Quality of Care

Community Based Behavioral Health

Agenda

- Community based Services and Quality of Care
  - Medical: prescribing and approach to medical care
  - Skill building/rehab: paraprofessionals; peer professionals
  - Family-based and Children's services
  - Long Term Care:
    - Day treatment/other day programming
    - Individual therapy
  - Individualized treatment
  - Substance abuse services
  - Fidelity to evidence based practices

Agenda

- Solutions
  - Outcome measures?
    - Which ones count?
  - Fidelity measures?
  - Training Programs
  - Clinical supervision and practice management

This is just an Overview

- Usual suspects missing: inpatient woes; restraints and seclusion
- Many quality of care issues weave their way through out the community based system
- Premise is that the community-based system must be vibrant, highly professional, and focused on quality of care – we already know that the alternatives do not work

Solutions

- Present some for each issue – some are non-solutions rather recognition of reality – my observations
- Quality of care is intertwined with compliance in strange ways – e.g. some services may not meet Medicaid quality of care standards but they are none the less quality services – just not treatment services
- "Medicaiding" services in community based treatment has led to some strange solutions

Issues: Medical Services

- Cost: among the most expensive drugs both in terms of cost and in follow-up medical treatment because of side effects
  - Magnified by medical "cocktails"
  - Greater need for high quality medical management
- Effectiveness: research tainted by relationships between medical and pharmaceuticals
  - Compounded by off-label usage
  - ineffective advocacy by non-medical staff, families – very little guidance
- Inappropriate prescribing: Benzodiazepines and other addictive medications – especially in the substance abusing populations
- Inappropriate management: lab testing, etc.
- Medical direction: who sets clinical policy?

Realities on the Ground

- Unless you are large the amount of time you can afford to pay for medical oversight via a true medical director is limited
- Psychiatrists for public mental health system clients are few and far between
  - Child psychiatrists are miracles
- Payment for psychiatric services usually does not cover the cost of the psychiatrist – leading to great reluctance to pull these individuals out of service delivery.
- Nursing support has disappeared in many states

Realities on the Ground

- Psychiatrists are in many cases the only medical care clients will get – the use of atypicals begs for new types of medical management
- Finding a psychiatrist that the organization can live with is an ordeal in many cases – making them mad, demanding productivity and accountability is a difficult and sensitive road
- Many of the docs are very very part time
- The community based clinics are often magnets for drug seeking individuals

The Result

- Medical directors have very limited role in developing and overseeing medical policy and prescribing practices.
- Management is reluctant to question psychiatric prescribing practices: cocktails, off-label usage, benzos - because of fear of losing doc time
- There are a great many very very part time docs involved in service delivery
- Training, medical meetings, case presentations, peer review limited and not often effective

Solutions

- More tools and technical assistance, especially for part time medical directors
- Medication management assistance: low tech and high tech; the MAPS more accessible and more rapidly modified in face of new information; substance abuse training; medical management best practices
- More money for psychiatry: cover costs of delivering services and oversight and on-going training
- Greater use of NPs with realistic rates associated with their work
- Greater role for nursing in medication education, medical follow-up
- Larger role for non –docs in AACP

Issues: Paraprofessionals and Peer Professionals

- Often provide most the services the Individual will get in the community based mental health system
- Often do not have any formal training in mental health - in some cases, e.g. residential treatment often only a high-school degree is required.
- Behavioral health's expectations of para and peer professionals is very high and often non-technical
- Turn-over is a significant work force issue – training systems are often inadequate to meet demand
- Very limited clinical oversight is available as many of these individuals work in high productivity systems
- Definitions of services and accountability is changing rapidly

Realities on the Ground

- A significant number of these individual could probably not adequately describe their job – case management, psychiatric rehabilitation, peer support, etc.
- Clinical supervision does not have new model to work from in managing these essential individuals in the delivery system
- Training and tools are limited resulting in cookie cutter and very limited approaches to care, e.g. showers not decision-making
- Recovery and person-centered planning is being taught in ways that compound the problem - passivity as a virtue
- Individuals often become more reliant, not less reliant on the system as a result of approaches to care

The Result

- Individuals stuck in system or bored with system – reluctance to participate
  - Poor engagement
- Recovery based approaches not understood or implemented
- Individuals lose as greater independence and recovery are lost in treatment models.
- Assessment of outcomes being done by same individuals who are providing the treatment

Solutions

- Training, training, training: skills built and maintained
- Clearer definitions of services and service content
- Upgrading credentials if supervision must be limited
- Supervision models: must be built into rates
- Understanding difference between evidence based practice and process – we need more process
- Tools: assessments; cheat sheets for individuals and providers; curriculum for skill building

Issues: Family Based and Children's Services

- Resurgence of exclusive benefit - Can a child recover within a family system that is highly dysfunctional? Child welfare models.
- Models that require intensive work by families who believe it is the "kid's" problem, not theirs
- High no show rates for treatment services
- Medication management: the external stakeholders
- Day programming: school based services – who's responsibility

Realities on the Ground

- A child's ability to participate in treatment is generally dictated by the willingness of the parent or caretaker to let them.
- Passing out goodies to one child often creates resentment, not support
- Schools are demanding medication for certain children
- Most clinicians are trained in family systems work and have a very difficult time putting into practice exclusive benefit
- Engagement is extremely difficult with some families limiting the effectiveness of services
- Many clinical staff are faced with denying care or providing what might be inadequate care
- Many clinicians providing children's services do not have special training in this area

Results

- Limited benefit where:
  - Care is intermittent
  - Families not engaged or understanding the commitment of time they must make
  - Schools not fully engaged and willing
- Over-medicating very possible especially when used to control behavior, not to treat
- Residential care and other highly restrictive environments

Solutions

- Rethinking family based treatment models – child welfare models incorporated into mental health models?
- Additional training for clinicians, case managers, rehab specialists
- Clinical supervision models to assist clinicians in managing “exclusive benefit”
  - Intermittent care models – can this ever work?

Issues: Long Term Care Models

- Maintenance services: articulating the benefit
  - New rehab rule
- Recognition of chronic care models
- Where else can they go?
  - Aging out

Realities on the Ground

- Day treatment models: caretaking function can be a prominent feature – the alternative is not pretty
- Therapy: for many this provides long term support, identification of escalation of symptoms, check-in or monitoring

Results

- Long term caretaking models of care - the continuum of care offers few alternatives
- Longer term maintenance of community placement – reasonable outcome – but what if it is not produced by therapy?
- Treatment planning: meds only long term models – none for therapy, day treatment

Solutions

- Quality of care measures that recognize benefit of longer term maintenance
- Alternatives within the continuum of care – recognition of new minimum care models
- Better training and understanding of recovery based models of care – not just maintaining

Issues: Individualized Treatment

- Determination that individuality should show up in the treatment plan and not just in the treatment
  - Treatment plan is probably the most difficult document to create in behavioral health
- General agreement on the benefit of "person-centered planning" but payment systems work as if this was an event not a process
  - Difficult and highly skilled process
  - Treatment goals vs individual life goals

Issues: Individualized Treatment

- Clinical tools used to manage treatment like Stages of Change will result in treatment plans having a similar feel if not identical
- Evidence based practices require fidelity to a model of care that can be quite prescriptive

Realities on the Ground

- Treatment planning and treatment strategies are one of behavioral health's weakest links
- Most states do not pay for treatment planning and therefore it becomes part of paperwork not treatment – results in vague, long term focus, not short term gains
- New models in PCP have clinician and Individual together working on plan – new skill
- Most organizations do not have models from which clinicians can work and measure progress
- Many treatment plans completed by parapros and then signed off by licensed staff
- MD input is limited because of cost

Result

- Audit findings re: non-individualized treatment
- New requirements: they either progress or the goal and/or strategy must change
- Progress or benefit can be very difficult to determine – direct hit to the quality of care being provided.

Solutions

- Tools and training
  - Use of models with benchmarking, e.g. Stages of Change, Stages of Recovery
    - Planning vs strategy
  - Recognition of need for special training to do concurrent treatment planning with Individual
  - Seeing individuality in the treatment – recognition that this is the place to look
- Clinical supervision models for paraprofessionals especially

Issues: Substance Abuse Services

- Individualized treatment: group models of care
- Re-admissions: benefit, eligibility
- Levels of care
- Cookie cutter approaches
- Dual diagnoses
- Court referrals

Realities on the Ground

- Readmissions: in outpatient treatment self-referral is usually sufficient
- Levels of care needed vs. level of care accepted
- Court referrals: level of participation, correct levels of care, voluntary services
- High no show rates: benefit issues
- Access to mental health services if needed, coordination of care – separate buckets of money will interfere – internal consultation not reimbursed – different credentials in SA
- Group models often used – mimic AA models – individuality lost, not clear if there is an individual focus at all –e.g. NY regs

Results

- Outcomes not clear – recidivism very high – difficult population to follow
- Readmits: many questionable leading to poorer outcomes
- Dually diagnosed often get fractured care
- Individuality sacrificed to group models
- Regulations to control quality that can create their own problems

Solutions

- Training: use of combined individual and group models; dual diagnosis
- Clinical supervision
- Negotiations with the courts – correct use of substance abuse service delivery system
- Harm reduction: better defined; recognized as sufficient

Issues: Fidelity to Evidence Based Practices

- Recognition that practice and process are different is slow in coming
- EBP's are often concerned primarily with the structure of the program
- Fidelity to model as a measure of the quality of the services can be very misleading
- Fidelity often costs more than the reimbursement – quality controls needed - alternative payment systems

Realities on the Ground

- Loss of fidelity can be a significant problem – especially for more expensive models
- Clients come into and out of eligibility - e.g. ACT – some models require minimum visits, etc.
- Turnover: minimum standards lost

Results

- Movement away from strict models – evidence base lost

Solutions

- Payment models that work:
  - Smaller populations
  - Managing minimum visits differently
  - Managing enrollment models
- Developing process along with practice to ensure high quality, not just management to the model

Summary

- Behavioral health faces a number of potential assaults on the quality of care it provides
- Often solutions are a combination of different financing of services along with better tools and training especially if we will continue to use a substantially high percentage of paraprofessionals
- Recognition of the breadth of the services provided – from medical to recreational services

Thank You!

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