DMHDD Integrated Quality Assurance Program

Fiscal Year 1999 Review

**Program Evaluation
and
Review Committee
●
November   1999**

Introduction

A | laska statutes mandate Alaska Mental Health Board (AMHB) review of the State Mental Health Program. The AMHB's Program Evaluation and Review Committee (PERC) undertakes these review and evaluation tasks. The committee's reports assist the AMHB in determining mental health service needs and efficacy, planning for mental health programs, and preparing budget recommendations. PERC reports also contribute to recommendations the AMHB makes to the Alaska Mental Health Trust Authority.

PERC Mission

The Program Evaluation and Review Committee is responsible for the evaluation and review of the state mental health plan and program to assure mental health services are accessible, meet needs, and provide quality mental health services to Alaskans.

This report summarizes the PERC staff review of the Integrated Quality Assurance (IQA) Program. The IQA program is housed in the Division of Mental Health and Developmental Disabilities (DMHDD) of the Department of Health and Social Services. DMHDD administers the program and performs elements of the reviews that evaluate fiscal accountability and medical necessity. A contractor, Northern Community Resources (NCR), undertakes those review components involving the assessment of consumer outcomes and satisfaction.

The committee resolved at its July 1999 meeting in Cordova, with Board approval, to initiate this review. The committee accepted the draft report at its November 1999 meeting in Anchorage. PERC asked the AMHB to forward the final report to the IQA Steering Committee for that body's use as it evaluated the initial year of the IQA program. The AMHB adopted the committee recommendation at that same meeting.

1. Agency Reviews

T his review is based on 12 Integrated Quality Assurance (IQA) reviews which took place during FY 99. Several other reviews took place during FY 99, but the Northern Community Resources (NCR)/Division of Mental Health and Developmental Disabilities (DMHDD) reports were not available at the time we composed this document. The reviews providing the basis for this synthesis are (with the date of each in parens):

1. Wrangell Community Services (January 25-27, 1999)
2. South Peninsula Mental Health Association (February 16-19, 1999)
3. Kuskokwim Native Association Community Counseling Center (February 23-25, 1999)
4. Seward Life Action Council (March 23-26, 1999)
5. REACH (April 5-8, 1999)
6. North Slope Borough Community Counseling Center (April 5-8, 1999)
7. Juneau Youth Services (April 12-15, 1999)
8. Juneau Community Mental Health Center (April 19-23, 1999)
9. Life Quest (May 3-6, 1999)
10. Tok Area Mental Health Center (June 1-3, 1999)
11. Copper River Mental Health Center, (June 2-4, 1999)
12. Yukon-Koyukuk Mental Health Program (June 8-10, 1999)

IQA review reports contain, in essence, two separate reports. The first covers the medical necessity review conducted by DMHDD Quality Assurance staff and the second, the site review conducted by NCR-led teams. This chapter devotes discrete sections to each.

Medical Necessity review findings may reveal issues related to administrative or clinical capacity.

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Medical Necessity Reviews

Medical necessity reviews entail determining whether randomly selected client files contain appropriate and complete documentation demonstrating the medical necessity of services, conformance with regulations and standards for clinical processes, and appropriate utilization of public funds. DMHDD QA staff examine both Medicaid and non-Medicaid cases. Given the nature of medical necessity reviews, we devote less scrutiny to this element of the integrated review, focussing on the patterns of findings rather than looking at individual criterion subsumed within each category.

Chart 1 indicates how the 12 centers for which we have medical necessity review results fared. The overall results tallied in the chart indicate a weighted score combining evaluation of the 12 centers' records on the following basis:

♦ Criteria meeting or surpassing standard
♦ Criteria partially meeting standard
♦ Criteria not meeting standard

The columns in the chart indicate the percentage of standards for which reviewers found that centers met or surpassed standards for each of the four categories.

Chart 1

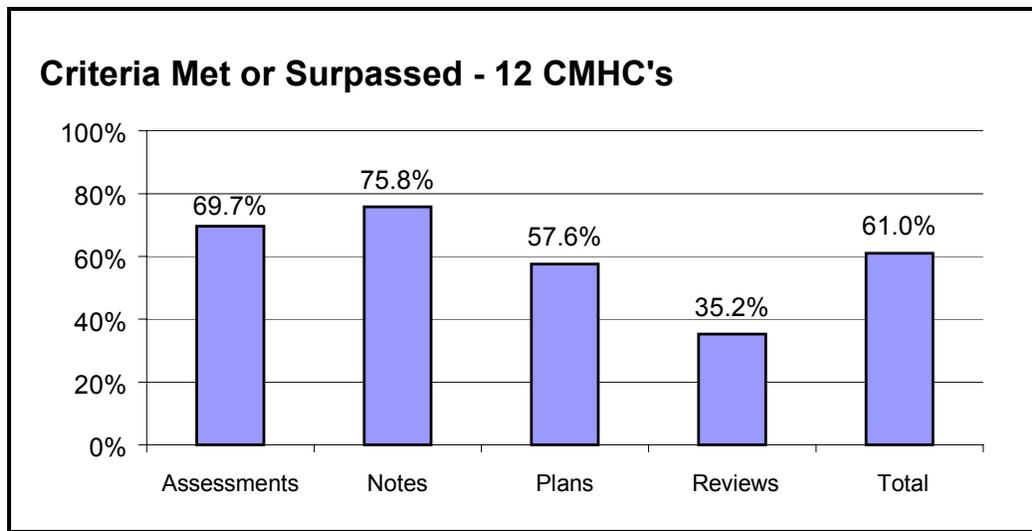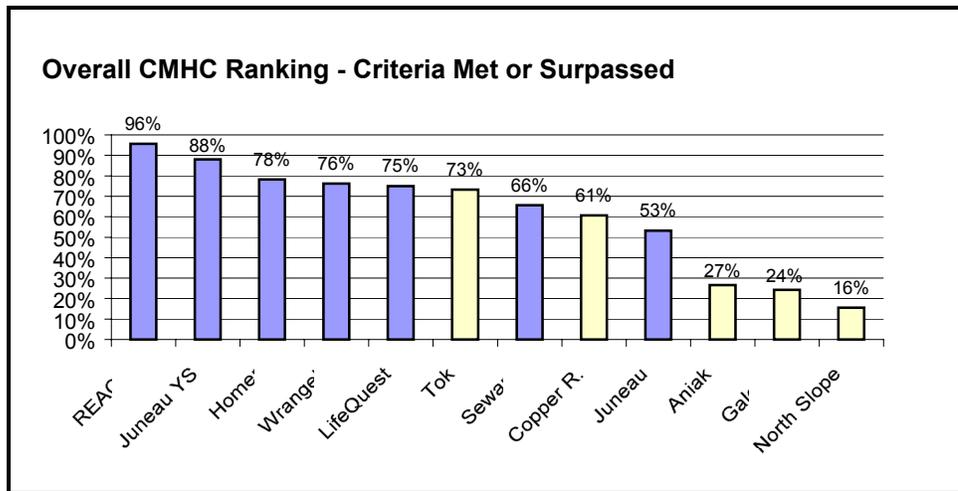**Criteria Met or Surpassed - 12 CMHC's**

Chart 1 reveals dispersed ratings (based on the mean of all scores) for the four review categories, from a high of nearly 76% for progress notes to a low of 35% for treatment reviews. Within each category, individual agency scores also showed considerable variance. One agency scored 100% on three of four categories. Another scored 0% on two of the four. As one might surmise, aggregated scores obscure a wide variance among agency scores. The top-rated agency had an aggregate score of 96%, but only one other agency met or surpassed at least 80% of criteria. The lowest grantee rated just over 15% and three other agencies fell short of overall scores of 30%. As a group, the 12 agencies did not meet or surpass medical necessity criteria at a high level.

The AMHB has long held that Alaska's mental health system actually consists of two separate systems. Larger communities from Anchorage down to some communities of a few thousand

population possess more or less full service care continuums. Smaller and more isolated towns generally have limited service and administrative capacities, as shown in Chart 2, in which the lightly shaded bars represent these communities. It is likely no coincidence that each of the three centers that fell below a 30% mark on their medical necessity reviews were small or isolated (a fourth scored right at the group average and one scored 73%). Only one center from a large community failed to score better than the overall group average. Overall, smaller, isolated grantees met or surpassed 40% of medical necessity criteria, while other grantees did so for 76% of criteria. While our sample consists of only 12 grantees, what we see accords with perceived disparities between urban and rural (or smaller) delivery systems. Medical Necessity scores appear to support the logical and direct correlation between program size and clinical and administrative capacity.

Chart 2

Overall CMHC Ranking - Criteria Met or Surpassed

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Community Site Reviews

Community site reviews seek to determine whether programs produce outcomes consistent with DMHDD Principles and IQA Standards and the degree of consumer satisfaction with outcomes. Each site review encompasses a variety of elements, beginning with an overview of the program and a summary of the program's response to any action plan generated as the result of a previous review. Review information sources are twofold: 1) interviews with program staff, other service providers, client families, and consumers and 2) review of administrative and personnel files. The basic components of a review report are the following:

♦ Areas of Excellence
♦ Administrative and Personnel Standards
♦ Quality of Life and Outcome Indicators
♦ Areas Requiring Response
♦ Public Comment

♦ Other Suggestions and Comments

Another site review element (Questions for Related Service Providers) was present in half of the reviews in question. Site review teams, facilitated by NCR, consist of one or more NCR facilitators, community members, peer service providers, and the occasional AMHB member.

Some basic statistics will set the stage for an overview of the site review portion of IQA reviews.

♦ Review teams numbered from 4 to 9 members, with the average number of members being 6.
♦ A review team typically interviewed 28 individuals, ranging from 47 down to 15.
♦ The number of consumers interviewed ranged from 5 to 18, with 10 (35% of all interviews) the average number.
♦ The number of consumers of mental health services interviewed ranged from 2 to 12 per site, with an average of 7 (25% of all interviews).

A key dilemma influencing our synthesis of NCR review findings was the inability in a number of instances to determine whether site review reports referred to consumers with mental illnesses or to consumers with developmental disabilities (or their families).

In examining the constituent elements of the site review, our primary purpose will be to identify any tendencies or trends suggested by the reports as a whole. Again, since we had but 12 reviews as our database, caution in ascribing global conclusions remains the watchword.

The number of reviews considered (12) urge caution in drawing broad conclusions.

Response to Action Plans
Five reports noted responses to previous action plans (i.e., plans of improvement or correction) from prior reviews. The dominant trend in the five reports revealed that previous reviews focused attention on consumer-oriented elements, most often surveys of consumers and inclusion of consumers in staff hiring processes.

Administrative and Personnel Standards
Two sections of site reviews deal with administrative and personnel standards, a narrative and a checklist. In looking at the narrative sections, only a fairly short list of issues appeared in as many as four reports (none in more than six or half of the reports):

♦ High staff and provider turnover rates

♦ Need to develop or revise policies and procedures
♦ Positive relationships with other providers
♦ Competent, caring staff

Chart 3

Adminstrative/Personnel Standards Met

Partial 23%

No 9%

Yes 68%

The Administrative and Personnel Standards checklist contains 34 items, which in some sense resemble the other side of the medical necessity standards. The standards address issues such agency mission; fiscal systems; consumer involvement; program development; collaboration with other providers; and staff qualifications, training, and development. Chart 3 summarizes overall compliance with administrative and personnel standards for the 12 programs covered by this review. In aggregate, about two-thirds of all standards are fully met. Underlying these aggregate numbers are several elements of interest. Four (12%) of the 34 standards were met by all 12 agencies reviewed. In the case of nine other standards, half or fewer of the group fully complied. Those standards were:
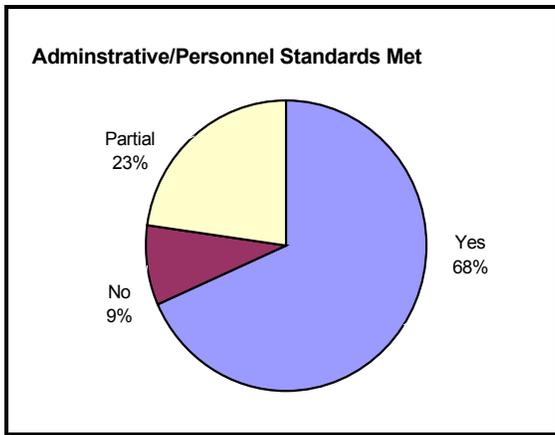
♦ Governing body includes significant consumer or family membership and embraces their meaningful participation (Standard 6).
♦ All facilities and programs operated by the agency provide equal access to all individuals (11).
♦ Agency actively solicits and carefully utilizes consumer and family input in policy setting and program delivery (12).
♦ Agency involves consumers, staff, and community in annual planning and evaluation of programs, including feedback from its current and past users about their satisfaction with the planning and delivery of services (13).
♦ Agency develops annual goals and objectives in response to consumer, community, and self-evaluation activities (14).
♦ Agency implements and maintains a system for review and revision of all job descriptions (20).
♦ Organization has and utilizes a procedure to incorporate consumer choice into the hiring and evaluation of direct service providers and to ensure that special individualized services have been approved by the family or consumer (22).
♦ Agency has policies and implements procedures to facilitate the development of non-paid relationships between consumers and other community members (26).
♦ Staff development plan is written annually for each professional and paraprofessional staff person (29).

Seven of these nine standards revolve around consumer involvement, choice, and empowerment. At two centers the number of non-compliance findings equaled or exceeded the number of compliance findings.

Areas of Excellence

Review reports include a section in which teams cite areas of excellence. Three agencies received no citations for areas of excellence (all were rural programs with the lowest total scores on the Medical Necessity reviews). Citations for excellence among the twelve agencies fell into the following general areas:

♦ Commitment to client needs (4 centers cited)
♦ Collaboration with other agencies (3)
♦ Strong consumer advocacy (3)
♦ Superb services (3)
♦ Comprehensiveness of services (2)
♦ Least restrictive service environment (2)

Quality of Life

Reviews included assessments of consumer quality of life in five areas or domains. Evaluation of the quality of life values and indicators reflects mainly interviews with consumers at each agency and is recorded in two different forms. Each review narrative includes a section in which the review team cites program strengths. The review also tallies the results of consumer interviews in a survey format. This report examines the narratives and the surveys separately.

First, we present the strengths identified by review teams in report narratives. The most often noted strengths in each domain are listed below, grouping similar citations into categories. Again, in some instances, certain assessment narratives did not clearly identify consumer disabilities.

Choice and Self Determination
♦ Consumer participation in plan development (6 centers)
♦ Provider choice (5)

Dignity, Respect, and Rights
♦ Consumer and families respected (11 centers)
♦ Consumers know rights (7)
♦ Consumer confidentiality maintained (6)
♦ Staff supports and responds to consumers (5)

Most of the Administrative and Personnel Standards found to show compliance problems involve consumer issues.

Health, Safety, and Security

♦ Clients feel safe (10 centers)
♦ Consumers linked to other services (6)
♦ Services are based on consumer health and safety (4)

Relationships

♦ Family preservation stressed and sought (5 centers)
♦ Social skills and relationships encouraged (4)
♦ Staff and consumers have a good relationship (3)
♦ Natural support utilized (3)

Community Participation

♦ Necessary accommodations or assistance provided (4 centers)
♦ Consumers encouraged to participate (3)
♦ Consumers actively participate at appropriate level (3)
♦ Consumers aware of activities and supports (3)
♦ Consumers accepted and valued in community (3)

Review teams interviewed 86 mental health consumers at the 12 centers. Part of the interviews consisted of 20 quality of life questions, four for each of the domains listed above. In this part of our report, we look at aggregated responses to those questions in order to develop an overall picture of consumer satisfaction. Some concerns should be noted at the outset. First, the number of consumers interviewed is small; both in total (86) and for each center (as few as 2 and no more than 12 at any one center). Second, the questions concern quality of life issues only and do not directly relate to many of the services provided by centers. Finally, a number of the questions reflect issues over which the influence of mental health service providers is mediated by a variety of factors over which those providers have limited control.

Chart 4 displays the overall rating of consumer satisfaction with quality of life. All 20 questions concerning the five quality of life domains are rolled into this rating. This sample of consumers appears rather satisfied with their quality of life, as defined by the assessment instrument. The response range (yes, no, partial) incorporates less nuance than possible under a scale response methodology (on which consumers could indicate satisfaction levels on a scale of one to five, for example). However, the message seems clear: 75% of the consumers interviewed said yes when asked if they were satisfied with their quality of life. A combined 21% said that they were either partially satisfied or not satisfied.

While in the ideal 100% of mental health service consumers would be satisfied with the quality of their lives; it is unlikely that a survey of the general population would reveal everyone to be satisfied. The response pattern for each of the five domains was essentially similar to that in Chart 4. The area in which most consumers were satisfied (81% yes responses) was Health, Safety, and Security. The lowest level of yes responses was for Community Participation at 71%. The partially satisfied responses ranged from 10% (Community Participation) to 14% (Dignity, Respect, and Rights). The no satisfaction response low point was 6% (Dignity, Respect, and Rights) and the high point, 12% (Community Participation). The largest combined partial satisfaction and no satisfaction response was 23% for Choices and Self Determination. To complete the picture, from 2% to 7% of consumers felt that a quality of life domain did not apply to them.

Quality of Life Satisfaction

No 9% NA* 4% Partial 12% Yes 75%
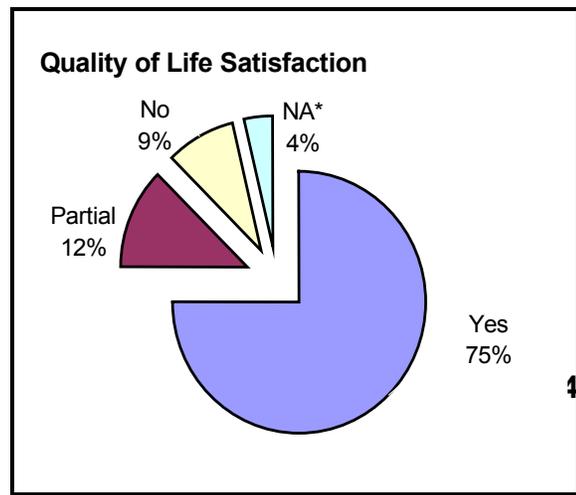
Areas Requiring a Response

Each site review report lists "areas that need attention from the organization." In most instances areas needing attention corresponded to an Administrative and Personnel Standard. We list those standards and other areas most frequently cited as requiring a response below, organized by the frequency with which review teams made the citation (we reproduce some standards in slightly abbreviated form). Standard numbers are noted in parens.

9 Citations

♦ Incorporates consumer choice into the hiring and evaluation of direct service providers, and ensures that special individualized services approved by the family or consumer (AP 22).

♦ Ensures that client records document all services and updates records regularly.

8 Citations

♦ Facilitates the development of non-paid relationships between consumers and other community members (AP 26).

7 Citations

♦ Systematically involves consumer, staff and community in annual agency planning and evaluation of programs, including feedback from current and past users about their satisfaction with the planning and delivery of services (AP 13).

6 Citations

♦ Governing body includes significant consumer or family membership and meaningful participation (AP 6).

5 Citations

♦ Has a clear written mission or philosophy that focuses on the services and empowers consumers and their families (AP 1).
♦ Governing body meetings are open to the public (AP 8).
♦ All facilities and programs provide equal access to all individuals (AP 11).
♦ Actively solicits and carefully utilizes consumer and family input in agency policy setting and program delivery (AP 12)
♦ Implements and maintains a system for review and revision of all job descriptions (AP 20).
♦ Staff development plan written annually for each professional and paraprofessional staff person (AP 29).
♦ Lack of adequate capacity to deliver various services.

4 Citations

♦ Agency-wide education and orientation about mission, philosophy, and values promotes understanding and commitment to consumer-centered services (AP 2).
♦ Develops annual goals and objectives in response to consumer, community, and self-evaluation activities (AP 14).
♦ Actively participates with other agencies in its community to maximize resource availability and service delivery (AP 17).
♦ Hiring process includes background and criminal checks for direct care providers, personal and professional references and follow-up on required references (AP 24).
♦ Evaluation system provides performance appraisal and feedback to the employee and an opportunity for employee feedback to the agency (AP 28).
♦ Performance appraisal system adheres to reasonably established timelines (AP 31).

On the flip side of this issue, agencies appeared to comply with six Administrative and Personnel standards as a group since none were directed to attend to these six.

♦ Has copy of a current external audit performed according to regulation (AP 3).
♦ Maintains policies and procedures to prevent and correct conflicts of interest (AP 10).
♦ Provides services and information on year-round basis (AP 15).

♦ Job descriptions specify minimum qualifications and responsibilities for all staff (AP 21).

♦ Personnel system complies with applicable laws, statutes, regulations, and EEO mandates (AP 23).

♦ Maintains written procedure for employee grievances (AP 34).

These high compliance items involve, for the most part, the internal operations of agencies.

Other Suggestions and Comments

Apparently relying substantially upon the comments of consumer interviews, site review teams compiled a list of other comments and suggestions for agencies to consider. Most comments (13 total) noted the need for additional services of various kinds. Four individuals noted that confidentiality concerns were paramount in small communities.

Public Comments

As part of each review, the agency schedules a publicly noticed forum to provide an opportunity for comment on the part of interested individuals in the community. A total of 22 individuals attended the 12 meetings. None of the reports directly identified the consumer status of individuals, but other information in the reviews identified seven as individuals with developmental disabilities or their family members. At five reviews, no public members attended the forums. No common thread emerged from the testimony of those attending the forums.

2. Agency Comments

A s part of this project, the Program Evaluation and Review Committee (PERC) wrote to the twelve agencies covered in this report. The committee asked those agencies to comment on the IQA review process from their perspective. PERC posed the following questions to the agencies:

1. Has integrated reviews reduced the overall burden for you?
2. What purpose does the Medical Necessity Review serve?
3. Are Medical Necessity standards reasonable? If not, why not?
4. What purpose does the Program Site Review serve?
5. Are the Administrative and Personnel Standards reasonable? If you do not believe so, why not?
6. What are your comments concerning Quality of Life Indicators? Do these provide useful information?
7. Was information useful to you generated by consumer interviews?
8. Have you any suggestions to increase public/consumer participation or comment?
9. What is your opinion concerning the appropriateness of the Areas Requiring Response identified by DMHDD/NCR? Have you or will you respond with a Plan of Action?

Five agencies responded to PERC's request that they provide information on IQA reviews.

Five of the twelve agencies responded to the PERC questions and in this chapter we consider those responses. Again, since only five centers responded, we suggest prudence when it comes to ascribing the views of these five to the population of centers reviewed. For each question, we list all responses; if more than one center had similar responses, we group those and indicate in parens how many centers shared that response. In several cases, our condensation of grantee comments masks lengthy and thoughtful discussions of the issues.

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Has the integrated process reduced the overall burden of reviews?

- Reduced staff preparation time and increased staff contact with reviewers.
- No reduction in burden.
- Increased team size complicated the process.
- Workload much greater, but will be only every other year.

♦   Reduced the time the agency was effectively closed for review. Preparation time and response time was still substantial.

What purpose does the Medical Necessity Review serve?

♦   Ensures that services are warranted, appropriate, and effective.
♦   Necessary evil-provided accountability and feedback.
♦   Federal Medicaid requirement.
♦   Compliance interpreted by reviewers. Significant inter-reviewer differences. Micro-management rather than focus on outcome. Why no technical assistance to prepare for reviews?
♦   Should assure agencies are providing the services funded and provide technical assistance in areas needing improvement. Standards are rigid and inflexible while quick response and professional judgement key to the provision of quality services.

Are Medical Necessity Review standards reasonable? If not, why not?

♦   Standards reasonable (2 centers).
♦   Progress made in reasonableness of review implementation.
♦   No. Too focused on minutiae instead of outcomes. Medical necessity does not equal consumer need.
♦   As a general guideline, yes. Not as rigid template for services. Individual consumers needs do not always fit into any single set of standards. Where is the accommodation for professional judgement?

Agencies felt that medical necessity and administrative and personnel standards were generally reasonable.

What purpose does the Program Site Review serve?

♦   Ensures legitimate, honest representation of capacity within fiscal, service, and philosophical requirements.
♦   Some ridiculous aspects-too many people, invasive.
♦   Assesses community and consumer support and satisfaction.
♦   Helpful-provides some good information to agency.
♦   Provides a balanced perspective to the review. Effective high quality services could feasibly be provided without formal assessments, treatment plans, treatment reviews, or progress notes. Ineffective and low quality services could meet every standard. Consumer opinion and experience and providers perspectives are key to assessing the actual value of services.

Are the administrative and personnel standards reasonable? If you do not believe so, why not?

♦ Yes (3 centers, although one qualified that, saying confidentiality should extend to employee records).
♦ Appear to be.
♦ Yes, as guidelines, but not as inflexible templates. In a small agency, minimal formal materials in combination with the inescapable and continual interaction between staff suffice. Standards and attitude are not the same. A paper deficiency may not reflect an inappropriate attitude.

What are your comments concerning the Quality of Life indicators? Do these provide useful information?

♦ Indicators difficult to evaluate-bias creeps in, meaning is individual.
♦ This piece is brilliant, but can it be applied? Will try.
♦ Useful, indicators are subjective and limited to client satisfaction.
♦ Limited utility. Agencies have little or no control over some indicators. Subjective and not linked to medical necessity.
♦ Reassuring consumer evaluation of agency service, but would be more helpful if more consumers were included.

Was any information useful to you generated by consumer interviews?

♦ Yes (3 agencies).
♦ We get consumer information constantly, no new information possible.
  ♦ Always useful to get feedback, but this is limited in content.

> *Centers do not appear to feel that Quality of Life indicators are relevant or objective.*

Have you any suggestions to increase public/consumer participation or comment?

♦ No (2 agencies).
♦ Work with providers to identify people willing to participate.
♦ Need better information on opportunities. Contractor, using information supplied by agency, should mail notices to clients.
♦ Give the agencies more freedom to structure opportunities for consumer participation and public comment. Every community is different.

What is your opinion concerning the appropriateness of identified Areas Requiring Response? Have you or will you respond with a Plan of Action?

◆ Reasonable so far. Will file POA.
◆ Will take time to satisfy. Will file POA.
◆ Improved over time and generally appropriate. Will file POA.
◆ Most areas already identified by agency. Agreed with findings, will file POA.
◆ Have filed Plan of Action.

In addition to these comments, one center stated in its response that positive comments made by the team during the review failed to show up in the subsequent report.

As noted at the outset, the very limited number of responses invites caution. However, the individual testimony provided by grantees that have experienced an IQA review is useful. The individual points, on their face, should be given thoughtful consideration by the framers of the process.

3. A PERC Perspective

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ERC members with direct experience in developing the IQA process as members of the IQA Steering Committee or as participants in IQA site reviews were asked to contribute their perspectives to this document. A PERC member who participated in the second phase of the South Peninsula Community Mental Health Center review and in the Yukon-Kuskokwim Health Corporation Mental Health Center review did so. This chapter summarizes the views of that committee member.

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Consumer Input

The lack of mental health consumer input raised concern. The Homer second phase (or addendum)) occurred as a direct result of the lack of consumer participation in the original review and subsequent pressure from local advocates to obtain consumer views. In Bethel, only two primary consumers appeared-one a last minute addition. The PERC member recommended other means of boosting consumer participation, including:

Meaningful consumer input to the IQA process may occur only under as yet unknown circumstances.

♦ Coordinating with local consumer organizations, if any.
♦ Separating consumer input from the site review and making it more of an ongoing, independent process (for example, posting an interactive survey on the Internet).

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Protecting Consumers

Following the Homer addendum, consumers reported that CMHC staff had questioned them about their participation and that the consumers felt threatened. These comments come in the context of several reports that some "less favored" consumers had suffered retaliation from staff in the past. A reluctance on the part of consumers to discuss issues concerning services delivered by grantees stemming from consumers' perception that consequences could ensue is thought to extend to parts of the state outside of Homer. If consumers have indeed suffered adverse consequences as a result of participation in the IQA process, steps should be taken to prevent future incidents.

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Cultural Relevance

The YKHC mental health program review sparked some strong concerns regarding the capacity of the IQA process as designed to respond to cultural and local diversity. These concerns fell into two major areas.

♦ **Survey Instrument**: A number of team members strongly objected that the process and instruments used were ill suited to the YKHC program (Pathways). The PERC member credited the efforts of the team facilitator in keeping the review on track in the face of these protestations. Team members felt that the five domains of the consumer questionnaire were not a good fit for the Yukon-Kuskokwim region. The questionnaire may make sense for people with serious mental illnesses who receive intensive or regular services, such as urban CSP clients. Survey issues did not seem to be a good match with issues expressed by people interviewed in Bethel. The PERC member felt that local staff should be consulted on appropriate means of uncovering the information sought.

♦ **Village Visits**: During the Bethel review it became apparent that it was impossible to discover what was going on outside Bethel without visiting one or more villages. Staff in the exit interview also brought this up. Village visits would increase the time and expense involved, but as much of the YKHC population is in the villages and so much of what Pathways does is village oriented, one cannot get a good sense of the program otherwise.

Team members felt that the Quality of Life survey did not accommodate diversity in culture or service delivery modes.

4. Trends and Issues

C ombining key elements of previous chapters covering individual site reviews, comments from programs, and PERC comments, this chapter offers overall trends and issues. We attempt to aggregate these into a group of key themes (order of presentation does not reflect a ranking of significance). Again the limited sample size should be an important consideration as you review these findings. The recently released DMHDD IQA annual report confirms much of what our smaller scope inquiry reveals and also highlights a number of other issues of concern.

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Rural/Cultural Relevance

Throughout the review reports themselves and from other sources, we find evidence intimating that the IQA process may require revision in order to be relevant to small and rural programs.

◆ Large review teams may be truly intrusive at smaller centers.

◆ Compliance with medical necessity standards varies widely from agency to agency, but is lower for smaller and more isolated centers than for others. The ratings seem to suggest a distinct difference in the capacities of larger centers and smaller, more isolated centers to respond to the standards. Comments from two centers question the applicability of standards for small centers.

◆ A lack of citations of excellence for smaller, rural centers may suggest either a lack of capacity on the part of such centers to meet the IQA standards or a question concerning the relevance of the standards to those centers.

◆ Review team members strongly objected that the process and instruments used were ill suited to the YKHC program. Team members felt that the Quality of Life issues may make sense for urban CSP clients, but did not for rural consumers. Nor did team members believe that visiting a regional center provided useful information concerning the situation in outlying villages.

Diversity Capacity

Some question whether the IQA process accommodates local and cultural diversity.

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Consumer/Community Involvement

Troubling questions emerge from the IQA process concerning the extent of community and consumer involvement in local mental health service delivery and the IQA process itself.

- Consumers numbered only about one-third of all local IQA interview subjects.
- The majority of review team findings calling for an agency response concern consumer or community involvement and orientation.
- Most of the Administrative and Personnel Standards identified as indicating low compliance dealt with key consumer or community involvement issues. It does not seem appropriate, without further scrutiny, to assume that low compliance is a paper trail issue only.
- While the Quality of Life Indicators suggest a relatively high level of consumer satisfaction, the sample, both for individual programs, and overall, is too small to be credible. Serious attention should be devoted to increasing consumer response.

Key IQA findings suggest that the mental health system falls short of a true consumer orientation.

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Process and Standards

This section combines issues relating to the standards applied under the IQA process and to the process itself. As expected with any newly developed and implemented process, opportunities for improvement surface.

- The current process may not be structured to recognize strengths of local programs, particularly when culture and delivery methods diverge from the mainstream mode. Review reports cite relatively few areas of excellence or strengths related to Quality of Life topics.
- Quality of Life findings suggest that consumers are relatively satisfied, but findings in narrative and Administrative and Personnel Standards sections indicate possible conflict with this impression of consumer satisfaction. The process should incorporate a means of reconciling apparent contradictions and/or revisit flaws in the process that may inevitably produce contradictory findings.
- It is unclear whether findings of Administrative and Personnel Standards compliance failures represent program orientation and service delivery issues or paper trail issues. Should the concern be with the standards themselves?
- Questions concerning the root of the low level of overall medical necessity compliance, which could stem from the recent origin of the standards, remain unanswered.
- The programs that replied to the PERC questionnaire do not feel that integrated reviews lessen the burden they face.

- Local programs, for the most part, judge Medical Necessity and Administrative and Personnel Standards to be reasonable, although needing some flexibility in application.
- Some centers characterize Quality of Life Indicators as subjective.
- None of the programs responding to the PERC questionnaire disputed the areas requiring a response identified by review teams.
- Consumers believe that the present review process exposes participants to retaliation from program staff. This perception may contribute to low consumer participation in the IQA process. The fear of retribution could conceivably also contribute to the relatively high satisfaction ratings produced by the quality of life survey.

ALASKA MENTAL HEALTH BOARD