DOCUMENT RESUME

ED 460 475 EC 306 851

AUTHOR Pires, Sheila A.; Behar, Lenore; Friedman, Robert M.; Lourie, Ira; Ferreiro, Beverly; Langmeyer, David; May, Ann; Lazear, Katherine J.

TITLE Lessons Learned from the Fort Bragg Demonstration.
PUB DATE 1996-02-00
NOTE 11p.; In: A System of Care for Children's Mental Health: Expanding the Research Base. Proceedings of the Annual Research Conference (9th, Tampa, FL, February 26-28, 1996); see EC 306 844.
AVAILABLE FROM For full text: http://rtckids.fmhi.usf.edu/Proceed9th/9thprocindex.htm.
PUB TYPE Reports - Evaluative (142) -- Speeches/Meeting Papers (150)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Adolescents; *Behavior Disorders; *Child Health; Children; Demonstration Programs; *Emotional Disturbances; *Mental Health Programs; Participant Satisfaction; Program Effectiveness; *Substance Abuse
IDENTIFIERS *CHAMPUS Program; North Carolina (Fort Bragg)

ABSTRACT

This paper discusses the results of a study that investigated the effectiveness of the Fort Bragg demonstration project, a program which provided a comprehensive approach to the delivery of mental health and substance abuse services to a population of approximately 48,000 military-related children residing within the Fort Bragg catchment area. Over a 6-month period, more than 200 individuals were interviewed, including administrators, clinicians, families, policymakers, and other stakeholders. Through the study, there emerged greater clarity as to what the Fort Bragg demonstration project was and was not. Fort Bragg was not managed care; it sought specifically to increase access and utilization without particular regard to cost. The demonstration also was not a system of care or a continuum for high end users. It was a demonstration of a community-based continuum of mental health and substance abuse services with a single point of access. It expanded the array of services, eliminated co-pays and deductibles, reduced use of inpatient and residential treatment, increased access and utilization, and was held in generally high regard by families and the larger community. Critical lessons learned are also discussed. (CR)

The 9th Annual Research Conference Proceedings, A System of Care for Children's Mental Health: Expanding the Research Base (February 26 - 28, 1996).

Lessons Learned From The Fort Bragg Demonstration

Introduction

The Fort Bragg demonstration provided a comprehensive approach to the delivery of mental health and substance abuse services to a population of approximately 48,000 (FY95) military-related children under 18 years of age who resided within the Fort Bragg catchment area. A major purpose of the project was to study the implications of expanding the health care benefit package provided to military families through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) by providing a full continuum of mental health and substance abuse services (Bickman et al., 1995).

As an experiment in systems change, the Fort Bragg demonstration yields a wealth of valuable "lessons learned" for policymakers, practitioners, researchers, and consumers. These lessons have implications both for those involved in children's systems reform efforts, as well as those undertaking managed care initiatives affecting children and their families.

Method

Over the last six months of the demonstration, over two hundred individuals were interviewed, including administrators, clinicians, families, policymakers, and other stakeholders, who had been involved in the Fort Bragg project since its inception. Interviews were conducted by a team of independent policymakers, researchers, family members, and clinicians, all of whom have been involved in national and state systems reform issues over the last decade. The team also reviewed the extensive written documentation available from the demonstration, the formal evaluation conducted by Vanderbilt University, and client characteristic and service data over the life of the project.

What Fort Bragg Was and Was Not

Through the study, there emerged greater clarity as to what the Fort Bragg demonstration was and was not.

Fort Bragg was not managed care. The demonstration sought specifically to increase access and utilization without particular regard to cost, in contrast to managed care, which is concerned fundamentally with controlling cost by managing access and utilization. There was no risk attached to management and service contracts (which were cost-reimbursable); many incentives existed, on both the supply and demand side, to provide and use services.

The demonstration also was not a system of care; that is, it was not an integrated continuum of mental health and related services and supports in which there is shared "ownership" of the system across multiple child-serving systems (i.e., education, child welfare, juvenile justice and mental health).

Fort Bragg was not a continuum for "high end users" (i.e., children with serious disorders, only). Nearly 60% of the evaluation sample received no service more intensive than outpatient.

Fort Bragg was a demonstration of a community-based continuum of mental health and substance abuse services, with a single point of access, for a total child/adolescent eligible population (i.e., for both acute and extended care populations and for children with both mild and serious disorders). It changed an existing, poorly regarded system, as it intended; it expanded the array of services, eliminated co-pays and deductibles, reduced use of inpatient and residential treatment, increased access and utilization, and was held in generally high regard by families and the larger community. With this success, however, there emerged countervailing pressures and issues (e.g., cost pressures, overutilization of multiple services, unrealistic expectations on the part of some families and clinicians, and apparent cost shifting to and from the demonstration). To its credit, the demonstration made every effort to be a self-correcting

the demonstration made every effort to be a self-correcting experiment.

Critical Lessons Learned

Service Utilization

At least two important lessons emerge from looking at the greatly expanded service utilization created by the demonstration. The first is the "if you build it, they will come" lesson. If mental health services are offered to families in ways that are accessible, stigma-reducing, and individualized, they will be used&endash;and probably more heavily than a developing system can accommodate without creating problems in other areas, such as cost problems, inadequate provider training, inadequate monitoring, and quality assurance. A response to these problems is not necessarily to restrict access, which remains a worthwhile policy goal, but rather to design the demonstration and manage services during implementation in ways that promote more deliberative start-up and efficient treatment.

A second lesson from looking at service utilization in Fort Bragg is the importance of analyzing as accurately as possible the population eligible for services prior to implementation (i.e., who and how many can be expected to use services). This requires striking some balance between using prior utilization and prevalence data. The Fort Bragg demonstration was hampered by the inadequacy of the Army's data regarding how many children were using services and the types of services being used, as well as the insistence to base expected use on prior utilization only. There is a particular lesson here for managed care initiatives which have a tendency to rely on prior utilization to develop capitation rates. The Fort Bragg project suggests strongly that use of prior utilization alone will be an inaccurate predictor if it is applied to a more attractive, accessible, community-based continuum of behavioral health services.

Fort Bragg points to the need for individualized system planning for different subclusters of children in a total eligible population. For example, while "high end" users may need intensive case management and treatment planning, this is clearly not the case for children using only outpatient services. Children involved in other public systems, particularly child welfare, will require more time on the part of clinicians to manage the boundaries between the systems and deal with the requirements of the other system. Children with ADHD may require less intensive involvement with mental health but greater collaboration with the pediatric services. Fort Bragg suggests an important lesson about the need to desegregate the eligible population into types of users and institute approaches that make sense for different subpopulations&endash;the "not every child needs the same system" lesson.

Cost

Perhaps the most important cost-related lesson from Fort Bragg is that of linking cost and quality issues in design and implementation&endash;a lesson which Fort Bragg itself learned, somewhat painfully, and took steps to change. It is not possible to maintain quality of care without paying attention to cost; clinical viability alone is not sufficient. Inevitably, costs will run high if not attended to from the outset, leading to enormous pressures for cost containment that then can jeopardize quality of care. Cost containment pressures, in turn, will aggravate tendencies of cost-shifting to other child-serving systems.

A related cost lesson is the importance of thinking through in advance the effect on supply and demand of the incentives that are built into the system for providers and consumers to provide and use services, respectively. To its credit, Fort Bragg took a number of steps by the latter half of the demonstration (post the evaluation phase) to modulate some of these incentives and control costs without necessarily jeopardizing quality of care. It also instituted greater efficiencies in service delivery through the following: (a) streamlining its intake process; (b) emphasizing shorter-term, problem solving therapies; (c) adhering more closely to level of care criteria; (d) instituting guidelines for use of psychiatrists; (e) streamlining its case management process; and (f) streamlining the treatment planning process. It created more structured utilization review, with a clearer focus on length of stay, and imposed a more integrated focus on cost, quality, and service issues through its quality improvement process with feedback loops to service providers about both cost and quality. In this process, the demonstration also had to begin to clarify its own values about cost and quality issues&endash;again, an important lesson. When cost containment values were introduced into the service system late in the demonstration, there was indeed a dramatic reduction in the cost of providing treatment.

A strong argument can be made from the Fort Bragg experience that research and development costs and costs associated with requirements imposed by demonstration sponsors should be budgeted and tracked separately from the costs associated with service delivery. Fort Bragg also suggests (as do many other demonstrations in the children's arena) that the time normally accorded to systems change efforts (typically, three to five years) is simply too short to preclude inefficiencies in start-up, development, and modification of new approaches (Friedman, 1996).

A final cost lesson from Fort Bragg relates to the possibility that greater efficiencies may very well have been achieved, at least with respect to Fort Bragg children involved in multiple systems, had the demonstration actually implemented a system of care with shared ownership across the major child-serving systems, instead of a continuum of mental health services "owned" by the Army. Certain inefficiencies occurred because separate systems prevailed.

inefficiencies occurred because separate systems prevailed.

Service Delivery

A great many lessons can be drawn from the demonstration about effective service delivery.

Regarding intake and assessment:

- Intake staff need access to an array of crisis options;
- intermediate-level services, particularly in-home services, need to be available from the outset to prevent inappropriate hospitalization and residential care;
- an intake process that focuses on presenting problems, using a problem list, rather than on "nailing a diagnosis" is needed to promote efficiency;
- small co-pays are needed to prevent an initial recurring problem of missed appointments; and
- intake staff need to be trained well in the treatment philosophy and goals of the demonstration, how the service system is organized, and the resources available to them.

Regarding the treatment team process:

- It is critical to make the treatment team responsible for managing/monitoring length of stay and appropriateness of care to better link treatment and cost concerns;
- a multidisciplinary treatment team does not have to be held for every child entering the system but should be reserved for children with serious or complex disorders;
- the more people who are involved in the treatment team process, the more time-consuming and expensive it will be (i.e, multiple players on the treatment team may aggravate the problem of overuse of multiple services, since each player has a tendency to become an advocate for the service he or she is representing, which also drives up costs);
- an effective treatment team process is one governed by tight clinical leadership and a better understanding of how the various levels of care relate to one another;
- much more needs to be learned about what service components work best for which types of children over what period of time; and
- it is important to be creative in treatment planning and not allow a child to stay in an inappropriate level of care simply because the needed service is unavailable.

Quality Improvement

A number of lessons can be drawn about quality improvement (QI). The QI program should be developed with the involvement of staff and providers, as well as families, and incorporate peer review to create ownership and "buy-in." QI should provide information to clinicians

and "buy-in." QI should provide information to clinicians concurrently with service provision, not retrospectively, so that feedback in areas such as length of stay and family satisfaction gets to providers in a timely fashion, not after the fact. QI should track more than cost and utilization; it needs also to track systems outcomes across the continuum, client outcomes, and family and youth satisfaction. QI and utilization review functions need to be integrated. QI data needs to be tied to credentialling of providers. It is unrealistic to expect a full-blown QI program to be in place before clinical services are fully developed. Implementation of an effective QI program is a developmental process that requires time.

Staff and Provider Network

One of the lessons of Fort Bragg is the importance of orienting the staff and provider network to the values and goals of the demonstration and of evaluating staff and providers against the demonstration's desired outcomes. Because differing values are inevitable among staff and providers, it is essential to articulate clearly the demonstration's values as a unifying element and to create an in-house process to air and resolve differing values. Without such a process, staff become polarized around different philosophies, instead of working synergistically.

Family Involvement

Perhaps the most salient lesson about family involvement is the danger in assuming that everyone means the same thing by "family involvement," the importance of articulating clearly what the demonstration means by it and the importance of training staff in the demonstration's philosophy and service approach to families. There needs to be clinical leadership to help families make good decisions. Lack of strong clinical leadership, particularly at a systems level, affects cost. In the absence of such leadership, there is a tendency for staff and providers to overload families with services and for families to become dependent, aggravating lengths of stay and therefore cost.

Environmental Context

Systems change experiments in the children's arena operate in complex political, social, and interagency environments. Particularly in the children's arena, changes in one system will affect all other child-serving systems.

Fort Bragg reinforces the usefulness of environmental and ethnographic analysis for anticipating how services will be used and for informing deliberations about optimal treatment approaches for the target population. For example, it might be anticipated that ready access would be a major factor in the willingness of Army families to use services because of the Army mentality of "do it now." Similarly, the location of services off-base might also have been

anticipated to increase demand for services because of the preference of military families to use non-base providers, particularly for mental health services where stigma is an issue. The transiency of the military family, particularly those at this rapid deployment base, might have argued in the design phase for shorter-term, problem-solving treatment approaches and shorter lengths of stay. The rapid deployment nature of the base, which has the effect of depleting medical staff from the base, might also have been anticipated to result in some patient-shifting from the Army medical center on-base to the demonstration, as indeed occurred.

Evaluation

Just as it is essential for demonstration implementers to be clear about their purpose, it is critical that evaluators are careful to define clearly what it is they are evaluating. It also is critical that appropriate caveats be included regarding comparison sites that are used. Typically, there are political, operational, and other constraints that influence the choice of comparison sites, which necessarily affects comparability. Those involved in the demonstration believe that the most, perhaps only, comparable site to Fort Bragg is Fort Hood, which, for a number of reasons, could not be used (L. Behar, personal communication, Summer, 1995). Both bases, unlike the comparison sites that were used, are involved in rapid deployment, house specialized forces, have large pediatric populations, have high birth rates, and have a large concentration of low income military personnel. It is possible that these factors create more difficult-to-treat mental health problems. If this is the case, then the fact that Fort Bragg had outcomes as good as, and in some cases, better than the comparison sites that were used, is encouraging. Similarly, a caveat might have been noted regarding the potential influence on outcomes of co-pays and deductibles, with which families at the comparison sites, but not Fort Bragg families, had to contend. Families at the comparison sites may have been more motivated, due to the presence of co-pays and deductibles, to use services and to use them more efficiently. This motivation, in turn, may have helped to produce better treatment outcomes.

In assessing adequacy of implementation, evaluators need to be clear about the stage of implementation that is being evaluated, as systems change experiments are highly developmental in nature. They also need to define carefully what aspects of implementation are being assessed and the limitations of those aspects to creating a holistic picture of implementation. The Fort Bragg evaluation, for example, evaluated case management and intermediate services as indicators of adequacy of implementation. The evaluation did not assess the appropriateness of case management for the various populations of children receiving that service, which proved to be an issue. The evaluators assessed intermediate services in one clump, rather than separately,

making it impossible to determine whether certain components were more or less well developed than others, which might affect results. Also, at the time of the implementation evaluation, the demonstration was at a relatively early stage of development, besieged by a heavy demand for services, an influx of new providers, and without well developed internal management and control, quality assurance and utilization review mechanisms, all of which affected results.

Evaluators need to be very careful in their interpretation of cost findings. In Fort Bragg, one might have concluded that the high costs associated with the demonstration were exactly what might have been anticipated given its design. This is a quite different interpretation than saying that costs were higher than expected. This goes back to the earlier point about the importance of both the demonstration and the evaluation being clear about purpose and goals.

Summary

Demonstrations are expected to undertake many new endeavors very quickly. Fort Bragg, for example, had to simultaneously educate the community, hire new staff, contract with outside providers, start new programs, build internal management and monitoring mechanisms, respond to sponsor demands for information and adjustments, orient and train new staff and providers, find facilities, etc. Multi-faceted systems, changing experiments in the children's arena, need time and a deliberately phased timetable, with benchmarks along the way, to be implemented (and evaluated) effectively.

References

Bickman, L., Bryant, D. M., & Summerfelt, W. T. (1993). Final report of the quality study of the Fort Bragg Evaluation Project. Vanderbilt Institute for Public Policy Studies, Center for Mental Health Policy, Nashville, TN.

Bickman, L., Guthrie, P. R., Foster, E. M., Lambert, E. W., Summerfelt, W. T., Breda, C. S., Heflinger, C. A. (1994). Final report of the outcome and cost/utilization studies of the Fort Bragg evaluation project. Vanderbilt Institute for Public Policy Studies, Center for Mental Health Policy, Nashville, TN.

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: Plenum Press.

Bickman, L., & Heflinger, C. A. (1993). Final report of the implementation study of the Fort Bragg Evaluation Project. Vanderbilt Institute for Public Policy Studies, Center for Mental Health Policy, Nashville, TN.

Friedman, R. M. (1996). Services and service delivery systems for children with serious emotional disorders: Issues in assessing effectiveness. In C. T. Nixon and D. A. Northrup (Eds.). Evaluating mental health services: How do programs for children "work" in the real world?"

Authors

Sheila A. Pires, M.P.A.
Partner
Human Service Collaborative
2262 Hall Place, NW, Suite 204
Washington, DC 20007
Voice: 202/333-1892
Fax: 202/333-8217
sapires@aol.com

Lenore Behar, Ph.D.
Head, Child and Family Services Branch
Developmental Disabilities and Substance Abuse Services
325 N. Salisbury Street, Room 523
Raleigh, NC 27603
Voice: 919/733-0598
Fax: 919/715-5722

Robert M. Friedman, Ph.D.
Chair
Department of Child and Family Studies
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Boulevard
Tampa, FL 33612-3899
Voice: 813/974-4640
Fax: 813/974-4406

Ira Lourie, M.D.
Partner
Human Service Collaborative
2262 Hall Place, NW, Suite 204
Washington, DC 20007
Voice: 202/333-5998
Fax: 202/333-8217

Beverly Ferreiro, Ph.D.
Department of Psychiatry
Box 3454
Duke University Medical Center
Durham, NC 27710
Voice: 919/687-4676
Fax: 919/687-4737

David Langmeyer, Ph.D.
909 Vestivia Woods Lane
Raleigh, NC 27615
Voice: 919/847-0098
Fax: 919/848-3288

Fax: 919/848-3288

Ann May
2908 Debra Drive
Raleigh, NC 27607
Voice: 919/787-8235
Fax: 919/783-6038

Katherine J. Lazear, M.A.
Department of Child and Family Studies
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Boulevard
Tampa, FL 33612-3899
Voice: 813/974-6135
Fax: 813/974-4406
lazear@hal.fmhi.usf.edu

Liberton, C., Kutash, K., & Friedman, R. M. (Eds.), (1997). The 9th Annual Research Conference Proceedings, A System of Care for Children's Mental Health: Expanding the Research Base (February 26 - 28, 1996). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research & Training Center for Children's Mental Health.

EC 306851

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

NOTICE

REPRODUCTION BASIS

☐ This document is covered by a signed "Reproduction Release (Blanket) form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.

☑ This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").