

9. GOVERNANCE AND FISCAL STRATEGIES FOR ACHIEVING MENTAL HEALTH REFORM

9.1 Introduction

The mental health system is often described as complex, fragmented and confusing. Hadley (1996) discusses how changes in methods of financing mental health services have contributed to the complexity and disarray that now plagues the system. His concern is echoed by Nasir (1994) who argues that lack of fiscal and management integration among the major sectors providing mental health care is seriously undermining delivery of quality care and progress in mental health reform. Mental hospitals, psychiatric units in general hospitals, community mental health services and physician services operate in virtual isolation from each other. As a result each sector is driven by its own agenda, leading to fragmentation, lack of continuity and cracks in the system for patients, and an absence of accountability.

The mental health care system spends a disproportionate amount of resources on institutional care. In Canada, the portion of the provincial mental health budget that is spent on community support services averages 13%, and ranges from 3.1% in Manitoba to 46% in New Brunswick (*Nasir, 1994*). This imbalance derives, in part, from the fact that spending on users of mental health services did not follow individuals into the community during de-institutionalization. In other words, the monies saved from bed reductions did not resurface in expanded community programs. This issue is emerging again with hospital restructuring and downsizing. As *Rachlis and Kushner (1994)* note “mental health resources are under constant threat from acute care poaching” (p 266). Unless strategies are put in place to protect mental health spending in institutions, hospitals will be tempted to use unspent mental health funds to meet other budget priorities. *Dreezer (1996)* acknowledges this problem and urges immediate identification and freezing of mental health dollars in the institutional sector. This can be followed by implementation of fiscal strategies that move mental health dollars into the community.

The challenge of implementing mental health reform is being faced by jurisdictions across Canada, United States and Europe. Other sections of this document focus on the services that comprise a reformed mental health system, and report evidence of best practices. In this section we identify methods that can be used to create an organizational infrastructure conducive to delivery of these best practices. In particular we will review governance and funding strategies to protect mental health resources, encourage transfer of funds from institution to community and an expansion of community care, increase continuity of care for users, and move to more cost-effective care delivery. Much of the material in this chapter is drawn from Nasir’s comprehensive review of fiscal restructuring tools and case studies (1994) and a review of structures for coordinating mental health care (*Goering et al., 1996*). Other sources are cited as used.

Rigorous evaluations are not feasible in service systems research but many jurisdictions have recorded markers of change over an extended period of time or identified comparison systems in order to assess progress and success. This section does not offer a comprehensive literature review but for each strategy examples of implementation experiences and findings are given.

While many of the fiscal and governance strategies discussed in this report have been identified as key elements and components of a public sector managed care system, (*Hogan et al., 1994*), we will not directly discuss the managed care concept. Our wish is to focus on tools and methods that can advance the specific objectives of mental health reform.

9.2 Needs Based Allocations

The two most common funding strategies used in health care today - global budgets and fee-for-service (FFS) - are driven mainly by provider preferences and past utilization of services rather than by current need. These methods are criticized for favouring the status quo and perpetuating inequities. Typically hospitals receive a global budget (based on past budgets) which is adjusted upward to reflect rates of inflation, new programs and new capital expenses. More recently, annual budget adjustments have been downward but still are indexed to the hospital's current budget. This approach does not take into account changes in need for services of both current hospital users and residents of the surrounding community. The FFS system which accounts for most physician reimbursement has other limitations. Until recently levels of reimbursement were open-ended in most jurisdictions, resulting in a rapid escalation in costs of physician services. FFS encourages high volume and incorporates few controls or incentives regarding where providers practice, who they serve and what they provide. Under FFS the nature of care provided is influenced by provider availability and preferences, factors that are not necessarily linked to population needs for health care (*Hughes, 1991; Nasir, 1994*).

A needs-based approach to funding strives to relate resource allocations to characteristics of populations served on the basis of health risks and morbidity. (*Nasir, 1994*) In this approach the estimation of need is relative. For example a jurisdiction with higher rates of psychiatric disorder can be deemed to have greater need and to require more resources. A needs-based approach is considered to be more efficient because services can be aligned with need. It is more equitable because resources are directed to where the need is greatest, regardless of availability of providers and past patterns of use. Fiscal allocations based on need can be used to establish the mental health funding pool for a specific area or to tie program funding levels more closely to individual need. However, planners still face the challenge of translating predictions of need into estimates of necessary services.

The validity of needs-based allocations in practice depends on what indicators can be collected to define need and how they are used. Often indicators are combined into a single measure such as a patient severity rating or area index that is used to rank areas or patients into groupings based on relative need. Indicators commonly used to assess individual need include diagnosis, age, medical complications, immediate risk, symptom severity, chronicity, social stability and level of functioning

(*Stoskopf & Horn, 1992; Lyons et al., 1995*). These can be obtained from clinician report, medical records or patient self-report.

Indicators of area need such as prevalence of disorder or disability are direct measures that are obtained from epidemiological surveys. To avoid the expense and time required to conduct such surveys, methods are developing that use social indicators as indirect or proxy measures of need. Variables such as age, gender, marital status and ethnicity (socio-demographic); and income, education, unemployment and poverty (socio-economic/deprivation) are felt to link with actual need but can be obtained from existing data bases (e.g., government census data) at much less cost than survey data. One problem of using social indicators to model need is that methodologies produce different results and vary in levels of accuracy.

9.2.1 Experiences

Lesage and colleagues (1996) used several needs assessment approaches to evaluate current distribution of staff among seven community psychiatric clinics in Montreal, Quebec. They assessed relative need within each clinic catchment area using prevalence data obtained from an epidemiological survey, utilization data and a model of utilization using social indicator data. In addition, patient populations in two clinic areas were compared using a case control study. The final social indicator model included variables related to dimensions of poverty, unemployment, occupational skills, social isolation and ethnic background. Staff allocations based on these three needs estimates were compared to actual staffing patterns.

Differences were found between predicted and actual distribution of staff, with each estimate of need yielding different results. Lesage concludes that a socio-economic indicators model of utilization represents an interesting and inexpensive planning tool and produces estimates of resource allocation that are consistent with sensible distribution of human resources. However, decisions about actual resource allocation should consider both empirical data and input from local practitioners and users. None of the needs assessment methods adequately reflected the severity of cases evidenced in the case control study.

Ciarlo et al., (1992) developed and assessed a number of indirect needs estimation models. They used measures of diagnosis, dysfunction and demoralization obtained from a Colorado state-wide survey as the need standard to be predicted. Most models provided some increase in accuracy over an assumption of no difference in need across subareas. The strongest model was based on only two indicators - percentage of persons in poverty and percentage of divorced males. The researchers conclude that any jurisdiction currently not using a social indicator or other type of indirect needs assessment model could probably improve accuracy of service planning by incorporating an indirect needs estimation technique.

Ontario recently incorporated area need into a methodology to distribute a Community Investment Fund of \$20 million among six planning regions in the province. The purpose of the Fund was to increase regional base funding for supporting individuals with severe mental illness in anticipation of

reductions in inpatient care. It was expected that the enhanced funding base combined with future reallocated inpatient resources would help each region to develop a comprehensive community support system. In dispensing the funds there was an attempt to recognize regional differences and inequities. The allocation methodology incorporated a number of regional factors, including population need (i.e., total population, distribution of ethnic and aboriginal populations), current resources (i.e., per capital mental health spending, inpatient bed ratios), and service delivery costs (e.g., geographic size, rural population) (*Ontario Ministry of Health, 1994*).

At a program level, capitation grants and prospective payment are examples of reimbursement structures that try to link program funding levels to needs of individuals served. These are discussed in detail in the next section.

9.3 Strategies for Integration

The existence of silos in funding and management of mental health care has allowed each sector to focus on its own growth and prosperity, without taking into account broader systems issues and consumer needs. Jurisdictions are most strongly positioned to break down the solitude of the different sectors and create more integrated mental health care if the following are implemented:

- a single funding envelope that integrates diverse mental health funding streams; and
- a single organization or authority responsible for management of mental health care within a defined area.

9.3.1 Single Envelope Funding

Integrating funding streams is a necessary condition for achieving progress in mental health reform. Evidence from other jurisdictions indicates that reform efforts are compromised if funding for hospital and community services, at a minimum, are not combined. One benefit of having a combined envelope is that fiscal levers can be used to increase integration of hospital and community care. For example, bonuses for reducing hospital bed use below a baseline target rate can be channelled into development of a stronger community service system. The resulting inter-dependence of hospital and community sectors promotes service innovation and benefits the consumer who can move more freely between settings and levels of support. Because funding is combined within one envelope, fiscal management is centralized and accountability clearly defined. Creation of a single funding envelope realizes another benefit by requiring all mental health funding to be explicitly identified. A clearly defined resource base should be easier to protect, and easier to protest if it is felt to be inadequate.

At a minimum, the funding envelope should integrate spending for general hospital inpatient psychiatric services, psychiatric facilities, specialty psychiatric facilities and community mental health programs. Spending for mental health services delivered by physicians is a significant component of the mental health purse but there are no jurisdictions in Canada or the United States that have isolated this funding and put it under the control of a separate mental health authority.

While major changes in how doctors are reimbursed for mental health care need to be made in conjunction with broader reforms in physician payment, there are small scale strategies that can be deployed now. *Dreezer (1996)* suggested using fiscal incentives to encourage more psychiatrists and other physicians to work with individuals, families and caregivers involved with chronic mental illness. Alternatives to FFS such as sessional fees and various salaried options could be made more available to physicians. The Business Plan recently published by the Ontario Ministry of Health promises an expansion of alternative payment plans for physicians and implementation of new funding models. Currently one in 10 physicians in Ontario is paid through an alternative method (Ontario Ministry of Health, 1996).

Because the needs of people with severe mental illness are broad, an ideal envelope also would contain funding for social welfare services. For example the Robert Wood Johnston Program on Chronic Mental Illness (RWJP/CMI), described in more detail in the next section on authorities, included Department of Housing and Urban Development (HUD) housing certificates in its allocations. This additional funding helped program participants access more independent and better quality housing. Improved living conditions were associated with greater residential stability, reduced use of hospital and reduced service needs (*Newman et al., 1994*).

9.3.2 Authorities

The benefit of having a combined envelope is most fully realized if a single body or **authority** is responsible for dispensing funds and organizing services for a defined area. Earlier reform efforts in mental health care focused on developing stronger community support systems and shifting the locus of care from hospital to community. While more community programs have resulted, service organization is generally fragmented and responsibility is diffused. Currently attention is focused on improving the service system infrastructure to address these problems. Mental health authorities have emerged as a promising vehicle for organizing administrative, clinical and fiscal aspects of care delivery to create a more integrated system of care (*Schinnar et al., 1992; Goldman et al., 1994*).

A mental health authority is a public, non-profit organization that manages all aspects of care to meet the mental health and possibly social welfare needs of persons living in a defined geographic area (*Shore & Cohen, 1990; Goldman et al., 1990*). An authority can be a newly formed organization or an existing organization with expanded responsibilities – e.g., county mental health boards in Wisconsin. While an authority can be a direct provider of services, more often it is a regulator, contracting delivery of services to local providers and monitoring their performance. This purchaser/provider separation minimizes potential for conflict of interest but distances managers from the providers of care (*Agus & Baron, 1995*). Because an authority is a centralized point of responsibility with clearly delineated relationships to providers and funders, accountability is enhanced.

An authority can use multiple tools to achieve administrative, fiscal and clinical integration. Examples of administrative tools include information systems for planning services and monitoring performance, housing and bed registries to monitor availability, referral agreements to formalize

program linkages, and training to increase skills and promote shared values among providers. Fiscal strategies for program reimbursement (see next section) can be used to shift resources into the community and encourage the programmatic links necessary to improve continuity of care. Clinical mechanisms for forging links across programs include case management, continuous treatment teams and crisis response systems. Primary goals are to divert or shorten hospitalization, connect discharged consumers with community services, increase engagement of the target population and minimize the fragmentation that allows people to “fall through the cracks”. Other chapters in this report review best practices for implementing these various clinical services.

While authorities are expected to improve cost effectiveness in the longer term, initially they increase administrative costs. Authorities can take years to implement as they overcome myriad political, legal and professional hurdles. Opposition from local providers who fear losing influence and autonomy can be considerable. In the RWJP projects, many sites spent years trying to obtain control over state mental hospital budgets (*Mechanic, 1991; Goldman et al., 1990*).

9.3.3 Experiences

The success of mental health authorities and single funding envelopes for implementing reform has been assessed to a limited degree in Canada and widely in the United States. This section includes reports from many American jurisdictions although we recognize that the unique Canadian health care context needs to be considered when applying American experiences to Canada.

New Brunswick is near the end of a ten year program for mental health reform. A provincial Mental Health Commission, administered by a provincial board and seven regional boards, was established by legislation to oversee reform implementation. The Commission was given control over all mental health resources. A recent evaluation by independent consultants (*PGF, 1994*) documents their progress. From 1990 to 1995 spending on community services in New Brunswick increased from 12% to 46%, beds in psychiatric hospitals dropped from 695 to 360 and admissions declined from 1305 to 371. The consultants identified several areas for further work, including improving communication and coordination between different system components and clarifying mandates and roles.

New Brunswick has just dismantled the Commission (at an annual saving of approximately \$500,000), and established a separate Mental Health Division within the Ministry of Health and Social Services that is advised by various provincial and local advisory committees. The Division directly manages 13 Community Mental Health Centres, funds seven regional hospital psychiatric units, and two psychiatric hospitals through yearly purchase of service contracts, and provides program grants to consumer, family and not-for-profit volunteer groups. The separate mental health funding envelope still remains but local authority over spending has been lost (*Lajeunesse et al., 1995; Allard, 1996*).

Greater Vancouver Mental Health Services (GVMHS) is internationally recognized as a comprehensive and effective system for providing mental health services to clients with serious mental illness. Single envelope funding has given GVMHS flexibility in developing, administering and operating an integrated system of programs that are responsive to community demands. There is one administrative agency responsible for the operation of a variety of services. Central to the program are nine mental health teams staffed by providers from a range of health disciplines, including medicine, that deliver services to defined catchment areas. The teams link with a continuum of services also offered by GVMHS that include assessment, mobile crisis response, safe beds, housing and vocational support. The only aspect of the system which has not been fully integrated is general and provincial hospital services. The downsizing of Riverview and the establishment of regional mental health boards is now addressing this issue (*Bigelow et al., 1994*).

In the **Robert Wood Johnston Program on Chronic Mental Illness**, nine cities throughout the United States received funds to develop community-wide systems of care for persons with chronic mental illness. Each city was expected to create a public mental health authority that would improve continuity of care, move funds to meet consumer needs, develop a range of housing options and enhance the range of available rehabilitation programs. The initiative began in 1986 and was accompanied by a comprehensive national evaluation project. Evaluators found that authorities could be successfully established, increasing centralization, coordination and continuity of care. Yet outcomes for program users did not improve. This negative finding may reflect methodological limitations in the evaluations. Alternatively, it may demonstrate that structural changes are important but do not obviate the need to expend more public funds to ensure that high quality clinical and social programs are available to persons with chronic mental disorders (*Morrissey et al., 1994; Shore & Cohen, 1994; Lehman et al., 1994; Okin, 1995*).

Wisconsin was one of the first jurisdictions in the United States to implement authorities and combine hospital/community funding. In each county an authority was mandated to organize delivery of care, including inpatient services, for people with severe mental illness. The hospital portion of each county's resource allocation was based on an index year of inpatient use, and authorities could use fiscal incentives to encourage less hospital use below the index year. Monies not spent on hospitalization remained with the authority and could be used to develop better community supports, but authorities were required to pay for overuse of hospital beds. Within 10 years, Dane County's expenditures for inpatient care accounted for only 9% of the mental health budget. Over 75% of chronically mentally ill persons were living in independent settings, hospital admissions had dropped and the readmission rate was only 25%. The rate of spending on inpatient care reported by Dane County may be artificially low because authorities were not charged for nursing home care where many people with mental illness were referred. The other 55 county mental health boards in Wisconsin achieved less impressive results, despite having similar systems. This reinforces the need for local stakeholder participation and support, even when structures are in place to support a system shift to community-based care (*Nasir, 1994*).

Michigan provides an example of a jurisdiction where authorities were implemented but not uniformly given control over an integrated funding envelope. Full management boards (similar to

local authorities) were allowed to either enter into performance contracts for purchase of hospital services or receive free inpatient care but relinquish control over hospital budgets. Compared with the Dane County authority, these Boards, in aggregate, were less successful in transferring funding from hospitals to the community – 50% of mental health funding still goes to inpatient care (*Nasir, 1994*). Nasir hypothesizes that those who opted out of the contracts were heavy hospital users.

In 1989, the **State of Washington** shifted responsibility for managing and delivering local mental health programs to county governments. Thirty-seven counties formed 14 Regional Service Networks (RSNs) which received a block grant of community and residential mental health funds, and additional funding for expansion of crisis, case management and housing services. Spending for state and community hospital use was added later. In 1993, the State developed a series of performance contracts with the RSNs pertaining to system goals such as increased community tenure, movement to independent living, engagement of homeless mentally ill, increased involvement in school or work and access for under-served groups. The State allocated new funds to develop a consumer-centred information system that attached service, demographic and outcome information to each system user, and allowed monitoring of system performance. Early findings were positive. After two years of operation, 16% more consumers were receiving services in the community and there were major improvements in continuity of care (i.e., discharged patients were linked faster and more often to community services). After the performance contract for state hospital use was implemented in 1993, the state hospital census dropped by nearly 300 beds (*Brown et al., 1994; Hanig & Gilman, 1995*).

The **State of Kansas** implemented a Mental Health Reform Act in 1991 that transferred control over state hospital admissions to community programs, established a new service to screen and divert consumers from hospitalization, set state hospital bed targets and increased funding for community programs. An evaluation of the first 18 months of implementation indicated that state level systems change can decrease state hospitalization, increase utilization of community services and improve quality of life for people with severe and persistent mental illness (*Rapp & Moore, 1995*).

9.4 Strategies for Program Reimbursement

Financing mechanisms are a powerful tool for shaping how health services are delivered. For example, fee-for-service (FFS) is a reimbursement method that encourages high volume, office-based care for problems that reflect provider priorities and preferences. If jurisdictions are to successfully implement mental health reform they need to use fiscal strategies that promote cost containment, transfer of resources from institutional to community care, priority to those in greatest need and better service for neglected populations. Reimbursement strategies can be broadly grouped into those that are linked to individual need and those linked to aggregate program and system performance. Strategies can use positive incentives (rewards) or negative incentives (penalties) to bring about the desired changes. They can link funding to an individual procedure, an episode of care or a period of time. Each strategy has strengths and limitations, and jurisdictions need to select those that are most likely to succeed in their environment. The following discussion outlines the most promising strategies for implementing reform and research evidence regarding their performance.

9.4.1 Strategies that link funding to individual need

Prospective Payment

Prospective payment is an approach to funding that moves the consumer to the centre of the financing policy. The level of payment for services rendered to an individual during an episode of care or defined period of time is determined before services are actually provided. Reimbursement rates are based on the illness characteristics and anticipated needs of the consumer, and are independent of the actual cost of providing service. Prospective payment is aimed at cost containment, and uses rewards and risk to encourage efficiency. Providers in prospective payment contracts can retain unspent revenues but bear the loss if costs exceed income (*Dickey & Cohen, 1993*).

The problem with implementing prospective payment in mental health is that efforts to establish reimbursement rates suffer from our inability to model how patient characteristics relate to service use. Since the advent of the Medicare Prospective Payment System (PPS) for reimbursing U.S. hospitals in the early 1980s, research on creating patient groups which can be expected to have similar care needs (and therefore a similar level of reimbursement) has flourished. Yet our capacity to predict patient service needs remains limited (*Frank & Lave, 1985; Mitchell et al., 1987*). If payment rates do not accurately reflect actual care costs, good providers are financially penalized and practices that undermine care are promoted – for example skimming (i.e., selecting more healthy, cheaper-to-treat patients), manipulation (i.e., recording information that places a patient in a higher reimbursement category) and under-servicing. Utilization review is a strategy used in environments where prospective payment is the basis for funding allocations. In hospitals UR can be applied to assess the appropriateness of clinical decisions and provide feedback to providers for future practice (*Yank, Hargrove & Davis, 1992*).

Prospective payment can also be applied to users of ambulatory services if appropriate methods for determining levels of prepayment can be developed.

Experience with Prospective Payment

In the United States the **Prospective Payment System** or PPS is the predominant tool for funding hospital services. While psychiatry has been excluded from the Medicare prospective payment plan because classification tools for setting patient reimbursement rates are felt to be inadequate, private insurers and managed care organizations are actively seeking better tools for determining psychiatric patient reimbursement. Many private companies are vying for this portion of the health care market.

In Canada global budgets are still the predominant form of hospital reimbursement but initiatives that link funding to volume and nature of patients served are emerging. In Ontario, the Hospital Funding Reform Project is developing methods for adjusting hospital global budgets based on patient and facility characteristics. Reimbursement for patient care in a hospital is prospectively calculated, based on the patient case mix in a previous year and expected costs of treating patients in each case mix group. More recently hospital characteristics have been incorporated into the funding methodology (*Lave et al., 1992; Joint Policy and Planning Committee, 1995a*). The difference between hospital

actual costs and expected costs is the basis for making budget adjustments. Refining budgets based on case mix does not work well in psychiatry because of the limited accuracy of the Case Mix Group (CMG) classification system (*Joint Policy and Planning Committee, 1995b*). This limitation has been recognized by the Ministry of Health which, in partnership with the Ontario Hospital Association, is currently investigating more effective approaches for funding and managing hospital psychiatric services.

The **Province of Alberta** is using a diagnosis-based classification system for funding inpatient care. Thus far, psychiatric hospitals have been excluded. A recent study concluded that a funding system based on the Refined Group Numbers (RGNs) classification system used in Alberta would result in inequitable funding for psychiatric discharges, with specialty facilities being substantially underfunded (*Wellock, 1995*).

Capitation

Capitation is a needs-based form of prospective payment wherein providers receive a preset fee per enrollee in exchange for delivery of a defined range of services in a specified period of time. Capitation plans strive to link reimbursement rates to the expected needs of enrollees so that providers are not penalized for accepting more ill, lower functioning individuals into the plan. Because the fee remains fixed regardless of the patient's level of use of services, the provider assumes risk and responsibility for costs exceeding the capitated amount (*Dickey & Cohen, 1993*).

Capitation has numerous advantages. It is a powerful device for consolidating fragmented funding streams including hospital and community resources, and linking funding to user need. Because services must be delivered within a fixed budget, capitation promotes substitution of less costly services for more expensive ones and use of preventive interventions to avoid more intensive care later. Because total spending is determined in advance, budgets can be controlled and contained. If a capitation plan is non-profit, savings can be redirected to development of more community services. Capitation can be used to encourage providers to serve neglected populations by setting higher rates for the care of these individuals. In contrast to environments where there is close monitoring of all care decisions (ie., managed care programs), capitation offers providers and consumers more freedom and flexibility in service choices. Capitation centralizes responsibility for service delivery, thus consolidating and clarifying accountability.

While capitation is the most comprehensive of strategies for linking reimbursement to individual need, it has serious vulnerabilities. The main danger of capitation is under-service. Because the care period for reimbursement is usually one year, providers tend to focus on immediate spending control rather than longer term health care management. Prevention is given little priority and services may be withheld to control expenses. Systems can be implemented to monitor under service but they are difficult to develop and costly to operate. A further limitation is that we lack understanding about how to calculate payment rates that accurately reflect the resources needed to treat patients with different illness and demographic characteristics. As a result providers may be unwilling to take on users with more complex needs for fear of inadequate reimbursement. Few administrators have the

technical expertise to negotiate agreements and work out the complicated arrangements for risk-sharing that capitation entails (*Lehman, 1987; Nasir, 1994; Okin, 1995*).

The vulnerability of capitation plans to under-service is a particular concern in mental health care. There are fears that private capitation plans will imitate other private insurance programs, imposing limits on allowed inpatient days and outpatient visits, and excluding rehabilitation services. As a result, people with chronic mental illness will be under-served or excluded from participating (*Lehman, 1987; Sharfstein et al., 1993; Hughes, 1996*). Yet, if pitfalls can be avoided, capitation affords many advantages. A number of jurisdictions have set up pilot projects to assess effectiveness of separate, publicly funded capitation programs with mandated minimum standards for people with chronic mental illness. Results have been encouraging.

Experiences with Capitation

Integrated Mental Health, Inc. (IMH) was a non-profit corporation established in Upper State **New York** to administer a capitation program for people with serious mental illness who were heavy users of hospital services. Multiple funding streams were integrated within IMH to make single capitation payments possible. Each of several community mental health centres (CMHCs) received a budget allocation from IMH determined by the number of enrollees and their projected respective levels of need. The Centres assumed responsibility for care of all rostered persons. Direct mental health services were generally provided by the Centre, with other services such as housing, social or rehabilitation services purchased from other local agencies. The CMHC also paid for use of acute and long-term hospitalization.

An evaluation compared individuals randomized into either the capitation program or a control group which received traditional mental health care. Capitation was successful in transferring heavy uses of inpatient services into the community and increasing use of less costly services. Consumers in the capitation project used fewer hospital services and more case management than those in the control condition at a lower overall cost. There were no group differences in functioning or level of symptomatology. A number of implementation difficulties were encountered, including defining capitation rates and establishing an information system for monitoring. Questions were raised about the appropriateness of capitation for all persons with serious mental illness as many criteria were applied to selection of participants for this project. For this reason, it was suggested that capitation programs target clearly defined groups (*Reed et al., 1994; Dickey & Cohen, 1993; Cole et al., 1994*).

Rhode Island implemented a partial capitation program to move long-term users out of the state hospital. Local mental health authorities were offered a fixed rate per annum to arrange for a patient's discharge and community treatment. Unlike full capitation plans, the authorities were not held financially responsible if rehospitalization was required. The program was successful in shifting funds from hospital to community mental health budgets, focusing care on seriously disabled consumers and providing individualized treatment and support. After seven years, all clients in the transfer program were living in community settings and more than \$7 million had been transferred annually to community programs. Levels of functioning and community tenure improved in the majority of consumers (*Nasir, 1994*).

Two sites in **California** were chosen to implement and test the effectiveness of an integrated service agency that combined capitation with assertive continuous treatment. Participants were screened for program eligibility (i.e., required a DSMIII-R diagnosis, substantial functional impairment and eligibility for public assistance) and then randomly assigned to the capitation program or usual county mental health services. After 12 months, those in the capitation programs had spent less time in hospital, were less likely to have dropped out and were more likely to work for pay. It was felt that the integrated service delivery model and flexibility of capitated funding increased access to vocational programming for consumers and contributed to the program's success in that area. Group differences were not found in symptomatology, number of friends, independent living, self-esteem and quality of life (*Chandler et al., 1996*).

Leff and colleagues (1996) compared outcomes over time of persons with severe mental illness who were randomly assigned to capitated and fee-for-service (FFS) programs in **Arizona**. They found that more disturbed persons had better outcomes under capitation than under FFS in symptom levels and social conflict while less disturbed persons had equal or poorer outcomes. Leff suggested that providers reimbursed under capitation are motivated to appropriately serve highly disturbed individuals in order to avoid expensive hospitalizations, but feel they can under serve less disordered persons without dire consequences.

Vouchers

This method gives purchasing rights directly to individuals by providing them with vouchers to buy needed services. While the voucher system should enhance consumer choice and provider competition, in practice there are rarely enough providers to realize either of these benefits. To use vouchers optimally, consumers need to judge quality and compare alternative providers but serious mental illness can interfere with decision-making capacity. Some consumers have difficulty pacing their use of vouchers and may run out or have vouchers left at the end of the period of coverage (*Frank & Goldman, 1989*).

In the **Robert Wood Johnson Program on Chronic Mental Illness**, individuals were given housing vouchers from HUD that allowed them to choose their own housing. Evaluators found that this funding served as a conduit to more independent living, more affordable housing and improved housing conditions for program participants (*Newman et al., 1994*).

9.4.2 Strategies that link funding to program and system performance

Performance Contracts

In contrast to strategies that link funding to individual care, **incentive or performance contracts** tie payments to aggregate measures of program performance to promote goals such as improved quality, contained costs, new service development and increased care for previously neglected populations. Financial incentives can be awarded for meeting performance targets and penalties imposed if targets are missed. Contracting can flag ineffective providers through close monitoring of performance if

consensus is reached on appropriate delivery and outcome measures. In mental health reform there has been progress in defining system targets (such as institutional/community spending ratios, hospital bed targets) but opinion still varies on what constitutes program success (see chapter on evaluation). With uneven progress and relapse common among people with severe mental illness, programs need protection against poorer outcomes.

Contracting is more likely to realize innovation and increased competence in programs when there is competitive bidding but, among programs that serve people with serious mental illness, there is often a lack of multiple bidders. If competition leads to frequent changes in recipients of contract awards, there will be a disruption in continuity of care for consumers. Contracts that impose strong penalties can create pressures to under-serve in order to meet preset targets (*Frank & Goldman, 1989*).

Experiences with Performance Contracts

Wisconsin used performance contracts successfully to reduce spending on inpatient care. Local mental health authorities, managing a combined hospital and community envelope, were given responsibility for purchasing hospital services for their patient population. If bed use fell below a preset rate they were reimbursed for the difference but if use exceeded the target, they paid the additional costs. Monies saved by decreasing inappropriate hospital use could be used to create or expand community mental health programs. As reported earlier this system worked well in Dane County but was less effective in other counties in Wisconsin. The **Ohio Plan** used a similar approach of allowing local boards to gain control over funds previously spent on inpatient care. Between 1982 and 1992 state psychiatric hospital census declined from 4375 to 2450 and community mental health spending increased from \$54 million to \$128 million (*Nasir, 1994*).

The State of **Texas** successfully used incentive contracts to reduce state mental hospital inpatient use even though state hospital funding was not contained in the local funding envelope. Local mental health authorities received a bonus for each day of hospital care in actual experience that fell below a preset baseline level. Penalties were not applied if bed use exceeded the targeted amount. This initiative resulted in a \$20 million transfer from the state hospital budget to community mental health centres in the first two years of the program and a 19% reduction in average daily census (*Nasir, 1994*).

New York State used financial incentives to encourage improved discharge planning and early patient linkage. Hospitals received a “bridging fee” for successfully linking a Medicaid patient with outpatient services within 10 days of discharge, and eligible outpatient providers were offered a 40% premium above base Medicaid fees-for-services provided during the first 30 days after discharge (*Mechanic, 1991*). **Washington State** worked with stakeholders and a technical work group to develop outcome measures and incorporate them into funding contracts with county mental health authorities or RSNs. Funding was tied to performance related to consumer engagement, community tenure, residential status, daily activity and parity for under served, domains which the state information system was able to monitor (*Hanig & Gilman, 1995*).

Grants

Grants are lump-sum transfers of resources, usually from government to non-profit providers, to deliver a specific type of service. They tend to be simpler vehicles for program reimbursement than performance contracts because they set fewer criteria and require less reporting (*Frank & Goldman, 1989*). Their advantage is that administration costs are kept low and providers have flexibility in how they deliver care. *Bigelow & McFarland (1994)* support use of less expensive forms of fiscal management, arguing that strategies such as peer review, site visiting and continuing education can be used to improve and monitor quality of care.

9.5 Discussion

The history of trying to create a system of care for the severely mentally ill can be traced for decades, since deinstitutionalization began releasing great numbers of individuals into communities ill-prepared to provide adequate substitute care. Earlier efforts focused on creating a stronger system of community services and supports that met basic needs and provided treatment and rehabilitation. More recently, concerns about fragmentation among diverse services have spurred efforts to improve coordination and service integration. Clinical coordinating mechanisms such as case management have achieved some success in improving coordination at the individual level but have not achieved system-wide change. More recently a number of jurisdictions have implemented separate mental health authorities that control a consolidated funding envelope to advance the goals of mental health reform and achieve a more integrated system of care. In many cases implementation of authorities has led to the desired structural changes of transferring more funds to community and increasing continuity of care, but as the Robert Wood Johnston Program discovered, systems still need adequate financing and service quality requires ongoing attention.

Concerns have been raised that creating separate authorities isolates mental health care, making funding more vulnerable to cutbacks and distancing mental from physical health care. Yet separate authorities are powerful structures for implementing mental health reform. Many believe that integration with health should only be considered after a stronger, more mature reformed mental health system has been established.

Allocating mental health resources on the basis of need should lead to more equitable and appropriate reimbursement but jurisdictions need to experiment with appropriate methodologies. While capitation and prospective payment are reimbursement methods that strive to link funding to individual need, they need to be applied carefully as they have many pitfalls. Performance contracts that offer awards and penalties are closer to current funding strategies and have been used successfully in many places to shift resources to the community and increase continuity of care. Better technical tools are needed to support implementation of these various funding approaches – for example, systems for classifying patients into groups that require similar levels of care, methodologies for estimating the proportion of a general hospital budget that is spent on mental health care, and models that can predict need using social indicator data.

9.6 Best Practices: Governance and Fiscal Strategies

Research Evidence

Empirical evidence from system evaluations indicate that:

- ★ Needs-based resource allocation is more effective in matching resources to local consumer needs than approaches based on historical funding levels and provider behaviour.
- ★ Local mental health authorities and single funding envelopes can create more integrated mental health delivery systems, shifting resources from institutions to community, expanding community services and increasing continuity of care.
- ★ Funding strategies that attach reimbursement to individuals have many advantages but are still limited by our capacity to calculate appropriate rates of reimbursement, monitor performance and develop/manage provider contracts.
- ★ Performance contracts can be used to reduce hospital use and shift resources into community supports.

Evidence from controlled and uncontrolled trials indicate that:

- ★ Despite implementation problems, non-profit capitation programs for people with severe mental illness can successfully direct care to a neglected population, reduce hospital use, increase use of community supports and lower overall treatment costs.

Key Elements of Best Practice

At a provincial level there are:

- ★ leadership which has an explicit and shared vision with all stakeholders for how the reformed system should be organized and what outcomes are desirable for people
- ★ a strategy that includes creating decentralized structures for managing local mental health care delivery
- ★ monitoring responsibility (e.g., through allocations, standard setting, audits)
- ★ separate, single funding envelope that combines various funding streams for delivery of mental health care
- ★ legislation or policy directives to preserve the mental health reform strategy and envelope
- ★ capacity to develop joint initiatives with other government departments

At a regional and/or local level there is a mental health authority in place that:

- ★ serves as a clear point of responsibility for people with serious mental illness.
- ★ controls a single, combined envelope for funding mental health care
- ★ has responsibility for planning, organizing and monitoring services and supports, and dispensing funds
- ★ uses clinical, administrative and fiscal mechanisms to achieve more integrated delivery of care.

Funding allocations for particular geographic areas are linked with unique characteristics and needs of area residents.

Reimbursement mechanisms (e.g., performance contracts, capitation) are used to promote program and systems change. The needs of the consumer are always central in this process.

There is a strategy to rebalance spending and increase the proportion of total mental health funds spent on community services and supports.

A consumer-centred information system supports decision-making in planning, funding and managing the system.

Policy and legislative mechanisms preserve the mental health envelope and prevent losses due to downsizing in the institutional sector.

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