

Where We've Been and Where We're Going

By

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Managed Behavioral Health Care in Massachusetts:
Challenges of Maintaining Access and Quality

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One of the most significant effects of managed care on the behavioral health system has been improvement in access to treatment of mental illnesses. I remember a time when a person in psychiatric crisis had to either wait or make an appointment to be seen before they could even be admitted to a hospital. Today, our expectation is clear: Admissions to our mental health system happen when they are required to meet the needs of consumers in crisis, day or night. I remember when every hospital had a “do not admit list” that was designed to bar those individuals who were deemed too disruptive or too recalcitrant or too difficult. Today, we expect all hospitals to take all patients regardless of their clinical presentation, and request that hospital providers think about what kind of services they need to keep their units safe in that environment. I remember a time when one’s ability to pay was the primary concern when someone needed hospitalization. We have made tremendous strides in this area. We have a long way to go, but we have succeeded in making sure that access is available for those who are unable to pay.

I can also remember a time when we lacked adequate mechanisms for tracking our spending on behavioral health care and treatment. Today tells a different story. We have a clearer understanding of the financial picture, and are better able to track how behavioral health dollars are being spent.

Looking forward to the future, we need to consider these five goals.

The goal of improving access to care and treatment is first and foremost. A system that works well is one that provides access to all individuals. However, experience has demonstrated to me that for many people, access remains a tremendous obstacle. Individuals generally fall into two groups: those who know how to obtain services through their sophistication or know-how; and those who never even get through the front door, or find it closed for one reason or another. I am often concerned that in our efforts to define service criteria, we are losing our most vulnerable citizens who don’t know where to begin to find and get mental health services.

Along with increasing access comes the recognition that we are requiring providers to change their services over time, acknowledging that the acuity and severity of individuals served in the community are higher. Access to services, therefore, must be coupled with excellent risk management techniques and superior quality of care.

Improving information systems is our second goal. A very important part of our future in behavioral health is our increasing ability to bring sophisticated information systems to the practice level. We must find ways to use our current data to better define our populations and their specific treatment needs. Information systems must also inform clinicians about best practices that are evidence-based in terms of effectiveness. Our information systems should inform the process of coupling service and programming needs together with the data we collect. Without this marriage, opportunities to improve

care and treatment and bring our services to sophisticated and excellent levels will be lost.

The third goal is truly integrating our services. We must bridge treatment across all levels of care, treatment groups, and funding entities. One of the opportunities to consider in the integration of the Behavioral Medicaid unit with the Department of Mental Health is to create continuity for clients coming out of the acute care public system and moving into the more long-term DMH system. This is an area where we can integrate physical and mental health providers more effectively.

Similar funding sources does not drive the integration of services. Integration occurs because providers make a commitment and a decision that they will work together and consider themselves members of the same team. It does require extra effort, a great deal of work, and often numerous phone calls to accomplish this, but it is an essential component of treatment. We must look at our treatments and services in new ways, ways that include effective collaboration among all providers.

Integration of care is also necessary for our clients who present with complex multiple needs. Whether it is substance abuse and mental illness, or mental retardation, or complex physical health needs, we need to be able to integrate clients' services across the spectrum of care so that that an individual experiences seamlessness and continuity across mental and physical health systems.

The fourth goal deals with fiscal responsibility. I am obligated to be an exceptional steward of public dollars. Improving efficiency and cost effectiveness is a part of, though certainly not the entire, picture of improving quality. Taxpayers deserve to be assured that every dollar is spent consistently and with the vision that we hold for the future. That vision includes a realistic hope for the eventual cure for mental illnesses. The vision also holds that we will be able to move to a system of care that embraces genuine prevention efforts around mental illness. We look to a future that holds the opportunity for us to treat and care for individuals in community settings rather than in hospitals. Community based care will be more and more the standard rather than the exception.

It is essential that we can demonstrate the value of the services we provide to the people we provide them to, to the taxpayers and to ourselves. It's not good enough to just say, "well, I think it works because that's been my experience." We need to shift that mindset, and must learn to rely on quantitative measurements that show the number of lives we have improved, we have saved, or the number of individuals with mental illness we have put to work, or the number of people we have placed in our communities with the right supports and services. When we can show the evidence of the success of our best practices, and explain why our treatments work well, our services will be funded.

The fifth and the most important goal is the demand that quality of care be our overarching operating philosophy. We want services that are high in safety, consistency and reliability. If everything we're doing is not to the benefit of improving a client's

care, then we need to question why we are doing it. I often say to my staff that their first thought should be whether they would have their own sons or daughters on our unit, and if they wouldn't, then they need to tell me why, because we have to fix it. That is a great standard. We must be able to assure that all the services we provide for citizens of the Commonwealth meet the standard that we would want for ourselves or our own families.

I get tired of hearing that individuals with mental illness are in a class by themselves. That is stigma talking. Individuals with mental illness are part of our community. We need to reach a point where we see them as individuals who work with us, walk with us, live next to us, and the quality of the care we deliver needs to be what we would give to our neighbor, our friends, our parent, our child. The idea that we do something different is simply not acceptable. We absolutely must help people understand that none of us are immune to the risk of mental illness. We have to help people see this is not something just for others; it is essential for all of us.