An evaluation of behavioral health services by Minnesota Medicaid managed care enrollees

A field test of the Experience of Care and Health Outcomes (ECHO™) Survey
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August 2001
Introduction

Context for evaluating managed behavioral health care

Over the past decade, studies have increasingly examined managed health care. However, comparable performance evaluations of managed behavioral health care are lacking. Particularly pronounced is the paucity of studies involving Medicaid beneficiaries, a population of critical importance considering their elevated rate of mental health and substance use disorders compared with the population as a whole.1

State government agencies purchase care for Medicaid enrollees by contracting with managed care organizations (also known as prepaid health plans). As a result, they bear the formidable responsibility of ensuring that vulnerable, low-income populations have access to and receive the behavioral health care they require. The urgent need for more information on the delivery of managed behavioral health care services has spurred more systematic investigations of access, quality, satisfaction, and outcomes.

In recognition of the critical importance of behavioral health care, the Minnesota Department of Human Services (DHS) has undertaken a series of studies to address key issues. One study, currently underway, is designed to determine how many public prepaid health plan enrollees need mental health services, how many who need care seek and receive services, and the barriers to care identified by individuals needing it. Results of this study will be available in the fall of 2001. Another study is testing a computerized screening instrument to detect mental health and substance use problems among adolescents seen in managed care settings. The findings from this study will also be available in the fall of 2001. DHS completed a comprehensive evaluation of chemical dependency treatment outcomes in 2000.2

Purpose of the Minnesota study

The study described in this report measures consumer satisfaction for recipients of managed behavioral health care services in a field test of a new survey. The study serves several objectives. The most important is to provide a benchmark of Medicaid enrollees’ evaluations of access to and quality of managed behavioral health care in Minnesota. The second is to examine how individual consumer characteristics influence ratings of care so that ultimately, when plan-to-plan comparisons are made in future surveys, interpretations of differences can be adequately informed. Finally, since the survey instrument is still in development, the voluntary participation of Minnesota’s Medicaid state agency as one of nine test sites serves as an opportunity to evaluate how the survey performs for public prepaid health program recipients and to suggest improvements for future administrations.

The study design

Survey background

The Experience of Care and Health Outcomes (ECHO™) survey was designed to evaluate behavioral health care from the consumer’s perspective. The survey combines items from two earlier surveys which were developed through collaborative processes that included consumers, family members, service providers, and researchers throughout the country, along with federal agencies and the National Committee for Quality Assurance (NCQA).3

Who was surveyed in Minnesota

A sample of 2,500 adult Minnesotans enrolled in Medicaid managed care plans was selected to receive the survey. In Minnesota, individuals with disabilities, including severe mental illness, are not enrolled in managed care, so the most severely impaired Medicaid recipients were not included in this sample. Information on Medicaid enrollees who receive health care services is available from the Medicaid Management Information System (MMIS) administered by the Department of Human Services. Health care services provided to Medicaid managed care enrollees are recorded in the system as “encounters.” Administrative codes identify the diagnoses and procedures associated with each encounter with a health care provider.

By design, the sample was predominantly comprised of Medicaid managed care enrollees whose encounter data for the first 6 months of year 2000 indicated receipt of behavioral health services (other than just medication) from a behavioral health care provider (94%), and 6% whose records gave no indication of behavioral health care during that period. Including this latter group enabled the research agency
to send letters which did not identify the potential respondents as recipients of behavioral health services, thereby ensuring their privacy. Individuals who were sent the survey were selected randomly from the two groups with and without records of behavioral health services.

**How the survey was conducted**

Contact information (names, addresses, and telephone numbers) for the survey sample was provided to the Center for Survey Research, University of Massachusetts – Boston, bound by a contract with DHS to protect Medicaid enrollee confidentiality. Each individual selected for the study sample was mailed a copy of the survey. Individuals who did not return the survey were contacted and asked to complete the survey by telephone. Because this study was a field test and funding was limited, only an English language version was available. Data were collected between September 2000 and February 2001.

Additional descriptive information for the sample was also provided to the research center, including demographic characteristics and behavioral health diagnoses, which were linked to the survey responses after the surveys were completed (this information was not available to interviewers). In order to protect the confidentiality of survey responses, names and other identifying information were stripped from the data set before it was returned to DHS for analysis.

**Survey completion rate**

Of the 2,500 adult Medicaid managed care enrollees in the sample, 1,118 (45%) completed the survey, 975 (39%) were not contacted, 243 (10%) were contacted but refused to participate, and 164 (6%) were unable to complete the survey primarily due to language barriers; in a few cases, the enrollee was seriously ill or deceased.

Among the sample of 1,118 survey completers, 212 said they had not received behavioral health services and were eliminated from further data analyses (of these, 163 had been identified by administrative data as service recipients). A small number of surveys (21) also were eliminated because they had been completed by a proxy (someone other than the consumer). The final sample described in this report consists of the remaining 885 individuals.

**Sample characteristics**

The study sample includes many more women (87%) than men (13%). The sample is predominantly white (77%), with 5% Black, 4% Asian, 4% Hispanic, 3% American Indian, and 7% biracial or race/ethnicity unreported. Almost half (47%) the respondents are 18 to 34 years old, 44% are 35 to 54 years old, and 9% are age 55 or older. The majority (54%) reside in Greater Minnesota and 46% reside in the 7-county Minneapolis-St. Paul Metropolitan Area (hereafter called the “Twin Cities Area”). Education levels reflect to some extent the lower income status associated with Medicaid enrollment: 17% did not complete high school, 33% have a high school or general equivalency diploma, 42% have some postsecondary education but not a degree, and 8% have a college degree.

The sample can also be described generally in terms of their primary behavioral health disorder diagnosis. Diagnoses were obtained from Medicaid encounter records and categorized into three groups as an approximate measure of severity. Schizophrenia and other psychotic disorders (with the exception of affective psychoses) were considered the most severe. Only 6% of survey respondents were classified in the schizophrenia/psychosis group; this small proportion reflects the exclusion of individuals with severe disabilities from managed care. Affective disorders, including depression, mania, and bipolar disorders, were the next tier; the majority of the sample were in this category (53%). The last and least severe category included primarily anxiety disorders, adjustment disorders and stress reactions (such as post-traumatic stress disorder), along with small numbers of personality disorders and substance use disorders; this group comprised 41% of the sample. (If encounter data included more than one diagnosis, the most serious according to this classification was used.)

This final sample varies somewhat from the original sample, indicating some degree of “response bias.” That is, the study sample is affected to some extent by researchers’ success in contacting different groups or their willingness to participate. For example, females had a significantly higher response rate than males (46% versus 39%), and residents of Greater Minnesota had a significantly higher response rate than residents of the Twin Cities Area (48% versus 41%). With respect to age, individuals 35–54 years old were significantly more likely to respond than either the
younger or the older group. In contrast, severity of behavioral health disorder (by our imperfect diagnostic measure) did not significantly affect the response rate. Response rates could not be compared for different racial/ethnic groups or individuals of different levels of education because these data were not obtained from administrative records but were based on self-report and thus unavailable for survey nonrespondents.

**Description of measures and item response rates**

A series of 15 survey questions addressed four important aspects of care: **Access to Care, Communication with the Clinician, Functional Improvement** over a 12-month period, and the **Effect of Treatment**. Between 91% and 93% of the survey respondents answered each question, with two exceptions. These two questions applied only to individuals who had tried to get an urgent appointment or help over the telephone, so responses represented only about half the respondents.

**Explanation of consumer ratings**

For each of the four aspects of care (**Access to Care, Communication with the Clinician, Functional Improvement**, and **Effect of Treatment**), consumer responses are summarized briefly in text and presented in bar graphs. These results are followed by a table which depicts the individual consumer characteristics that are significantly associated with differences in ratings. Where the effects are consistently significant over items within a domain, possible explanations for the findings are offered.

The specific factors examined include five sociodemographic characteristics and one measure of behavioral health disorder severity.

- Gender

- Age, divided into three categories (18–34, 35–54, and 55+)

- Race/ethnicity, divided into two categories (whites and people of color)

- Level of education, divided into four categories (less than high school, high school or general equivalency diploma, some postsecondary education, and college graduate)

- Geographic area (7-county Twin Cities Area and Greater Minnesota)

- Behavioral health disorder severity, divided into three categories (psychotic disorders, affective disorders, and others as described on page 2).
Consumer ratings of aspects of managed behavioral health care

Access to care

Three measures of Access to Care were addressed by the survey: scheduling timely appointments, getting urgent care, and getting assistance over the telephone.

Slightly more than one-third of behavioral health care consumers reported that they always obtained an appointment as quickly as they wished, saw someone right away if they felt they needed to, and got help over the telephone when they requested it. An additional one-third said they usually were able to get timely appointments or immediate visits when needed, but fewer were usually successful obtaining telephone counseling. Looking at the more negative responses shows that telephone counseling was the least accessible, with 40% of consumers who sought such help saying they got it only sometimes or never, compared with 31% who gave these responses for timely appointments and immediate visits.

How often did you...

| Get an appointment as soon as you wanted | 7% | 24% | 35% | 34% |
| See someone as soon as you wanted when you needed help right away* | 13% | 18% | 35% | 34% |
| Get help or advice you needed over the phone* | 12% | 28% | 25% | 35% |

*Includes only consumers who attempted to get this type of assistance.
**Relationship of individual factors to access**

- Education level was the only factor significantly related to all three measures of access. Satisfaction with access was consistently lower among individuals with higher levels of formal education.

- Greater Minnesota residents reported more success getting timely appointments and being seen immediately when needed than residents of the Twin Cities Area.

- Women were more likely than men to report successful access to telephone counseling.

- Adults age 55 and older were most likely to report getting timely appointments.

- Whites were more likely than people of color to report being seen immediately when needed.

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<th></th>
<th>Gender</th>
<th>Age</th>
<th>Race</th>
<th>Education level</th>
<th>Area of state</th>
<th>Disorder severity</th>
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</thead>
<tbody>
<tr>
<td>Get appointment soon</td>
<td>✓</td>
<td></td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>See someone right away</td>
<td>✓</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Get help over the phone</td>
<td>✓</td>
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<td>✓</td>
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</tbody>
</table>

**Comments**

The survey measured subjective assessments of clinician accessibility rather than the actual length of time between the request for an appointment or telephone consultation and the subsequent contact with the clinician. Therefore, differences in ratings between groups may reflect variations in their expectations, their wait times, or both. The finding of more negative responses by more highly educated people seems more plausibly related to differences in expectations than differences in actual service receipt. It seems unlikely that more highly educated consumers were actually less successful at obtaining the services they desired since they are probably more articulate at expressing their needs and advocating for timely care than people with less formal education.

The difference in timely service by geographic area seems more difficult to interpret. It may be that mental health clinics are less crowded and wait times are actually of shorter duration in Greater Minnesota than in the Twin Cities Area, although no objective data are available to support this inference. Alternatively, it is possible that the less demanding pace associated with rural life makes Greater Minnesota consumers more tolerant of similar or even longer waits.
Communication with the clinician

Six questions measured the relationship between the consumer and the clinician, including the clinician’s communication skills (displays of respect, adequate explanations, and attentive listening), the consumer’s comfort level with self-disclosure, the amount of time invested by the clinician in the therapeutic relationship, and the consumer’s involvement in treatment planning.

The majority of consumers said that the individuals who provided care always respected what they had to say, explained things in a way they could understand, and listened carefully to them. However, fewer than half said that they were always involved in their care as much as they wished, felt that treatment personnel spent sufficient time with them, or felt comfortable raising issues or concerns. The most negative answers were in response to the question regarding comfort raising concerns; 29% of consumers were only sometimes or never comfortable doing so. More than one of five also gave these more negative responses to the questions about sufficient time and being personally involved in treatment planning.

How often...?

Did your counselor show respect for what you had to say

- Never: 11%
- Sometimes: 27%
- Usually: 59%
- Always: 3%

Did your counselor explain things in a way you could understand

- Never: 11%
- Sometimes: 29%
- Usually: 57%
- Always: 3%

Did your counselor listen carefully

- Never: 13%
- Sometimes: 29%
- Usually: 55%
- Always: 3%

Were you involved as much as you wanted

- Never: 4%
- Sometimes: 17%
- Usually: 30%
- Always: 49%

Did your counselor spend enough time with you

- Never: 5%
- Sometimes: 18%
- Usually: 33%
- Always: 44%

Did you feel comfortable raising issues or concerns

- Never: 7%
- Sometimes: 22%
- Usually: 27%
- Always: 44%
**Relationship of individual factors to communication**

- People of color were consistently less satisfied than whites with their interpersonal interactions with their counselor or therapist.
- Twin Cities Area residents were less satisfied than Greater Minnesotans with respect to all measures except counselor explanations.
- Men were less satisfied than women for all measures of communication except for the counselor listening carefully and the extent of the consumer’s involvement in treatment.
- Less highly educated consumers were less satisfied with all aspects of communication except counselors showing them respect and spending sufficient time with them.
- Individuals with more severe behavioral health disorders were less satisfied with the respect and explanations given to them by their counselors and with the extent of their own involvement in their treatment.
- Younger consumers were less satisfied than older consumers with the amount of time their counselors spent with them.

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<tr>
<th>Gender</th>
<th>Age</th>
<th>Race</th>
<th>Education level</th>
<th>Area of state</th>
<th>Disorder severity</th>
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</tbody>
</table>

**Comments**

The consistent pattern of less favorable ratings given by consumers of color may be due to the likelihood that they received mental health services from white clinicians. Dissatisfaction may result from cultural differences in communication styles or from clinicians intentionally or unintentionally discounting the needs and perspectives of people of color. It is also possible that consumers of color are seen more often in crowded clinics where the demand outstrips the available resources, putting more pressure on clinicians to rush through appointments. The finding that more highly educated consumers rate their interactions with their counselors more favorably than less educated consumers suggests that clinicians and/or consumers may be more comfortable interacting with individuals whose sociodemographic characteristics are more similar to their own. Greater Minnesotans also gave more favorable ratings than their Twin Cities counterparts. This could be because urban clinics are more crowded, or because Greater Minnesotans have a generally more positive outlook which influences their ratings of care, a possibility that has been suggested by other research.⁴
The fact that women are more satisfied than men with the interpersonal aspects of care may reflect their generally greater comfort with seeking health care services and disclosing personal information, or it may be that clinicians actually interact differently with women and men. Lower ratings among individuals with more severe disorders suggest that they believe their clinicians may be underestimating the extent to which they want to understand the nature of their illness and the recommended course of treatment as well as how much they want to be involved in decisions regarding their care.

**Functional improvement compared with 12 months earlier**

Consumers were asked about four aspects of Functional Improvement: changes in their ability to deal with daily problems, social situations, and crises, as well as their ability to accomplish the things they set out to do.

Two of five consumers reported being much better at coping with daily life compared with one year earlier. Somewhat fewer (just over one-third) said they were much better at dealing with crisis situations. Fewer than a third reported the same level of improvement in terms of being able to accomplish the things they wanted to do or to deal with social situations.

**Compared to 12 months ago, how would you rate your ability now to...?**

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Much worse</th>
<th>A little worse</th>
<th>About the same</th>
<th>A little better</th>
<th>Much better</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deal with daily problems</td>
<td>5%</td>
<td>4%</td>
<td>20%</td>
<td>32%</td>
<td>39%</td>
</tr>
<tr>
<td>Deal with crisis situations</td>
<td>4%</td>
<td>6%</td>
<td>25%</td>
<td>31%</td>
<td>34%</td>
</tr>
<tr>
<td>Accomplish the things you wanted to do</td>
<td>5%</td>
<td>8%</td>
<td>29%</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>Deal with social situations</td>
<td>4%</td>
<td>6%</td>
<td>36%</td>
<td>25%</td>
<td>29%</td>
</tr>
</tbody>
</table>
Relationship of individual factors to improvement

- More highly educated consumers reported the greatest level of improvement with respect to all four measures.
- Individuals with more severe disorders reported less improvement than other consumers with respect to all four measures.
- Whites were more likely than people of color to report improvements in accomplishing what they want to do and dealing with crises.
- Women were more likely than men to report improvement in personal accomplishments, but men were more likely than women to report improvement in dealing with crises.
- Greater Minnesotans reported greater improvement than Metropolitan Area residents in their ability to deal with daily problems.

<table>
<thead>
<tr>
<th></th>
<th>Gender</th>
<th>Age</th>
<th>Race</th>
<th>Education level</th>
<th>Area of state</th>
<th>Disorder severity</th>
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<tbody>
<tr>
<td>Deal with social situations</td>
<td>✔</td>
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<td>✔</td>
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<td>✔</td>
</tr>
<tr>
<td>Accomplish what you wanted</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<td>✔</td>
</tr>
<tr>
<td>Deal with crisis situations</td>
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<td>✔</td>
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<tr>
<td>Deal with daily problems</td>
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Comments

The greater improvement reported by more highly educated consumers is consistent with their greater satisfaction with communications with their clinician but inconsistent with their greater dissatisfaction in terms of access to prompt care. Successful and comfortable interpersonal communications, combined with consumers’ involvement in their own treatment, would likely lead to greater improvement. Whites’ reports of greater improvement relative to those of people of color may reflect a similar phenomenon in terms of the parallels with differences between the two groups in terms of their respective levels of satisfaction with clinician communications. Lesser improvement reported by individuals with more severe disorders may reflect the reality that some disorders are less responsive to therapy or that the services received were inadequate to produce desired changes.
**Effect of treatment in the past 12 months**

Consumers were asked two questions to determine whether they believed that the behavioral health services received had an effect. One question addressed specific symptoms or problems for which they may have sought care and the other addressed the overall quality of their life.

Half of the consumers credited their treatment with being very helpful with alleviating their symptoms or problems and almost half said it was very helpful in terms of its effect on the quality of their life. A substantial proportion rated the effect of treatment in these areas as a little helpful. However, 13–14% of consumers thought treatment had no effect or was actually harmful.

**What effect has your counseling had on...?**

<table>
<thead>
<tr>
<th></th>
<th>A little or very harmful</th>
<th>Not helpful or harmful</th>
<th>A little helpful</th>
<th>Very helpful</th>
</tr>
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<tbody>
<tr>
<td><strong>Your symptoms or problems</strong></td>
<td>5%</td>
<td>8%</td>
<td>37%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>The quality of your life</strong></td>
<td>4%</td>
<td>10%</td>
<td>38%</td>
<td>48%</td>
</tr>
</tbody>
</table>
Relationship of individual factors to effect of treatment

- Older consumers were more likely than younger consumers to attribute to treatment a reduction in their behavioral health disorder symptoms or problems and improvements in the quality of their life.

- Females reported a greater effect of treatment on symptom or problem reduction than males.

- Consumers with less formal education were more likely than those with more education to report that treatment reduced their symptoms or problems.

<table>
<thead>
<tr>
<th>Gender</th>
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<th>Race</th>
<th>Education level</th>
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Comments

In terms of overall health care, women use more services than men, and older individuals use more than younger ones. Greater levels of use may reflect, in part, greater faith in the effectiveness of health care services, which might in turn account for the greater likelihood seen among these groups to attribute their improvement to the services they received. Alternatively, greater trust in health care providers may make consumers more compliant with treatment recommendations, leading to greater symptom reduction.
Summary of factors associated with ratings of behavioral health services and outcomes

All the sociodemographic factors examined for this report and the measure of diagnostic severity were significantly related to at least some of the survey measures of Access, Communication, Functional Improvement, or Effect of Treatment (see page 13).

Level of education was the factor most frequently associated with measures of satisfaction, but the pattern of the relationship was not consistent. As educational level increased, consumers were less satisfied with access to care and less likely to attribute symptom or problem reductions to treatment, but they were more satisfied with their relationship with their clinician and they reported greater functional improvement.

Race was significantly associated with one measure of access, all six measures of communication, and two measures of functional improvement. The pattern for race was consistent across aspects of care in that ratings by whites were more favorable than those by people of color.

Geographic area was significantly associated with two measures of access, five measures of communication and one measure of functional improvement, with a consistent pattern reflecting more positive ratings among residents of Greater Minnesota.

Female gender was significantly associated with more positive ratings for one measure of access, four measures of communication, one measure of functional improvement, and one measure of treatment effect. Male gender was associated with more positive ratings for one measure of functional improvement.

Severity of behavioral health disorder diagnosis was significantly associated with three measures of communication and all four measures of functional improvement, with more negative ratings given by individuals with more severe disorders.

Age was least often associated with the measures of aspects of care. Older consumers were more satisfied with one measure of access, one measure of communication, and both measures of treatment effect.
**Summary of significant associations between consumer characteristics and aspects of behavioral health care**

<table>
<thead>
<tr>
<th></th>
<th>Gender (Female)</th>
<th>Age (Older)</th>
<th>Race (White)</th>
<th>Education (Higher)</th>
<th>Area (Greater MN)</th>
<th>Disorder severity (Higher)</th>
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</thead>
<tbody>
<tr>
<td><strong>ACCESS</strong></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Get appointment soon</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>See someone right away</td>
<td>+</td>
<td>-</td>
<td>+</td>
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<tr>
<td>Get help over the phone</td>
<td>+</td>
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<td><strong>COMMUNICATION</strong></td>
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<tr>
<td>Counselor showing respect</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Counselor explaining things</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselor listening carefully</td>
<td>+</td>
<td>+</td>
<td>+</td>
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<tr>
<td>Your being involved</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
<td>-</td>
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<tr>
<td>Counselor spending time</td>
<td>+</td>
<td>+</td>
<td>+</td>
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<tr>
<td>Your feeling comfortable</td>
<td>+</td>
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<td><strong>IMPROVEMENT</strong></td>
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</tr>
<tr>
<td>Deal with social situations</td>
<td>+</td>
<td></td>
<td>-</td>
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<tr>
<td>Accomplish what you wanted</td>
<td>+</td>
<td>+</td>
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<td>-</td>
</tr>
<tr>
<td>Deal with crisis situations</td>
<td>-</td>
<td>+</td>
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<td>Deal with daily problems</td>
<td>+</td>
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<td><strong>EFFECT OF TREATMENT</strong></td>
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<td>Your symptoms or problems</td>
<td>+</td>
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<td>The quality of your life</td>
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Note: (+) sign depicts a significant positive association (higher ratings) between the aspect of care listed in that row and the consumer characteristic identified in the column heading; (−) sign depicts a significant negative association (lower ratings).
Conclusions and implications of the findings

The primary purpose of this study was to establish some benchmarks for Medicaid enrollees’ evaluation of the behavioral health services they receive through managed care organizations. Of the four aspects of care discussed in this report, Effect of Treatment and Communication with the Clinician received the highest ratings, as determined by the percentage of consumers who selected the most favorable option from the choices they were given; Access to Care and Functional Improvement received the lowest ratings. Determining whether the ratings demonstrate acceptable care is difficult without data from other populations or data over time. However, some discussion of the measures used in the survey may help to inform the interpretation of the study results.

The finding that roughly half the consumers described the treatment they received as very helpful, and six of seven described it as at least a little helpful, seems to indicate that consumers generally believe they are benefiting from the behavioral health services they receive. These findings could be used to dispel the idea that behavioral health services under managed care are so inadequate as to provide no benefit. However, an appraisal of the Functional Improvement ratings paints a less optimistic picture. Only about one-third of consumers described themselves as much better in terms of coping with stressors and accomplishing their goals than they were a year earlier. More than half to more than two-thirds described themselves as at least a little better, depending on the measure.

A couple of comments about the measurement of the outcome domains are in order. The measures of Functional Improvement in the survey address only a limited set of indicators of improvement, primarily the ability to cope with stressors. The survey questions addressed coping with daily problems, social situations, or crises. If these were not target areas of the treatment, improvement would not be an anticipated outcome, and lack of improvement would not necessarily be a poor outcome. The benefits of treatment perceived by an individual consumer could be broader than the survey measures of functional improvement, including, for example, improvements in significant relationships or self-esteem. In addition, factors other than behavioral health disorders affect one’s ability to cope with daily life and accomplish goals, such as financial problems or demands of caring for children or ill family members. The ratings for both outcome domains, Functional Improvement and Effect of Treatment, are also complicated by the fact that they are likely to be influenced by treatment duration and completion status. Some consumers may have just started treatment, others may have been well into their therapy, and still others may have finished. Perspectives on treatment’s benefits and changes in symptoms or ability to handle challenges are likely to vary over the course of treatment, as a natural part of the process of confronting difficult changes and taking risks to make life changes. A final consideration is that consumers’ ratings of Functional Improvement are affected by the type of dysfunction that led them to seek help.

Consumer appraisals of their relationship with their clinicians also merit some attention. Although Communication with the Clinician ratings compare favorably with other aspects of care, one could argue that a higher standard should apply in this area. Unlike measures of Functional Improvement, measures of clinical interactions are less likely to be influenced by factors outside the control of the health care provider. Being respected and understood, feeling comfortable and not rushed are likely prerequisites for consumers engaging in a therapeutic relationship, and it is the clinician’s responsibility to create a welcoming, trusting and safe environment. Because achieving high marks in this area is a realistic goal for all behavioral health specialists, this is an area that could be targeted for improvement.

The subjectivity of ratings of Access to Care is somewhat more problematic. A timely response is in the eye of the beholder. To a consumer in distress, immediacy may be defined much more stringently than to clinic staff who schedule appointments based on their own appraisal of urgency and competing needs of other patients. A standard that consumers should always or even usually get appointments as quickly as they wish must be weighed against the associated increase in staffing and costs this could entail.
A critically important finding from this study is the extent to which consumer characteristics influence their evaluations of behavioral health services. These effects have important implications for future survey administrations, especially those which include comparisons of different managed care organizations. Meaningful comparisons would have to take into account differences in populations served by different health plans. It is also worth noting that the effect of any single characteristic is not always consistent, either in terms of its magnitude, or more importantly, its direction. Moreover, it is impossible to tell from existing data how much of the difference observed for any measure is due to a variation in expectations versus a variation in service delivery. Finally, the consumer measures used in the analyses for this report may not include all important influences and some that were used are inexact (such as the measure of disorder severity).

Several of the survey’s limitations in terms of question content have already been discussed. However, a few others bear mention. The response rate, while not atypical for a Medicaid population, is fairly low. The study results represent fewer than half of the respondents originally selected. In addition, the representativeness of the study sample is a concern. Male, urban, and young enrollees were underrepresented in the study because they were less likely to complete the survey. Finally, some consumers whose administrative records indicated that they had received behavioral health services denied that they had. The records may contain error, or the consumers may have forgotten, but there is also the possibility that the stigma associated with mental health and substance use disorders affects willingness to participate in a study of this kind.

Most of the limitations described are not unique to this study. Some affect almost all population surveys regardless of survey purpose (such as the higher participation rates seen for women, older people and rural residents), and some affect all health care consumer satisfaction surveys (such as effects of recall and varying expectations). While study limitations cited may not preclude releasing comparative data for managed care organizations in the future, they highlight the importance of exercising caution in conclusions drawn about the delivery of behavioral health care services in general and the comparative quality of different managed care organizations or providers in particular.
The study findings also point to the necessity for a multidimensional approach to evaluating health care. Consumer satisfaction surveys are appealing because they are relatively easy to conduct and they represent the perspectives of the service recipient. As such they may represent one important component of a strategy to evaluate care. However, other objective measures would enhance our understanding of care delivery. For example, measures of average delays between a request for a behavioral health care appointment and the scheduled visit would be helpful as a complementary measure of access. Outcome studies that include both pretreatment and posttreatment ratings of symptoms and functional status would also be valuable.

Evaluating managed behavioral health care will be a continuing process. Improving access to care and quality of care is a joint responsibility of purchasers and service providers. The field test findings summarized here provide some useful information to prompt discussions of how to improve consumer satisfaction. However, the value of the survey measures as benchmarks will accrue over time, as repeated administrations reveal the magnitude of change. This report may serve as an impetus to identify areas where improvements could be initiated, and future studies may note the benefits of those efforts.
References


