

## Minds on the Edge Moderator Report – Group 3

### Group Number: 3

**Topic:** How should we address uneven quality of behavioral health care (both quality of providers and identifying best practices)?

**Moderator names:** Harris Sokoloff and Joan Davis

### Group Description:

The group had 10 participants; 2 male and 8 female, all with a personal or professional vested interest in the topic. Some had been consumers themselves or were parents of mentally ill children. Most were associated with the behavioral health professions or advocacy organizations, bringing perspectives from the Mental Health Association of Southeastern PA, Philadelphia Department of Behavioral Health, local NAMI Chapters, U of P School of Social Policy, and private practice.

Their discussion of the causes and effects of the uneven quality of behavioral health care was experience-based and well-informed. The final activity to define Action Steps to resolve 3 key causes of unevenness revealed some commonality across causal factors and solutions:

- ⌚ Those responsible for taking action are overburdened; “Actors” overlap.
- ⌚ A common definition is needed for the standard of quality care.
- ⌚ Quality is often constrained by workforce capacity. Coordination of care across a team and operating at an “optimal” patient:provider ratio are dependencies.
- ⌚ The stigma of behavior health impacts consumers and professionals alike.
- ⌚ Consumer ability to “self-help” influences their quality of care.

The discussion began with the participants introducing themselves, noting reasons for selecting this topic:

- ⌚ It’s hard to find proper care, negatively impacting consumers and their families.
- ⌚ The quality issue is critical to getting consumers back on track.
- ⌚ Concern for Providers’ ability to do “best practices”.
- ⌚ A desire to learn ways to address quality issues.
- ⌚ Debate over evidence-based practices.
- ⌚ If the expectation of outcomes at different levels of care is known then we’re able to measure actual outcomes.

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### *What's it like now?*

The group described the current quality of behavioral health care as follows:

- ⌚ Quality is there, but difficult to find. Success is often based on aggressive advocacy, networking, and chance – finding someone to connect with who cares or finding someone who has been successful at what you are trying to do..
- ⌚ Time restrictions influence the quality of care. Organizational demands and the Agency bottom line impact the Provider's ability to deliver quality diagnosis and care.
- ⌚ Some positive change has been observed with team-based Providers.
- ⌚ Leadership from county officials is influencing a positive trend toward family inclusion; emphasis on input to the Request for Proposal (RFP) process.
- ⌚ Public vs. private resources and who pays the bill are factors in uneven quality. Private has different limits than public. (Public funding may be better for severe disorders.) State hospitals, government funded are considerations in quality issues.
- ⌚ Differing levels of provider access influences better care. One participant reported care improving as the consumer moved through a chain of Providers - from insurance company options to private practice, then University trials, then National Institute of Mental Health (NIMH) resources.
- ⌚ There is a need for better professional networks.

### **Problem Mapping**

The group identified the following causes of uneven quality of behavioral health care:

- ⌚ Training variances.
  - level of education & ongoing education/professional development [staying current]
  - orientation or philosophy of treatment
  - quality dependent on institution's branding, focus, research
- ⌚ Supervision variances.
- ⌚ Professional accountability of providers to stay current.
  - whether or not accountability is reinforced and valued
  - requirements for ongoing licensing
- ⌚ How providers are structured.
  - the support system within a practice; individual vs. team
  - lack of accountability for individual practice
- ⌚ Adaptation of Best Practices – the balance of art and science.
  - consumer reluctance to demand the science
- ⌚ Use of evidence-based assessment.
  - struggle w/ translation – research to practical application (adapt)
  - dissemination of best practices (adopt versus adapt)
- ⌚ Organizational culture
  - expectations on productivity
  - “tone at the top”
- ⌚ Insurance Company demands on intake information – data collection.
  - strengths-based vs. problems-based assessment
  - checklists / rules vs. flexible assessment based on circumstance / condition of consumer
- ⌚ Screening of applicants for therapy training.
- ⌚ Workforce capacity.
  - suffers from insufficient number of workers, impacting workload
  - suffers from low salaries [in public sector], impacting turnover

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- ⌚ Cost of good evaluation – lack of money for supervision.
  - ability to pay
  - insurance willingness to pay
- ⌚ System accountability.
  - variability in oversight
  - lack of clear protocols (compared to protocols for physical issues)
  - “need” for privacy leads to lack of transparency of practice
- ⌚ Resources of the community.
- ⌚ Salary disparities.
- ⌚ Accessibility of resources.
- ⌚ Financial resources of Consumer.
- ⌚ Social capital of consumer.
- ⌚ Competency to self-advocate.
  - consumer knowledge – therapy, general
- ⌚ Stigmatization.

Two additional causes were identified initially, then later determined to be aspects of quality and best practices, rather than causes of unevenness:

- ⌚ A good initial evaluation and assessment is required. Must be thorough and comprehensive, for all treatment is based on the intake process. This process can be slipshod, and is negatively impacted by not having good sources of information.
- ⌚ Provider should be willing to accept family input and use multiple sources of data.

The group identified the following effects of uneven quality of behavioral health care:

- ⌚ Suffering.
- ⌚ Staying sick – health disparities.
- ⌚ Poor quality of services.
- ⌚ Clients withdraw.
- ⌚ People fall through cracks.
- ⌚ Death / tragedy.
- ⌚ Poor outcomes.
- ⌚ Loss of function.
- ⌚ Physical impact / health disparities.
- ⌚ Jail.
- ⌚ Chronic undifferentiated treatment.
- ⌚ Re-traumatization.
- ⌚ Low staff morale.
- ⌚ Staff turnover.
- ⌚ Loss of productivity.
- ⌚ Even care generates great treatment.
- ⌚ Uneven perpetuates socio-economic differences.
- ⌚ Breeds mediocrity.
- ⌚ Good will leaves, creates frustration.
- ⌚ Examining reasons why quality is uneven; could lead to better quality.
- ⌚ Risk that entire field not taken seriously.

As the final part of this exercise the group “mapped” the causes in relation to the problem and as they inter-relate with other causes. Their work product is depicted in the diagram below. Proximity to the problem statement “Uneven Quality of Behavioral Health Care” indicates how closely related the cause is to the problem. Lines and arrow directionality indicate connections between causes.

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The problem map revealed 3 richly connected causes that if resolved could generate the greatest impact on uneven quality of behavioral health care.

### A. Access to Resources

is influenced by:

- Stigmatization
- Consumer Social Network
- Consumer Financial Capital

is a direct cause of uneven quality of behavioral health care and a causal factor for unevenness in:

- Professional Accountability



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### Action Planning

The group divided into subgroups in order to develop action steps addressing the 3 most richly connected causal factors.

We asked them to develop action plans that start with a goal, and then listing the “dependencies” or those things that goal-achievement is dependent upon. Then they listed what action steps needed to be taken to address the dependencies and who the key actors are.

### Causal Factor A: Access to Resources.

**Goal:** Reasonable access to quality behavioral health care.

**Dependencies:**

- Definition of quality care.
- Removal of stigma.
- Getting information.
- Ability to network (social)

**Actions & Actors:**

To resolve the definition of quality care:

- Create a national policy.

Actors:

- National Institutes of Health (NIH)
- Substance Abuse and Mental Health Services Administration (SAMSHA)
- National Alliance on Mental Illness (NAMI)
- Mental Health Association (MHA)

To remove the stigma of behavioral health care:

- Educate the public. Initiate a public campaign with celebrities taking a stand.

Actors: Celebrities

To resolve the dependency on getting information:

- Create appropriate databases [electronic records / information sharing].
- Service – Communication – both government and commercial
  - Commercial communication services
  - call “311” for mental health hotlines.

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- Bus-stop billboards.

Actors:

- Department of Public Welfare (DPW)
- NAMI
- Local Government
- Non-profits
- Commercial service for hotline support

To resolve the Consumer need to be able to network

- Utilize *FaceBook* & similar social network resources.

### **Causal Factor B:** Workforce Capacity.

**Goal:** Increase the number of providers.

#### **Dependencies:**

- Ability to define optimal patient:provider ratio.
- Perceived attractiveness of the field of Behavioral Health Care as a career.
- Number of quality training programs.
- Improve the low pay scale.
- Achieving gains in efficiencies through access to electronic records / information sharing.

#### **Actions & Actors:**

- Promote coordination of care.  
Actors: Agency Administrators, new professional “guilds”.
- Determine “gold standard” of ratio.  
Actors: Team of providers, researchers, administrators, and policy makers.
- Create dollar incentives for underserved areas.  
Actors: medical schools / residency programs.

### **Causal Factor C:** Professional Accountability.

**Goal:** Improved professional accountability is a tool to improve quality.

#### **Dependencies:**

- Licensure.
- Performance-based contracting.
- Provider report cards.
- Self-regulated Professional organizations.

#### **Actions & Actors:**

Actors: Advocacy Organizations should lead the way for all action steps.

To encourage licensure:

- Efforts to Educate Consumers and families.
- Mandate Continuing Education Unit requirements.
- Introduce an expiration date on certification.

To encourage performance-based contracting:

- Funders adopt that policy and put it in RFPs.

To utilize Provider report cards:

- Introduce financial impacts and factor for inclusion in professional networks.

To improve self-regulation of Providers:

- Utilize peer review.
- Utilize advisory boards of consumers.

**Goal:** Improved professional accountability is a tool to enhance system accountability.

#### **Dependencies:**

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- Training (Evidence-based training)
- Well-defined expected outcomes (naming, measuring, consequences)

### **Actions & Actors:**

- Community Behavioral Health (CBH) institutes a 3-strike rule for Providers.
- Technical assistance and coaching.
- External review.
- Enhance electronic records / information sharing.