Crossing the Quality Chasm:

Adaptation to Mental Health and Addictive Disorders

July 2004

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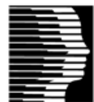

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Introduction

Good afternoon, my name is Linda Rosenberg. I'm the incoming President and Chief Executive Officer of the National Council for Community Behavioral Healthcare and, on behalf of our members I want to thank the Committee on Adapting the *Crossing the Quality Chasm* Report to Mental Health and Addictive Disorders for inviting us to testify. It is an honor and a responsibility.

The National Council for Community Behavioral Healthcare is the country's oldest and largest membership association that is dedicated to ensuring access to, and the availability of, safe and effective community-based mental health and substance abuse services for adults, for seniors, and for our children and their families. For more than three decades, our provider members and state associations have trusted us to serve as their national voice.

Background

Over the years, the National Council has testified before committees and received many reports, including the report of the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* and the Surgeon General's Report on Mental Health. Each has described an environment with high rates of behavioral health disorders, low rates of detection, limited access to treatment, and barriers to the provision of appropriate and effective evidence-based treatments to culturally diverse populations. Dr. Mike Hogan, the chair of the President's New Freedom Commission, directly implicates the structural, financing and organizational problems of the delivery system in behavioral healthcare's high rates of morbidity, mortality and burden.

Operating within unique and distinctly different state systems of care that have been collectively called a "shambles" are our members. Essential community providers in a chronically under funded system, they struggle to transform lives and communities. Each day, they find practical solutions to complex problems. These leaders have heard the call to action but need assistance in their efforts to deliver recovery-focused and consumer-centered services. They are trying to

develop a staff that is competent in the delivery of practices based on evidence, while facing a growing crisis in the recruitment and retention of staff at the salary levels supported by behavioral healthcare reimbursement structures. Expertise does not come cheap.

"Transforming a system that is in shambles" is language designed to galvanize the troops. Michael Friedman, Director of the Metropolitan Center for Mental Health Policy and Advocacy, presents a more balanced view. "In shambles is what it was when there were hundreds of thousands of people warehoused in state institutions where conditions were shameful. There has since that time been the creation of outpatient and rehabilitation programs, case management, peer support, housing programs, available inpatient care at local hospitals and the remaining state run services are often of very high quality. It can be offensive to those who have advocated—with considerable success—for community mental health services to characterize the system in a way that appears to dismiss all that has been achieved." The National Council and its members agree that there are serious inadequacies in the current behavioral healthcare system but reform efforts must meaningfully go beyond rhetoric if those inadequacies are to be addressed.

The National Council was asked by this committee to do several things today. We were asked to speak to issues that National Council members face in delivering high quality care. We were also asked to describe ways in which behavioral healthcare diverges from the six aims, what strategies could be used to improve the defects in the quality of care and what issues the committee should assure receive priority attention in its study. The simple answer to your questions is that behavioral healthcare is no different than general healthcare. We diverge from the six aims in the same ways and all of the strategies in *Crossing the Quality Chasm* apply. The complicated answer is that issues in behavioral healthcare are even more complex and there are far less resources with which to address those issues.

We cannot do justice and adequately describe to you the institutional barriers and challenges to quality care that face our providers and, more importantly, our consumers and families. These challenges include: the enormous complexity of services for individuals with mental illness and substance use and criminal justice involvement, the complex and cross system needs of children and families, particularly those who are involved in the public welfare or juvenile justice

systems, and the delicate balance between issues of public safety and consumer choice. Services are often complicated by poverty, by a lack of stable housing, by fear and confusion and by the risk of suicide. Poverty, homelessness and long term dependency on public systems leads to the deaths of those we serve, on average, 12 years earlier than their age and sex matched cohorts.

The National Council views today as an important opportunity to offer a perspective that we believe would more effectively engage and enable providers as true partners. And so with the six aims and ten rules as our "true north," we will focus on: an organizational support process to facilitate improvements at the provider organizational level; a systems management approach to evidence-based practice implementation; alignment of fiscal policies to support improvements; workforce strategies; and the National Council's work to promote integration of behavioral and primary healthcare.

Our strategies aren't without cost. By all measures, the public behavioral health system is grossly under-funded. The burden of disease in the U.S. accounted for by mental disorders is 20 percent with only 5 percent to 7 percent of all expenditures for healthcare spent on treatment of those disorders. The need for services throughout the nation far outstrips capacity, our workforce is underpaid, there is little technology infrastructure and we are increasingly tied to the billable hour when the demand is for customized services provided in a wide range of settings and meetings between multiple systems to ensure collaboration. We have attempted to keep our suggestions practical and within the realm of possibility but there can be no improvement, much less transformation, without adequate resources.

Effective Organizational Support Processes

We applaud the efforts of SAMHSA as well as those of the National Association of State Mental Health Program Directors (NASMHPD) to engage and influence state behavioral health leadership in the design and funding of quality services. Their funding of academies, state infrastructure planning grants and demonstration projects brings attention to and seeds initiatives that are consistent with SAMHSA's matrix. We expect these efforts to be expanded in the soon

to be released first “action plan” for implementing the Freedom Commission’s goals and recommendations.

Incentives to providers for improvements are left to the states, where the agenda can be spending reductions dressed up as improvements. Persons with serious behavioral health disorders are quickly reduced to poverty and the lack of insurance parity quickly moves them into the public care system. People who are stigmatized for their behavioral health disorders and who receive care paid for with public dollars, are an easy target for funding reductions and service reorganizations under the guise of efficiency. Providers are told that they need to demonstrate the effectiveness of their services to avoid such “efficiencies” but have never been given the resources or tools to do so. The connection has not been made between a provider organization’s capacity for quality improvement activity and reduction of errors, increased safety or increased adherence to practices based on research findings.

Providers who function at the level closest to the experience of patients and families haven’t been given and are not themselves sufficiently funded to acquire the tools and skilled staff they need to collect and analyze data to allow them to ask “how are we doing?” and use the answers to continuously improve practices and client outcomes. It is this internal feedback loop—providers and practitioners systematically collecting and analyzing the outcomes for their programs and the individuals they treat—that can serve as what is referred to in *Crossing the Quality Chasm* as an effective organizational support process to make change in the delivery of care possible.

Strategy: Invest in provider level capacity to collect and use data to measure and continuously improve practices and consumer outcomes.

An important organizational support to improving quality is the availability and use of information technology. Most provider organizations dream of an automated medical record but the few that have moved forward to automate their clinical systems find little available support,

funding or technical assistance. Another approach is the introduction of automated registries to track key data regarding specific patient populations. Registries can help to ensure that contact is maintained even with the intermittent nature of care as consumers move through a fragmented system, are hospitalized in local or state hospitals, lose stable housing, or become entangled in the criminal justice system. Registry support can be critical to the implementation of protocols and guidelines, as the registry is structured to "tickle" key status information and check points. When the Texas MedMap project was in the research phase, registry support was available to the participating psychiatrists. Unfortunately, as is too often the case when a demonstration project moves to full-scale implementation and funds and supports are reduced, the registry was not included with widespread implementation

> **Strategy:** Offer fiscal incentives to behavioral healthcare provider organizations for the implementation of information technology designed to improve clinical care.

Infrastructure to Support Evidence-Based Practices

Goal Five of the President's New Freedom Commission on Mental Health is to ensure that "excellent mental health care is delivered and research is accelerated" a goal that calls for immediate transfer of technology from research to practice. Considerable resources are being dedicated to the "science to service" agenda, including the state-based demonstration projects studying the implementation of the six evidence-based practices for adults with serious mental illness.

The toolkit implementation project developed by Robert Drake and a group of skilled researchers and practitioners, supported by SAMHSA and NASMHPD, has been very helpful and has sparked spirited discussions. It is, however, slow going with efforts for the most part being focused in a few small sites that are implementing one practice. Studying the implementation will yield helpful information, but appears to have the same shortcomings as research: very slow with questions about the applicability of the findings to extremely diverse settings and

practitioners, populations and fiscal structures. Missing in all the activity are the design and implementation of more effective organizational processes for making practice change possible.

Ken Minkoff, in the March 2003 edition of *Psychiatric Services,* described the organizational processes as the missing link between science and service. "Often EBP implementation strategies focus on improving communication between researchers and clinicians. But that is not where the answer lies. Implementation of EBPs is fundamentally a systems management function. Success depends on the application of sound management and administrative practices—for example, strategic planning, management science, and quality improvement—to build and organize systems capable of adopting innovative technologies." An example we would like to offer of a systems management approach is the Health Disparities Collaboratives, a broad-based federal project that funds and supports providers in the implementation of a "care model" that builds the capability to determine which patients have an illness, ensuring that they receive evidence-based care and actively aiding them in participating in their own treatment.

The Health Disparities Collaboratives is a multi-year initiative of the Health Resources and Services Administration's Bureau of Primary Health Care, focused in Community Health Centers and designed to eliminate health disparities by improving the health status of underserved populations. When a gap exists between what is known to be effective care and what is actually done in practice the Collaboratives seeks to close the gap. It is a holistic approach for serving patients with diabetes, cardiovascular disease, asthma and **depression** that is intended to transform a system that is traditionally reactive—responding mainly when a person seeks care—to one that is focused on promoting and maintaining health. To implement this "care model" an improvement model and a collaborative learning model, developed by the Institute for Healthcare Improvement, is applied. Community Health Centers apply and are selected for participation through a "letter of intent" process.

One caveat however is that the Collaboratives "care model" is referred to as the chronic care model. A basic element of the model is community education and patient self-management; however the use of the term "chronic" in behavioral health has come to mean "without hope of recovery." Given the history of warehousing persons with mental illness and the relatively recent

understanding that recovery must be the focus of treatment, it is important that we are aware of sensitivity to language and that when translating *Crossing the Quality Chasm* to behavioral health or adapting models from health that we avoid offensive language.

Nevertheless, the Health Disparities Collaboratives is an important example of going beyond a limited demonstration project that implements evidence-based practices in silos, to a systems management approach.

Strategy: Support evidence-based practice in behavioral healthcare by inviting provider participation in a national initiative modeled on the Health Disparities Collaboratives.

Although the Institute of Healthcare Improvement (IHI) is an important partner in the Health Disparities Collaborative, its work extends far beyond that project. Many financially able healthcare organizations participate in IHI's "Breakthrough Series," sharing data with each other and working together in Expert Panels, Learning Sessions and Action Periods for six-to-eight-months. The IHI Model for Improvement serves as a guide through the change process, provides fundamental measures for improvement and offers tools for gathering data, working in groups and documenting improvement. These efforts create in participating agencies a "culture of measurement" and the capacity for "evidence-based thinking."

Centers for Excellence have been created in some states to implement specific evidence-based practice and SAMHSA has funded Technical Assistance Centers to support special initiatives, such as systems of care for children. These are important resources; however their focus is on the practice area, not on preparing for and creating capacity for change within the organization. Behavioral Health Provider Organizations want very much to meet the needs of the children, adults and families they serve and they spend time and what money they have on workshops and training for staff. They have not, however, had the opportunity to receive organizational support to assist their improvement efforts.

Strategy: Create an Institute for Behavioral Healthcare Improvement that is funded to offer support to provider organizations.

Aligning Fiscal Incentives

Consumers deserve and should demand a behavioral healthcare system of the highest quality, but to deliver services of the highest quality you need an adequately and rationally financed system. The most glaring example of the inadequacy of financing for behavioral healthcare is the lack of parity with healthcare. Cost shifting from the for-profit insurance industry further stresses an under-funded public system. We will not have a rational system until there is parity.

As the *Quality Chasm* makes clear, there is no existing payment method that perfectly aligns financial incentives with the goal of quality improvement, but we offer a set of strategies that we believe support improved practices and quality care.

There continues to be confusion about reimbursement for evidence-based practices. In New York, we issued a letter for several of the toolkit practices in which we assured providers that they would receive payment, answered frequently asked questions particularly those about which supported employment services are billable, and provided samples of documentation and billing. These letters are available on the New York State Office of Mental Health web site.

Strategy: Clarity is provided by SAMHSA, with the support of the Center for Medicare and Medicaid Services, on Medicaid reimbursement for evidence-based practices.

Services now covered in a third of the states under the Medicaid rehabilitation option include skill building, assertive community treatment, intensive in-home services for children, school-based, after school and summer day treatment programs, mentors and multi-systemic therapy,

but questions continue to arise about the legitimacy of Medicaid reimbursement for these services.

> **Strategy:** Clarity is provided by SAMHSA, with the support of the Center for Medicare and Medicaid Services, about which services are reimbursable under the Medicaid Rehabilitation option.

All fiscal policies should support keeping children at home, out of trouble, and in school.

> **Strategy:** Amend Medicaid to include residential treatment centers as institutions for the purpose of children's home and community-based waiver programs.

> **Strategy:** Allow families of children with serious emotional disorders to buy into Medicaid to allow them to access intensive community-based services that are available only through publicly funded programs.

> **Strategy:** Support the treatment of children in the context of their families by amending or clarifying the current rule directing the delivery of all services to the "identified" patient.

Medicare limitations on the types of behavioral healthcare outpatient services it will reimburse and the expanded co-pay for those services results in the unnecessary use of more restrictive care. Medicare policy makes inpatient psychiatric treatment far more fiscally attractive than treatment in the community and the effect of the policy can be seen in the proliferation of

specialized psycho-geriatric inpatient units and the growth of Medicare as a payer for inpatient psychiatric hospitalization.

Strategy: Reform Medicare to include community-based services that are offered through Medicaid.

Strategy: Replace the discriminatory 50 percent Medicare co-pay for outpatient mental health services with the 20 percent co-pay that is required for all other health services.

Reports that use predictive models have recently emerged from some states, indicating that the public mental health system is funded at approximately half the needed level; in some states the substance abuse treatment system has the capacity to assist only one-quarter of those who need services. In addition, Medicaid behavioral health managed care adds complexity. Roughly half of the states have federal waivers for managed care of their Medicaid mental health programs and, in a number of programs, assumptions regarding utilization and cost have been built from commercial models or the general Medicaid population rather than the public mental health specialty population. The Community Health Centers receive a differential rate in states with fee-for-service systems, and a prospective payment to offset reduced payment models in managed care systems. In contrast, behavioral health providers in managed care states can be reimbursed based on commercial rates paid to private practitioners, who are not expected to treat the same population, offer the same services and/or meet the same regulatory requirements.

Strategy: Create a standard model for forecasting and costing behavioral health service demand and capacity as well as revenues and expenses based on accepted prevalence data, delivery of evidence-based practices, appropriate staffing levels, salaries and benefits, and a quality improvement infrastructure.

This summer, more than 200 California physician groups will be eligible for up to $100 million in potential incentives through the Pay-for-Performance initiative, the nation's largest effort to reward physicians for superior clinical quality, high patient satisfaction and investment in information technology. Six of the state's largest health plans are participating and physician group report cards will be released later this year. The Integrated Healthcare Association is spearheading the project and NCQA will gather, analyze and report physician group quality information to be used in bonus decisions and consumer report cards. Report cards will include six clinical measures, patient experience data, and information technology investment.

Strategy: Explore a Pay-for-Performance initiative in behavioral healthcare.

Preparing the Workforce

All behavioral treatments, whether evidence-based or promising, take place in the context of a relationship. The ability to fully explore and understand the experiences of an individual or of a family and then finding common ground for a merging of perspectives, are essential ingredients for establishing “a continuous healing relationship.” Changes we make in practice and in training must always serve to strengthen this alliance between practitioner and consumer. Perhaps we focus too much on the qualities of practice and not enough on the qualities of the practitioner. Those involved in supporting practitioner implementation of evidence-based practices are seeing that the enthusiasm, confidence, helpfulness and the planful and action-oriented commitment of the practitioner are critical ingredients that underlie the effectiveness of the intervention.

Perhaps, as Bill Anthony has suggested, “it is time to emphasize the human interactive process as it occurs within differing programs as a fundamental target of research.” The capital of the behavioral health field is our staff, and we must do as other service industries and invest in the development and nurturing of that staff. Systems can promote quality services or promote the under-use, overuse or misuse of services but an individual’s recovery is promoted in the context of the practitioner/consumer partnership.

Before we proceed any further, we must acknowledge and thank the leadership of the Annapolis Coalition for their examination of the current system for educating the behavioral healthcare workforce and their call for reform of that system. We hope that the Annapolis Coalition continues their efforts, as educational reform is vital to quality improvement. We don’t want to repeat what we are sure you have already heard about the need for a core curriculum to be shared by all disciplines, the need to develop minimum standards of competence, the need to fund and implement ongoing processes for clinical supervision and mentoring, the need for loan forgiveness programs, and the need for special efforts to recruit and support a diverse workforce. We will instead focus on the issue of salaries and my New York experiences with graduate training.

The New York Times recently reported on a study that assessed the importance to graduating college students of being well off financially versus developing a meaningful philosophy of life over the period from 1967 to 2003. In 1967, more than 80 percent said they valued a meaningful philosophy of life, compared with 2003 when 40 percent said they held that value. There was almost the exact opposite trend of those who valued being well off financially. Given these trends, it is not a surprise that low salaries and a perceived and at times real lack of prestige is creating a recruitment and retention crisis for behavioral healthcare provider organizations. Talk with any faculty of a School of Social Work and you will learn that social work has again become exclusively a woman’s field, which remains, unfortunately an indicator of low salaries and lack of prestige. We are demanding increased skills and commitment but offer salaries that are far below those of any other professional industry and, as a bonus, we offer a work environment we describe as in “shambles.”

Strategy: Benchmark behavioral healthcare salaries with other sectors including general healthcare that require the same degree of training.

Across the country there is a gulf between the skills of those who are emerging from graduate programs and the skills that they will need to deliver optimal services. In New York State, as in many other states, a majority of mental health services are provided by social workers. Under the leadership of Jim Stone - a social worker and at the time the Commissioner of the New York State Office of Mental Health -we developed a partnership with the Deans of the graduate Schools of Social Work. The Deans agreed to examine the graduate curriculum with us and to our working collaboratively to make needed changes particularly in the area of clinical practice. As a result of our joint efforts faculty with expertise and interest in the six evidence-based practices for the treatment of adults with serious mental illnesses developed, in collaboration with staff of the Office of Mental Health, a second year evidence based practice (EBP) course Tied to the course are placements in programs delivering evidence-based practices including Assertive Community Treatment (ACT) teams, supported employment and family psycho-education. A very small stipend was made available to the faculty for the curriculum development and for student placements. The Hunter School of Social Work in New York City is now leading the way in connecting the EBP course to the required research course with the aim of preparing students to read and evaluate the practice literature throughout their careers.

Strategy: Support state/graduate school partnerships in the development and implementation of curriculum that are consistent with evidence-based practices.

The New York effort to address social work school curriculum is introducing students to public behavioral healthcare practice, based on research and expert consensus. It has also served as a recruitment tool for ACT, an important result, given the difficulties providers have in influencing the traditional office-based culture.

Academic accrediting bodies' curriculum requirements for graduate education are broad because they are designed to prepare trainees for a broad range of employment settings. As a result there is a need for training beyond what can be provided in traditional graduate programs, particularly for those who are committed to clinical or operational leadership in public sector behavioral health. An example of such training is the Public Psychiatry Fellowship program at Columbia University led by Jules Ranz, M.D. This small but potent program has produced many of the recovery-focused psychiatry leaders in New York City. The policy and rehabilitation-oriented curriculum can be found on the program's website and has applicability for all disciplines.

> **Strategy:** Explore the development of postgraduate behavioral healthcare fellowship programs for public sector leaders across clinical disciplines.

Funding for the administration of the Medicaid program is available to states and counties. Uses include the salaries of staff involved in the management of Medicaid services. It appears that the administrative funding available to manage the Medicaid program can also be used for training of staff in the delivery of services contained in the state's Medicaid plan. Training funds can be accessed in two ways: funds can either be incorporated into the Medicaid payment rates to providers; or, for staff on the payroll of county or state government, training costs can be included in the funding states and counties draw down for administering the Medicaid program. It also appears that the overhead costs of public universities can potentially serve as the state match for the federal portion of Medicaid administration/training funds. As we understand it Medicaid is used to support medical education. Given the multidisciplinary treatment approach of behavioral health, it makes sense to access Medicaid funds for the training of other professional groups and Katherine Briar Lawson, Dean of the School of Public Welfare, State University of New York at Albany, is leading an initiative to facilitate the use of Medicaid to expand and refine mental health training for social workers.

Strategy: Support efforts to access Medicaid funding for multidisciplinary behavioral health education.

Integration: Behavioral Healthcare and Primary Care

The National Council initiated a process in late 2002 to study the issues related to the coordination of behavioral healthcare and primary care services. Our members, who are well aware of the many health problems of those they serve as well as the need for behavioral health treatment for many people being served in community health settings, are reaching out to their healthcare neighbors. Our providers want to be effective partners with primary care providers in their state and local delivery systems—with a specific focus on safety net populations.

In 2003, the National Council issued a Background Paper on Behavioral Health/Primary Care Integration. We applied the mental health/substance abuse four-quadrant paradigm to describe potential areas for integration and collaboration as well as target populations.

The National Council developed a state level policy and financing assessment tool for use by behavioral health and community health providers and their associations. The tool helps users to assess their state's environment for collaboration and the development of a joint strategic action plan. This tool is posted on the National Council's web site, as are two provider level readiness assessment tools, one for behavioral healthcare agencies and the other for community health centers, that were also developed by the National Council.

The President's New Freedom Commission on Mental Health calls for increased federal-level collaboration, and our experience supports the need for executive agencies to coordinate policy directions in health and behavioral health. The current Health Resources and Services Administration (HRSA) grant application that community health providers can use to access behavioral healthcare funding does not include a requirement for collaboration with their community behavioral healthcare partners. This lack of policy support for collaboration sets an unfortunate tone.

Strategy: Alignment of SAMHSA and HRSA quality improvement initiatives and policy directives.

Conclusion

It can feel to community behavioral healthcare providers as if the activity, the spending and the support for behavioral healthcare improvement are at a level far above the work they do each day. Yet, recovery occurs at the provider level, taking place within the relationship of the consumer and the practitioner. The National Council believes that the vision of a behavioral healthcare system of the highest quality will not be achieved without providers and practitioners as partners.

Thank you for the opportunity to provide comments to the Committee. We look forward to your report and to working with you to continuously improve the behavioral healthcare system.