

*Lessons from
Managed Care*



Chapter 4

Chapter 4: Lessons from Managed Care

What Happens When Capitated Mental Health Comes to Town? The Aftermath of the Fort Bragg Demonstration

Introduction

Since the original description of the Fort Bragg Child and Adolescent Mental Health Demonstration (Behar, Bickman, Lane, Schwartz, & Brannock, 1996) and the initial findings of the evaluation (Bickman, et al., 1995), a number of significant changes have occurred regarding behavioral health service delivery at Fort Bragg specifically, and in behavioral health care in general. First, the Fort Bragg Child and Adolescent Mental Health Demonstration, which had been a cost-reimbursement contract, was completed in May 1994. At that time, a contract extension was issued to the same organization so that services would continue for CHAMPUS-eligible children and youth until a follow-on contract could be developed. This interim Demonstration Extension contract, also cost-reimbursement but including an incentive to reduce costs, was for the time period May 1994 to September 1995 (see Heflinger & Northrup, 1997a). A separate follow-on contract for capitated managed mental health services was awarded to a private, for-profit, behavioral health company to cover services from October 1995 to the present.

The purpose of this study was to document the implementation of the current system of capitated managed mental health care. The goal for examining this time period is to explore issues and the impact pertaining to the start up and maintenance of a capitated managed mental health program. The study looked at both the service system and the individual consumer levels. These findings have relevance for health

Craig Anne Heflinger, Ph.D.
Senior Research Associate
Vanderbilt Center
for Mental Health Policy
1207 18th Avenue, South
Nashville, TN 37215
615/322-8275 Fax: 615/322-7049
E-mail: c.heflinger@vanderbilt.edu

Denine Northrup, Ph.D.
Research Associate
Vanderbilt Center
for Mental Health Policy
1207 18th Avenue, South
Nashville, TN 37215
615/343-4554 Fax: 615/322-7049
E-mail: d.northrup@vanderbilt.edu

services planning for both Fort Bragg and other areas developing contracts for managed mental health care programs.

Method

A case study approach (Yin, 1984, 1993) was taken to describe the structure and processes of the managed care system during the 1995-1997 time period. The goal for examining this time period is to explore issues pertaining to contract transitions and implementation at both the service system and the individual consumer level. This case study approach incorporated multiple methods and multiple sources of information.

First, a wealth of documentation was available for review and analysis, including correspondence, program descriptions, policies and procedures, administrative reports, stakeholder survey results, and committee meeting minutes. Second, a series of semi-structured interviews was held with key informants ($n = 65$) from the local Army medical facility (Womack Army Medical Center [WAMC]); the funding source (U.S. Army Medical Command) and health policy planners (Department of the Army Office of the Surgeon General); administrators and staff of the managed care company with the current contract; the previous contractors; and community service representatives. Third, telephone surveys were conducted with families who had children in service with the Demonstration and through the transition period (Northrup, 1997). Fourth, a series of questionnaires and interviews with service providers and service agency representatives ($n = 59$) yielded information about the coordination within the mental health system for children and adolescents and their families at Fort Bragg (Heflinger & Northrup, 1997b). Information from these multiple sources was integrated to form the findings reported below.

Results

The fidelity of program implementation was judged by examining performance within four dimensions: *program participants*, the *mode of service delivery*, the *program implementers and implementing organization*, and the *interorganizational context*. The first three dimensions assess the environment created by the program, and the last dimension describes the effect of the external environment on program implementation. Findings included the following:

- The capitated managed mental health contract was issued for less money than had been spent in that catchment area on children alone but with the requirement to serve a larger beneficiary group.
- The capitated managed mental health contractor appeared to maintain a similar level of overall access for children and adolescents in the first year, but access dropped in the second year.
- The capitated managed mental health contractor significantly reduced the use of residential treatment, inpatient care, and intermediate services such as intensive outpatient services and therapeutic group homes.
- Changes in service philosophy and delivery did not reflect best practice principles.
- Problems interfered with a smooth transition from the previous contractor to the capitated managed mental health contractor.
- Under the capitated managed mental health contract, system-level coordination of mental health services for children and adolescents decreased significantly.
- The capitated managed mental health contractor met the minimal requirements of the contract and worked collaboratively with Contract Officer's Representatives, but other Army personnel and other stakeholder groups were dissatisfied with quality of care issues.

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- Data needed by health care planners and the contractor to assess quality of care and clinical outcomes were not adequate.

Discussion

Issues surrounding contract development and monitoring are being widely discussed by all types of private and public health planners, contract monitors, and purchasers. Methods to assure appropriateness and quality of care are not well established and therefore difficult to include in contracts. The focus in the past has been on monitoring to prevent fraudulent overuse of services. This focus was developed during fee-for-service funding mechanisms when the purchaser was at risk for total cost and the incentives to the providers/contractors were to provide as many services as possible. Thus, limits on length of stay in certain levels of care, utilization management stressing decreased use of high-end services, and reliance on claims data to develop profiles of care were stressed.

However, these methods are not adequate in the current environment of capitated health service contracts, where the risk is shifted to the contractors and the incentives point to providing as few services as possible, regardless of need. This new funding mechanism means that contract monitors must shift their monitoring efforts to detect fraudulent *under use* of services. When average days of inpatient hospitalization drop from the 30s (pre-Demonstration) to the 20s (1993-1994) and down to 5 days (1997), inappropriately lengthy care is likely no longer an issue. The issue becomes: how can it be established that this number of inpatient days allowed adequate stabilization of the crisis situation that brought the individual into care? When average daily census of children in intermediate levels of care drops from 53.3 (1995) to 8.6 (1997) while, at the same time, the number of children in outpatient treatment also drops by over one-third (37% decrease), the questions to be asked should be: what happened to

all of those children with high needs? How well are they doing? Such monitoring efforts are more difficult, because claims data or utilization management reports contain only data on those who actually receive services. A looming concern is the status of the beneficiaries who do not receive any care or those who do not receive care at sufficiently intense levels. Furthermore, when standardized clinical outcome data (such as behavioral or symptom checklists, quality of life indicators, health status) are not available, it is difficult to judge just what the mental health status of the beneficiaries are and whether they are being helped or harmed by this method of contracting for services.

References

- Behar, L., Bickman, L., Lane, T., Keeton, W.P., Schwartz, M., & Brannock, J.E. (1996). The Fort Bragg child and adolescent mental health demonstration project. In M.C. Roberts (Ed.), *Model programs in child and family mental health* (pp. 351-372). Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.
- Bickman, L., Guthrie, P.R., Foster, E.M., Lambert, E.W., Summerfelt, W.T., Breda, C.S., & Heflinger, C.A. (1995). *Evaluating managed mental health services: The Fort Bragg Experiment*. New York, NY: Plenum Press.
- Heflinger, C.A., & Northrup, D.D. (1997a). *Interim report of the implementation study of the transition to managed health services at Fort Bragg*. Nashville, TN: Center for Mental Health Policy.
- Heflinger, C.A., & Northrup, D.D. (1997b). *Measuring change in the mental health service system at Fort Bragg 1992-1996: A network analysis*. Nashville, TN: Center for Mental Health Policy.
- Northrup, D. A. (1997). *Experiences of families of children targeted for major case management*. Nashville, TN: Center for Mental Health Policy.
- Yin, R. K. (1984). *Case study research*. Newbury Park, CA: Sage Publications.
- Yin, R. K. (1993). *Applications of case study research*. Newbury Park, CA: Sage Publications.

The Impact of Medicaid Managed Care Financing Strategies on Children's Health and Mental Health Status

Background

Nationally, Medicaid expenditures have steadily risen at an alarming rate. In Florida, for example, Medicaid has grown at a rate of 28% since 1988, consuming 50% of all new general revenue. To gain control of these spiraling costs, many states have implemented reforms to their Medicaid systems. One common approach involves removing or “carving out” the Medicaid mental health service dollars for specific populations from general health and managing them separately.

Proponents of “carve outs” argue that they ensure adequate resources are devoted to mental health, that reviews of service providers are evaluated using mental health indicators, and that coverage includes a broader range of services. In contrast, critics believe the removal of mental health services promotes isolation, frustrates access to and continuity of care with primary care services, and increases stigmatization.

Florida Context

Florida, like 20 other states, has received a waiver from the Health Care Financing Administration to experiment with the use of managed care strategies for the provision of mental health services. In March 1996 the Florida State Medicaid Authority implemented a mental health “carve out” program in the Tampa Bay area. The demonstration covers mental health services only; primary health care and alcohol and other drug services continue to be funded on a fee for service basis. In August 1996, the Medicaid authority authorized HMOs in the

Roger A. Boothroyd, Ph.D.

Department of Mental Health Law and Policy

Louis de la Parte

Mental Health Institute

University of South Florida

13301 Bruce B. Downs Blvd

Tampa, FL 33611

813/974-1915 Fax: 813/974-9327

E-mail: boothroyd@fmhi.usf.edu

Mary I. Armstrong, MSW, MBA

Department of Child and Family Studies

Louis de la Parte

Mental Health Institute

University of South Florida

813/974-4601 Fax: 813/974-6257

E-mail: armstron@fmhi.usf.edu

Oliver T. Massey, Ph.D.

Department of Child and Family Studies

Louis de la Parte

Mental Health Institute

University of South Florida

813/974-6403 Fax: 813/974-6257

E-mail:massey@fmhi.usf.edu

Krista Kutash, Ph.D.

Department of Child and Family Studies

Louis de la Parte

Mental Health Institute

University of South Florida

813/974-4661 Fax: 813/974-6257

E-mail: kutash@fmhi.usf.edu

David L. Shern, Ph.D.

Dean

Louis de la Parte

Mental Health Institute

University of South Florida

813/974-1919 Fax: 813/974-4699

E-mail: shern@fmhi.usf.edu

Tampa Bay area to provide mental health services thus creating an integrated model for delivering health and mental health care. A third health care arrangement that exists in some parts of Florida (e.g., Jacksonville) involve a primary care physician model where health, mental health, and substance abuse services are all provided on a fee for service basis. These three different health care plans are summarized in Table 1.

Overall Study Design

The Louis de la Parte Florida Mental Health Institute (de la Parte Institute) was selected by the state to evaluate the effects of this experimental prepaid mental health plan on enrollees' access to, quality of, and outcomes of the services they receive. In our evaluation we used a mixed-method approach to assess the impact of these managed care arrangements on children with severe emotional disturbance. These methods included: (1) intensive case studies intended to describe the status of the health care system and to understand the experiences of children with serious emotional disabilities (SED) and their families interfacing with the system; (2) mail survey methods to obtain population-based (*i.e.*, covered lives) estimates of children's health and mental health status, irrespective of whether they entered the system of care; and

(3) an analysis of the Florida's performance outcome measures database, to examine changes in children's functioning and symptomatology. The methodology and a brief summary of the findings from each component are provided below.

Case Study

Case Study Methodology

The case studies focused on the interface between the system of care and children with SED and their families. Questions examined how each managed care arrangement (Mental Health Carve Out and HMOs) addressed and worked to meet the needs of children and their families. The Case Study protocol was designed to investigate four aspects related to system functioning and families' experience interacting with it, using standards based on a professional consensus of effective children's mental health systems (Stroul & Friedman, 1986; Stroul & Friedman, 1988). The approach allowed us to synthesize two key elements of services research: the strength and integrity of the system intervention, and the outcomes and status of individuals served by the system.

Our procedures closely followed those proposed by Yin (1988) and assumed that each child was a microcosm of how the system behaved and responded (Groves & Foster, 1995). To achieve reliability and validity, we triangulated data from

Table 1
Summary of Health Care Plans

Plan	Area 4 (Tampa) Florida Health Partnership Mental Health Carve Out	Area 4 (Tampa) HMOs Mental Health Carve In	Area 6 (Jacksonville) Medipass Primary Care Physician
Medical Services	Fee for Service	Managed	Fee for Service
Mental Health Services	Managed	Managed	Fee for Service
Dental Services	N/A	Managed	N/A
Substance Abuse Services	Fee for Service	Fee for Service	Fee for Service

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various sources and methods (Merriam, 1988) that included observations, interviews, and case record analysis. For each case, data were collected from the child, his or her primary caregiver, and representatives of the different systems providing service, including case managers, therapists, and direct service providers.

The sample of 30 children included 15 enrolled in the Mental Health Carve Out and 15 enrolled in HMOs. Sixteen children were under the age of 13; 14 were between the ages of 13 and 18. Twenty-five of the children were living with their biological family and five lived with a foster family.

Case Study Findings

The findings are organized by each domain, and include a summary of perceptions of system effectiveness by different study participants. Each section includes a summary of the findings for the Mental Health Carve Out followed by a summary of the HMO findings.

System Effectiveness. With respect to the effectiveness of the system, the overall experience with the service system was generally positive for all 15 families enrolled in the Mental Health Carve Out, although for 3 of the families, their experiences were less adequate. Families repeatedly reported that case managers and therapists were accessible and responsive to their needs. Many families had their case managers' pager numbers and knew who to call in an emergency. The youth interviewed also expressed satisfaction with services received and stated that they had been helped by their therapists and case managers. In contrast, one foster mother indicated that despite improvement in the child's behavior, she had no involvement in any planning for her foster child's treatment, and that she would like to "add my input." Another foster parent expressed similar concerns and was not aware of her foster child's treatment plan or what issues were being addressed by the plan.

The experience of families enrolled in HMOs was mixed; 8 of the 15 families had an overall positive experience with the system, while 4 families reported one or more negative experiences. On the positive side, one mother reported direct involvement in preparing treatment and service plans, including attending the planning meetings. She also noted that her case manager was always available for consultation during emergencies with her child. Another parent reported that both she and her son had benefited from services, especially the in-home therapy they received. Another primary caregiver, a step-grandmother, reported overall satisfaction but noted that she had asked for "more involvement" with her grandson's problems, including a better understanding and "more training and advice on how to deal with his behavior."

In contrast, one HMO enrolled mother recalled waiting for 8 hours for her son to be admitted to a crisis stabilization unit because the HMO was slow in authorizing admission. She also described instances when she had to pay for a new medication due to the HMO's refusal to authorize payment. A mother who had switched to a new HMO reported that her foster son's in-home therapy was terminated so she requested a change in her insurance coverage. Another parent expressed grave concerns because her son's respite services had been reduced.

Treatment Planning. Overall, 14 of the 15 families enrolled in the Mental Health Carve Out reported positive experiences with treatment planning. In all 15 cases the child and family's needs were assessed and considered in the treatment plan. For 13 families, providers recognized and considered child and family strengths in developing the treatment plan. Ten families stated that they participated in the development of the treatment plan.

For families enrolled in HMOs, the overall experience was positive for 12 of the 15 families. In 12 cases, child and/or family strengths were recorded on either the treatment plan or the family service plan. In 7 of these 12 cases, child strengths only were reported; in 5 cases both child and family strengths were included. Fourteen of the treatment plans reviewed assessed and considered child and family needs. The remaining case included child needs only, although the case manager reported that the family's needs had been addressed although not recorded on the treatment plan. Nine of the 15 families responded that they had participated in the development of the treatment plan.

Quality of Life. The quality of life of children and families enrolled in Mental Health Carve Out was positive for 11 families interviewed. These families reported that the quality of their lives had improved primarily for two reasons: (1) the treatment received by their children, and (2) assistance received by the family in their ability to handle most problems. One mother commented that their family life had improved because her child was no longer fighting with his brother or getting into trouble on the school bus. Another parent mentioned that as a result of services the family situation had improved. Family counseling also helped improve the quality of life for these families. For the 4 families for whom quality of life had not improved, the reasons were varied and included services that had only recently been implemented and families in which the severity of the child's emotional disturbance placed limitations on what could be accomplished.

Quality of life improved for 9 of the 15 families enrolled in HMOs, 4 families reported no change, for 2 families things were worse. The two key services that positively impacted the lives of children and families were the individual and family counseling. As stated by a case evaluator:

"Both child and primary caregiver have strongly benefited from their association with the counseling center." Other comments noted to improvements made by children at school and an improved home environment. In the words of an evaluator: "The home environment has improved. Grandparents are equipped with useful behavior management techniques."

Among the two HMO families for which quality of life had decreased, one foster parent reported no improvement in the child's behavior. According to the case manager, the lack of improvement was due to the extremely difficult home environment from which the child had been removed twice during the past year. For the other case, the parent's lack of participation in services was reported as the primary reason for the lack of improvement.

Experiences with the system. For 12 families in the Mental Health Carve Out, their overall experience with the service system was positive, 2 were neutral, while 1 was negative. In 3 of the positive cases, it was specifically noted that improvements in school and home behaviors were attributed to the provision of counseling, medication management, and the case manager. Positive experiences appear to be associated with close relationships established between children and/or families and either a case manager or therapist. In fact, one family specifically commented that their only concern with the system was the turnover rate of therapists (5 therapists for the child during the past year). For the 2 neutral families, 1 noted some dissatisfaction with in-home therapy stemming from their lack of involvement and the other family involved a teenage mother with multiple problems. The overall sense was that the lack of improvement was due to family circumstances rather than the services offered or provided. For the 1 family who had a negative experience with the system, they did not feel that their needs had been properly

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addressed, were not satisfied with services provided, and did not feel that their situation was improving as a result of services. A valued service, mentoring, had been discontinued, much to the family's dismay. Early improvements in the child's behavior had been attributed to this service by the family.

For HMO enrolled families, 10 had an overall positive experiences with the system while 5 characterized their experiences as neutral. Among those having a positive experience, one family noted that the case manager accompanies the youth to court; another believed that the providers had "her son's best interests in mind", and another family were pleased with the efforts of the therapist and case manager on their behalf. These were also instances where the family was satisfied in spite of service limits. For example, one family expressed belief that services had improved their child's ability to cope with daily stressors but also expressed discontent with unannounced changes in HMOs and service limits. Another family expressed satisfaction despite the fact that case manager contact time had been reduced and the therapeutic mentor service never materialized. More neutral experience included families who specifically noted that problems with their HMOs service limits were interfering with behavioral changes and improvement in their family situation.

Mail Survey

Mail Survey Methodology

The second component of this mixed methods evaluation involved a mail survey sent to the caregivers of a stratified random sample of 1,800 children, ages 5 to 21, who were receiving SSI and enrolled in one of the three managed care arrangements previously described (600 in each plan). Children's names and address were obtained from the state's Medicaid eligibility file.

The mail survey procedures followed those recommended by Dillman (1978) and Salant and Dillman (1993). In total, five mailings were conducted. The initial mailing involved a prenotification postcard informing respondents that they would receive a questionnaire within the next week. The second mailing included a personalized cover letter to the child's caregiver explaining the purpose of the study, that he or she would be paid \$5.00 for completing the survey, a questionnaire (in both English and Spanish), and information about days and hours of operation of a toll-free telephone number that had been installed for this study. A preaddressed stamped return envelope was also included. As recommended by Dillman (1978), first class postage was used on both the outgoing and return envelope.

One week after the second mailing, a postcard reminder was sent to each caregiver that had not yet responded. Two weeks after the postcard reminder was mailed, a second complete mailing containing a personalized cover letter, survey, and return envelope was sent to each non-respondent. Four weeks later a third complete mailing was sent via certified mail to those who still had not responded. As with the first and third mailings, enrollees received a personalized cover letter, survey, and preaddressed stamped return envelope with information about the toll-free telephone line.

Mail Survey Findings

Response Rate. Of the 1,561 questionnaires mailed for whom we had correct addresses, 695 completed surveys were returned for a response rate of 44.5%. Of the 695 returned, 197 were returned from caregivers of children who received SSI because of a behavioral/emotional problem. One hundred and sixty three of these children were enrolled in one of the three health care conditions being studied. The results presented here are specific to these 163 children.

Characteristics of the children. The average age of these children was 13.7 years old, ranging from 7 to 20 years (*SD*= 3.27). Most respondents (64%) were youth (i.e., 13 years old or older) while 36% were children (i.e., under 13 years old). Nearly 72% were boys. With respect to race/ethnicity, 45% were White, 43% Black, 9% were Hispanic, and 4% were Asian. The average score on the Pediatric Symptom Checklist (Jellinek, Murphy, & Burns, 1986) for these children was 32.1 (*SD*=8.36). Approximately 74% of the children had PSC scores above 28, the cut-off score denoting serious mental health problems. No between health care plan differences were found with respect to age, gender, race/ethnicity, or PSC scores.

Penetration Rates Among Children Who Have Self-Identified Service Needs. The use of services (i.e., the penetration rate) among children whose caregivers reported service needs for their child are summarized in Table 2. In terms of physical health services, children enrolled in each of the three health care conditions had similar high rates of service use. Children whose caregivers reported their child needed mental health services, however, were significantly more likely to receive them if the child was enrolled in the Fee-for-Service condition (95.5%) than in either the Mental Health Carve Out or the HMO conditions (78.3% and 80.0%, respectively). No meaningful between plan differences were noted with respect to dental care services. Children in the Fee-for-Service condition were somewhat more likely to have their eye care needs met (92.3%) than were children enrolled in HMO (79.2%).

Medications. Caregivers whose children had used medications during the past months were asked to answer several question regarding their child's medications. These findings are summarized in Table 3. Caregivers whose children were enrolled in the Fee-for-Service conditions were less

likely to report difficulties getting medications for their child (6.1%) than were caregivers of children enrolled in either of the two managed care conditions (19.4% and 15.3%, respectively). Caregivers of children enrolled in HMOs were more likely to report having paid for medications for their child during the past month (22.4%) compared to caregivers of children enrolled in the Mental Health Carve Out (15.8%) or Fee-for-Service (12.1%) conditions. Caregivers of children in HMOs were also more likely to indicate that their child was put on medications they did not want (22.4%), compare to the Fee-for-Service condition (15.2%), while this occurred with the least frequency in the Mental Health Carve Out.

Satisfaction with Mental Health Services. Caregivers whose children had used mental health services during the past month were asked about their level of agreement with 12 statements concerning various aspects of the services their child received using a five-point Likert-type scale ranging from 1= *Strongly Disagree* to 5= *Strongly Agree*. No significant differences were noted across the three health care conditions in caregivers' level of satisfaction with mental health services among those whose child had used services. In general, caregivers reported a moderate level of satisfaction with the mental health services their child had received.

Table 2
Penetration Rates Among Children with SED
Who Have Identified Service Needs

Service Area	MH Carve Out		MH Carve In (HMO)		Fee-for-Service	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Medical	34	94.1	45	97.8	20	100.0
Mental Health	23	78.3	40	80.0	22	95.5
Dental	31	83.9	33	78.8	16	81.3
Eye	21	85.7	22	79.2	14	92.3

Performance Measures

Performance Measures Methodology

The third component of the evaluation involved an analysis of the State's Performance Outcomes database housed at the Louis de la Parte Institute. As a result of the Florida's 1994 Government Performance and Accountability Act, the Alcohol, Drug Abuse and Mental Health program of the Department of Children and Families was mandated to include performance outcome measures in every service providers' contract. As part of the state's performance monitoring system, the Child and Adolescent Functional Assessment Scale or CAFAS (Hodges, 1996; Hodges & Summerfelt, 1994), and the Children's Global Assessment Scale or CGAS (Shaffer, Gould, Brasic, Ambrosini, Fisher, Bird, & Aluwahlia, 1983) are collected for all children. The CAFAS and CGAS are completed by mental health providers at intake, every six months, and at discharge.

Performance Measures Findings

Characteristics of the children. For the purposes of the analyses, all children from the Tampa and Jacksonville areas for whom performance outcome data was available were selected from the statewide monitoring system database. At least partial information was available for 1559 children for whom

performance outcome measures were completed between July 1, 1996 and June 30, 1997. Of these children, 68% were children with SED, while 27% were children at risk of serious emotional disabilities (At Risk). Sixty-three percent of the children were male. The average age of all children in the sample was 9.6 years, and 69% were between the ages of 4 and 14 years of age. The average CAFAS score for all children was 57, a score that is considered indicative of a youth who "may need care which is more intensive than outpatient and/or which includes multiple sources of supportive care." The average CGAS score for all children was 55; this score is characterized as "variable functioning with sporadic difficulties or symptoms in several social areas." On average, the children had been in the local community 26 of the last 30 days.

Differences among children at admission.

Small but non-significant differences were found among children in the three health plans with regard to gender, age, days spent in the community during the last month, and days spent in school during the last month. However, significantly more children receiving services under the fee-for-service condition were identified as children with Serious Emotional Disabilities (SED) than under either of the other financing conditions ($\chi^2=8.75$, $p < .05$).

**Table 3
Medication**

Health Care Condition Question	MH Carve Out (n = 39)	MH Carve In (HMO) (n = 58)	Fee-for-Service (n = 33)
Had problems getting medications	19.4% ¹	15.3%	6.1%
Child asked to take medications that do not work well	10.5%	19.0%	12.1%
Had to pay for medications out of plan	15.8%	22.4%	12.1%
Child put on medications that you did not want	7.7%	22.4%	15.2%

¹Percentage of caregivers answering yes

Significant differences also were found among the children with regard to measures of functioning. Significantly higher scores were found for those children in the Fee-for-Service condition than those children in either the HMO or Mental Health Carve-Out plan. Significant differences were found for the *Performance*, *Mood*, and *Thinking* sub-scales of the CAFAS and the total CAFAS score ($F=22.7$, $p<.001$; $F=22.2$, $p<.001$; $F=53.7$, $p<.001$; and $F=43.0$, $p<.001$, respectively). In each case, higher scores for the fee for service condition indicate worse functioning. The only statistically significant but very small absolute difference for those children in the other two conditions occurred for the Thinking sub-scale of the CAFAS, with children in the Mental Health Carve In option scoring worse than those children in the Mental Health Carve Out plan ($F=7.7$, $p<.01$).

Treatment Outcomes. For the analysis of treatment outcomes, children enrolled in each of the financing conditions at admission and discharge were compared. To be included in the analysis of change over time, the child must have had an admission assessment and a discharge assessment and must have remained in the same financing condition during the entire assessment period.

A total of 92 children had assessments at both admission and discharge. For these children, statistically significant decreases occurred for the total CAFAS score ($t=-4.77$, $p<.001$) and each of the sub-scales of the CAFAS. These include the *Performance* sub-scale ($t=-3.2$, $p<.01$), the *Behavior* sub-scale ($t=-3.29$, $p<.01$), the *Mood* sub-scale ($t=-3.29$, $p<.01$), and the *Thinking* sub-scale

($t=-3.24$, $p<.01$). In each case, differences reflect a mean increase in functioning of the children from admission to discharge.

Results of these analyses are consistent with results statewide for children receiving mental health services, and indicate that, as a whole, children in the financing conditions show significant improvement over time in their psychosocial functioning. Small sample sizes precluded determining if financing conditions produced more favorable outcomes for children. However, the data collection process is continuing with the expectation that sample sizes in successive years will provide an opportunity to compare outcomes for children under each of the different financing strategies.

Conclusions

The preliminary findings from our evaluation examining the impact of different types of managed care plans on children with SED and their families are summarized in Table 4 by ranking the plans from highest to lowest. Overall, these results are mixed across evaluation components and at times

Table 4
Ranking of Programs on Major Findings

Component/Findings	MH Carve Out	HMO	Fee-for-Service
Case Studies			
System Effectiveness	1	2	N/A
Treatment Planning	1	2	N/A
Quality of Life	1	2	N/A
Experience with System	1	2	N/A
Mail Survey			
Access to Medical Care	2	2	1
Access to Mental Health Care	2	2	1
Medications	2	3	1
Satisfaction with Services	1	1	1
Performance Measures			
CAFAS at Intake	2	2	1
Change in CAFAS over time	1	1	1

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within evaluation components. Findings from the case studies indicate that the experiences of children and families were generally more positive among those enrolled in the Mental Health Carve Out compared to the HMOs. No information was obtained within the case study component, on children enrolled in the Fee-for-Service condition. Findings from the mail survey indicate that access to medical and mental health services was greatest in the Fee-for-Service condition relative to both managed care conditions, although some slight differences were noted between the Mental Health Carve Out and the HMO conditions. With respect to medication issues, the Fee-for-Service condition ranked first, followed by the Mental Health Carve Out, and finally the HMOs. No differences were found, however, in the level of satisfaction among respondents with mental health services received across the three plans. Significant health care plan differences were also found in the performance measures component of the evaluation. Children enrolled in the Fee-for-Service condition had significantly higher CAFAS scores at intake (i.e., had the most severe dysfunction), than were children enrolled in either the Mental Health Carve Out or HMO conditions. Collectively, however, all of the children demonstrated significant improvements in their level of functional from intake to discharge.

References

- Dillman, D. A. (1978). *Mail and telephone surveys: The total design method.* New York, John Wiley & Sons, Inc.
- Groves, I. D., & Foster, R. E. (1995, March). *Service testing: Assessing the quality and outcomes of systems of care performance through interaction with individual children served.* Paper presented at the 8th Annual Research Conference, A System of Care for Children's Mental Health: Expanding the Research Base, Tampa, FL
- Hodges, K. & Summerfelt, W. T. (1994). *Reliability and validity of a multidimensional measure to assess impairment: The Child and Adolescent Functional Assessment Scale (CAFAS).* Ypsilanti, MI: Department of Psychology, Eastern Michigan University.
- Hodges, K. (1996). Psychometric characteristics of a multidimensional measure to assess impairment: the Child and Adolescent Functional Assessment Scale. *Journal of Child and Family Studies, 5,* 445-458.
- Jellinek, M. S., Murphy, M., & Burns, B. J. (1986). Brief psychosocial screening in outpatient pediatric practice. *Journal of Pediatrics, 109,* 371-378.
- Merriam, S. (1988). *Case study research in education: A qualitative approach.* San Francisco, CA: Jossey-Bass
- Salant, P. A., & Dillman, D. A. (1993). *How to conduct your own survey.* New York, John Wiley & Sons, Inc.
- Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A Children's Global Assessment Scale (CGAS). *Archives of General Psychiatry, 40,* 1228-1231.
- Stroul, B. A., & Friedman, R. M. (1986). *A system of care for severely emotionally disturbed children and youth.* Washington, DC: Georgetown University, CASSP Technical Assistance Center.
- Stroul, B. A., & Friedman, R. M. (1986). *Caring for emotionally disturbed children and youth: Principles for a system of care.* *Child Today, 17(4)* Washington, DC: Georgetown University, CASSP Technical Assistance Center.
- Yin, R. K. (1988). *Case study research: Design and methods.* Beverly Hills, CA: Sage Publications.

Towards an Outcome-Oriented Evaluation of Intensive Mental Health Services for Children in Managed Care

Introduction

This summary describes the Oregon Mental Health and Developmental Disability Services Division's (MHDDSD) evaluation of a state initiative designed to transition intensive treatment services for children into the Oregon Health Plan. State legislation directs the MHDDSD to conduct this initiative, which includes an evaluation to determine the efficacy of children's mental health organizations participating within Oregon's managed care environment. For purposes of this legislative action, "intensive services" are those mental health programs that include psychiatric day treatment and residential services, excluding inpatient acute care.

A 1997 Oregon Legislative Budget Note requires the MHDDSD to "specify a process by which intensive services for children shall be transitioned into capitation..." This Budget Note also requires the MHDDSD to allow for a process by which service providers voluntarily establish pilot projects for integrating into the Oregon Health Plan. During this transition, fiscal contracts held by MHDDSD with all the intensive treatment service providers are not subject to any reduction of contracted rates. Finally, the Budget Note requires the MHDDSD to evaluate the efforts of the pilots transitioning into the Oregon Health Plan.

Hanteng Dai

*Chief Researcher
Office of Mental Health Services
(OMHS)*

*2575 Bittern Street NE
Salem, OR 97303*

503/945-9726 Fax: 503/373-7327

E-mail: daih@mail.mhd.hr.state.or.us

Stephen Perkins

*Office of Mental Health Services
(OMHS)*

*2575 Bittern Street NE
Salem, OR 97303*

503/945-9739 Fax: 503/373-7327

In response to this Budget Note, the MHDDSD has initiated the Children's Intensive Mental Health Treatment Services Project. This project will allow intensive treatment services providers who wish to participate as pilot sites to determine how to restructure their agencies to best meet the clinical and market demands within a capitated managed care environment. This summary describes the projects' evaluation design.

Method

Research Questions

The overarching research question regarding this project is to what extent does the pilot model contribute to improvements, as related to the current program structures, in: (a) the mental health and social service delivery system for children and families; (b) family-level functioning; (c) individual child functioning; (d) and cost-effectiveness. In other words, the key issue is whether the redesign of the pilot programs can provide the appropriate level and mix of services to children in a more streamlined and cost effective fashion, so that the children's conditions show greater improvement or improvements more quickly, at either less or no additional cost increase.

The fundamental hypothesis to be tested is whether the redesign of the pilot programs can provide the appropriate level and mix of services to children in a more streamlined and cost efficient fashion than the existing systems. This would establish the intensive treatment services pilots as cost-effective and quality-oriented programs– the basic tenants of managed care.

The following hypotheses address child and family outcomes in the pilot initiative. These hypotheses were developed through a series of meetings with representation from service providers, other child-serving state agencies, and parents of children receiving intensive treatment services.

- Pilots will report more improved or maintained functional outcomes for children served.
- Pilots will report easier transition of children to other levels of services.
- Pilots will have shorter lengths-of-stay for children in the initial placement.
- Pilots will serve more children with the same level of diagnostic severity than non-pilots, at the same or less cost.
- Pilots will serve the same or more numbers of Service to Children and Families (SCF) and Oregon Youth Authority (OYA) kids.
- Allied agencies will report increased satisfaction with treatment outcomes and case coordination activities provided by the pilots.
- Family members will report increased satisfaction with access and treatment outcomes for their children provided by the pilots.

The Intensive Treatment Services evaluation will use a mixed-methods approach that will focus on two major areas:

1. How pilots are implemented; what changes occur in the service delivery system (primarily a qualitative analysis), and
2. The impacts of the model on child, family and service delivery system outcomes (primarily a quantitative analysis).

Sites/Subjects

A quasi-experimental design is incorporated for part of the study. Those programs volunteering to participate as pilot sites are considered as the experimental group. Of the eight Joint Commission of Accredited Organizations (JCAHO) residential programs in Oregon, all have requested to participate as pilot programs. Therefore, because no JCAHO centers elected to remain outside the pilot, there is no JCAHO control group. For these eight programs, a pre-post comparison design will be used to address the hypotheses stated above. For

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non-JCAHO programs, approximately fifty-percent have volunteered to participate as pilots; the remaining non-pilot programs will act as the control group. Comparable data is collected from both the pilots and the non-pilot control groups.

The target population consists of children under age twenty-one and their families in Oregon who are referred and accepted in either the DARTS (day treatment programs) or JCAHO (long term residential care) programs. For the JCAHO programs all children receiving services will be used to provide aggregate data for pre-post comparisons.

For those children receiving intensive treatment services through other than JCAHO programs, a sample of 200 children is used for both the experimental and control groups. Children from both groups are selected based on age, gender, diagnosis, and functioning level. Children and families will continue to receive services either through the pilots or the non-pilot programs. Because children were not preselected into one group or another, there is no need for human subject review regarding this evaluation.

Data Collection/Instruments

The evaluation was initially designed for two years, from January 1, 1998 to December 31, 1999. Current discussions may extend the evaluation. A baseline is established for all programs, with data collection occurring within the first few months of 1998. Data collected includes sociodemographic, and behavioral functioning scores, acuity levels, current diagnosis, and parent satisfaction. The instruments utilized are described below. Additionally, a list of services provided before the implementation of the pilots will be compared with the array of services provided at the end of the two-year period. Finally, division staff will use on-site program guides to facilitate monitoring and measurement of changes occurring within each pilot organization.

Child Acuity of Psychiatric Illness (CAPI)

Scale. This instrument measures the severity of a child's psychiatric disorder and indicates the level of out-of-home care the child needs. The Oregon Professional Medical Review Organization (OMPRO) administers the CAPI in JCAHO programs for all children at intake (retrospective review) and every ninety days following intake within a residential facility. The CAPI is not currently administered in DARTS programs (Lyons, 1997).

Children and Adolescent Functional Assessment Scale (CAFAS)

This is a functional assessment instrument designed to measure a child's functioning in community and residential settings. The instrument is sensitive to changes in a child's environment and can be used to determine service level as well to measure impairment. The CAFAS is administered through facility staff and repeated at the time the program staff transitions a child from one level of care to another (Hodges, 1995).

Client Satisfaction and Services Fit Survey. This survey measures the "fit" between services provided and family satisfaction with the services. It was developed for OMHS with Portland State University. The survey is used in certifying OMHS contracted children's community and intensive treatment services programs and by Oregon Health Sciences University researchers in evaluating the Oregon Health Plan 25% mental health demonstration. All Oregon Health Plan Mental Health Organizations are required to use the survey as a part of their quality assurance evaluation. The Client Satisfaction and Services Fit survey was conducted in February 1998 and will be repeated once each year of the pilot initiative (MHDDSD, 1997).

Allied Agency Survey. The Children's Community Treatment Services Allied Agency Survey used to certify outpatient providers will be the model for a like survey to evaluate the pilot initiative.

Organizational Reviews. Information provided in the letters of intent will be used as a baseline to review the effectiveness of changes made by pilots over the duration of the pilot initiative in preparation for providing services through Mental Health Organizations. On-site reviews by OMHS staff will supplement the baseline data.

Focus groups. A series of focus groups has been designed for parents of children requiring intensive mental health services. In coordination with the Oregon Family Support Network (OFSN), a series of meetings will be conducted throughout the state to solicit parental input regarding the changes being made within the Oregon Health Plan and managed care. These meetings will collect information from parents about the current mental health system, managed care, and how the state mental health division may best implement policy to improve the current children's mental health system. The focus groups will also solicit guidance from parents regarding the information they need to maximize the use of mental health services through managed care.

Data management. Data will be collected using state-supported CPMS and MMIS data system reports. A specialized CAFAS database is used to collect additional information not currently available through either data system. Completed CAFAS forms are sent to the MHDDSD for data entry. The CAFAS database is designed to provide information about the child, family and agencies with which the child is involved. All intensive treatment services programs, whether participating as a pilot project or not, are using the CAFAS database.

Discussion

In designing this evaluation we acknowledge the importance of collecting anecdotal information from parents, agency staff, and caseworkers from other child-serving state agencies through various satisfaction surveys. However, recognizing that this method alone is not comprehensive and is somewhat one-dimensional, additional data regarding a child's level of acuity and functioning will be collected to establish a more robust outcome-oriented evaluation.

The goal of this evaluation is to provide state policy makers with adequate information to plan next steps in integrating intensive mental health treatment services into the Oregon Health Plan. This evaluation will help determine the feasibility of continued service integration into managed care; it may, conversely, reveal that a specialized carve-out for intensive treatment services, or maintaining intensive treatment services in a fee-for-service contractual relationship with state agencies promise better outcomes for these children and families.

Regardless of Oregon's inclusion of these services into the Oregon Health Plan, state officials will have the benefit of baseline information regarding children currently accessing these services. Data from this evaluation will facilitate future monitoring activities around cost-shifting, appropriate service utilization, and functional improvement for this population.

From a Traditional Mental Health Treatment to a Managed Care Type of Treatment: Challenges and Solutions

Introduction

In Florida, as in many states, extended lengths of stay of youth in residential treatment programs are a concern. Children are experiencing stays that are longer than is clinically appropriate, leading to youth becoming “institutionalized.” Further, extended lengths of stay prevent access to treatment for youth on waiting lists. The high cost of maintaining youth in residential treatment, when they could be transitioned into some other type of care, has become untenable to the State because it diverts resources that could be used for more appropriate after-care placements. In an effort to establish a more effective system, a local state mental health program responsible for administering the Purchased Residential Treatment Services (PRTS) funds (funding agency) developed a proposal for a pilot program that addresses these concerns as well the issue of quality of services.

The Children’s Mental Health Managed Care Pilot Program, focused on services provided by their primary residential treatment provider. Its intent was to establish an agreement between this provider agency and the funding agency in which the provider would pilot the proposed project. Key aspects of the pilot include: (1) the development of a managed care type of mental health treatment that would foster the appropriate utilization of non-residential services; (2) the provision of mental health services to 30 clients per year for which the provider would receive an agreed upon case rate; (3) the provider’s accountability for treatment success/failure rates; (4) stipulations

Angela Gomez, M.A.

*Department of Child and Family Studies
Louis de la Parte
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, Fl. 33612
813/ 974-6415 Fax: 813/ 974-7376
gomez@hal.fmhi.usf.edu*

Nicole Deschênes, M. Ed.

*Department of Child and Family Studies
Louis de la Parte
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, Fl. 33612
813/ 974-4493 Fax: 813/ 974-7376
deschene@hal.fmhi.usf.edu*

Leigh Nations, MSW, MPH

*Department of Child and Family Studies
Louis de la Parte
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, Fl. 33612
813/ 974-7128 Fax: 813/ 974-7376
nations@hal.fmhi.usf.edu*

regarding staff qualifications, appropriate client-to-staff ratios, and the definition of admission and discharge criteria; and (5) a list of clearly defined outcome measures and performance standards.

An evaluation and technical assistance component was included in the Children's Mental Health Managed Care Pilot Program. The purpose of this study was to report, to the funding agency and service provider, the effectiveness of the pilot program and the challenges encountered during the transition from a traditional program to a managed care mental health treatment program for youth. Solutions to these challenges, which ultimately included a change in the evaluation methodology, are also discussed.

Method

The initial evaluation methodology was selected to address the funding agency's two central questions: (1) how were the clients doing clinically; and (2) was the program meeting appropriate performance standards? To address the funding agency's questions the evaluation design was centered around two specific activities requested by the funder: (1) the provision of technical assistance to the provider and (2) an outcome evaluation. These two aspects of the evaluation would be intertwined and would take place simultaneously.

There were four components to the design. First, site visits were used to obtain a deeper understanding of the program and the services being provided and to identify areas in which technical assistance would be needed. Staff interviews were conducted to determine the effect of staff roles and their understanding of the pilot program on service delivery. Next, record reviews were conducted using an assessment tool, the Childhood Severity of Psychiatric Illness (CSPI: 1995 Northwestern University Medical School and the Department of Child and Adolescent Psychiatry, Children's Memorial

Hospital) that allowed both the provider and the evaluation team to determine if clients were served at an appropriate level of care for an appropriate period of time. Case studies were intended to look at the interface between the services provided and the needs of the clients and their families. This method allowed the evaluation team to inquire about the perspectives of key players involved with the clients (e.g., client, primary caregiver, case manager, therapist, teacher, etc.). Case studies also addressed effectiveness and satisfaction issues. The fourth component was comprised of stakeholder interviews, was designed to determine the effects of the pilot project at an administrative and systems level. In addition, a project management team was created to oversee the progress of the evaluation. The team included representatives from the funding agency, the provider's agency, the evaluation team, and a parent.

The study was conducted at an adolescent residential treatment center in Pinellas County. The participants in the study were the staff of the center who were involved in the Pilot project either as direct care providers or in an administrative capacity and the clients. The Pilot was intended to cover a total of 30 clients per year, however, this did not mean that all of them would be at the residential treatment center at the same time.

Data collection followed the sequence outlined in the design. The evaluation team began by conducting site visits at the residential treatment center to observe the treatment process, the intervention activities, and learn about the different functions of the staff involved with the clients. The observations and visits led to the development of the staff interviews. These interviews were conducted on site. A total of 16 interviews were conducted with staff from the different operational areas (i.e., administrative, direct care, nursing, education, etc.). Next, the record reviews were completed. The review consisted of physical

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review of the content of the medical records to establish an understanding of the record keeping process and to come to a descriptive understanding of the clients being treated and their treatment progress, and of the rating of each client utilizing the CSPI based on the information contained within the records.

The evaluation team agreed to provide monthly update reports and a final report. The monthly reports described the activities completed during the particular month. A total of six monthly updates were completed. At this point the evaluation team felt that in order to make the data collected up to that point accessible and usable to both the provider and the funding agency that a more comprehensive report needed to be completed. The report was based on preliminary findings gathered through site visits, record reviews, and staff interviews only. It was provided to the funding agency, which then decided to furnish it to the provider agency. The report contained observations and recommendations made by the evaluation team in regard to the administrative, clinical, family and community systems.

Preliminary Results

The findings that emerged from the data collected were divided into three specific areas: (1) administrative system; (2) clinical/treatment system; and (3) family/community system. The evaluation team felt that proper functioning of these systems was central to the success of the Pilot. The findings reported focused on the strengths and areas of concern present in these systems.

At the administrative level, the evaluation team found that the administrative structure currently in place was somewhat fragmented. Consequently, communication did not flow through the entire organization in a systematic and even manner. Staff at different levels received certain information, but not enough to allow them to place it in the proper context and get a sense of the full picture.

A similar situation emerged at the clinical/treatment level, but for different reasons. The difficulties at this level were not caused by a lack of communication, but rather by an apparent lack of integration and coordination of the different treatment components (i.e., behavioral, clinical, recreational, education, etc.). The family/community level had not been addressed to the extent needed to create working partnerships. Family participation, in some respects, had been defined and consequently interpreted as limited by the contract stipulations, which required that families participate in support groups and take their children on week-end passes. Similarly, the development of community links that would offer the clients increased opportunity to experience true community living was not explored.

The study revealed that the educational level of the staff, their commitment to their work, their willingness to learn new ways of helping clients were the most valuable assets of this organization. Furthermore, it seemed that all the pieces needed to make this treatment center a comprehensive and effective service provider were present within the organization. Thus, we recommended that the organization develop an implementation plan in which the talents and skills of the staff were effectively channeled.

Intertwined with the evaluation was the provision of technical assistance. A one-day workshop addressing the changes taking place in service provision due to the adoption of the managed care approach and the utilization of the CSPI assessment tool was organized for the staff.

The next steps pending for the evaluation team were the case studies, the stakeholder interviews, and additional technical assistance. However, after the preliminary findings were presented to the project management team, the need to switch the focus of the evaluation became apparent and a revision of the methodology was necessary.

Revised Methodology

Following the presentation of the mid-point report to the project management team, the evaluation team became aware of the need to switch the focus of the evaluation into a technical assistance approach. Previous evaluations sponsored by the funding agency generally had addressed the same issues and current site visits revealed concerns about the provider's willingness to implement and utilize the evaluation data in meaningful ways. At this point, it also became clear to the evaluation team that the "expert" approach used resulted in a design aimed at providing answers to the needs and interests of the funding agency leaving the staff of the provider agency unaware of the purpose, methods, and use of the evaluation. Without information about the progress and results of the evaluation, the provider was likely to perceive the process as threatening rather than beneficial. Taking all this into consideration, the evaluation team concluded that the provider needed assistance not in identifying the problems but in addressing some of the issues raised by these evaluations. In turn, the provider indicated an interest in selective technical assistance.

The provider's primary concern was the need for a review of the agency's organizational structure. The evaluation team was invited to submit a technical assistance proposal. The proposal developed by the evaluation team included the following: formation of a review committee composed of representatives of all services offered by the agency; meeting times convenient to the agency; and suggested background elements to be reviewed and discussed by committee members. Those elements identified included the agency's mission, guiding principles, target population, program functions, goals, outcome measures, strategies, roles and responsibilities, organizational structure, and communication and performance measures. Through this involvement and careful

consideration of front-line perceptions and misgivings, the evaluation team believed it would be possible to obtain information that would be useful to everyone involved.

To increase the utility of the evaluation data, the evaluation team decided that a participatory approach would be more relevant. This view suggests that the evaluation is no longer the simple application of technical expertise to clearly defined problems (Allen, Gilchrist, Brown, Cox, Semke, Thomas, & Perry, 1994). Instead, the evaluator is called on to work collaboratively with staff and program stakeholders in defining what the evaluation will focus on, how, and with what outcomes. The proposed participatory evaluation model included the following:

1. staff and program managers were to be meaningfully involved in the design, implementation, and reporting of data;
2. inquiry and dialogue among staff, program managers and evaluators/consultants would be encouraged;
3. collaboration and the development of a collective vision would be promoted;
4. a context for group learning would be created;
5. information provided through the evaluation design, at least in part, would be immediately and directly useful in the provision of services;
6. required program development activities would be determined by staff and program managers; and
7. minimal disruptions related to evaluation activities would occur.

Table 1 compares elements of the expert model of program evaluation with the participatory model.

The primary advantages of the participatory model of program evaluation are that it (1) empowers the system; (2) connects the organization to its environment; (3) allows for organizational development to occur; (4) permits ownership of results; and

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(5) allows the system to become “evaluation ready.” With this understanding, the evaluation team developed a follow-up proposal that would attend to the needs and concerns of all parties who had a stake in the design, implementation and utilization of the evaluation data. This also allowed for greater commitment to the utilization of findings

A total of four monthly meetings were conducted with a committee made up of eight representatives from the different staff levels and two members of the evaluation team. The meetings were held at the provider’s office during times that were convenient for the staff.

The first meeting was spent reviewing the committee membership, the review process proposed, the goals and objectives of this effort, the elements to be addressed and expected outcomes. The eight-committee members agreed to review the various elements of the current system and to develop a series of proposals/recommendations aimed at providing a more functional service delivery system.

During the subsequent meetings, committee members reviewed and adopted minutes of prior meetings; discussed agreed upon agenda elements; shared information on the agency and other systems involved with the agency; used various sources of

Table 1

PROGRAM EVALUATION	
Expert Model	Participatory Model
Evaluator assumes an expert/ dominant role (one up position).	Evaluator assumes a reflective/ facilitative role. All stakeholders collaborate in evaluation process.
Professional status and opinions of evaluators are valued. Evaluators remain distant in order to maintain objectivity.	All participants are recognized for their knowledge and opinions.
Provides direction for change	Direction of change unpredictable/ evolutionary.
Examines elements of the program and the system microscopically and independently.	Examines the functioning of system as a whole.
Focus is on deficits.	Focus is on strengths.
Assumes that service provider may lack knowledge and expertise.	Believes in learning organizations/ systems. Learning occurs through interaction, participation, and action.
Emphasizes the need for the provision of assistance (technical assistance).	Emphasizes the need to use own natural resources/ can evaluate self and find solutions.
Service provider assumes the passive role of recipient.	Service provider is involved and empowered.
Not always coherent with managed care principles.	Isomorphic with managed care principles.

information to feed and support their discussions; disagreed on various issues and agreed on many others. Various members took varying positions and recommendations were made.

Discussion

Considering the methodological changes made half-way into the evaluation project, the implications of the findings aim at aspects related to interagency understanding and expectations when contracting for an evaluation and at the impact that technical assistance had on the provider's staff.

The agencies' original understanding and expectations regarding the evaluation turned out not to have been clearly delineated once the presentation of preliminary findings to the project management committee was completed. The reaction of the provider and of the funder made it clear to the evaluation team that the recommendations could not be implemented at the current time. This was due to the presence of more immediate and underlying challenges that superseded the needs identified and presented in the report. The research team concluded that the unrecognized challenges represented the real issues. First, the Pilot Project was actually the result of the funding program's motivation to control costs and a rather immediate financial need on the part of the provider agency. The provider agency did not appear to be in agreement with or committed to the types of changes associated with the managed care approach sought by the funding program.

The second issue is that the program funder and provider entities were operating from two different paradigms while the evaluation team was operating from a paradigm based on an incorrect understanding that the other two parties were in agreement with each other. The evaluation team was under the impression that the central aim of the Pilot was to transition clients into the community and offer them the supports to successfully adapt to

community living. It turned out that the contract between the funder and the agency did not clearly stipulate that and therefore the provider's efforts were not focused on that direction.

Next, the findings and recommendations provided by the evaluation team were difficult for the provider agency to accept because it was operating from a different paradigm from that of the evaluation team. This led to the evaluation team incorrectly taking the "expert" approach to the evaluation. During initial discussion on the evaluation design with both the funder and the provider, the provider communicated that they were completely in agreement with the decided-upon approach and that they would willingly participate with the evaluation team. However, as the evaluation started and the provider's input was sought a sense of uneasiness on the part of the staff was detected.

Similarly, the provider agency was not explicitly clear about their expectations for the evaluation component of the Pilot Project, the types of changes they were willing to embrace, and the type of assistance they sought, nor was the funding agency. The evaluation team incorrectly assumed that changes and assistance in service delivery/outcomes were mutually desired.

Finally, it was difficult for the evaluation team to evaluate the changes that were to take place once the implementation of the Pilot was begun since the provider had yet to develop a strategic plan or model for change implementation and had not communicated to the staff the nature of the Pilot.

As the original evaluation/technical assistance project was switched into a technical assistance project much progress was made with the staff committee. As the staff committee defined the areas in which they needed to focus, its members felt empowered and more in control. They were able to openly talk about the ways in which they felt their agency could improve and ways to

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implement changes. They learned to value the perspectives that each brought to the committee and to explore other alternatives. Overall, the committee found the process useful and, once the contract with the evaluation team expired, they decided to continue on their own.

For the evaluation team, this was a lesson about spending more time in upfront talking and clarifying with the agency(ies) involved concerning their wishes, expectations, participation, and previous experiences with evaluation before coming up with a design. This experience was also valuable in showing the difference between the “expert” approach and the participatory approach. While not all research fits the participatory approach, the evaluation team felt that, in this case, it should have never been otherwise.

References

Allen, D.G., Gilchrist, L.D., Brown, L., Cox, G.B., Semke, J., Thomas, M.D., & Perry, R.D. (1994). One System Many Perspectives: Stakeholders & Mental Health System Evaluation. *Evaluation and Program Planning* 17(1), 47-51.

Mental Health Services and Policy Program, Department of Psychiatry & Behavior Science, Northwestern University Medical School and the Department of Child and Adolescent Psychiatry, Children’s Memorial Hospital. (1995). *Childhood Severity of Psychiatric Illness Manual*. Chicago, IL

