitals, 37.66.301 – 37.66.316

Senate Bill No. 534; 1999 Montana Legislature

Letter to State Board of Land Commissioners re: Transfer of Xanthopolous Building to Butte-Silver Bow; from Senator Charles Swysgood, Chairman, HJR 35 Subcommittee Study of Public Mental Health Services (9/29/00)

Presentation by the Department of Public Health and Human Services to the Legislative Finance Committee (10/03/00)

Drafts of Amendments to sections 33-31-115, 53-6-116, 53-6-131, 53-6-702, 53-6-703, 53-21-701 and 53-21-702, MCA; repealing section 53-21-704, MCA; Drafted by the Legislature of the State of Montana (10/7/00)

Quality Assurance Measurement under the Montana Mental Health Access Plan – A Report for the Montana Legislative Finance Committee (Undated)

Mental Health Ombudsman Recommendations to the HJR 35 Interim Study of Public Mental Health Services (9/27/00)

Recommendations to the Legislative Finance Committee from Senator Swysgood (Chairman HJR 35 Subcommittee Study of Public Mental Health Services) to the Legislative Finance Committee (10/2/00)

Unofficial Draft of Legislation: “A Bill for an Act entitled: An Act revising the laws relating to the public mental health system and managed care; amending sections 33-31-115, 53-6-116, 53-6-131, 53-6-701, 53-6-702, 53-6-703, 53-21-701, and 53-21-702, MCA; repealing Section 53-21-704, MCA.” (10/2/00)

Unofficial Draft of a Joint Resolution of the Senate and the House of Representatives of the State of Montana “directing the Dept of PHHS and the Dept of Corrections to coordinate and collaborate with state agencies, local governments and the judiciary regarding training and education programs on issues surrounding persons with mental illness and the criminal justice and corrections systems” (10/2/00)

Unofficial Draft of a Bill for an Act entitled: “An act defining professional person to include advance practice registered nurses; providing that advanced practice registered

nurses with prescriptive authority have similar rights and responsibilities as physicians in certain settings; amending sections 53-21-102, 53-21-145 and 53-21-165 MCA.” (10/2/00)

Unofficial Draft of a Bill for an Act entitled: “An act generally revising the statutes regarding the mental health managed care ombudsman; amending sections 2-15-210 and 53-21-166, MCA” (10/2/00)

Thumbnail Sketch of State Funding for Public Mental Health Services and Eligibility for and Access to Services; Lois Steinbeck (1/19/00)

Mental Health Oversight and Advisory Council (MHOAC) Documents

Mental Health Oversight Advisory Council Work Plan and Ground Rules (adopted 10/13/99)

MHOAC Agendas and Attachments (May-December 2000)

Monthly Report to the MHOAC from the Mental Health Services Bureau (5/00)

Monthly Report to MHOAC from the Mental Health Services Bureau (6/00)

Monthly Report to MHOAC from the Mental Health Services Bureau, September 2000 (10/10/00)

Monthly Report to MHOAC from the Mental Health Services Bureau, December 2000 (12/05/00)

MHOAC Recommendations 1-7 from the Subcommittee on Criminal Justice

MHOAC Recommendations 9-12 from the Subcommittee on Adults (4/10/00)

Memo to MHOAC Subcommittee on Children from John Munding: Summary of May 8th Meeting and Next Steps (5/22/00)

Recommendations 15-22 from the Subcommittee on Adults (6/12/00)

Recommendation from Subcommittee on Children re: State, Regional and Local Interagency Agreement for Youth (MHOAC review date 10/18/00)

Recommendation from Subcommittee on Children re: Family Support (MHOAC review date 10/18/00)

Recommendation from Subcommittee on Children re: Assessment and Treatment Planning (MHOAC review date 10/18/00)

Recommendation 16 from the Subcommittee on Adults re: MHOAC Link to State Workforce Investment board (MHOAC Review Date: October 18, 2000; Draft 8/28/00)

Recommendation 19 from the Subcommittee on Children re: School-Based Mental Health Services (MHOAC Review Date: October 18, 2000)

Recommendation 23 from the Subcommittee on Children re School-Based Mental Health Services: Response to Proposed Rule (MHOAC Review Date: October 18, 2000)

Recommendation 24 from the Subcommittee on Children re: School-Based Mental Health Services: Reimbursement Model (Date for MHOAC Review: October 18, 2000)

Recommendation 19 from the Subcommittee on Children re: School-Based Mental Health Services (Date for MHOAC Review: October 18, 2000)

Recommendation 25 from the Subcommittee on Children re: State, Regional and Local Interagency Agreement for Youth (Date for MHOAC Review: October 18, 2000)

Recommendation 26 from the Subcommittee on Children re: Family Support Services (Date for MHOAC Review: October 18, 2000)

Recommendation 27 from the Subcommittee on Children re: Assessment and Treatment Planning (Date for MHOAC Review: October 18, 2000)

Final Proposed Policy on The Relationship Between Local Advisory Councils and the Mental Health Oversight Advisory Council; prepared by MHOAC (Draft 6/6/00)

DPHHS Response to MHOAC Recommendations (6/1/00)

Memo to MHOAC: Summary of July 10th Meeting and Next Steps (7/12/00)

Memo to Oversight Advisory Committee (8/30/00)

Memo re: Next Steps for MHOAC Subgroup on Mental Health System Performance Indicators; Nedra Chandler (8/2/00)

Memo to MHOAC: Summary of August 15, MetNet Meeting; Kathy A. van Hook, Montana Consensus Council (9/12/00)

Improving Mental Health Services in Montana – A Report on the Accomplishments of the Mental Health Oversight Advisory Council (MHOAC) (8/30/00)

Improving Mental Health Services in Montana – A Report on the Accomplishments of the Mental Health Oversight Advisory Council (MHOAC): Biennial Progress Report; Prepared by the Montana Consensus Council on Behalf of MHOAC (November 2000)

***Paid Claims and Other Utilization and Evaluation Data (See Also, Task
One Report Narrative)***

Consultec Prescription Drug Card Services Monthly Payment Summary – Claims from
3/1-3/31/00 Mountain Pacific Quality Health Foundation

MT MH Service Plan Consultec Prescription Drug Card services - regular claims, mail-
order claims and all claims for March 2000

MT MH Service Plan Consultec Prescription Drug Card services – age/sex utilization
summary, claims paid for March 2000

MT MH Service Plan Consultec Prescription Drug Card services – claims payment
summary, claims paid from 10/1/98 – 3/31/00

MT MH Service Plan Consultec Prescription Drug Card services – monthly denied
claims summary, denied claims from 03/1/00 – 3/31/00

Consultec Paid Claims 7/1/99-5/30/00

Montana State Hospital Admissions and Discharges by Type, County of Residence, and
Legal Status (FY 1999 and 2000)

MH Expenditures; (SFY 1992-SFY 2000)

MH Program FY00 Claims Month of Payment

Primary Diagnosis for all Clients with Activity During FY00

Out-of-State Placement by Region – Enrolled/Non-Enrolled Facility (April 2000)

Non-Medicaid Facility Placement Out-of-State FCS/Corrections; comparing July-Dec.
with February and with April 2000

Out-of-State Continued Stay and Initial Reviews; comparing January 2000 with
February 2000

Provider Census Reports – November 1999-April 2000

Provider Placement History – January-March 2000 (Updated 4/25/00)

Prevalence of Serious Emotional Disturbance Nationally and In Montana

Procedure Code Use for MMIS State Medical and All Others

Montana Medicaid – Medstat Data Dictionary

HMA Case Management Evaluation Data and Additional Outcome Reporting

Old AS/400 Community Mental Health System (CMHC Data Elements) (Date and authorship unknown)

MHA COMPdata Screens – Inpatient psychiatric care provided by Montana licensed hospitals participating in the MHA COMPdata program; Services provided primarily for MH diagnosis; Admissions between 1/1/98-9/30/99; Services provided to persons over 17 years of age; data provided by Robert W. Olsen (5/1/00)

Non-Medicaid Actual and Projected Expenditures and Medicaid Actual and Projected Expenditures (8/8/00)

MHSP Penetration Percents Chart– September 1, 1999 through April 30, 2000 (9/11/00)

DPHHS Mental Health Program Monthly Summary Report for April 2000

Diagnoses for Youth by Region – July 1, 1999-February 29, 2000

Other Documents

Montana Mental Health Ombudsman Report (8/25/99)

Montana Mental Health Ombudsman Report (6/1/00)

Montana Mental Health Ombudsman – Fiscal Year 2001 First Quarter Report (10/10/00)

Montana Aims at Outcome Measures - Managed Care Reforms Uncertain; article from Managed Behavioral Health News (5/18/00)

Report to the State of Montana for October 1997: Mental Health Access Plan Monthly Report; Montana Community Partners (11/14/97)

Report to the State of Montana - Quarterly Report for October, November, December 1997; Montana Community Partners (1/20/98)

Report to the State of Montana - Report for 2nd Quarter of 1997; Montana Community Partners (11/4/97)

Recommendations for MHAP Implementation; Health Management Associates (8/97)

Decision Support 2000+, Summaries and Data Elements; various authorship (MHSIP)

Survey: Treatment of Persons with Mental Illness in Montana Jails: A Report by the Montana Advocacy Program (9/00)

NAMI E-News re: *Drug Benefit Debate Ignores People Most In Need*; Vol. 01-28; (10/4/00)

Racicot Appeals to Manufacturers for Drug Rebate; article by Pat Bellinghausen; Billings Gazette (6/16/00)

TAC Montana Mental Health Provider Information Systems and Performance Indicators Survey Tool and Memorandum (July 25, 2000)

Mental Health: Enrollment Cap Fallout Expected; article by Ginny Merriam printed from The Missoulian web site (9/20/00)

Uniform Data Collection and Reporting System, Proposed Data Domains and Data Elements: Discussion Document; Center for Mental Health Services (7/26/00)

Table of the Components of a System of Care; Joan Nell McFadden

Brochure for NAMI – Billings (4/00)

Mental Disabilities Board of Visitors Site Review Report for Eastern Montana Community Mental Health Center, Region 1 (10/2/98)

Mental Disabilities Board of Visitors Site Review Report for Golden Triangle Community Mental Health Center (Helena), Region 2 (11/6/98)

Mental Disabilities Board of Visitors Site Review Report for Golden Triangle Community Mental Health Center (Great Falls/Havre), Region 2 (6/30/98)

Mental Disabilities Board of Visitors Site Review Report for Montana Mental Health Nursing Care Center (12/8/98)

Mental Disabilities Board of Visitors Site Review Report for Montana State Hospital (5/29/98)

DPHHS Division of Quality Assurance – Consumer Quality Assurance Survey
Mental Health Center Policy and Procedure Checklist; Licensure Bureau Site Review File Review Form; Mental Health Center Survey Tool (3/00); Adult Foster Care Table and Summary

Memo re: Gaps in Service; Diane White (5/23/00)

Evaluation and Management – Office or Other Outpatient Services – American Medical Association (Undated)

Mental Health Association of Montana Public Policy Platform for 2001-2002

Building a Continuum of Community Living Options: Housing Needs, Strategy, and Resources for the Montana Mental Health System; Presentation to Final State Conference on Mental Illness Housing; Michael M. O'Neil (Fall 2000)

APPENDIX B

PERSONS CONTACTED AND/OR INTERVIEWED FOR THE TECHNICAL ASSISTANCE COLLABORATIVE INC.'S REVIEW OF MONTANA'S MENTAL HEALTH SYSTEM

APPENDIX B

PERSONS CONTACTED AND/OR INTERVIEWED BY THE TECHNICAL ASSISTANCE COLLABORATIVE, INC.

State – AMDD

- Marcia Armstrong – MHSB Consumer Issues Specialist
- Ed Amberg – Montana State Hospital Director
- Dan Anderson – AMDD Administrator
- Dave Bennetts – MHSP Children’s Services Specialist
- Dena Froehlich – MHSB Administrative Assistant
- Susan Haran – AMDD Office Manager
- Mary Letang – AMDD Operations Bureau Program Analyst
- Colleen Matoon – AMDD MMIS Coordinator (Consultec Liaison)
- Bob Mullen – AMDD Budget Director
- Randy Poulsen – Mental Health Services Bureau (MHSB) Chief
- Dennis Prody – AMDD Operations Bureau Information Systems Manager
- Rusty Redfield – MHSB Adults Services Specialist
- Bobbi Renner – MHSB Quality Assurance Manager
- Lou Thompson – MHSB Program and Policy Coordinator
- Charles Williams – MHSB MMIS/Provider Relations Specialist

State – Advocacy Groups

- Bonnie Adee – Ombudsman for Mental Health
- Nita Johl (for Bernadette Franks) – Montana Advocacy Program, Advocacy Specialist

- Brian Garrity – Mental Health Ombudsman Office and MHOAC Vice-Chair
- Don Harr, M.D. – Billings Psychiatrist and MHOAC Member
- Katharin Kelker – Parents, Let’s Unite for Kids (PLUK) and MHOAC Member
- Charlie McCarthy – Montana Mental Health Association Executive Director
- Sandy Mihelish – National Alliance for the Mentally Ill (NAMI) Montana and Mental Health Advisory Oversight Council (MHOAC)
- MHOAC Members – (Not all members were present during meetings TAC attended)
 - Kathie Bailey – Fergus County Commissioner (Lewistown)
 - Claudia Clifford – State Auditor and Insurance Commissioner Representative (Helena)
 - Dan Foster – Blackfeet Mental Health Advocate (Browning)
 - Brian Garrity – Mental Health Advocate (Helena)
 - Donald L. Harr, M.D. – Mental Health Provider (Billings)
 - Barbara Hogg – Mental Health Advocate (Billings)
 - Senator Bob Keenan – Legislator (Bigfork)
 - Katharin Kelker – Mental Health Advocate (Billings)
 - Joan-Nell Macfadden – Mental Health Advocate (Great Falls)
 - Sandy Mihelish – NAMI (Helena)
 - Tim Miller – Bitterroot Valley Education Cooperative (Stevensville)
 - Michael O’Neil – Department of Commerce, Housing Division (Helena)
 - Boyd Roth – Mental Health Advocate (Kalispell)
 - Jacob Wagner – Mental Health Advocate (Bozeman)
 - Senator Mignon Waterman – Legislator (Helena)
 - Maryann Wells – Mental Health Advocate (Glendive)
- Performance Measurement Advisory Group – (Persons below plus state staff attended at least one meeting with TAC)
 - Peggy Beier – NAMI Montana (Billings)
 - Norma Jean Boles – DPHHS Professional Services Division (Helena)
 - Bennett Braun – Shodair Children’s Hospital (Helena)
 - Dan Cerise – Youth Dynamics (Billings)
 - John Clymer – Child and Family Services Division (Helena)
 - Art Dreiling – CFS Western Regional Administrator (Missoula)
 - Liza Dyrdaahl – Eastern Montana CMHC (Sidney)
 - Jody Engleman – Family Support Network Director (Billings)
 - Jeff Folsom – AWARE (Helena)
 - Donald Harr, M.D. – Psychiatrist and MHOAC Member (Billings)
 - Ron Hildebrand – Family Support Network (Billings)
 - Katharin Kelker – PLUK (Billings)

- Mike McLaughlin – Golden Triangle CMHC (Helena)
- Sandy Mihelish – NAMI Montana (Helena)
- Nathan Munn, M.D. – St. Peter’s Hospital (Helena)
- Jeff Sturm – Golden Triangle CMHC (Helena)
- Ann Westerman – Deaconess Hospital (Billings)

State – Legislators and Staff

- Senator Bob Keenan – MHOAC Co-Chair and Legislative Finance Committee Member (now Chair)
- Senator Mignon R. Waterman – MHOAC Member and Legislative Finance Committee Member
- Senator Eve Franklin – Legislative Finance Committee Member
- Lois Steinbeck – Staff to Legislative Finance Committee and HJR 35 Subcommittee on Mental Health

State – Consultec (Claims Processing Vendor)

- Brett Jacovac – Consultec Accounts Manager
- Greg Patterson – Consultec Chief Programmer

State – Mountain Pacific Quality Health Foundation (Utilization Management Vendor Prior to Fall 2000)

- Paulette Geach – Utilization Review and Clinical Eligibility Supervisor

State – Other

- Shirley Brown – Child and Family Services (CFS) Division Program Bureau Chief
- Nedra Chandler – Montana Consensus Council (Staff to MHOAC)
- Laurie Ekanger – DPHHS Director

- Tiffany Ferguson – TRW Consultec
- Chuck Hunter – CFS Division Administrator
- Sally Johnson – Department of Corrections, Administrator of Professional Services Division
- Roy Kemp – DPHHS Health Care Facility Licensure Bureau, Quality Assurance (QA) Division Chief
- Matthew McKinney – Montana Consensus Council (Staff to MHOAC)
- John Paradis – Department of Commerce, Community Corrections Division
- Stacy Roope – Public Assistance MHSP Eligibility Specialist
- Cil Robinson – Board of Crime Control Juvenile Justice Planner
- Bob Runkel – OPI Special Education Division Administrator
- Diane White – Licensure Surveyor, DPHHS QA Division (now MHSB Children’s Services Specialist)

Billings

- Chris and Frank – Family Members
- Roger Scarborough – CMHC Alternative Programming Director
- Joel – HUB Clubhouse
- Peggy Hough – Rainbow House Day Treatment Services Director
- Libby Artley – Deaconess Hospital Psychiatric Services Director
- Reno Charette – In-Care Network, Inc.
- Leo Hammond – Youth Dynamics Executive Director
- Dee Holley – NAMI Montana Member
- Dave Pierce – CMHC Out Patient Director

- Terry Smith – Deaconess Hospital Psychiatric Services Clinical Coordinator
- Ry Sorenson – Yellowstone Boys and Girls Ranch President
- Shawn Byrne – Yellowstone Boys and Girls Ranch Case Management Director
- Glenn – Yellowstone Boys and Girls Ranch Chief Financial Officer
- Dave Stern – State CFS Intervention Specialist
- Deborah Wetsit – In-Care Network, Inc. and University of Montana
- Various Consumers

Eastern Montana

- Sue Anderson – State CFS Intervention Supervisor
- Noel Drury, M.D. – CMHC Psychiatrist
- Frank Lane – CMHC Executive Director
- Grant Larson – State CFS Intake Administrator
- Candyce Powell – CMHC Nurse

Great Falls

- Linda Hatch – CMHC Executive Director
- Joan-Nell Macfadden – Mental Health Association, Local Mental Health Advisory Board, and MHOAC Member
- Mike McLaughlin – CMHC Adult Family Services Director
- Nina Wendt – CMHC CSP Services Assistant Director
- Ramona Sing – Family Member of Child in Out-of-Home Placement
- Bob and Jeannie – Therapeutic Group Home Operators

Helena

- Jeff Folsom – AWARE Program Officer
- Michael O’Neil – CMHC Program Development Specialist (now State Department of Commerce, Housing Division, HOME Program)
- Darren Nealis – CMHC Child Services Coordinator (now Program Director)
- Randy Fuhrmann – CMHC Helena School and Smith School Day Program Supervisor
- Debra Sanchez – Private Practice Child Psychologist
- Jeff Sturm – CMHC Program Director
- Various Consumers

Missoula

- Gene Durrand – CMHC Adult Services Director
- Don Goeke – Stevens House Crisis Respite Director
- John Lynn – CMHC Deputy Director
- Libby McIntyre – River House Program Manager
- Paul Meyer – CMHC Executive Director
- Tim Miller – Bitterroot Valley Education Cooperative Special Education Director
- Jim Parker – CMHC Child and Adolescent Services Director
- Boyd Roth – Advocate and MHOAC Member
- Dorothy Salmonson – NAMI Montana Member
- Jean Sharky – NAMI Montana Member
- Various Consumers

APPENDIX C

REPRESENTATIVE OUTCOME AND PERFORMANCE INDICATORS AND/OR MEASURES FROM OTHER JURISDICTIONS AND NATIONAL ORGANIZATIONS

MISSOURI – PROPOSED 1999

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
Telephone answering by live voice; Telephone abandonment Rate; 800 telephone # 24/7; telephone assisted technology for the deaf	Less than ___ % discharged from inpatient readmitted within ___ days by specified demographic groups	___ % of clients under age ___ years are referred for EPSDT screening within ___ days of service request	___ % of emergency authorizations provided without pre-authorization.	
Access to culturally and linguistically competent providers	# of SMI Clients, ADA women, independently housed increase by ___ % per year by demographic groups specified by DMH	Method to decrease suicide attempts in all populations	Pre-authorizations and notification for urgent care and routine care occur within ___ hours	
Penetration rate	# of Kids in single consistent families increases by ___ % per year by demographic groups specified by DMH	Method to decrease % of babies born drug free to enrollees and persons served	___ % of in and out of network clean claims paid within ___ days of receipt	
Access for emergency within XX minutes of call, urgent and routine requests for service	# of competitively employed SMI and ADA adults increases by ___% per year	% of clients seen within XX days of discharge	All providers issues a copy of QSME Provider manual within ___ days of contract	
Linkage to primary care clinicians	# of SED kids and ADA teens remaining in formal academic study increases by ___ % per year. Teens in vocational training or employment increases by ___ % per year	Inpatient readmissions	___ % of consumers and families receive educational and informational materials within ___ working days of contract	
Outreach to Special Populations (cultural and linguistic minorities with # and % served)	Clients arrested following discharge decreases by ___ %.	% increase of those released from inpatient detox to residential treatment	% of all encounter data submitted electronically within ___ days of service. ___ % submitted correctly within ___ days.	
Access to emergency and inpatient services 24/7	Continuity and coordination with physical health care including information, sharing and joint drug utilization reviews	% of grievances and appeals resolved within X days	Monthly, quarterly, and annual reports submitted within ___ days of the end of the time period.	
Availability of Provider Network	Assessment of consumers' perceptions of quality of life	Psychiatric and Addiction consultation line for primary care providers operates ___ hours per day, six days per week.	Quarterly reports on # of complaints, grievances and appeals by identified category. Reports will include resolution and trends.	

MISSOURI – PROPOSED 1999 (CONTINUED...)

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
	Employment	% of clients screened for primary health care needs	% complaints and inquiries resolved without formal grievance	
	Rate of hospital readmission	The MCO has a process for dealing with providers who are not, do not meet, or who lose credentialing and privileging criteria.	No disenrollment of client except pursuant to rules	
	Score on Addiction Severity Index (ASI)	There are demonstrated linkages and coordinated treatment and services with primary care providers and identified ancillary service systems.	Engagement in Quality Improvement Projects (QIPs)	
	Score on Psychiatric Symptom Distress Scale (PSDS)	The MCO cooperates with the DMH Clinical Record review process.	Demonstrated Improvements based on QIPs sustained at least one years	
		There is inclusion of consumers and families in treatment planning process.	Use of DMH proposed quality indicators to assess performance	
		The MCO has clear process for clinical privileging of practitioners for specialized services.	Assess performance based on systematic and ongoing data collection and analysis	
		The MCO has a clear process for Credentialing and re-credentialing of Provider Network	The MCO engages providers in developing and implementing QIPs.	
		There is evidence of consultation with dual diagnosis specialists on Dual Diagnosis cases.	Clear administrative arrangement and commitment to QM/I	
		The clients participate in treatment plan.	Cooperation with annual consumer and family satisfaction assessments by DMH	
		There is evidence that clients receive integrated dual diagnosis treatment.	Use of satisfaction results to improve services	
		There is screening for SA or MI for MI or SA admissions.	NCQA or related QSME accreditation or a plan to achieve it within __ years	
		There is evidence of integrated treatment for MR/MI clients.	Network Capacity	
		The providers and MCO track medication errors.	Timeliness of Physician Reviews, Appeals and Denials	
		The MCO promotes coordination of care among providers.	Quality Improvement Plans; Quality Improvement in MCO culture	
		The clients have access to and use of new medications- protocols and data.	Follow up on non-credentialed providers	

MISSOURI – PROPOSED 1999 (CONTINUED...)

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
			Timeliness of pre-authorization and payment to non-network providers	
			Involvement of consumers and families in administration of MCO and policy making	
			Completion and distribution of Provider Manual	
			Distribution of Consumer Handbook	
			Establishment of policy and procedure on appeals and grievances and service denials	
			Members materials are available in language other than English when ___# or ___ % of the Medicaid eligible population speak the language.	
			Customer relations will be operational between _ and _ ___ days per week and be available 24/7.	
			Persons on hold for member services will be on hold for no longer than ___ minutes.	
			Plan for coordination of clinical services through all Levels of Care.	
			Assignment of easily accessible care coordinator for each active client, esp. those known to be at risk.	
			Demonstrated ability to manage the system consistently with all State and federal laws and regulations.	
			Demonstrated ability to abide by all defined documentation requirements.	
			Sufficient and qualified administrative staff	
			Sufficient and appropriate staff training at provider and QSME levels	
			Demonstrated ability to meet DMH and DOI financial and insurance requirements.	
			Notification of key staff changes within ___ days; vacancies permanently filled within ___ days.	
			Demonstrated ability to meet DMH provider network requirements.	
			Monitoring access of provider to provide for sufficient capacity to serve consumers in the region.	
			Ability to receive and pay provider claims electronically within prescribed timeframes.	
			Sufficient outreach and marketing materials including required and additional offered services, how to choose providers, how to obtain/get services authorized, and how to file complaints, grievances, and appeals.	

MISSOURI – PROPOSED 1999 (CONTINUED...)

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
			Written policies and procedures for enrolling any member within ___ of working days of notification from State and incorporation into MIS.	
			Member information written culturally and sensitively; at sixth-grade level and available in alternative forms and languages.	
			Membership cards issued within 30 days or enrollment or initial services.	
			800 # on form member services and other information determined by DMH on membership cards.	
			Written policies and procedures regarding authorization of services.	
			Written policies and procedures for client complaints, grievances, and appeals.	
			Written appeal process for providers regarding service authorization, denials available at least during business hours weekdays.	
			Development and maintenance of a provider manual including how to get claims paid.	
			Real, meaningful involvement of consumers and their families.	

MISSOURI – ACTUAL AS OF 10/1/00

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
Increase % of children and youth in the juvenile justice system screened for MH problems	Decrease the % of DMH consumers who report reduced participation in work or school due to mental health difficulties by 6/30/03	Decrease the rate of rehospitalization from 25.3% (FY99) to 20.3% for consumers in the Comprehensive Psychiatric Rehabilitation (CPR) program by 6/30/04	Increase from 50.5% (FY99) to 60.5% retention (employment for 12 months after hire) of DMH direct care staff who successfully pass the initial evaluation period, by FY04	
# of children 0-5 who receive a psychosocial EPSDT screen	Increase from 30 to 35 the percent of DMH consumers who are employed by 6/30/02	Increase percent of families receiving supports for their children that report improved independence and self-sufficiency	Assess, establish, adjust and monitor appropriate and adequate 24-hour/seven-day staffing levels for services in DMH-operated and contract residential facilities	
% of children 0-5 receiving follow-up treatment or referrals after EPSDT screen	Increase from 57% in FY99 to 60% MH consumers living independently by 6/30/02	Percent of resident/consumer injury-related incidents involving direct care workers	Increase among DMH providers data collection on quality and quantity of services provided	

MISSOURI – ACTUAL AS OF 10/1/00 (continued...)

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
	Percentage of SED children with improved functioning on the Child Behavior Checklist	Decrease the % of licensed or certified providers for whom deficiencies in training are cited in survey reports	Increase return rate of Consumer Satisfaction Survey 5 percentage points from FY01 to FY04	
	Percent of children living in a safe, nurturing environment one-year after receiving DMH services	Percentage of DMH consumers who are receiving services from providers who meet established standards of care without reservation as reported in CTRAC from FY01 data	Improve integrity of clinical data by 5 percentage points from FY02 to FY04	
	Increase percent of children and youth with disabilities who spend at least 80% of their time in regular education programs by 2010	Increase use of best practice standards in the treatment of Missourians with mental and addictive illnesses, by 6/30/04	Maintain at 17.01% (FY00) the % of minority DMH employees earning over \$30,876 (4 th quartile)	
	Increase % of students actively served by DMH who receive GED or graduate from high school	Decrease admissions and use of addictive substances among CPR consumers by 5% from FY00 to FY03 (psychiatric hospitalization from 24.1% to 22.9%; substance abuse from 5.8% to 5.51%; alcohol abuse from 9% to 8.55%)	Maintain at 65.84% (FY00) the % of female DMH employees earning over \$30,876 (4 th quartile)	
		% of consumers who complete the Consumer Satisfaction Survey and report that they were satisfied or very satisfied with services received from DMH	Increase from 5.95% to 8% DMH purchases from minority-owned business by 6/30/02	
		% of people who complete the Family Member Satisfaction Survey and report that they were satisfied or very satisfied with the services their family member received from DMH	Increase from 1.83% to 3% purchases from female-owned businesses by 6/30/02	
		% of people with SMI served by DMH who move toward independence and recovery as reported in the prototype Consolidated Composite Indicator for CPRC consumers during 97-98		

ARIZONA

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
(Maricopa County): Increase penetration rate of children and youth enrolled in services	(Maricopa County): Increase in number of clients with SMI with paid employment, involved in vocational rehab	Increase the % of clients who receive timely follow up outpatient visits following discharge from inpatient care	(Maricopa County): Timely data submission (95% standard)	
Provide interpreter services to 100% of consumers who speak a language other than English in the receipt and delivery of mental health services.	Monthly Outreach to 200 homeless per month and enrollment of 20 into treatment	% of received discharge plans that have a follow up appointment date	Data shall be 90% complete and accurate at the time of submission	
100 % of all case managed clients who are incarcerated receive case management contact in jail.	Increase \$ amount of federal rent subsidies available to persons with SMI	% of clients readmitted within 30 days of inpatient hospitalization	85% of claims will be paid or denied within 30 days or receipt and 90% of submitted claims paid or denied within 45 days, and 100% of submitted claims paid or denied within 90 days	
80% of all clients in the jail diversion program receive outpatient care. Increase the number of youth in DYS to receive evaluations while in detention and timely follow up outpatient care.	Increase the # of permanent or contractor-owned housing units for persons with SM		100% of uncontested errors corrected within 5 business days and 100% of contested errors corrected within 30 days.	
Monitor penetration rate quarterly.	Increase # of housing units available to persons with SMI			

IOWA

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
The contract shall provide services to at least 15% of Iowa plan enrollees.	The average time between hospitalizations for high need clients will be more than 60 days.	The Consumer shall participate in 96% of all joint treatment planning conferences.	New enrollee information will be mailed to each new enrollee within 10 days after their name was provided to the Contractor.	Administrative Expenses % of overall costs of care
90% of all persons discharged from inpatient care will receive other treatment services within 7 days of discharge date.	Involuntary admissions will not exceed 20% of all children's admissions and not exceed 15% of adult admissions	At least 2.5% of expenditures will be used in the provision of integrated services and supports, including natural supports, consumer-run programs, and services delivered in the home of the enrollee.	Claims shall be paid in the following time period: 85% w/ 12 calendar days; 90% w/ 30 days; 100% w/ 90 days.	By the end of the contract, 15% of the expenditures from claims will be for services not funded previously through the Medicaid for-service program.
85% of enrollees who received services in an emergency room and for whom inpatient care was requested but not authorized will have a follow up contact within 72 hours of the date the Contractor is notified of the ER visit.	The rate of commitment of MHAP enrollees will be reduced by 5% in the contract year.	The number of ER visits shall not exceed 8.5 visits per 1000 enrollee months.	Provider applications for credentialing shall be completed within 60 days of the receipt of all required documentation.	
At least 90% of the top MHAP providers of MH services and 85% of SA providers shall be in network provider status with the contractor.	The contractor will calculate the 7-day, 30-day, 60-day, and 90-day readmission rates for adults and children.	90% of all discharge plans written for enrollees being released from inpatient hospitalization shall be implemented.	Revisions to the provider manual will be distributed to providers at least 30 days prior to the effective date of the revisions.	
MBCI will have contact with an average of 6% of Iowa Plan enrollees and provide services to at least 5% of enrollees each month.		86% of enrollees being discharged from inpatient settings, partial hospitalization, and day treatment programs will have a discharge plan documented in the record on the day of discharge.	The contractor will provide at least four educational offerings to enrollees during the contract year.	
98% of all enrollees who request a mental health service shall be authorized a mental health services		The percentage of enrollees under the age of 18 discharged to a homeless or emergency shelter shall not exceed 3% of all inpatient discharge of enrollees < 18.	A written clinical review will be completed for all requests for mental health services that are not authorized.	

IOWA (continued...)

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
95% of enrollees who access non 24-hour services will be served within the county in which they live or in the adjacent county		The contractor shall arrange or participate in at least 20- joint treatment planning conferences per month	The contractor will track the instances when a higher level of service for children or adults was required due to lack of needed community-based services categorized by geographical area, level of service needed	
Compliance with access standards for Emergency, Urgent, Persistent Symptoms, and Routine service standards		Consumer satisfaction surveys shall be conducted at least twice per year with questions relating to areas identified by the Consumer Roundtable and a response rate determined by DHS in consultation with university researchers and MBC. The process will include corrective action plans based on the results. 85% of the respondents will indicate some degree of satisfaction	The contractor will conduct an annual survey of provider satisfaction in which at least 75% of providers will indicate satisfaction	
Compliance with geographical access standards		All plan members who meet the criteria for the At Risk program through the MBCI criteria will receive Joint Treatment Planning services	The contractor will survey affiliated agencies and primary care physicians at least once during the contract year to improve service linkages	
		The number of instances in which joint treatment planning was requested by MBCI or a consumer and the request could not be honored	The contractor will communicate with each county Central Point of Coordination regarding procedures for coordination of services	
			No more than 19% of claims will be denied	
			25% of claims will be received electronically	
			95% of care reviews will be resolved within 14 days	

COLORADO – FROM PILOT PROGRAM

ACCESS	CLIENT OUTCOMES	QUALITY OF CARE	ADMINISTRATION	COST/VALUE
Crisis Response	Client Satisfaction	Client Complaints and Grievances		Days of inpatient care per 1,000 enrollees
Aftercare appointments and follow up (HE)	Housing	Coordination of Care among providers		
Use of alternative Services	Primary Health Improvement			
Children and Adults receiving services	Placement of children at discharge and family satisfaction with placement			
Reduction in Waiting Lists				

COLORADO – FROM PROPOSED MANAGED CARE PROGRAM RFP

ACCESS	CLIENT OUTCOMES	QUALITY OF CARE	ADMINISTRATION	COST/VALUE
Penetration rate	Improvement in Employment	Consumer/Family participation in service planning	% of Program revenue spent on administration	
Consumer perception of access via MHSIP survey	Improvement in School Performance	Services within 7 days after discharge from the hospital		
% of consumers who had at least one non-emergency face-to-face contact with PCP in last year	Increased level of functioning	Treatment of persons with MH and SA diagnoses		
	Maintained level of functioning	Consumer perception of quality		
	% of adults living independently	% of families satisfied with care		
	Consumer Satisfaction with services via MHSIP survey	% of adults with SMI receiving new generation anti-psychotics		
	% of homeless adults receiving services	% of adults with SMI receiving supported employment services		
	Consumer perception of outcomes via MHSIP survey	# of consumers and family members serving on governing boards, planning committees and other decision-making bodies		

UTAH

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
Penetration Rate: children and youth receiving mental health services	Client Satisfaction. Dimensions include responsiveness, helpfulness and concern of support and clinical staff; clients participate in their treatment; general well being.	Rating of problems that resulted in initial referral.		Days of inpatient care per 1,000 enrollees
Penetration Rate: Adults receiving mental health services	Brief Psychiatric Rating Scale (BPRS) at Utah State Hospital;	Parent/Guardian Response to how Child/Youth will handle future problems.		
	Client and Staff rating of progress on individual goals.	Overall satisfaction		
	General Well-Being Plus (GWB)	Recommend this center to family or friends		
	Mental Health Corporation of America Customer Satisfaction Survey (MHCA)	Adults willingness to return to treatment		
	Managed Care Plan (MCP)			
	Youth Consumer Satisfaction (n=284 youth, 186 Parent/Guardian responses)			

NEW MEXICO – BEHAVIORAL HEALTH

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
Average time from request for services to first face-to-face meeting. Standards are for emergent, urgent, and routine	% of consumers accessing supported employment who attain and retain employment during the course of treatment	Use of a full range of state-of-the art/best practice behavioral health services for all populations in need	The % of consumers who report that they were informed at registration and at regular intervals about the range, length, and availability of services, including peer support	
Clients have access to emergency services 24/7	% of consumers who report that their housing situation is being addressed	The percent of consumers who actively participate in decision making concerning their treatment	Increase in the support services that assist consumers to access and maintain any service benefits for which they are determined eligible	
% of people discharged from inpatient services who receive prompt (w/ 7 days) follow up care	% of consumers who experience a decreased level of psychological distress	% of people with a dual diagnosis of MI/SA who receive integrated care	The % of persons who are self-identified consumers or family members who actively serve on policy boards or advisory boards, participate in QI activities or who hold paid staff positions in regional care coordination activities or direct care system	
Increase in outreach to and provision of services for the homeless populations in need of behavioral health care	% of clients receiving SA treatment who experience diminishing severity of problems after treatment as measured by the ASI	% of people who present with psychiatric issues who are screened for SA and vice versa		
	% of all persons in jail or detention in the past year as a result of MH/SA related problems	% of people with MR/DD/TBI and MI or SA disorders who receive integrated care		
	Decrease in the # of persons incarcerated during treatment			
	% of consumers involved in suicide, homicide, or a fatal accident			
	Proportion of consumers who are involved in employment			
	Increase in # of homeless members who attain stable housing during treatment			
	% of consumers who indicate an improvement in quality of life & increased independent functioning in their community as a result of treatment			
	% of consumers who feel it is safe to be honest with staff in their treatment setting			

NEW MEXICO – LONG TERM SERVICES

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
% of applicants who are satisfied with the timeliness of feedback.	% of individuals who report that their team members listen to them.	% of providers who have implemented and use a Community Incident Management system.	% of providers utilizing data on cost by service and service utilization to plan for program needs.	
% of individuals served in each region compared to the general population.	% of individuals who report that their choices and preferences are reflected in their ISP's.	% of medication errors	% of providers in substantial compliance per review by Medicaid Fraud Unit of DOH Office of Internal Audit.	
% of individuals seen by a primary health care professional as indicated in their ISP.	% of individuals who report that they have friends and caring relationships with people outside service system	% of providers who inform clients of their rights and complaint process.	% of ISD and CMS office staff that are informed of LTSD services and application process	
% of individuals needing language or cultural accommodations for whom such accommodations are available.	% of individuals who use public services (bank, Post Office, shops or place of worship) on a weekly basis.	# of community health education activities annually per LTSD program related to services and/or high-risk behaviors.	% of staff who meet qualifications and/or training requirements.	
% if primary referral sources who are aware of LTSD program application process	% of crisis interventions needed annually for individuals in service for whom earlier services could have prevented the crisis.	% of ISP's that contain specific strategies to promote or maintain independence.	% of direct contact staff (at least half time spent in face-to-face contact with individuals) leaving employment annually (separation rate).	
# of regional offices and LTSD units with written information and knowledge.	# of individuals aged 18-22 in public school special education who have applied for LTSD services.	% of providers giving consumers at least one opportunity for input	# of training and/or technical assistance/supports on prevention of secondary medical problems made available in each LTSD program annually statewide.	
Time between referral and entry into services is reduced or in compliance with requirements.	% of individuals who report that they are receiving services at the frequency specified in their individual service plans.	% of individuals in services providing input annually		
Time from application to first service	% of individuals for whom (or who report that) service related activities reflect the goals and objectives within their individual service plan.	% of providers whose QMI plans show evidence that input is incorporated into provider goals and plans, and/or resources allocation.		
Comparison of the number of clients actually served with the targeted number of clients as stated in the agency contract.	Frequency with which individuals spend service time in settings with non-handicapped peers.	% of providers that comply with maximum (3-yr) national accreditation requirements.		

NEW MEXICO – LONG TERM SERVICES *(continued...)*

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
% of individuals served compared to age and ethnicity.		% of providers meeting a specified % of DOH program standards.		
% of individuals meeting eligibility guidelines for the program from which they are receiving services		# of individuals in services in which medical neglect is confirmed.		
Annual percentage of clients actually served vs. contracted or targeted number.		# of individuals in residential services with uncontrolled seizures, aspiration pneumonia, and decubitus ulcers that could have been prevented.		
		% of assessments addressing all domains/elements required by DOH standards.		
		% of assessments conducted with required frequency according to DOH policy		
		% of individuals who have current ISP's		
		% of individuals for whom the initial or renewal date of the ISP was in accordance with program requirements.		
		% of providers that translate key documents into native and dominant non-English languages orally or in writing		

OHIO

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/ VALUE
Person/Family who receives little or no services has secure sense that they can obtain more/additional services in a timely manner.	Level of symptom distress	Treatment effects such as medication are more positive than negative.		
	# of psychiatric emergencies	Person/Family terminates services safely and with a plan.		
	Emotional/behavioral crises			
	Satisfaction with: family relationships, social involvement, financial resources, physical health, control over life and choices, individual and family safety, participation in community life, living situation, productive activity, and overall satisfaction with life.			
	Feeling a sense of overall fulfillment, purpose in life, hope for the future and person or parental empowerment			
	Attainment of person/family goals related to culture, spirituality, sexuality, individuality, developmental stage and liberty			
	Family's sense of balance between providing care and participation in other life activities.			
	Identifying, accessing and using community resources to fulfill needs, such as spiritual, social, cultural and recreational by participating in organizations that are not primarily MH organizations.			
	Developing and managing interpersonal relationships.			
	Managing Money			
	Managing personal hygiene and appearance; utilizing skills such as public transportation, phone books, grocery store, etc; maintaining home environment in safe and health manner.			
	Advocating successfully for self with MH professionals, landlords, families, etc.			
	Remaining in home or family like environment			
	Engaging in meaningful activity			
	Avoiding incarceration and/or justice system involvement			
	Person is physically healthy			

MASSACHUSETTS – FY '97 (MBHP)

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
% of Children and Adolescents attending at least one appointment per month for four months following discharge from acute care	5% or less of discharges readmitted within 7 days of discharge from acute care.	87.5% of charts with evidence of completed discharge information available at time of discharge from acute care for children and adolescents.	100% of corrective action plans issued to network providers with less than 95% endorsement rate of referrals to DMH.	
90% of Inpatient dispositions will occur within 2 hours of initial contact from an Emergency Services Program		27.5% of acute care discharges attending an outpatient appointment within 3 calendar days of discharge.	95% of continued care requests completed within 24 hours of the time of the initial request.	
90% of prior approval decisions rendered within 1.5 hours of receiving assessment information from an ESP for admission to acute care			95% of authorization decisions will be made within 10 days of receipt of request for outpatient care.	
			95% of clean claims processed within 30 days.	
			95% of reports are submitted to the Division of Medical Assistance by 5 p.m. on due date.	

MASSACHUSETTS – FY '00 PERFORMANCE STANDARDS (MBHP)

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
Contractor will collaborate with self-help and peer support leaders to facilitate implementation of self-help and/or peer support groups and activities.	Survey providers on their use of various outcomes measurement systems.	Provide training for Emergency Services Program (ESP) staff on provision of adult and youth-consumer oriented and family-oriented crisis services. Training will include culturally competent assessment and interventions strategies.	Contract with consumer advocacy group to conduct satisfaction surveys and provide analysis and feedback on providers	
78% of adult mental health discharges will have a medication appointment within 14 business days of discharge.		The contractor shall ensure and coordinate the provision of dual diagnosis recovery, education, and support.	The contractor will sponsor a one-day conference on recovery and rehabilitation.	
Develop a process for reimbursing providers for LAMM and develop a case rate pilot for methadone maintenance		Implement the Enhanced Residential Care pilot program	The contractor will collaborate with the homeless advocacy and health care provider community to develop and construct a discrete for providers of services to homeless members.	
		The contractor shall develop a community-based assessment for children and adolescents in the Northeast.	The contractor shall implement an educational and support model curriculum for families at risk including foster families. The model will be delivered to 100 families.	
		The contractor shall convene two statewide Provider QI Forums and two QM Workshops.	Quarterly reports will be provided within 48 hours of the stipulated deadline.	
		The contractor will increase the % of members discharged from inpatient mental health treatment who receive aftercare within seven calendar days of discharge to 80% of all discharges.	The contractor will continue to collaborate with the homeless advocacy community to facilitate appropriate discharge dispositions for homeless adults.	
		The contractor will develop a psychopharmacological evaluation and treatment protocol for ERC programs and participants. The contractor will also provide in-service training to milieu and clinical staff on state of the art practice in child/adolescent psychopharmacology.	The contractor will work with homeless shelters & detoxification facilities on completion of the Medical Benefit Request.	
		Design and implement in collaboration with DMH at least one jointly funded ACT team.	The contractor will complete a study using pharmacy, medical service, and behavioral health claims data on the service utilization patterns of enrolled members receiving psychotropic medications.	

MASSACHUSETTS – 1992-1996 (MHMA)

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
Telephone Access	Client Satisfaction survey with response rate of 30% (n=700) with analysis of variation. Use results to improve provider management.	Reduce Readmissions of inpatient adult programs.	Complete provider profiles of inpatient, outpatient, detox, and acute residential programs. Review profiles with providers individually and in groups.	Length of stay
Inpatient Provider Network will accept all referrals 24/7		Increase quality of discharge planning from children's acute services	Establish contracted inpatient network.	Inpatient Cost per episode
Establish alternative programs to inpatient care		Establish Intensive Clinical Management Program	Establish Quality Council. Establish CQI teams (4).	Outpatient cost per client per year by age.
Improve cultural competency of provider network.		Develop Quality Improvement Plans with all hospitals and large outpatient providers. Follow up on plans every 6 months, more frequently for providers with significant issues	Improve review process of outpatient authorizations.	Work with outpatient provider network to conduct prospective utilization management and to identify "outlier" cases.
Measure response time of Designated Emergency Services Teams.		Increase participation in outpatient substance abuse treatment	Complete provider manual. Complete updated version of provider manual.	
		Improve dual diagnosis programming.		

PENNSYLVANIA (PERFORMANCE OUTCOME MEASUREMENT SYSTEM)

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
Increase utilization rates by priority group and type of service.	Reduce days in Inpatient Mental Health for Priority Group Members (N)	The average number of days elapsed between placement on probation or parole and first date of MCO contact with the priority group members after the disposition.		
Increase utilization rates by age group and type of service.	Reduce State Mental Hospital days for behavioral health enrollees.	Increase annual physical exams among priority group members.		
Improve and/or increase array of service options.	Decrease the rate of incarceration of priority group members.	Reduce Hospital Medical ER use.		
Improve entry into behavioral health services.	Decrease placements for delinquency for priority group members under 18.	Decrease % of priority group members using only inpatient and ER services.		
	Reduce the % of "point-in-time" placements in residential care for adult priority group members as compared to the total number of priority group members.	Reduce 90-day and 365-day readmission rate.		
	Decrease out-of-home placements for priority group members under 18	Reduce drop out rate of a specific course of treatment		
	Decrease the % of "point-in-time" homelessness among priority members	Increase consumer/family satisfaction		
	Decrease the % of "point-in-time placements" in Children and Youth Custody of priority members under 18			
	Reduce the % of priority group members who had two or more residential moves.			
	Reduce the % of priority members in a regular classroom setting w/ 3+ & 9+ days tardy or absent			
	Increase school retention of priority group members.			
	Increase % of priority group members engaged in employment, sheltered workshop, school/vocational training, or volunteer work			
	Reduce # of arrests among priority group			
	Reduce positive drug screens			
	Reduce status offenses among priority group members under 18			
	Reduce rate of prenatal addictive disorders			

AMERICAN COLLEGE OF MENTAL HEALTH ADMINISTRATORS & THE ACCREDITATION ORGANIZATION WORKGROUP

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
The rate of persons served reporting that they receive services they need	The rate of persons served who are better, worse or unchanged at the termination of treatment compared to the initiation of treatment*	The rate at which persons served report they received useful information to make informed choices about their treatment		
The rates of utilization of services compared to the identified needs of the community	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*	The rate of participation in decisions regarding treatment by persons served		
The rate of persons served reporting that transportation is not a barrier to recovery	<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	The rate of participation in decisions regarding treatment by families of children and adolescents when indicated		
Geographic analysis of population-to-provider rates and travel times for behavioral health professionals	<i>For employed adults:</i> the average number of days not worked counted as a standard interval following the termination of treatment	The rate of persons served who receive timely face-to-face follow up care after leaving a 24 hour care setting		
The rate of persons reporting timely response from first request for service to first face-to-face meeting with a mental health professional	<i>For children:</i> the average number of missed class days counted as a standard interval following the termination of treatment	The rate of persons served who receive a timely course of treatment following diagnosis of a behavioral health disorder		
The average number of days from first request for service to first face-to-face meeting with a behavioral health professional	The rate of episodes of victimization or vulnerability as a concern at the initiation of treatment	The rate of persons served who report experiencing treatment as non-coercive		
The average number of days from the first appointment to the second appointment	<i>For persons served who identify victimization or vulnerability as a concern at the initiation of treatment:</i> the rate of perceived vulnerability measured at the termination of treatment and at a standard interval following the termination of treatment	The rate of involuntary treatments		

* For persons served with problems requiring extended treatment, evaluation should be conducted at regular intervals during the course of treatment.

American College of Mental Health Administrators & The Accreditation Organization Workgroup (cont'd...)

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
The rate of utilization of services at each available level of care described by meaningful groupings of persons served	<i>For persons served who identify problems with the law as a concern at the initiation of treatment:</i> the rate of arrests, detentions and/or incarcerations counted at a standard interval following the termination of treatment	The rate of seclusion and restraint		
	The rate of domiciled/homeless persons at the termination of treatment and at a standard interval following the termination of treatment	The rate at which persons served report they were treated with politeness, respect, and dignity by staff		
	<i>For adults who identify housing as a concern at the initiation of treatment:</i> 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 termination of treatment	The rate at which persons served report feeling hopeful about their recovery		
	<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	The rate at which persons served report they were treated with sensitivity to their gender, age, sexual orientation, culture, religious, ethnic, and linguistic background		
	The rate of suicide, homicide and unexpected deaths	The rate of persons served diagnosed with co-occurring mental illness and substance abuse disorders		
		The rate at which persons served report that they feel safe in treatment		
		The rate at which persons served report that they feel safe in the community		

NATIONAL ALLIANCE FOR THE MENTALLY ILL (NAMI)

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
People with serious brain disorders and their families are treated fairly and equitably in health care, employment, housing, and all areas of life.	Referral to supported employment and supportive housing	Complete physical examination within 24 hours of admission into any inpatient facility. Treatment integration of all medically recognized conditions.	Interagency agreement with vocational rehabilitation service providers.	
People with serious brain disorders have access to information and emergency hot lines 24/7 including a response in languages prevalent within the system of services as well as an appropriate level of care in a seamless system and geographically convenient care.		Is there an assignment of care coordinators?	Consumers and family members are involved in all aspects of the treatment system.	
Persons served report that services are well located and offered at convenient hours.		Availability of crisis support programs as an alternative to hospitalization.	There is an independent consumer satisfaction team.	
Persons report that services received from the time of first request are timely.		Clients are discharged from inpatient programs only when clinically indicated.	Providers report on outcome measurements including satisfaction, homelessness, employment status, and, for children, school attendance.	
Consumer run/peer support groups and clubhouses are part of the provider network.		Appropriate distribution of medication in terms of dosage and type of medication.	Investigation of deaths and serious injuries from seclusion and restraint	
Consumers report ability to obtain timely appointment with appropriate clinician or specialist.		Provision of family education	Adequately disseminated policy for grievance and appeal	
The system of care demonstrates knowledge of sensitivity to cultural differences by employing representatives of diverse groups in assessing the cultural appropriateness of services.		Provision of psychotherapy	Adequate confidentiality policies	
Consumers experience a choice of clinician who understood their racial and ethnic issues.		Consumer and family members are involved in treatment	Jail diversion programs and mental health courts	
		There is a continuum of safe and decent housing with necessary supports.	Does the state or other MH authority have appropriate work incentive policies?	
		The number of deaths, serious injuries resulting from seclusion and restraint	Does the state of MH authority provide for family Education?	

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS (NASMHPD)

ACCESS	CLIENT OUTCOMES	QUALITY OF CARE	ADMINISTRATION	COST/VALUE
Penetration/Utilization Rate.	Employment of adults with SMI	% consumers who actively participate in decision making regarding treatment	% of expenditures accounted for by administrative costs and profit	Average resources expended on mental health services
Average time from request to first face-to-face contact with MH professional.	School Improvement as an increase in number of days of school attended	% of consumers linked to physical health services.	Consumer involvement in policy development, quality assurance, and planning.	
Consumer perception of access.	Consumers report positive outcomes as a result of services	% contacted in community within 7 days of hospital discharge.	Cultural diversity of administrative staff	
Proportion of persons who were denied services.	Improvement in functioning based on scores of selected instruments.	% of adults with SMI receiving services that promote recovery.	Stakeholder satisfaction	
	% of consumers experiencing adverse outcomes such as medical legal deaths, serious injuries, negative side effects of medications, out of home placements for children, drug interactions due to medication errors.	Family members report that they were involved in treatment planning and implementation for their children (0-17 years old)		
	The consumer experiences an increase in hope and recovery.	% readmitted to the hospital within 30 days		
	Reduced impairment from substance abuse	Consumer perception of quality and appropriateness		
	Independent living			
	Reduction in involvement in the criminal justice system			

MENTAL HEALTH STATISTICS IMPROVEMENT PROGRAM REPORT CARD (MHSIP)

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
Average length of time from request for services to the first face-to-face meeting with a mental health professional	Referral to supported employment and supportive housing	% of consumers who actively participate in decisions concerning their treatment	Interagency agreement with vocational rehabilitation service providers	The average resources expended on mental health services per enrollee receiving service.
% of consumers for whom the location of services is convenient	% of people with mental illnesses who are connected to primary care	% of consumers who feel coerced into treatment options or services	The % of enrollees who are adult consumers and family members who serve on planning boards and development groups or hold paid staff positions in the health plan.	The proportion of resources expended on consumer-run services.
% of consumers for whom appointment times are convenient	Differential evidence of mortality due to medical causes for service recipients who have/do not have serious mental illness	% of involuntary admissions to inpatient hospitals	The % of consumers who receive adequate information to make informed choices.	The proportion of resources expended on mental health services provided in a natural setting.
% of consumers who report that physicians, mental health therapists, or case managers can be reached easily	Average level of involuntary movements resulting from the use of psychotropic medications for specified service recipient groups	% of consumers who receive services that support recovery		The proportion of resources expended on services that promote recovery.
% of consumers for whom services are readily available	% of consumers who experience a decreased level of psychological distress	% of people discharged from inpatient services who receive ambulatory services within 7 days of discharge		Expenditures per enrollee on dissemination of preventive information
% of consumers who report that staff is sensitive to their ethnicity, language, culture and age	% of consumers who experience an increased sense of self-respect and dignity	% of people discharged from emergency care who receive ambulatory services within 3 days		The % of enrollees participating in selected or indicated preventive programs.
% of consumers served in a year who had only one mental health contact	Average level of impairment in service recipients with substance abuse problems	% of service recipients who had a change in principal mental healthcare provider during the year or term of treatment		
Penetration rate of people receiving SSI or SSDI benefits	% of SMI people involved in competitive employment	% of service recipients whose treatment follows accepted, best-practice guidelines		
% of consumers for whom cost is an obstacle to service utilization	Average change in days of work lost	% of readmissions that occur within 30 days of discharge		
	Increase in the level of school performance			

MENTAL HEALTH STATISTICS IMPROVEMENT PROGRAM REPORT CARD (MHSIP) (CONTINUED...)

ACCESS	CLIENT OUTCOMES	APPROPRIATENESS	ADMINISTRATION	COST/VALUE
	The extent to which alcohol, drugs or mental problems interfere with productive activity.			
	The % of adults with serious mental illnesses living in residences they own or lease			
	The % of children with serious emotional disturbances placed outside the home for at least one month during the year.			
	The % of consumers whose housing situations improve as a direct result of treatment.			
	The % of consumers who experience an increased level of functioning (CAFAS for children)			
	The % of people who were in jail the past year.			
	The % of consumers who are involved in self-help activities.			
	The % of consumers who report positive changes in the problems for which they sought help.			
	The % of consumers who experience increased activities with family, friends, neighbors, or social groups.			

TASK ONE DATA TABLES AND CHARTS