

Musing on Quality of Care Issues Where do we insist Medicaid Dollars be Focused?

**Mary Thornton
Mary Thornton & Associates, Inc
617-730-5800
mthornton@marythornton.com**

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

Solutions

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

This is just an Overview and usual suspects missing: inpatient woes; restraints and seclusion. Many quality of care issues weave their way through out the community based system.

My premise is that it is in everybody's interest 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. Secondly, it has become increasingly apparent that the federal government is prepared to use quality of care as an enforcement tool.

The solutions presented in these musings - some for each issue –are sometimes not really solutions at all but rather a recognition of reality now. In all cases it is important to understand that these are my observations and they represent a federal, not just a state view of current issues.

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, for example, recreational and social opportunities. Not recognizing the limits of Medicaid has led to the “Medicaiding” of services in community based treatment. Some very strange solutions have resulted.

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 and productivity
- 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 paraprofessionals 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