Managing Behavioral Healthcare:

A Practical Approach to Providing the Right Services at the Right Times in the Right Amounts

By Laura Faulconer

Since the US Congress passed the 1964 Community Mental Health Act—legislation initiated by President John F. Kennedy—public awareness of mental illness has increased, and the continuum of care (see Fig. 1) available to people with single-episode or chronic mental illness has significantly broadened. Now the service system as a whole, compared with treatment services considered in isolation, dictates the outcome of treatment.[1] New medications, new community-based services, successful public-awareness campaigns, and evidence-based treatment interventions have had a positive, discernible impact not only on those who receive services, but also on the system of care and the skills necessary to manage these systems as well (see Fig. 2, page 40). Facility- and community-based behavioral healthcare administrators are increasingly challenged to manage their own organizations in a way that delivers both a continuum and an integrated system of care that meet the needs of those they serve in an effective and efficient manner.

Many books and articles on being a better manager begin with the importance of a clear and simple mission statement to guide a manager's work. But mission statements rarely address effectiveness and efficiency, the core elements of successful management. Managers need a more practical and universal mission statement—one that provides a basis for daily decision-making and reminds managers of the "bottom line." The best mission statement I have found that meets these criteria was buried in 20 inches of managed-care material developed by Value Behavioral Health (now Magellan). It is: *Provide eligible individuals with the right services, at the right time, in the right amounts; no more, no less.*

Regardless of what type of behavioral healthcare setting—inpatient facility, comprehensive mental health center, or program component in the continuum of care—every manager can navigate daily decisions and competing priorities more effectively by changing the above statement into a question: Are you providing the right individuals with the right services at the right time in the right amounts?

This "how to" article looks at the managerial issues facing the administrator of a US behavioral healthcare facility. While at times it is specific to the US healthcare system, the issues it addresses have relevance for NIS and CEE administrators and managers of behavioral healthcare facilities or other facilities—such as primary care centers—that want to expand such services.

Is the Individual Eligible?

It is necessary to understand the numbers of people affected with mental illness before a manager can determine how many their own agency needs to plan to serve. According to "Mental Health: A Report of the [US] Surgeon General, 2000," epidemiological estimates state that at least one person in five—or approximately 20 percent of the US population—has a diagnosable mental disorder *during the course of a year* (emphasis added). This includes both mental (around 19 percent) and addictive disorders (around 6 percent).[2] This percentage holds true for both older adults (ages 55 and up) and children, who are estimated to have a mental disorder with at

Mental Health Continuum of Care

In behavioral health, the following services and levels of care are available to adults with serious mental illness—who also may be chemically dependent—in a seamless system that is closely linked with each individual's needs, goals, and preferences.

- Diagnosis, assessment, and evaluation.
- Medication management to stabilize symptoms of the illness.
- Psychiatric rehabilitation to increase level of functioning and the ability to manage the effects of the illness.
- Assertive case management to coordinate all aspects of services and deliver necessary treatment and rehabilitation.
- Crisis services to prevent relapse and hospitalization.
- Residential treatment program to serve as an alternative to acute or long-term hospitalization.
- Partial hospitalization to provide acute care services as an alternative to 24-hour acute hospitalization or transition to community care.
- Inpatient hospitalization only for acute care in a secure environment or acute treatment for concurrent medical needs.
- Access to non-medical support services such as housing and vocational rehabilitation.
- Programs for co-occurring disorders, specific age groups, and specific disorders.
- Peer support.

Figure 1. An outline of the components of a continuum of care in mental health treatment.

Prepared by Carolyn Peterson and Dennis Jacobs 4/96. International Association of Psychosocial Rehabilitation Services.

least mild functional impairment, although it should be noted that the prevalence of mental disorders in children and adolescents is not as well documented as for adults. In addition, 5-9 percent of children ages 9-17 are considered seriously emotionally disturbed.[3]

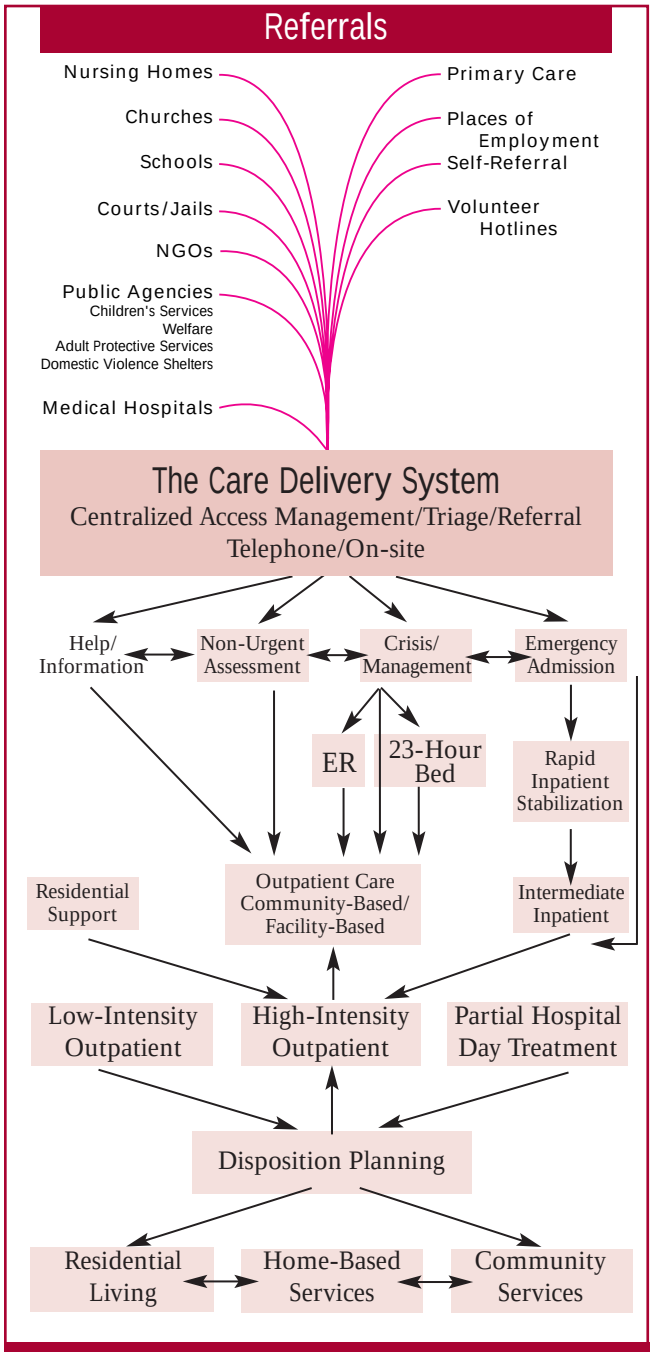

Illustration based on diagram courtesy of Harry M. Shallcross, PhD, behavioral health and human services consultant.

Figure 2. Referral agencies must know how to access behavioral healthcare services to provide seamless services to persons with mental illness, as illustrated in the top diagram. The behavioral healthcare system must also be responsive and identify the appropriate services and interventions. The bottom diagram provides an overview of typical clinical pathways within a services delivery system.

National demographics and prevalence rates for mental disorders and illness can be used by managers to establish estimates of the numbers of persons "eligible" for behavioral healthcare services in a particular community or "catchment area." Local population figures can be multiplied by the national prevalence rates to determine the expected number of persons with mental disorders in a particular area. Although this number does not provide the manager with the number of people who will actually seek treatment, it does tell the manager about the total number of people who may need services. This number can also be used as one indicator to determine the effectiveness of the agency's community outreach efforts. For example, if the prevalence figures indicate that 5,000 persons have a mental disorder in catchment area X and only 2,000 persons are receiving care, a manager can now use this information to advocate for a community education and outreach program designed to reach the other 3,000 people, and determine how many staff may be necessary to provide services for these 3,000 people. The use of historical agency data of the number of people receiving services can also be helpful information, but does not provide the number of people who need, but do not receive, services.

"Knowing the numbers" is not enough to determine eligibility or who the "right" people are. The numbers do not reflect the strong and differing opinions of community members, referral agencies, and consumers of services about who should be served, nor do they reflect the local, state, and federal government's mandated populations to be served. Thus, to determine eligible or target populations, it is essential to go beyond the definitions of "mental disorders" and "mental illness" used for statistics. In the reality of limited resources and competing interests, a clear mission that includes eligibility criteria can be a useful management tool to ensure service to those who are meant to be served and minimize misunderstandings by the public and by funding agencies. In reality, eligibility is often tied to economics.

What Are the Right Services?

Once a person is identified as meeting the established eligibility criteria, the "right" services for that person need to be delivered. Although national demographics can be used to establish estimates for the number of people who will likely need behavioral healthcare services, these figures do not provide the information necessary to determine what service or treatment intervention is appropriate.

As mentioned in the first paragraph, a continuum of services is required to meet the many and varied needs of persons with

mental disorders or mental illness. But clinicians—whether psychiatrists, psychologists, social workers, nurses, or para-professionals—often do not agree on what intervention(s) should be used or how they should be delivered. The establishment of clinical practice guidelines and protocols is perhaps the single most effective tool a manager in the field of behavioral healthcare can use to provide direction to answer these questions. The guidelines must at a minimum include the following:

- diagnostic and functioning level criteria;
- risk assessment for violence against others and the self;
- appropriate assessment instruments;
- appropriate intervention and/or service(s);
- which professions should provide the service(s); and
- recommended lengths of service and outcome criteria, most often the criteria for discharge from a program (see Fig. 3).

Without these practice guidelines and time frames, a manager has little information against which to measure whether the service is the "right" service, the consistency in clinical decision-making, and whether the services prescribed were the services rendered.

Who provides the service is directly related to the effectiveness and efficiency of service delivery and should be briefly touched upon. Because persons with mental illness usually have multiple life problems resulting from their illness, more than one professional is often needed to adequately address their care. Interdisciplinary treatment teams are the standard of practice for both inpatient and outpatient services and most often consist of psychiatry, psychology, social work, and nursing. In addition, it is not uncommon for there to be a case manager (either professional or para-professional), peer counselor, and/or volunteer who is actively involved with the patient and who needs to be included in the treatment planning. A member of each discipline should not only be involved in individual patient clinical decisions, but also in establishing clinical practice guidelines, utilization management, and peer review.

Are the Services Provided at the Right Time?

People often seek behavioral health services when they feel personally ready, so it is important that they be aware of what programs exist before they need them. To assist clients at the right time, referral agencies and other support systems need to be aware of program options offered by behavioral healthcare facilities, as well as any referral procedures. Making programs and services easily accessible and inviting is also important; clinical practice guidelines should address what interventions and/or services are appropriate at what point in a person's treatment. Even when the appropriate service exists within the manager's agency or referral network, access to that service at "the right time" can be hindered by lack of capacity and/or waiting lists. Thus, it is important for managers to track waiting periods to help answer the question of "right time."

> Provide eligible individuals with the right services, at the right time, in the right amounts; no more, no less.

What is the Right Amount?

Even in cases where mental health services are required throughout a lifetime, different types and intensity levels of services are needed throughout the course of the illness. Two helpful tools that may be used to address the question of the "amount of service" and to facilitate ongoing medical and managerial decisions are:

- data from utilization management systems that track both the use of services by individuals and diagnostic category; and
- clear clinical practice guidelines that use this data and include recommended lengths of service and specific achievable outcomes.

Who Pays for the Services?

Although not one of the original questions, funding is an obvious reality that can greatly impact the type and number of services a behavioral healthcare facility can offer and to how many people.

Patient Outcomes

- Reduction and management of illness symptoms and functional disabilities.
- Frequency of crises requiring intensive intervention is decreased.
- Improved relationships with family and friends.
- Improved level of functioning as indicated by Global Assessment of Functioning scores.
- Improved level of functioning as indicated by independent living skills, ability to work/attend school.
- Decreased number of days hospitalized/Increased community tenure.
- Increased number of days in the community between hospitalizations.
- Decrease in the level of service necessary to maintain community tenure.

Figure 3. This list is an example of outcomes behavioral healthcare services use to measure program success and to seek additional funding.

US expenditures for behavioral healthcare—both mental health and substance abuse—totaled US$81.2 billion in 1996. Insurance and fees paid by individuals accounted for 33 percent, with Medicaid (28 percent), state and local funding (27 percent), Veterans Administration (4.5 percent), Medicare (3.8 percent), and "other" federal funding (3.4 percent) covering the remainder. Expenditures for the year 2000 are expected to be well over US$110 billion, with the proportion of spending expected to be comparable.[4]

A manager must be able to calculate the cost of each of the services provided to appropriately establish fees and allocate resources This can be particularly difficult to do in the public and non-profit sector where indirect costs are hidden or shared with other public sector agencies. One method to "price the system" is to use the following steps:

- identify populations to be served;
- set desired outcomes by population subgroups;
- estimate utilization by service;
- establish service unit, case rate, and administrative costs;
- multiply utilization by cost to get desired budget; and
- compare current resources and desired budget, then adjust the populations, outcomes, or funding to meet the budget.

No More, No Less: How Do You Know?

You can't manage what you don't measure. It has only been within the last 10-15 years in the United States that decreasing resources, increasing public scrutiny, and the need for license/accreditation has forced behavioral healthcare managers to recognize the need for data and outcome measures. Utilization management has already been mentioned as one tool to review the appropriateness of service and the amount of service. Consistent clinical standards and practice protocols provide the foundation for establishing both utilization measures and clinical outcome measures. Performance indicators for the agency or facility should also be developed and might include:

- access to services;
- appropriateness of services;
- individual clinical and aggregated outcomes;
- number of adverse incidents;
- cost;
- complaints/grievances; and
- patient satisfaction.

There is Never Enough Money: The Toughest Management Decisions

I have never met a manager, in any country, in the business of delivering healthcare services—whether it be emergency medicine, cardiac care, or behavioral healthcare—who is not challenged by the demand to provide quality services with insufficient funding. However, time and time again, each manager has been able to "do more with less" by employing two basic strategies: looking with new eyes at individual programs as well as the total delivery system, and using the information gained by asking the questions reviewed in this article for critical analysis.

Our systems for delivering services and providing care can always be improved, but improvement does not always require money. For example, changing who provides the care may not only keep a manager within his or her budget, but save money that can be allocated for additional services. For instance, is it necessary for a psychiatrist to provide a service or can a nurse be trained to do it? Is it necessary for a social worker to execute a specific task or can a trained volunteer supervised by a social worker provide the same level of care thereby allowing the social worker to deliver other services? One way of looking with "new eyes" at an existing program is to have an outside surveyor ask people requesting services what they really would find most helpful. When one clinic did this, they discovered that most of the responses were simple requests for specific assistance like filling out a form, getting a family member to take medicine, or learning how to tell a family member about a difficult personal situation. From this information, they learned that their use of trained healthcare professionals to provide such services was time-consuming and costly, especially given the fact that these services could be provided by an administrative staff member or volunteer.

Data are essential to provide a manager the information necessary to make informed defensible decisions, especially when there are conflicting priorities, multiple demands, and no additional money. By asking the question "are we providing the right individuals with the right services at the right time and in the right amounts?" I have found the framework to identify the fundamental data elements and guidelines necessary for successful behavioral healthcare program management, and a foundation for making tough decisions, including who should not receive services and why, what services can be reduced or eliminated, and how scarce resources can be allocated to achieve the best outcomes.

References

1. Goldman, 1998.
2. US Department of Health and Human Services, *Mental Health: A Report of the [US] Surgeon General*, Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health (1999) chapter 2.
3. See above.
4. See above, chapter 6.

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