Examining the Value of Mental Health Services

How do we know we are making a difference in people's lives?

The Jackson County Community Mental Health Fund (Levy) provides public support to non-profit organizations in the delivery of mental health care, toward the ultimate goal of service participants' support and recovery. This project was exploratory. Its purpose was to explore a conceptual shift away from a fee-for-service payment model, reimbursing the cost of service units delivered, and toward a value-based model, where quality and the outcomes are major drivers of reimbursement. In exploring the distinction, we ask, "*Are we paying for units of service, or are we paying for people to get better; for their lives to change.*"

As an initial step, we wanted to know how Levy-funded organizations define and measure success at different levels within their organizations. As has been practice in the past, getting feedback from providers was an important and valued part of the process.

Structured interviews were incorporated into our regular on-site audit, or review process.[i] All Levy grantee agencies (providers) were given an introduction to this concept in advance of the interview. Upon notice of the review, a qualitative questionnaire was given instead of the customary data-driven report. Questions were brief, qualitative and open-ended. Providers were directed to complete the questionnaire, and in doing so, consider how their organization defines and measures the impact of their work. Providers were invited to include whomever they felt appropriate in responding to the questionnaire, as well in-person during the on-site review. The written questionnaire consisted of 5 open-ended questions. We then asked whether and how these items were measured.

Interview Questions – Part 1

1. How does your organization define success?
2. Is your definition of success guided by a value?
3. How do you know whether people are getting better?
4. How do staff know when they are successful?
5. Why do people leave your services?
6. Why do employees leave your organization?

Additional questions, asked during the discussion, focused on process and exploring to what degree the concept of value was present.

Interview Questions – Part 2

1. What was the process used to complete the survey and who was involved?
2. To what degree are formal outcome measures useful?
3. How do you know if staff and participants feel valued, and was this different than knowing if participants get better and staff feel successful?
4. Do providers have participants who initiate service and not return, and are they tracked?
5. What position in the organization has the highest turnover?
6. What single role in the organization has the greatest impact on a participant?

Structured interviews were carried out as part of on-site reviews for all grantees from February through December, 2015.

Providers were assured that results would be reported in aggregate (not individually identifiable), and that there would be no ranking or score. Rather, the summary report would allow them to compare their own organization's internal process and responses to other providers as reported.

Responses and notes from follow-up discussion were analyzed to identify themes and indicators for each question. We drew these from providers' reported responses and did not add information based on experience with or knowledge of the provider organization.

The frequency of each response was tallied within and across funding categories. Few differences were found between funding categories, therefore unless noted in the results below, indicators are presented for providers in all funding categories.

RESULTS

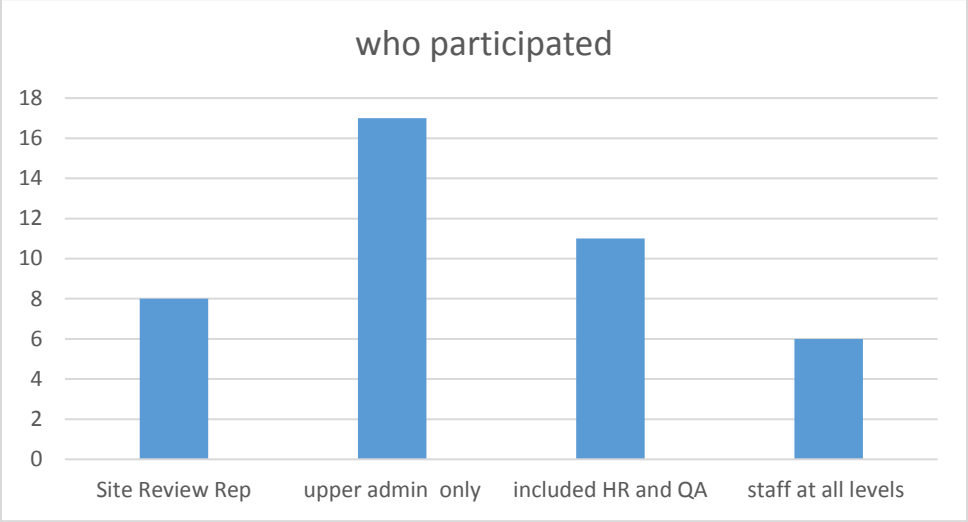
Interview Participation

The on-site review (or audit) is a routine part of our oversight process. However the interviews had important differences. Larger numbers of provider staff participated and discussions were more lengthy and thoughtful.

Of particular interest were the provider agency staff who participated in the process. Shown in the chart below, upper administration completed the questionnaire and participated in the discussion in the majority of provider organizations. Most of these included staff responsible for quality assurance and/or human resources. Executive directors participated in a few discussions.

Direct participation from staff at all levels of the organization was the least prevalent. Supervisors communicated on behalf of front line staff, reporting what they knew or thought to be the opinions or beliefs of staff.

Providers with Special Population[ii] grants were more likely to have staff at all levels participate. This was an "a-ha moment" for one organization, who questioned why they had not, and considered taking the survey back to all staff in the agency.



HOW DOES THE ORGANIZATION DEFINE SUCCESS?

A number of organizations found defining success a difficult question. Most conveyed a general assumption of what success meant, but found it difficult to characterize specifically. Although mission, strategic plans, quality assurance, and standing with accrediting or other monitoring institutions were mentioned, by far the greatest indicator of success was tied to participant "success" or outcomes.

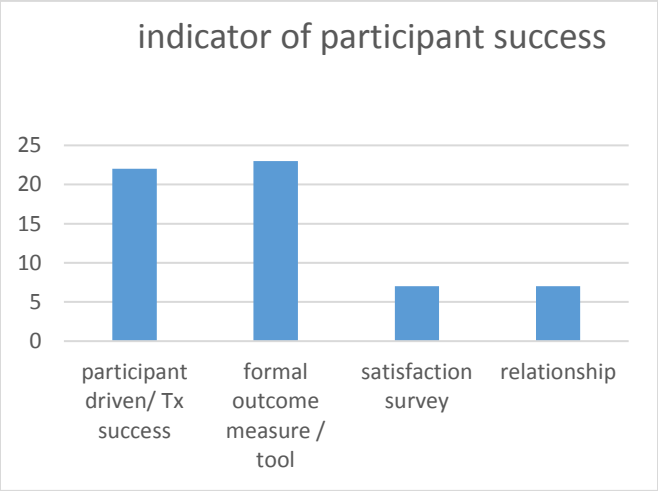
When asked if the definition of success was guided by a value, most referenced the organization's mission. If one or more guiding values were identified, it was separate and unique from the mission statement and used as a measure of success overall. In a few instances, these were being incorporated in multiple levels, from strategic planning and participant outcomes to employee evaluation.

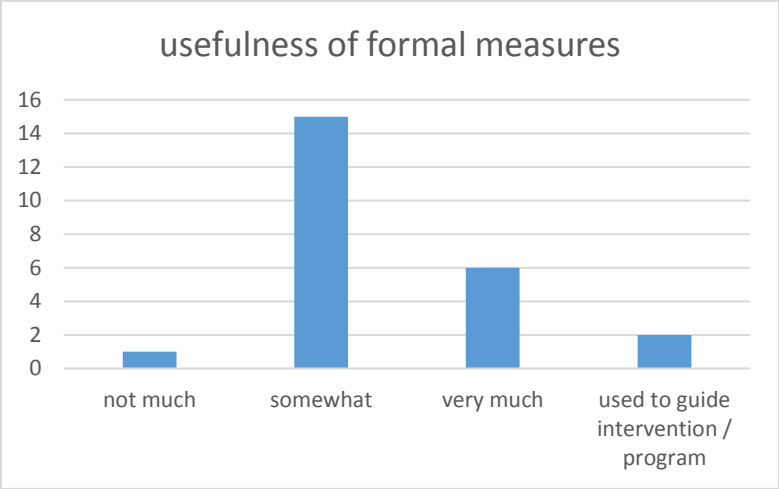
HOW DO YOU KNOW IF PEOPLE GET BETTER?

Participant outcomes and treatment success consistently were identified as the primary indicator in knowing whether or not people in service "got better." Nearly all providers indicated that they use a formal tool to measure treatment success. Participant satisfaction was also mentioned as an indicator. The majority of providers who use a formal outcome measure also had a formal quality assurance process to track and analyze outcome data.

As the charts below indicate, when asked how useful formal outcome data was, the majority of providers said it was "somewhat" useful or helpful.

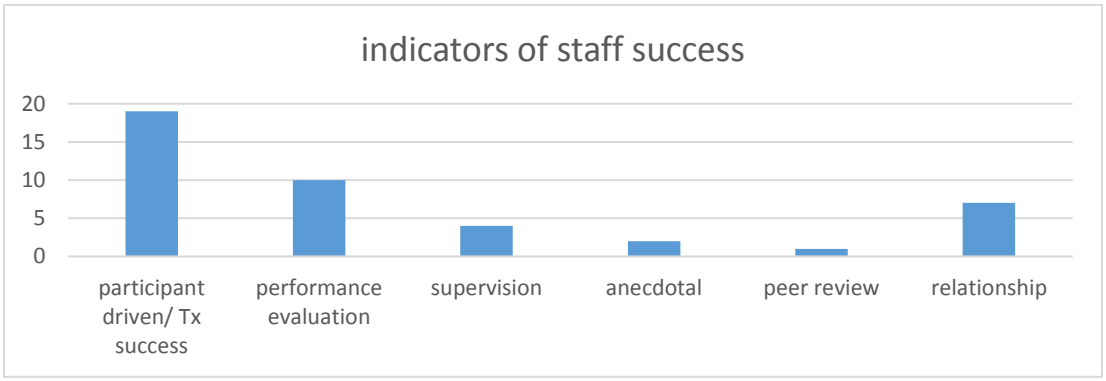
Among Special Population grantees, a theme developed with regard to the relationship between provider and participant. This was described as a qualitative measure of participants getting better, based on factors such as alliance, authenticity, quality, and change in the relationship.





HOW DO STAFF KNOW THEY ARE SUCCESSFUL?

When asked how staff know they are successful, participant success was mentioned most often. For Special Population providers, relationship was the most prevalent indicator. Formal performance evaluation was also mentioned, but about half as often as participant success. Larger organizations reported formal indicators such as meeting productivity quotas and evaluation, while smaller organizations reported evaluating success through supervision and peer review processes.



Providers were asked whether the indicator of success would change if asked whether or not participants and staff feel *valued* versus "getting better" or "successful." This caused many to pause. If the response was decidedly yes, then the organization already had this concept integrated

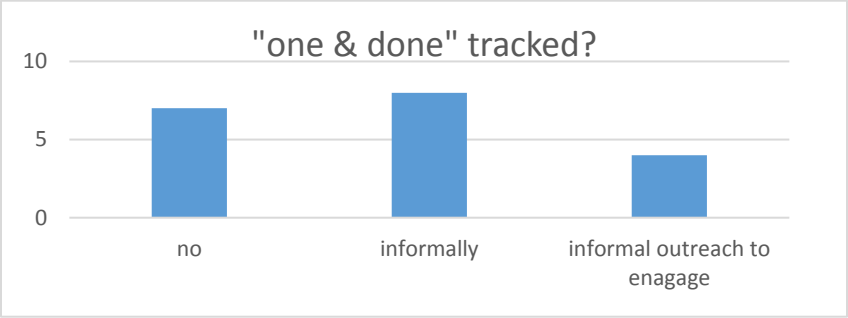
with a formal means to collect feedback. For those who collected staff input, they did so through surveys and/or participation on a committee or work group.

The greatest contributor to *feeling valued* for staff was to see their input making an impact in practice or policy, and then seeing change as a result of their input. The concept of *measuring value* with regard to staff was broader and more easily understood than for participants. Participant feedback was collected primarily through satisfaction surveys, and occasionally in focus groups.

REASONS PARTICIPANTS LEAVE SERVICE

14 organizations indicated discharge was tracked formally by reason, with 9 documenting discharge informally. It was reported that most participants who discontinue service did so either because they moved or simply stopped coming. Completion of treatment was the least reported reason for discharge.

One organization characterized participants coming in for an intake or assessment, but not returning for treatment, as "one and done." When this pattern was common in an organization, we found little in the way of formal tracking or outreach to engage. One provider commented that "with so many coming in the door we can't track those going out".



WHY STAFF LEAVE THE ORGANZATION

The most common reasons staff leave were career advancement, followed by higher pay. The position not being a "good fit" was also often cited. Examples of this included the level of stress and secondary trauma engendered by the positions. This was most prevalent with special population providers with targeted services for sexual abuse or domestic violence.

When asked *"what position in the organization has the greatest impact on a participant," responses varied.* Larger organizations such as community mental health centers identified case managers as having the greatest impact. Providers serving children and families identified direct care staff most often. Special population providers identified the role with the greatest impact was *"the first person the participant has contact with"* such as the advocate in a domestic violence shelter, crisis line responders, or front desk staff.

As a follow up, providers were asked what positions in the organization had the greatest turnover. In all circumstances, positions identified as having the greatest impact on a participant were those with the highest rate of turnover. In discussing this dynamic further, responses can be categorized as either complacent (this is just how it is; these are entry level positions) or there was an admission

that strong connection between high-impact and high-turnover staff positions had not been sufficiently acknowledged.

TAKE AWAYS/HIGHLIGHTS:

The Qualitative Process: The majority of participants found the structured interview questions and process thought provoking. Many also described the format as refreshing in the context of typical site review questionnaires. Many indicated that the interview prompted insight, acknowledging having "never thought of" an issue or question "like this before". From the interviewer's perspective, the questionnaire seemed to have been thoughtfully completed by nearly all participants. Some even augmenting their qualitative responses with internal data.

Internal Usefulness Outcome Data: We are concerned that the majority of providers apparently find formal outcome data only "somewhat" useful in managing service delivery. In considering the financial and human resources needed to administer, collect, analyze and report outcomes, this seems a significant disconnect. The selection of outcomes, collection and analysis of data, and utilization of results will need more exploration as the idea of 'value based' payment is further developed.

Participant-Provider Relationship: The provider-participant alliance / relationship emerged as an important theme, understanding whether staff feel successful and as a way to know whether participants "get better." Relationship as an indicator was noted primarily by Special Population providers, which are relatively smaller agencies serving specialized populations. This does not mean larger organizations do not place a priority on relationship; we simply note that this indicator was not highlighted. From this emerging theme it is probably important to continue asking the degree to which we value and acknowledge the provider-participant relationship, and if (or how) this can be operationalized within an outcome measurement framework.

Participant Engagement: Reasons that participants leave service are generally surmised but seem not well tracked. This issue appears similar to the disconnect we observed regarding the usefulness of outcome data. Given participants' likely need for service and the up-front agency costs of enrollment and assessment, it seems important to develop a better understanding of the underlying issues, particularly in situations where participants come in once and do not return. From that, we might develop better engagement processes or develop a strategy for a standalone initial session that is more impactful. For example, one organization approaches the initial session as if it could be the only encounter. Participants were given the best possible information and invited to return, but that was not presumed. In offering a choice, perhaps the participant felt empowered in considering their return for service.

Staff Value: When providers considered the most impactful positions in the organization also having the highest rates of turnover, two themes emerged. For some, this connection was a new realization. For the majority though, the problem was seen as unavoidable. Either response is significant, and leads us to consider to what extent the most critical positions are valued by the organization, to what extent that value is demonstrated, and whether a pattern of severed staff relationships is viewed as a concern in the contexts of participant engagement and recovery.

When identified, the greatest contributor to feeling valued for staff was that their input was heard and resulted in changes in policy and practice. With this observation we note that direct engagement of staff in this way was rarely reported in responses to the questionnaire.

CONCLUSIONS

The information and responses gathered from the qualitative interview process provide a unique and compelling foundation for further examining services from a value-based perspective. To this end, an initial step may be to identify indicators of value that may include:

- Outcome data that are meaningful and informative to agency audiences that are both internal and external. It may be useful to begin to consider some common measures in order to compare outcomes across similar organizations or subsets of participants.

- Provider-participant relationships emerged as an extremely important factor in the perception of success. Part of the Levy's future planning process might include examining how are these relationships are valued by organizations and how they can this be measured.

- Participant engagement is at the core of treatment, yet it seems little understood. At the same time, high-impact staff who are key to participant and organizational success, are often high turnover positions. The behavioral health field is beginning to address questions of tracking and enhancing participant engagement. The Levy's role in dissemination and support merits consideration. It is also worth considering our role in continuing a conversation on how organizations measure the impact of turnover and incentivize retention of key staff.

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[i] On-site reviews are conducted at least twice each contract year for all grantees and include, but are not limited to: review of treatment records, billing chain, quality assurance/quality improvement processes and provider credentials

[ii] Special Population grant programs include Domestic and Sexual Violence; Consumer Services; Forensic Services; Education and Vocational.