

## ***ACMHA Santa Fe Summit 2001 Presentations***

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# **ACMHA SANTA FE SUMMIT 2001**

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**FINANCING FOR POSITIVE  
RESULTS: PURCHASING  
QUALITY AND OUTCOMES IN  
BEHAVIORAL HEALTHCARE**

# MONEY TALKS

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- BEHAVIOR IS SHAPED BY FINANCING
- 1950s – MONEY FOR COMMUNITY MENTAL HEALTH OUTSIDE HOSPITALS
- 1960s – SOCIAL SECURITY/DISABILITY
- 1970s – PUT MONEY INTO QUALITY IN THE FORM OF ACCREDITATION AND STAFFING GRANTS AND PROFESSIONAL EDUCATION
- 1980s – CSP AND “MONEY FOLLOWING THE CLIENT”; NEW MEDICATIONS
- 1990s – MEDICAID AND MANAGED CARE<sub>2</sub>

# HEADLINES

## (Glied and Frank)

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- Since 1997, rates of treated prevalence that did not involve the use of prescription drugs grew at a much slower rate than those involving prescription drugs
- Publicly insured had a constant level of treated prevalence until 1987, then increased
- Other groups show a decline in treated prevalence
- Hypothesis – new therapies and expanded coverage for those treatments reduced barriers to seeking care or to making a diagnosis

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- All the growth in mental health spending occurred between 1977 and 1987, after which it fell as a percentage of all health care spending
  - Per user spending doubled then fell by 23%
  - Fell significantly in every category of spending other than prescription drugs which nearly tripled (esp. for depression)

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- Spending per user declined but more individuals received services
  - Shift from high cost to lower cost services
  - Managed care has decreased out-of-pocket expenses generally
  - Substance abuse getting short shrift in these expenditure patterns; fell in last 10 years reported
  - 2/3 of substance abuse treatment paid by public sector

# MORE HEADLINES

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- Behavioral health problems are second only to childbirth in the numbers of uninsured hospital stays
- 8% of hospital stays for depression and 23% for substance abuse disorders are uninsured
- Federal MH spending grew twice as fast and surpassed State and local spending from 1987 to 1997
- Incentives under capitation sometimes lead to reduced support for PACT, supported housing and employment

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- Medicaid now accounts for 20% of all mental health spending
  - Medicare jumped from 8% to 20%
  - Public sector pays 55% of mental health care and 46% of healthcare spending

# ISSUES FOR DISCUSSION

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- How do these expenditure patterns affect service delivery patterns?
- How do the various financial and political players' roles (e.g., Medicaid) affect service delivery
- Do we need "more" money or "better" money?

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- Are there payment mechanisms more conducive to getting good results?
  - Why is there such antipathy to paying for administration while the clamor is for more accountability, data, quality oversight, and qualified staff?

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- Does it matter who controls the various funding streams (i.e., is it important that Medicaid, state, local and block grant funds be managed all together?)
  - What about housing and employment and income support funding?
  - If we want to buy prevention, outcomes, and recovery, why do our fund sources by units, episodes, programs and “heads?”

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- What's the right way to influence the way behavioral health financing affects consumers and their families and the systems and providers that try to serve them?
  - What is our role in these dilemmas?
  - How does where you sit affect where you stand on these issues?

## **USE THE POWER OF PURCHASING TO GET WHAT YOU WANT**

### **Report to the College**

#### **Activities**

Strategic use of financing techniques to get results you want

Given the existence of a problem, use “root cause analysis” to identify the factors that financing techniques can change

Use financial incentives to produce the best consumer and family outcomes

#### I. Recommendations to the College:

- Educate members on types of financing mechanisms and “goodness of fit” with purchaser’s objectives
- Survey members on “creative financing mechanisms”; distribute survey results to College
- Develop and distribute brief case studies on various techniques
- Offer internet classes: 1) review case studies: 2) develop financing mechanisms to address specific objectives
- Convene a diverse group of College members (purchasers, providers, consumers, families) to create model processes for designing and implementing specific financing mechanisms
- Use “mini” Harvard Business School model for creation of full case studies
- Partner with purchaser’s associations (e.g. NASMHPD, NACBHD) on any of the above

#### II. Considerations in Selecting a Financing Mechanism:

- Purchaser’s capability
- System’s political climate
- Specifications of the desired system
  - Goals
  - Covered population(s)
  - Benefit package
  - Consumer choice
  - Evidence-based treatment
  - Clinical management
  - Incentive payments
  - Provider readiness
  - Training & continuing education
  - Key performance indicators
  - Information capacity
  - Outcomes

#### III. Types of mechanisms:

- Grants
- Performance contracts
- Fee for service (vendor agreements)
  - Discounted fee for service
  - Capped fee for service
- Managed fee for service
- Shared risk contracts
  - Annual episode rates
  - Case rates/DRGs
  - Risk corridors with capitation
- Full risk contracts
  - % of premium
  - Capitation without corridors
- Vouchers

## **ACMHA CONSUMER/FAMILY SERVICES – March 23, 2001**

**STRATEGY ONE:** Develop an action plan for the field with the goal of achieving 5% or more of the national behavioral healthcare dollar to be spent on consumer/family operated and controlled services by 2005.

**THEME: “*THERE OUGHT TO BE 5 BY AUGHT 5*”**

### **CONTENT:**

1. Define the range of and characteristics of consumer/family operated, controlled and delivered services (C/F services)
2. Define role of professional and clinician and related HRD issues for C/F employees within the MH system
  - a. barriers (e.g., licensure and certification requirements)
  - b. attitude of professionals/clinicians re fear of losing jobs, consumer/family role in confidentiality, etc. [NOTE: If folk DO lose their jobs, those left will be better accepting of C/F services]
  - c. educate and use community to deal with HRD issues
3. Inventory current C/F services and identify exemplary ones based on the characteristics
4. Identify outcomes (e.g., jobs, school, housing, reducing use of corrections)
5. Set goals and strategies (esp., ACMHA's role)
6. Connect to Bush's Freedom Agenda for persons with disabilities
7. Set realistic timelines
8. Develop a comprehensive political strategy to convince public funders
9. Identify strategy for reaching traditional parts of the system to use C/F services
10. Identify unique financing strategies to encourage this.
11. Identify amount and source of resources needed to implement the plan
12. Identify oversight mechanisms to assure system adherence to 5% goal, C/F services characteristics, quality of C/F services, and practice guidelines
13. Identify and track performance expectations and actual performance and outcomes

**STRATEGY TWO:** Develop a marketing strategy regarding return on investment for consumer/family services for both children/adolescents and adults

**THEME: “*INVESTING 5% GETS YOU 100% EVERY TIME*”**

### **ACTIONS:**

1. Review cost offset literature

2. Define the value in terms of service offsets
3. Address concern for loss of job among traditional providers
4. Target communities, businesses, private purchasers, insurance companies, public funders
5. Get on available agendas in business world
6. Use public service announcements

**STRATEGY THREE:** Increase the evidence base for C/F services.

**CONTENT:**

1. Identify examples through a survey or nomination process
2. Use of existing research -- disseminate
3. Partner with academic facilities to develop new research
4. Utilize consumer and family researchers and evaluators
5. Develop practice guidelines and performance expectations

**STRATEGY FOUR:** Use non-BH resources for adults and adolescent consumer-operated businesses.

**ACTIONS AND EXAMPLES:**

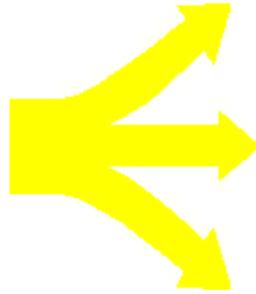
1. Inventory examples of such uses nationally
2. Identify strategies for getting these systems available and accessible for C/F wanting to do businesses and providers wanting to assist C/F in these processes
3. Council of Businesses
4. SCORE
5. Small business incubators
6. Enterprise communities
7. Small business loans
8. Junior Achievement

**STRATEGY FIVE:** Use education, training and support for Child and Adolescent (C/A) families to develop C/F services with and in schools, homes, juvenile justice systems, etc., including C/F services in the transition from child to adolescent to adulthood (and relevant services, if needed), using a recovery model in the transition.

**ACTIONS:**

1. Use C/F in education and training efforts as curriculum developers and faculty
2. Develop a conceptual paper on the relation between recovery and transition
3. Bring together groups who have interests that are aligned (e.g., Federation of Families, NASMHD CYF Division, Outcomes Roundtable for Children and Families)

*CPM*



## Group 4: Financing Evidence-Based Practices

Membership:

Ed Gentile

Fred Hawley

Don Hevey

Jim Pisciotta

Carole Romm

Howard Savin

Sonja Schoenwald (co-facilitator)

Aimee Schwartz (co-facilitator)

# CPM

## CRITICAL PATHWAYS MARKETING

*"We take you there"*

### 1. We create demand for best practices through:

- *Market Research and Analysis to identify the drivers (i.e., values, needs, etc.) of all relevant audiences' current preferences and purchasing patterns; and, their reactions to specific evidence-based practices. Based on this analysis, we identify the features of specific evidence based practices that are most important to each of these audiences. This information forms the basis of:*
- *Messages Tailored to Your Target Audiences (See grid below))*
- *Impact Assessment*

### 2. The overarching goal of this group is:

*To raise awareness of and interest in the use (receipt, provision, purchase) of specific evidence based practices across all relevant audiences. Taking this approach avoids the potential pitfalls associated with approaches to raising awareness about "evidence based practices" in general, which can mean all things to all people. The credibility (and potential survival) of the behavioral and substance abuse field is more likely to be enhanced by a differentiated versus generic approach to raising awareness about "evidence based practices," in part because results of specific practices can be demonstrated. To the extent that demonstrated success can be linked to a specific practice implemented by a specific provider-consumer duo, value and credibility are enhanced.*

### 3. Possible shifts in thinking required to pursue this goal:

- *Marketing may be essential to increasing the use and financing of evidence-based practices, thus marketing expertise (some of which is informed by behavioral sciences) may be needed.*
- *Specific strategies for facilitating adoption of a demonstrably more effective evidence-based practice will be generated on the basis of the information from the market analysis regarding what combination of things is most important to different audiences. Some commonly used strategies include: targeted education efforts; demonstrations of the impact of an evidence based practice on the specific audience (consumer, provider, payer, etc.); the creation of cognitive dissonance; the "latest breakthrough" approach, and so forth.*

### 4. Recommendations regarding ACHMA's involvement:

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## CRITICAL PATHWAYS MARKETING

*"We take you there"*



### TARGET AUDIENCES

Sample Segmenting Dimensions	Consumers	Providers	Payers	Regulators	Training
Values					
Demographics					
Preferences					
Diagnosis/Condition					
Organizational Affiliation					

# Ideas to Make Promising Practices Proven to Gain Funding

Give Some Evidence through Evaluation

Create new, more accessible evaluation techniques:

- ❖ Not necessarily scientific
- ❖ Not Necessarily Rigorous

Develop Housing Body

- ❖ Data Warehouse

Effective Marketing

- ❖ Web-based
- ❖ Common Profile for describing promising practices

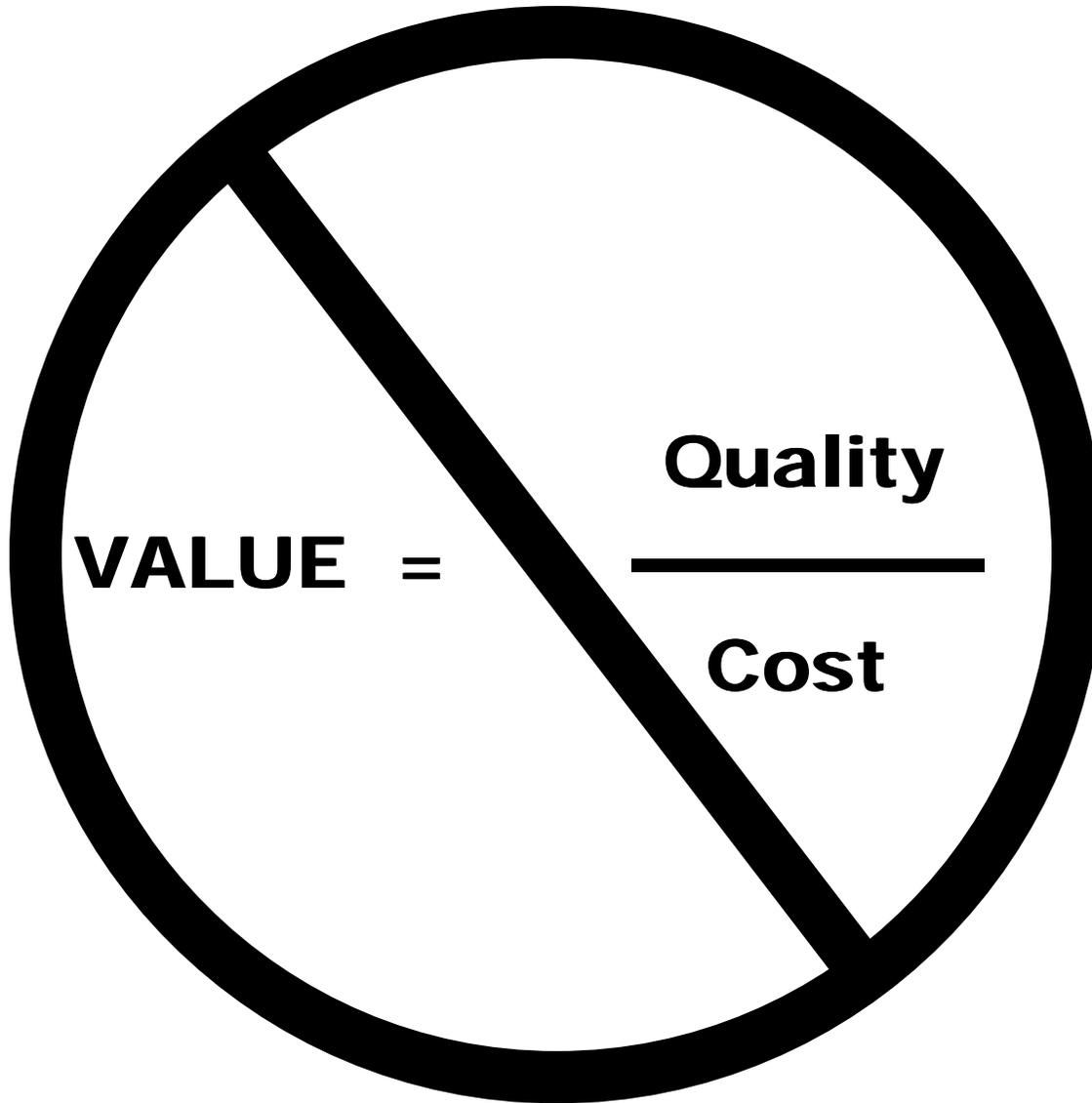
ACMHA's Role:

- ❖ LACK OF FUNDING IS NOT GOING AWAY
- ❖ Advance the Learnings

***Fixing Unmet Needs:  
Beyond the Community Reinvestment  
Approach***

- Communities as their own experts
- No single strategy – numbers not possible
- Recognize that unmet needs are more than mental health and substance abuse services
- Determine what is structurally possible: What is the community “culture”? Its history?
- Everyone needs to bring something to the table — resources as well as funding
- All parties should be involved in any “product” — community buy-in
  - People don’t experience need in the segmented ways we handle them
  - The consensus approach — top-down and bottom-up
  -
- **EDUCATION, EDUCATION, EDUCATION**

# *Old Paradigm*


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

# *New Paradigm*

Social Value = Social Benefit – Social Cost

Social Value = Cumulative Outcomes

Outcomes = Efficiency \* Quality

**“THE DIRTY DOZEN”  
TWELVE IDEAS STEMMING FROM THE 2001 SANTA FE SUMMIT**

**Status as of March 16, 2002**

1. Development of a new model for determining the value added of services purchased by public payers (to be included in the Financing Paper)
2. Survey of key MH/SA leaders and systems to determine creative financing strategies most promising for assuring quality (surveys out; results to be included in the Financing Paper)
3. Case studies on financing techniques (to be included in the Financing Paper)
4. Offer internet classes on financing mechanisms (under discussion between the ACMHA Board and NCCBH)
5. Development of a “white paper” about network financing rather than unit or program financing (in process; Financing Paper drafted and revisions in process; ACMHA members requested to review key chapters of the paper)
6. Call to action and an action plan for increasing the percentage of consumer and family-operated services funded by public systems (“5 by 5”) (initial planning meeting held in conjunction with BHT conference in September 2001; follow-up meeting scheduled for May 2002 to draft proposal for “toolkit” to make 5 x 5 happen; funding for toolkit development promised from SAMHSA)
7. Support for a multi-institutional collaborative to fundamentally change pre-professional university training (Annapolis Conference on Behavioral Health Workforce Education and Training held September 2001; resulting papers scheduled for publication in a special edition of the Journal of Mental Health Administration and Policy for release in June 2002; conference to become an annual event; Academic Behavioral Health Consortium created to continuing working on these issues)
8. Accreditation and credentialing changes regarding professional qualifications and competencies (not yet begun);
9. Federally commissioned report on the workforce crisis (partially addressed in the Annapolis Conference);
10. Complete the Critical Pathways Marketing matrix re target audiences to tailor messages re evidence-based practices (not yet begun);
11. Develop a common profile/format for describing and a data warehouse on promising practices (being developed for children/adolescents by the MacArthur Foundation Initiative on Children’s Mental Health; being developed in part by the Center for Evidence-Based Practices, funded by CMHS and housed within NASMHPD)
12. Create a new more accessible evaluation technique for promising practices (see 11 above).

Crossing the Quality Chasm – Being a convenor for the field’s blueprint on MH response to that report’s call to action.

6 focus areas from report.