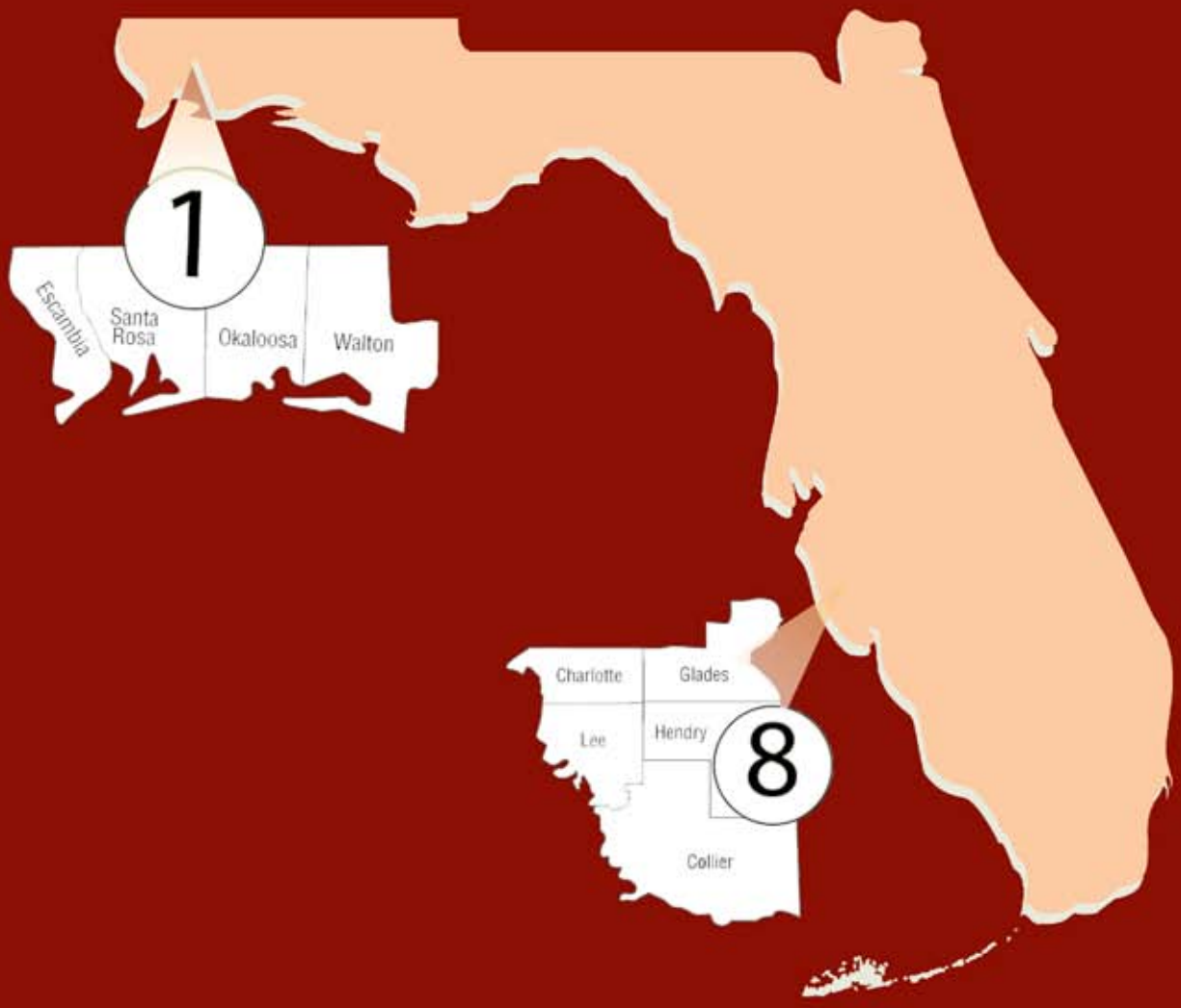
Evaluation of Florida's

Mental Health and Substance Abuse System Redesign Strategies

FINAL REPORT
December 31, 2006



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Louis de la Parte Florida Mental Health Institute

The Louis de la Parte Florida Mental Health Institute at the University of South Florida has a mission to strengthen mental health services throughout the state. The Institute provides research, training, education, technical assistance, and support services to mental health professionals and agencies as well as consumers, consumer organizations, and behavioral health advocates statewide. At the state level, the Institute works closely with the Departments of Children and Families (DCF), Corrections (DOC), Elder Affairs (DOEA), Education (DOE), and the Agency for Health Care Administration (AHCA), as well as with members and staff of the State Legislature and providers of mental health services throughout Florida.

Comprised of three primary research departments, Mental Health Law & Policy, Child & Family Studies, and Aging & Mental Health and a number of specialized centers, the Institute conducts research and program evaluations, provides training and consultations, and offers a number of academic courses at the masters and doctoral levels.

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Executive Summary

Under contract with the Department of Children and Families (DCF) and in accordance with the requirements of s. 394.9082, F.S., the Louis de la Parte Florida Mental Health Institute (FMHI), University of South Florida, has conducted a formative evaluation of financing strategies for the public mental health and substance abuse systems. New financing strategies were tested in two demonstration sites: DCF District 1, including Escambia, Okaloosa, Santa Rosa and Walton Counties, and DCF District 8, including Charlotte, Collier, Glades, Hendry and Lee Counties. The purpose of the evaluation was to identify the most effective methods and techniques used to manage, integrate, and deliver behavioral health services as specified in the legislation.

Districts 1 and 8 implemented two very different types of interventions in response to s. 394.9082, F.S. The DCF Substance Abuse and Mental Health Program (DCF/SAMH) fully implemented their system redesign strategy in District 1 in July 2002 through a contract with Lakeview Center which serves as a managing entity. The Agency for Health Care Administration (AHCA) had implemented Medicaid managed mental health care for MediPass enrollees in District 1 in November 2001 also through a contract with the same managing entity, Lakeview Center. This common managing entity and provider network for AHCA and DCF/SAMH, combined with prepaid financing from Medicaid has provided opportunity for more system integration and service flexibility for providers in District 1. In District 8, the other demonstration site, DCF/SAMH implemented their system redesign strategy in January 2004 when they contracted with an administrative services organization (ASO), Central Florida Behavioral Health Network. AHCA had not yet implemented Medicaid managed mental health care in Area 8 by the end of this evaluation, thus, the service flexibility and service integration that was anticipated was not realized.

Summary for District 1

Implementation of the financing strategies in District 1 appears to be well established. Contracting with a managing entity has yielded some important benefits, but it has taken time for the managing entity to fully assume its role of managing the service delivery system. In the initial years, organizational structures and relationships had to be developed and roles for the managing entity and the district DCF/SAMH office needed to be clarified. While some agencies argued that there is no need for both a managing entity and a District DCF/SAMH office, especially when considering the resources needed to support both, the DCF/SAMH staff have indicated that they are now more able to address system development issues without having to deal with the daily operational issues for which the managing entity is responsible. Providers are also appreciative of the fact that the managing entity has a greater understanding of their issues, since they are part of a provider agency. Providers also appreciate the technical assistance and consultation they can access through the managing entity.

Stakeholders have indicated that there has been variable progress in meeting the 13 original goals established in the enabling legislation. However, there was some agreement that there have been improvements in the continuity of care across agencies, reducing hospitalizations, and using data for managing the service system. There are still some areas needing improvement, such as services to people who reside in assisted living facilities and children and families who are in the child welfare system. Most stakeholders did feel that access to services had improved and that they were serving more individuals than previously. However, stakeholders were quick to point out that there have been no increases in DCF funding.

Analysis of the administrative data indicates that the intervention was associated with a significant increase in the number of persons served in the DCF/SAMH system from the baseline period to the follow-up period. This increase was larger for persons not enrolled in Medicaid. The data also indicated a significant difference in the change in acute care usage (both in terms of number of persons and number of days) from baseline to follow-up in District 1 compared to Districts 3 and 7. District 1 had a decline in acute care usage, whereas the comparison districts had a increase in acute care usage. The intervention was associated with little or no change in Baker Act examinations, state hospital usage, or arrests from baseline to follow-up in District 1 compared to Districts 3 and 7. Overall, District 1 had lower rates of Baker Act examinations, acute care services, and arrests than the comparison districts, but had a higher rate of usage of the state hospitals.

There was little change in the base administrative expenditures rate in District 1 from the year prior to implementation of the pilot through the first four years of operation of the pilot project. When the administrative cost associated with the managing entity was factored in, however, the administrative expenditure rate increased significantly. However, the overall administrative expenditure rates observed were still clearly lower than the 10% rate permitted by the legislation.

Summary for District 8

Despite most stakeholders feeling disappointed with the process and outcome of this pilot project, they did note accomplishments as a result of the ASO pilot in the important areas of strengthening the provider network, quality improvement (i.e., training on evidence-based practices), consumer advocacy and involvement, and improved outcome data reporting to the DCF data warehouse. The challenges seemed to stem from a lack of clarity among the key stakeholders about the goals and role of the ASO at the initiation of the project coupled with an ASO that did not have experience functioning as the unique kind of managing entity model that was being sought in District 8 (i.e., that does not manage contracts).

The District 8 pilot was a pioneer in the sense of trying a very different kind of "managing entity" model than what is currently being used in other districts. This pilot reminds us of the importance of being clear about the goals, communicating the goals continuously to all stakeholders, translating the goals carefully into contract language, matching expectations and services sought with a vendor that has experience and interest in delivering those services, and holding contractors accountable.

In terms of the thirteen goals and four areas of improvement that the Legislature designated for these pilots, there was some progress. Thirteen disparate goals are probably too many for this kind of a managing entity to realistically accomplish given the challenges posed by our under-funded and fragmented system. Nevertheless, the goals regarding quality, accountability, improved assessment of local needs, integration with other systems and improved use of data were thought by the key informants to have been impacted positively by the ASO. The other eight goals were either not seen as relevant for their community (e.g., there are no assisted living facilities in District 8) or the strategies used by the ASO ultimately did not impact the goals (e.g., improved continuity of care). Consumer satisfaction was thought to have improved because of the consumer affairs staff member at the ASO, timeliness of service and effectiveness of services were thought to have improved somewhat, but cost effectiveness of care was said to not have been affected by the ASO.

Key informants made several recommendations for their district going forward and for other districts. For their district, several of the key informants suggested discontinuing the ASO as it currently exists and to use the provider network, Southwest Florida Behavioral Health Network, as the contractor to conduct the quality management functions that the District DCF/SAMH Office would like done. They would also like contracting flexibility with the network possibly managing some contract funds. For other districts, their recommendations focused on coming to consensus on what the services are that the District Office wants to purchase and not limiting themselves to one vendor. It might be better to contract with multiple entities that perform distinct tasks given their experience, interest, and knowledge of the community rather than contracting with one entity to perform a wide variety of tasks that does not have experience or interest in some of them.

Systems change, systems transformation, or systems redesign takes years and multiple strategies. There was progress and lessons learned through this ASO project that will help them to get "to the next level" as a system. Several recommendations are offered for the next iteration of their systems change strategy.

Analysis of the administrative data for the District 8 pilot project indicates that the intervention was associated with a significant increase in the number of persons served in the DCF/SAMH system from the baseline period to the follow-up period relative to the number of persons served in the comparison districts. This increase was larger for persons not enrolled in Medicaid. The data analysis indicated a significant difference in the change in arrest rates (both in terms of number of persons and number of arrests) from baseline to follow-up in District 8 compared to District 15 and the Suncoast Region. Both areas experienced a decrease in arrests and arrest rates, but District 8 had a larger decrease in both the number of arrests and the proportion of persons arrested than the comparison districts. Similarly, state hospital usage declined more in District 8 than in the comparison districts, however, this finding was not statistically reliable (probably due to extreme variability in the data). The data analysis indicated a significant difference in the

change in Baker Act examination rates (both in terms of number of persons and number of arrests) from baseline to follow-up in District 8 compared to District 15 and the Suncoast Region. Baker Act examinations and rates went up in District 8, but declined in the comparison districts. The intervention was associated with little or no change in acute care services from baseline to follow-up in District 8 compared to District 15 and the Suncoast Region. Overall, District 8 had lower rates of arrest and state hospital usage than the comparison districts, but had a higher rate of usage of the acute care services.

There was little change in the base administrative expenditures rate in District 8 from the two years prior to implementation of the pilot through the first three years of operation of the pilot project. When the administrative cost associated with the managing entity was factored in, however, the administrative expenditure rate increased significantly. However, the overall administrative expenditure rates observed were still clearly lower than the 10% rate permitted by the legislation.

Overall Conclusions and Recommendations

Although the two pilot projects involved very different models, both projects were able to implement their models, and the projects have operated for several years. In District 1, the roles and responsibilities of the managing entity (relative to the DCF/SAMH district office) evolved over time, but the general expectations for the role of the managing entity was fairly well established from the outset. In contrast initially in District 8, there was considerable ambiguity regarding the role and future of the ASO resulting in some key participants being reluctant to support the project. This underscores the importance of establishing a clear role for the managing entity or ASO at the outset of the project.

Both pilot projects were able to at least partially meet a subset of the goals that were set forth in the legislation. However, in both cases several goals were not met. Overall, the goals that were set forth in the legislation appear to have been overly ambitious, particularly in light of the level of resources available to accomplish them. In some cases, goals were not relevant to the local district in which the project was established. In future projects prior to implementation, it will be very important to establish consensus on clear, reasonable, and measurable goals that are relevant to the local community in which the project is being established.

It was clear that administrative cost and administrative effort were increased as a result of the implementation of the projects. In District 8, some positive results were observed, but there seems to be some consensus among key stakeholders that the system had not benefited in proportion to the increase in administrative cost. In District 1, there continues to be concerns about the cost of supporting both a managing entity and a district office. In future projects, managing entities should have to demonstrate adequate value added to the system or be discontinued.

Initially, data systems were very problematic in both districts. However, over time significant progress was made in this area, both in the reporting of data and use of data to manage the system. More improvement is needed in this area, but the improvements to date are encouraging.

The Agency for Health Care Administration was only minimally involved in these demonstrations. The management, oversight, and funding of these projects were essentially entirely supplied by DCF. Little progress has been made on the integration of resources at the district level. Ongoing requirements related to state and federal funding continue to limit the capacity for managing entities to integrate these resources.

The addition of a consumer affairs position in the project in District 8 was seen as very positive by the key stakeholders in that District. In District 1, there is a consumer advisory council in place that has increased level of consumer involvement in the system. Future projects should develop ways to similarly increase consumer involvement.

Introduction

Under contract with the Department of Children and Families (DCF) and in accordance with the requirements of Chap. 394.9082 F.S., the Louis de la Parte Florida Mental Health Institute, University of South Florida, has conducted a formative evaluation of the system redesign strategies authorized by the statute. The demonstration sites that were selected were DCF District 1, including Escambia, Okaloosa, Santa Rosa and Walton Counties, and DCF District 8, including Charlotte, Collier, Glades, Hendry and Lee Counties. The Florida Mental Health Institute's role was to help identify the most effective methods and techniques used to manage, integrate, and deliver behavioral health services as specified in the legislation. This document describes the evaluation results through fiscal year 2005-2006, the fifth and final year of the evaluation. This final report summarizes the results of this past year's evaluation activities and discusses the overall findings from prior years. In each of the previous years of the evaluation, a report of the year's findings and results was prepared and submitted to the Department of Children and Families Mental Health and Substance Abuse (DCF/SAMH) Office and to the Agency for Health Care Administration (AHCA). A summary of each year's report was also submitted to the Florida Legislature.

The Interventions

The statute required DCF and AHCA to develop service delivery strategies that would improve the coordination, integration, and management of mental health and substance abuse services to persons with behavioral disorders. The goals were to achieve a "single well-integrated behavioral health system". The statute specified several forms that the interventions could take, but essentially it mandated that "both the DCF and AHCA must contract with the same managing entity" in at least one of the districts and that DCF and AHCA shall work together to have the same benefits, policies and procedures through the managing entities.

District 1 implemented several changes as of July 1, 2002, and FY2005-2006 represents the district's fourth year under a managing entity (ME). District 8 implemented its administrative services organization contract in January 2004.

Figure 1 (below) illustrates the intervention design in District 1. Lakeview Center, through its Access Behavioral Health division, is the managed care organization for the Medicaid Prepaid Mental Health Plan that began November 1, 2001. The District 1 DCF/ SAMH Office began contracting with Lakeview Center as the managing entity for DCF/SAMH-funded services district-wide on an aggregate fixed-sum basis on July 1, 2002. This common managing entity for both AHCA and DCF/ SAMH services fulfilled a major mandate in the statute.

Figure 1. System Redesign Intervention in DCF District 1.

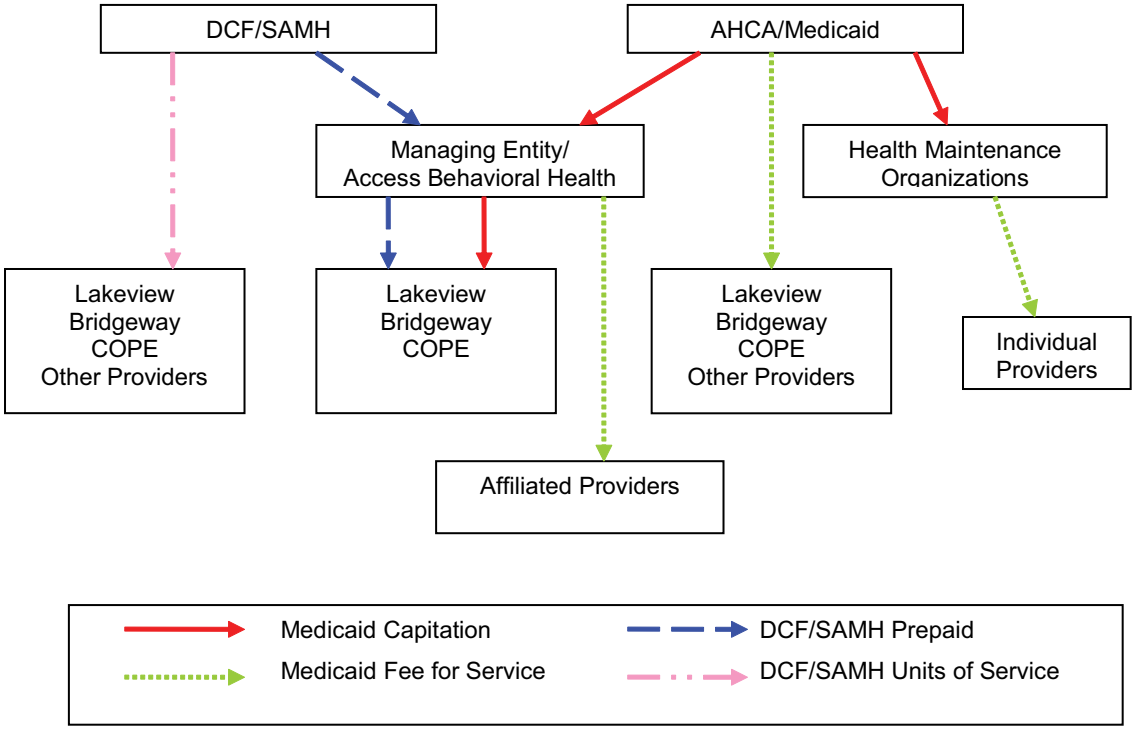


Figure 2 (below) illustrates the service delivery strategy that was implemented in District 8 during FY2003-2004. DCF/SAMH contracted with Central Florida Behavioral Health Network as an administrative services organization (ASO) that was to provide technical assistance to providers in the district to improve the coordination, integration, and management of mental health and substance abuse services to persons with behavioral disorders. It was anticipated that the ASO would be in place at least through June, 2006. While the ASO did not contract directly with providers (DCF/SAMH continued to do so), the ASO provided technical assistance to providers.

Previous Findings

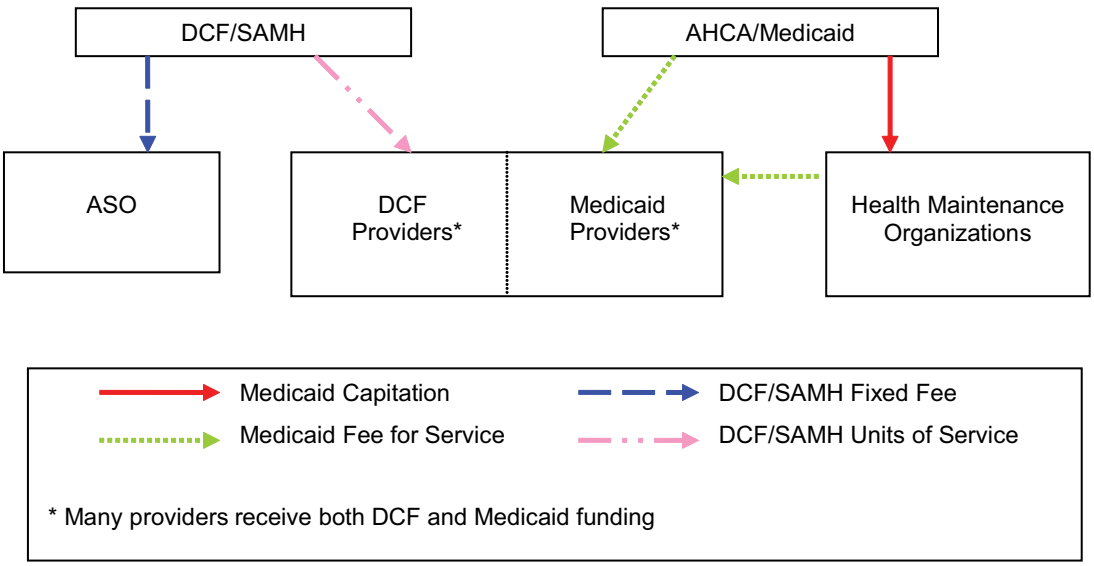
Based upon the findings from the previous years' evaluation activities, a summary report was prepared for the Florida Legislature in December 2005. That report describes the evaluation objectives, methods, and findings related to the implementation of the new financing strategies through fiscal year 2004-2005. The following conclusions were offered in that report:

Conclusions and Recommendations: District 1

Implementation of the financing strategy in District 1 appeared to be progressing well. The establishment of a managing entity had yielded some important benefits, but it was apparent that there were differing expectations about what its role should be vis a vis the District DCF/SAMH office. Some argued that there was no need for both a managing entity and a District DCF/SAMH office, especially when considering the resources needed to support both. Given that district offices are leanly staffed, (according to DCF/SAMH Central Office respondents), the concerns about duplicative oversight seemed especially important and should be examined, and where possible, eliminated through better role differentiation. Also, where possible, efforts should be made to combine monitoring and auditing visits in order to avoid significant disruptions caused by numerous visits.

During the 2004-2005 year, problems encountered with the data systems continued to the extent that district providers and the managing entity reported that they had not been able to access their data to run their own queries and still lacked confidence in the data that were in the DCF/SAMH data warehouse. Significant efforts were made by central DCF/SAMH staff to address the problems associated with the data systems. [For example, DCF/SAMH staff reported that they developed two data reporting modules, including the ad hoc-to-email utility that allows providers to download their raw data, and the ad hoc reporting utility that allows providers to run queries from various tables. They also reported that, a copy of the data from the DCF/SAMH system is downloaded monthly to the District 1 server for local data analysis and reporting.] However, they also reported that they lacked sufficient hardware capacity to accommodate all the demands on the system. One possible solution for this problem would be for the

Figure 2. System Redesign Intervention in DCF District 8.



managing entity to either assume the role of coordinating data submissions from providers to the data warehouse or to at least have copies of provider data submissions sent to them for use in conducting district-level analyses. Either option would enable the managing entity to have data available to them that could be very useful for managing their service network and improving practice.

There was little change in the base administrative expenditures rate in District 1 from the year prior to implementation of the pilot through the first three years of operation of the pilot project. When the administrative cost associated with the managing entity was factored in, however, the administrative expenditure rate increased significantly. However, the overall administrative expenditure rates observed were still clearly lower than the 10% rate permitted by the legislation.

Conclusions and Recommendations: District 8

The ASO and provider network reported working well together, which is a needed foundation for the important systems change work yet to be done. It is in the best interest of the provider network to function more concretely as an interdependent and organized entity, if they are to bid or contract in the future as a network, with DCF, AHCA, or another organization for the management and provision of mental health and substance abuse services to the citizens of District 8.

There was little change in the base administrative expenditures rate in District 8 from the two years prior to implementation of the pilot through the first two years of operation of the pilot project. When the administrative cost associated with the administrative services organization was factored in, however, the administrative expenditure rate increased significantly. However, the overall administrative expenditure rates observed were still clearly lower than the 10% rate permitted by the legislation.

We recommended that DCF determine whether or not they plan to continue contracting with the ASO after June 2006 or develop another plan and communicate that to the ASO and providers. The lack of a decision on this point had been a distraction and the long-term plan may have implications for the emphasis they place on certain activities during the coming year.

All DCF/SAMH providers within the district including those beyond the five main centers are formally part of the network. However, some of these other providers may not have been aware of or participating in the ASO activities (e.g., trainings, consultation). We recommended that a community-wide advisory group or steering committee be established (as provided for in the authorizing legislation) and meet on a regular basis:

> "(7) ESSENTIAL ELEMENTS, paragraph (d)
>
> (d) A local body or group must be identified by the district administrator of the Department of Children and Family Services to serve in an advisory capacity to the behavioral health service delivery strategy and must include representatives of the local school system, the judicial system, county government, public and private Baker Act receiving facilities, and law enforcement agencies; a consumer of the public behavioral health system; and a family member of a consumer of the publicly funded system. This advisory body may be the community alliance established under s. 20.19(6) or any other suitable established local group" (Chap. 394.9082(8) F.S.)."

By engaging more providers and other system stakeholders in information sharing and planning, a shared vision would be more likely to occur and be implemented.

We recommended that the ASO play a larger role in the area of data management and knowledge generation from the data. Since they have access to the providers' One Family data submissions and the DCF/SAMH Data Warehouse, and given that the One Family system was not fully functional and providers may not have the capacity to fully analyze their own data (and probably no capacity to analyze their data relative to the other providers in the network/system), this service seemed sorely needed. This kind of service can model for the network what kind of information they would need to be able to generate, if and when, they are managing funds in the future. Data analysis illustrating overall resource utilization, outcomes, and consumers' pathways through the system seems doable and within the realm of the work the ASO has been contracted to do.

It seemed it would be very helpful if some service funds were managed by the ASO/network (e.g., funds for the Temporary Assistance to Needy Families [TANF] program). Perhaps the funds could be contracted with the provider network directly instead of being added to the ASO contract, since that has been the obstacle. This would give the provider network some funds to manage as a network and the ASO could assist them in managing those funds with the expectation that the network will increasingly manage more funds over time. This kind of arrangement might maximize or increase the potential of what could be the last year of the ASO services.

Overall Conclusions and Recommendations

Districts 1 & 8 continued to make good progress on implementing the pilot projects. District 1 established a managing entity as the primary contractor for mental health and substance abuse services, implemented a new contracting mechanism, and designed data systems intended to support it. District 1 also has an advisory board that relates to both the Medicaid Prepaid Mental Health Plan as well as the DCF/SAMH funding strategies. District 8 contracted for a very different model. They contracted with an ASO that has responsibility for working with the provider network to accomplish some important system goals. This may prove challenging for the ASO since it does not contract directly with the service providers. In addition, because the ASO was funded with a special allocation from DCF/SAMH, there was concern about sustaining the ASO functions once the funding ends. The uncertainty had been problematic for the ASO and the providers in District 8. District 8 had yet to establish an advisory board as required by the legislation. Recommendations: The future of the funding for the ASO in District 8 should be resolved as soon as possible. District 8 should also proceed promptly with convening an advisory board for the pilot project.

In both districts, the roles and expectations of the managing entity and ASO relative to the district DCF/SAMH office were still evolving. In District 1, providers were particularly concerned about duplication of functions between the district DCF/SAMH office and the managing entity, especially regarding monitoring and auditing. In District 8, providers were still hopeful that some creative and flexible DCF/SAMH and/or Medicaid financing strategies would be introduced. To that point, little had changed with respect to contracting practices in District 8. Essentially, while the districts had implemented these two pilot projects, DCF/SAMH had also maintained their original systems and ways of doing business. Nothing had been removed, but the system had been added to, thereby increasing the complexity of a very leanly funded system. Unfortunately, service providers were experiencing additional administrative burden with this increased complexity (e.g., multiple monitoring and reporting requirements) as district service dollars were diverted to cover increased administrative costs (albeit costs that were within allowable limits). Recommendations: Oversight functions and reporting requirements should be reviewed in order to minimize or avoid duplication. In District 8, the network could be given some resources to manage in order to create flexibilities in service delivery.

Problems with data systems continued to be a significant barrier to progress in both districts. Both Districts 1 and 8 were attempting to implement new data systems that should inform system management and aid in clinical decision-making. However, local stakeholders (providers and the managing entities) had been unable to produce reports to the extent anticipated and they lacked confidence in the data that were in the DCF/SAMH data warehouse. Recommendation: The managing entities coordinate data submission to the data warehouse from the providers and/or maintain copies of provider data submissions with which to conduct district-level analyses.

Evaluation Objectives

The authorizing legislation for this project (Chap. 394.9082 F.S.) directed the Louis de la Parte Florida Mental Health Institute, University of South Florida, to conduct an ongoing formative evaluation of the system redesign strategies authorized by the statute. The legislation further indicated that the evaluation was to "identify the most effective methods and techniques used to manage, integrate, and deliver behavioral health services…. [and] include a summary of activities that have occurred during the past 12 months of implementation and any problems or obstacles that have in the past, or may in the future, prevent the managing entity from achieving performance goals." The status report must include an analysis of administrative costs and the status of achievement of performance outcomes. The final report must include an assessment of best practice models in other states [and] must address programmatic outcomes that "include, but are not limited to, timeliness of service delivery, effectiveness of treatment services, cost-effectiveness of selected models, and customer satisfaction with services."

In addition to the direct statements in the legislation about what shall be included in the evaluation, the legislation indicated that the overall goal for the interventions was to "provide a design for an effective coordination, integration, and management approach for delivering effective behavioral health services." Thirteen other goals were also outlined for the interventions. These included the following:

(a) Improve accountability for a local system of behavioral health care services to meet performance outcomes and standards.

(b) Assure continuity of care for all children, adolescents, and adults who enter the publicly funded behavioral health service system.

(c) Provide early diagnosis and treatment interventions to enhance recovery and prevent hospitalization.

(d) Improve assessment of local needs for behavioral health services.

(e) Improve the overall quality of behavioral health services through the use of best practice models.

(f) Demonstrate improved service integration between behavioral health programs and other programs, such as vocational rehabilitation, education, child welfare, primary health care, emergency services, and criminal justice.

(g) Provide for additional testing of creative and flexible strategies for financing behavioral health services to enhance individualized treatment and support services.

(h) Control the costs of services without sacrificing quality of care.

(i) Coordinate the admissions and discharges from state mental health hospitals and residential treatment centers.

(j) Improve the integration, accessibility, and dissemination of behavioral health data for planning and monitoring purposes.

(k) Promote specialized behavioral health services to residents of assisted living facilities.

(l) Reduce the admissions and the length of stay for dependent children in residential treatment centers.

(m) Provide services to abused and neglected children and their families as indicated in court-ordered case plans.

Research Design, Data Sources, and Methodology

Data for evaluating changes in structural capacity and processes for the districts were collected primarily through document reviews and interviews/discussion groups with key informants in Districts 1 and 8, including providers, DCF & AHCA Central Office administrative staff, DCF district & AHCA area representatives, and managing entities. Administrative data were used for a few specific selected analyses.

Document Reviews

Pertinent documents were collected from the SAMH District Supervisors and the managing entities in Districts 1 and 8 pertaining to the pilot project activities over the past year. These were reviewed for issues related to the progress of the pilot projects, accomplishments, and barriers. Documents that were reviewed include the contracts between DCF and the ME/ASO, contracts between the ME and providers (District 1 only), contracts between DCF and the providers (District 8 only) organizational plans/charts for the ME/ASO, and quality assurance / quality improvement reports from the ME/ASO. This review guided the development of questions that were used in the interviews and discussion groups.

Interviews/Discussion Groups

Semi-structured interviews were conducted with the following people in each of the intervention districts:

- District DCF/SAMH Program Supervisors and selected members of their staff
- Directors for the Managing Entity/ASO and selected members of their staff
- Executive Directors or other leadership staff of the primary service provider agencies
- Executive Directors of Mental Health Associations, consumer and advocacy groups, as well as other relevant key community agencies

The same semi-structured interview protocol was used for all interviews in this evaluation. The interview protocol used for data collection was designed to obtain the views of top managers from the District's mental health and substance abuse programs regarding the financing redesign strategies that have been implemented and to what extent they have had success in achieving the goals outlined in Chapter 394.9082, F.S. Because this was the final year of the evaluation, stakeholders also were asked to reflect on the factors that contributed to the implementation of the new financing strategy as well as the barriers to success. They were asked to address future directions for the ME/ASO in the district and to offer their recommendations regarding the implementation of managing entities in other areas of the state should the DCF decide to implement managing entities in other districts.

Interviews were done in person and were audio taped. Participants were asked to sign informed consent forms. The tapes and notes of the interviews were examined for common themes. An analysis and summary of the major findings are presented below.

In District 1 in November 2006, semi-structured, interviews were conducted in person with key district

stakeholders, including two of the directors of the major providers (Bridgeway Center, and COPE Center) the managing entity (Access Behavioral Health), the Department of Children and Families District 1 Substance Abuse and Mental Health (DCF/SAMH) Program Supervisor, and the Executive Director of the Mental Health Association of West Florida in Pensacola.

In District 8 in August 2006, individual semi-structured interviews were conducted with key stakeholders, including the directors or other leadership staff of the five major providers, the Administrative Services Organization (ASO), the District 8 DCF/SAMH Program Office, the District's community based care provider, consumer advocates, and a consultant to the District.

The following questions were used to guide the interviews of provider staff, district staff, and ME/ASO staff in the evaluation.

1. What have been the factors that have contributed positively to implementation of the managing entity (ASO) in your district? What have been the barriers to implementation?
2. What changes have occurred in the service delivery systems that have directly benefited consumers *as a result* of establishing the managing entity (ASO)?
3. What were your expectations regarding outcomes as a result of establishing a managing entity (ASO)? How well have your expected outcomes been achieved?
4. What factors contributed to achieving your expected outcomes? What were the barriers to achieving those outcomes?
5. Tell us what specific steps have been undertaken by the managing entity (ASO) to accomplish each of the following 13 goals established in the legislation?
   (a) Improve accountability for a local system of behavioral health care services to meet performance outcomes and standards.
   (b) Assure continuity of care for all children, adolescents, and adults who enter the publicly funded behavioral health service system.
   (c) Provide early diagnosis and treatment interventions to enhance recovery and prevent hospitalization.
   (d) Improve assessment of local needs for behavioral health services.
   (e) Improve the overall quality of behavioral health services through the use of best practice models.
   (f) Demonstrate improved service integration between behavioral health programs and other programs, such as vocational rehabilitation, education, child welfare, primary health care, emergency services, and criminal justice.
   (g) Provide for additional testing of creative and flexible strategies for financing behavioral health services to enhance individualized treatment and support services.
   (h) Control the costs of services without sacrificing quality of care.
   (i) Coordinate the admissions and discharges from state mental health hospitals and residential treatment centers.
   (j) Improve the integration, accessibility, and dissemination of behavioral health data for planning and monitoring purposes.
   (k) Promote specialized behavioral health services to residents of assisted living facilities.
   (l) Reduce the admissions and the length of stay for dependent children in residential treatment centers.
   (m) Provide services to abused and neglected children and their families as indicated in court-ordered case plans.

6a. What has been the impact of the managing entity (ASO) on the timeliness of service delivery? If there was an impact, what did the managing entity do (either directly or indirectly) to impact the timeliness of service delivery?

6b. What has been the impact of the managing entity (ASO) on the effectiveness of treatment services? If there was an impact, what did the managing entity do (either directly or indirectly) to impact the effectiveness of treatment services?

6c. What has been the impact of the managing entity (ASO) on the cost effectiveness of service? If there was an impact, what did the managing entity do (either directly or indirectly) to impact the cost effectiveness of service?

6d. What has been the impact of the managing entity (ASO) on consumer satisfaction with services? If there was an impact, what did the managing entity do (either directly or indirectly) to impact consumer satisfaction with services?

7. What other changes have occurred in the district to enhance the integration of resources and better coordination of services?

8. How successful has the overall strategy to better integrate resources (DCF/SAMH and Medicaid) through the establishment of a managing entity (ASO) been within the district?
9. What has been the value added by establishing the managing entity (ASO)?
10. Where does your district go from here? What are your recommendations for continuing/discontinuing/changing the managing entity (ASO) and the way it operates?
11. What are your recommendations for establishing managing entities (ASOs) in every district?

The following questions were used to guide the interviews with external agencies i.e., the local Mental Health Association, consumer organizations, and other community organizations.

1. What were your expectations regarding outcomes as a result of establishing a managing entity (ASO)? How well have your expected outcomes been achieved?
2. What factors contributed to achieving your expected outcomes? What were the barriers?
3. What changes have occurred in the service delivery systems that have directly benefited consumers *as a result* of establishing a managing entity (ASO)?
4. How successful has the overall strategy to better integrate resources (DCF/SAMH and Medicaid) through the establishment of a managing entity (ASO) been within the district?
5. What has been the value added by establishing the managing entity (ASO)?
6. What are your recommendations for continuing/discontinuing/changing the managing entity (ASO) in the district and the way it operates?
7. What are your recommendations for establishing managing entities (ASOs) in every district?
8. In your opinion has there been any change in the following over the past four years (two and a half years for District 8)?
   - The timeliness of service delivery in the public behavioral health care system?
   - The effectiveness of treatment services in the public behavioral health care system?
   - The cost effectiveness of service in the public behavioral health care system?
   - Consumer satisfaction with services in the public behavioral health care system?
   - The accountability of the local behavioral health care system to meet performance outcomes and standards.
   - Continuity of care for all children, adolescents, and adults who enter the publicly funded behavioral health service system.
   - The provision of early diagnosis and treatment interventions to enhance recovery and prevent hospitalization.
   - The assessment of local needs for behavioral health services.
   - The overall quality of behavioral health services through the use of best practice models.
   - The service integration between behavioral health programs and other programs, such as vocational rehabilitation, education, child welfare, primary health care, emergency services, and criminal justice.
   - Testing of creative and flexible strategies for financing behavioral health services to enhance individualized treatment and support services.
   - Costs of services without sacrificing quality of care.
   - Coordination of the admissions and discharges from state mental health hospitals and residential treatment centers.
   - The integration, accessibility, and dissemination of behavioral health data for planning and monitoring purposes.
   - The availability of specialized behavioral health services to residents of assisted living facilities.
   - The number of admissions and the length of stay for dependent children in residential treatment centers.
   - The availability of services to abused and neglected children and their families as indicated in court-ordered case plans.

Administrative Data Analysis Methods

Several types of administrative data were available for this evaluation. The Florida Mental Health Institute, Policy and Services Research Data Center had Medicaid enrollment and claims data, DCF/SAMH community services data, DCF/SAMH state hospital admission and discharge data from FY98-99 through FY04-05. The Policy and Services Research Data Center also had Baker Act involuntary examination data available from April, 1999 through December, 2005. All of these data sets contain statewide data. Arrest history data were obtained

from the Florida Department of Law Enforcement for individuals served in the study districts for the time periods of interest.

Overall Design

FY03-04 was a transition year for the One Family SAMH data system. Because of problems with data integrity during that period, we excluded data from that fiscal year from our analyses. Since the two interventions began at different times, we selected the years of data to be used in each analysis based on the start of the interventions. For each intervention district we used the last full fiscal year prior to the start of the intervention as the "baseline" year (FY01-02 for District 1 and FY02-03 for District 8). Then we used the most recent full fiscal year of data available (FY04-05) as the "follow-up" year. Thus, the overall design involved an analysis of the change in outcome measures from the baseline year to the follow-up year for each intervention district (analyzed separately) compared with the average change in the outcome measures for the comparison districts (see below) for each intervention. For some of the analyses, separate analyses were conducted for persons who received all their services through the DCF/SAMH system and for persons who received services from DCF/SAMH providers and were simultaneously enrolled in Medicaid.

Outcome Measures

The administrative data analysis focused on overall utilization of the public behavioral health care system, amount of acute care utilization, Baker Act involuntary examination rates, state hospital utilization and number of arrests.

Overall utilization. The DCF/SAMH community services data were utilized to identify persons who used the public behavioral health care system in each district during the study periods. The rates of utilization as a percentage of the district population for each intervention district for the baseline year compared to the follow-up year were compared to the rates of utilization for the comparison districts for the same time periods. We also compared the proportions of persons receiving DCF/SAMH services who were simultaneously enrolled in Medicaid for the intervention districts compared to the comparison districts.

Acute care utilization. Acute care included any crisis stabilization unit use, short-term residential treatment use, or behavioral health-related community hospitalization. We used the DCF/SAMH data warehouse community service event records to identify these events for all individuals. We calculated the proportion of people using any acute care and average days of acute care service use for each of the fiscal years studied.

State hospital utilization. We used the DCF/SAMH data warehouse state hospital data for all individuals in the study. We calculated the proportion of people hospitalized in the state hospital and the average days of hospitalization for each of the fiscal years studied.

Baker Act involuntary examination rates. We used the Baker Act Examination database (which is maintained at the Florida Mental Health Institute for AHCA) to identify Baker Act examinations for each individual in the study. The proportion of people in the study who had a Baker Act examination during each study year and the average number of examinations for the people in the study were used as outcome measures.

Arrest rates. Florida Department of Law Enforcement arrest records were used to identify individuals who were arrested during the study period. We calculated the proportion of people who were arrested during each study year and the average number of arrests.

Selection of Comparison Districts

Based on an analysis of demographic variables from the 2000 Census, per-capita DCF budget figures, and variables calculated from the DCF/SAMH data warehouse service use data for each District in the state, we selected Districts 3 and 7 as comparison districts for the analysis of administrative data pertaining to the demonstration in District 1 (Jordan et al., 2003). To simplify the presentation of results, the data for each pilot project will be compared with the average of the data for the two comparison districts for that project.

Administrative Cost Analysis

The legislation mandated that the evaluators analyze administrative costs after the service delivery strategies have been operational for one year. The pilot projects in both District 1 and District 8 have been operational for more than one year. A complete analysis of administrative costs associated with the implementation of the redesign strategies (e.g., administrative costs incurred at the provider level) is beyond the scope of this evaluation. Instead, we limited the cost analysis to administrative costs incurred by DCF/SAMH in the implementation districts compared to the comparison districts. It should be noted that in addition to DCF/SAMH administrative costs incurred in the implementation districts, there are

administrative costs associated with the managing entities themselves. In District 1, administrative costs associated with the managing entity are contractually capped by DCF at a percentage of the managing entity's contract. In District 8, the entire amount of the contract with the ASO is considered to be administrative cost (since no direct service funds are included in the contract). As noted, there are also administrative costs incurred at the provider level, which cannot be captured here.

Florida Accounting Information Resource (FLAIR) data from FY01-02, FY02-03, FY03-04, FY04-05, and FY05-06 were obtained from the DCF Office of Revenue Management to identify administrative expenditures at the central office and district levels. Using other cost accumulators (OCA) data from budget entities (BEs) 60910502, 60910503, 60910505, 60910601, 60910602, and 60910603, we identified appropriate BE-OCA combinations that were used for district-level administrative expenditures associated with adult and child mental health and substance abuse services. Non-operating expenditures and transfers to other agencies were excluded from the analysis, as were administrative expenditures incurred by the DCF/SAMH central office that benefited the district. In addition, certain non-recurring funds such as special hurricane-related appropriations, facilities appropriations, and operating capital outlay (OCO) appropriations were excluded from the analysis.

The percentage of administrative cost was calculated in two ways. The "base" administrative cost percentages were calculated using only the district-level administrative costs in the numerator. The "total" administrative cost percentages were calculated using both the district-level administrative costs and the ME or ASO administrative costs in the numerator. In both cases the denominator included all these administrative costs plus all direct service costs (non-recurring expenses as noted above were excluded).

For this administrative cost analysis, comparison districts were those that were selected for each of the pilot projects in the prior years' analyses. Based on an analysis of demographic variables from the 2000 Census, per-capita DCF budget figures, and variables calculated from the DCF/SAMH Data Warehouse service use data for each district in the state, we selected Districts 3 and 7 as comparison districts for the analysis of administrative cost data pertaining to the demonstration in District 1, and we selected Districts 15 and the Suncoast Region as comparison districts for the analysis of administrative cost data pertaining to the demonstration in District 8 (Jordan et al., 2003).

Results

District 1 Results

This year (FY05-06) concludes the fourth full year of implementation of the new financing strategies for District 1. Access Behavioral Health, the managing entity, has continued to contract with the community mental health centers in Okaloosa and Walton Counties as well as Lakeview Center for general revenue supported substance abuse and mental health services. The method of contracting continues to be based upon an aggregate fixed-sum payment which is based upon the numbers of individuals served and the services that historically have been provided. Agencies are pre-paid on a monthly basis. There are now only four major cost centers: adult mental health and adult substance abuse and children's mental health and children's substance abuse. The District 1 DCF/SAMH Office continues to contract directly with providers (outside the managing entity contract) for certain specific services, such as substance abuse prevention services, individual and family education and advocacy services, the indigent drug program and services to individuals eligible for Temporary Assistance to Needy Families.

The funding structure for behavioral health services in District 1 is depicted in Figure 1 (page 4) and includes the organizational relationships that are pertinent to the Medicaid Prepaid Mental Health Plan that is also in operation in District 1. These organizational relationships have not changed throughout the four years they have been in operation.

Key Informant Results

Information obtained and consistent themes that emerged from the key informant interviews are summarized below.

Managing Entity and the Value-Added

Access Behavioral Health moved its offices from Lakeview Center to a separate location. Also, Access Behavioral Health has added staff in order to carry out their responsibilities independently rather than to share staff with Lakeview Center. These changes have helped establish an identity for Access Behavioral Health that is separate from Lakeview Center.

As we have found in previous years, the managing entity has continued to serve as a catalyst for more collaboration and information sharing among the network providers. Provider agency staff indicated that

they now can get assistance with problem solving from either the managing entity or from another provider, which would likely not have happened in the past. Because the managing entity was also a part of a provider agency, providers felt that the managing entity staff better understood what other provider agencies were experiencing. Additionally, the managing entity was seen as having access to clinical expertise that was helpful to other agencies through their monitoring and technical assistance role.

The managing entity also was noted to have introduced consistency and comparability among the provider agencies in several administrative areas. It was particularly helpful to have many of the same policies and procedures implemented across all the agencies for different funding streams (e.g., Medicaid and general revenue).

Stakeholders also noted that the managing entity has made progress in improving the data that are used to manage the system. There is still room for improvement, according to one provider, but there has been progress. Agencies are receiving regular feedback from the managing entity on their performance.

Because the managing entity in District 1 is part of a large provider agency, there was concern initially that Access Behavioral Health would be less than impartial in their dealings with providers. However, providers have agreed that this has not been an issue. As was indicated by one provider, the managing entity has carried out its functions impartially and has been inclusive of providers in disputes. They also noted that Access Behavioral Health has attempted to serve as an advocate for the providers in dealing with the state.

It was anticipated by the legislature that these new pilot managing entities or ASOs would have a positive impact on the timeliness of service delivery, effectiveness of treatment services, cost effectiveness of service, and consumer satisfaction with services. In District 1, most of the key informants that were interviewed said the managing entity had an impact on the timeliness of service delivery because the District DCF/SAMH office has been requiring (through the managing entity) that providers meet the same access standards that are required by the Medicaid Prepaid Mental Health Plan. This assures that people who request services have access within specified time frames depending upon the urgency of their need.

In terms of the managing entity's impact on the effectiveness of treatment services, two of the five stakeholders indicated that there had been no improvement in treatment effectiveness. However, the other respondents indicated that there have been more discussions by the managing entity about quality of treatment and that practice standards had been introduced. The managing entity is also interested in more detailed and extensive use of functional assessment ratings (Functional Assessment Rating Scale (FARS) and Functional Assessment Rating Scale for Children (CFARS)) to improve treatment for both children and adults.

With respect to the managing entity's impact on the cost effectiveness of treatment services, two people said there was no change in the cost effectiveness of services, but others noted that the funding source is getting more service for fewer dollars and that there had been less use of the more expensive services. As one respondent noted, however, the providers were being expected to do more and more with no increases in funding.

Only three respondents commented on the managing entity's impact on consumer satisfaction with services and most felt that there was little change (i.e., no improvement) or that there was not a good mechanism in place to obtain information from consumers about their satisfaction with DCF funded services.

Oversight

In the past, there were concerns expressed by the provider agencies regarding excessive oversight, i.e., duplicative monitoring and audits. Providers reported that they had been monitored by the DCF/SAMH office as well as the managing entity and that the visits were rarely coordinated. This year, providers reported that there has been better coordination of visits between the managing entity and the district office and less duplication in their monitoring activities. One provider noted that they have appreciated the fact that the oversight provided by the managing entity was more holistic than what was traditionally done by DCF/SAMH in the past.

Data Systems

Over the previous three years, there have been significant concerns raised about the reliability of the data systems that provide the data needed for managing the service system. The DCF/SAMH central and district offices have indicated that they have continued to work on correcting those problems. For the first time, District 1 providers and the managing entity reported that there have been improvements in the data systems

this year. There have been concentrated efforts by the managing entity and the district DCF/SAMH office to insure that the data are more accurate and can be used to provide reports to the provider agencies as part of system management. While reportedly there are still data issues yet to be resolved (e.g., questions about the algorithms used to clean and edit the data that are submitted to the DCF/SAMH data warehouse), it is important to note that progress in this critical area is being achieved.

Resources

The managing entity in District 1 was established without any new resources being added to the district budget; the costs for the managing entity were covered from the District's existing budget allocations. Also, there have been no significant increases in DCF/SAMH resources over the past several years. Respondents indicated that, given the reductions in Medicaid revenues due to managed mental health care in the District and the fact that general revenue allocations have not increased in several years, they are now expected to do even more with less. Providers continue to question the need for both a managing entity and a district DCF/SAMH office. However, they also prefer the current arrangements over returning to the previous arrangements where they contracted directly with DCF. They appreciate the flexibility afforded them through the new financing strategies (both Medicaid capitation and the prepaid contracting mechanism associated with their general revenue resources). These prepaid arrangements have enabled them to use their resources in better ways and to stop "chasing the dollars", but there has been little success in fully integrating funding because of federal and state requirements related to the different funding sources (e.g., Medicaid and state general revenue).

DCF/SAMH staff have indicated that they are now more able to address system development issues without having to deal with the daily operational issues that are the responsibility of the managing entity.

Progress Toward Goals

According to respondents, there has been uneven progress in achieving the thirteen goals that were included in the enabling statute for this demonstration. Respondents' views varied in terms of which goals were being addressed and whether or not there had been actual progress in those areas. One respondent indicated that there had been no progress in reaching any of the goals, while others believed that some progress had been achieved. While respondents were not specific about what activities were being carried out in support of those goals, there was some agreement that progress was being made around improving continuity of care across agencies, reducing hospitalizations, and using data for managing the service system. There was also some agreement about which areas were not being addressed which included providing services to residents of assisted living facilities and the additional testing of new creative or flexible funding of services to enhance individualized treatment planning. (This latter finding is surprising given that agencies have reported that they appreciated the flexibility that is afforded them through the prepaid funding model.) Services to children and families in the child welfare system also were noted as needing improvement.

Stakeholders Recommendations for Other Districts

Stakeholders were asked for their recommendations to the state regarding establishing managing entities should they choose to expand implementation to other areas. Their suggestions included:

- Managing entities must have clinical expertise and contract management experience
- The state should contract only with non-profit agencies as managing entities
- Managing entities should not be the community based care agency for child welfare recipients
- Managing entities should be independent of providers, their relationship should not be collegial, instead they should manage this system
- Managing entities need to understand consumer/family-focused care
- There must be trust among the managing entity, their providers and the State DCF/SAMH office
- Implementation of a managing entity is a developmental process that takes time.
- The cost of the managing entity should, at least, be partly funded from sources other than service dollars.

Administrative Data Analysis Results

As shown in Table 1, the number of persons served in the DCF/SAMH system in District 1 increased substantially (60%) from the baseline year to the follow-up year. The comparison districts had only a very small increase (9%) in the number of persons served in the DCF/SAMH system during those three years. Thus, the number of persons utilizing the DCF/SAMH system appeared to increase more from the baseline year to the follow-up year in District 1 than in the comparison districts.

This apparent large increase in the number of people who used services may be partially due to the removal of certain data entry restrictions when District 1 began piloting the One Family SAMH data system in January 2002. Consequently, the FY01-02 (and prior years') data found in the DCF/SAMH data warehouse system probably underreport the true number of unique individuals that used services.

Table 2 shows the number of persons in the sample who were also enrolled in Medicaid during each time period. While the absolute number of persons on Medicaid increased by similar amounts, the proportion of persons from the sample on Medicaid in District 1 decreased over time because of the large increase in the number of persons not on Medicaid from the baseline to follow-up.

Table 1. Persons using the DCF/SAMH system in District 1 and Comparison Districts

	District 1		Districts 3 & 7	
	# of Persons	% of District Population	# of Persons	% of District Population
FY 01-02	19,229	2.99%	57,375	2.27%
FY 04-05	30,846	4.57%	62,472	2.30%

Table 2. Persons using the DCF/SAMH system in District 1 and Comparison Districts that were enrolled in Medicaid during each study period

	District 1		Districts 3 & 7	
	Not on Medicaid (%)	On Medicaid (%)	Not on Medicaid (%)	On Medicaid (%)
FY 01-02	7,796 (57.2%)	5,823 (42.8%)	39,236 (48.6%)	41,455 (51.4%)
FY 04-05	10,532 (60.8%)	6,787 (39.2%)	43,174 (48.5%)	45,867 (51.5%)

Baker Act Examinations

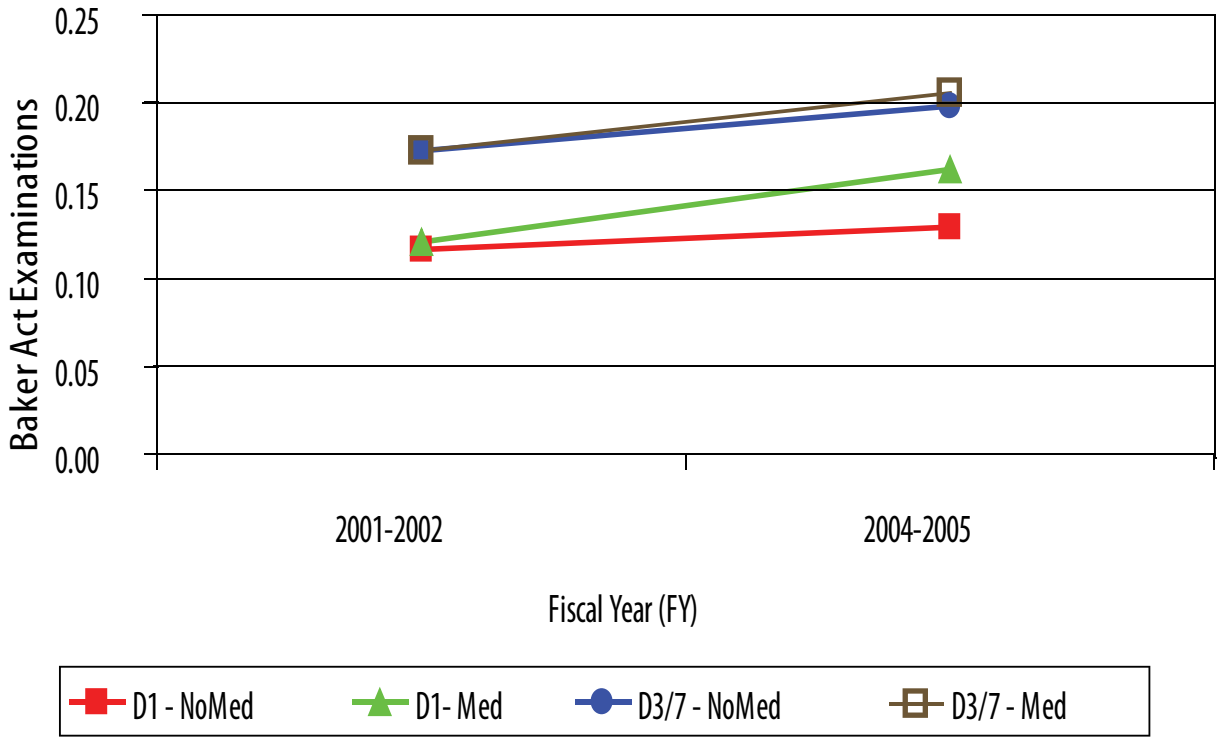
The rate of Baker Act examination (percentage of people that had at least one Baker Act examination) by District, Medicaid enrollment status and year are shown in Table 3. Inspection of this table shows that the rates differ by only a small amount as a function of Medicaid enrollment status. Overall, the rates of having a Baker Act examination were higher in the comparison districts than in District 1. Baker Act examination rates rose from the baseline period to follow-up in both areas. Overall, the Baker Act examination rates appeared to rise by comparable amounts in District 1 (9.2% to 10.4%) and in the comparison districts (12.0% to 13.3%).

A graph of the average number of Baker Act examinations by District, Medicaid enrollment status and year are shown in Figure 3. Inspection of this figure shows that the average number of Baker Act examinations differs only slightly as a function of Medicaid enrollment status (none of the effects involving Medicaid was significant in an analysis of variance). Persons served in District 1 had a lower average number of Baker Act examinations than persons served in the comparison districts ($F(1,169914) = 272.10$, $p < .0001$). The average number of Baker Act examinations rose from the baseline period to follow-up in both areas ($F(1,169914) = 84.00$, $p < .0001$). However, there was no difference in the change from baseline to follow-up for the two areas ($F(1,169914) =$

Table 3. Number of Persons with a Baker Act Examination by District, Medicaid Status and Year

	District 1				District 3 & 7			
	Not on Medicaid		On Medicaid		Not on Medicaid		On Medicaid	
	No Exams	>= 1 Exam	No Exams	>= 1 Exam	No Exams	>= 1 Exam	No Exams	>= 1 Exam
FY 01-02	8430 (90.5%)	887 (9.5%)	9026 (91.1%)	886 (8.9%)	26345 (87.1%)	3893 (12.9%)	24166 (89.0%)	2971 (11.0%)
FY 04-05	16189 (89.8%)	1848 (10.2%)	11449 (89.4%)	1360 (10.6%)	25820 (85.6%)	4354 (14.4%)	28347 (87.8%)	3951 (12.2%)

Figure 3. Average Number of Baker Act Examinations by District, Medicaid Status and Year



0.20, p = .653). The average number of examinations rose from 0.173 to 0.201 in the comparison districts (an increase of .028, 17%), and it increased from 0.118 to 0.146 in District 1 (an increase of .028, 23%).

Thus, overall there appeared to be little difference in the change in Baker Act examination rates or number between the two areas over time.

Acute Care Service Utilization

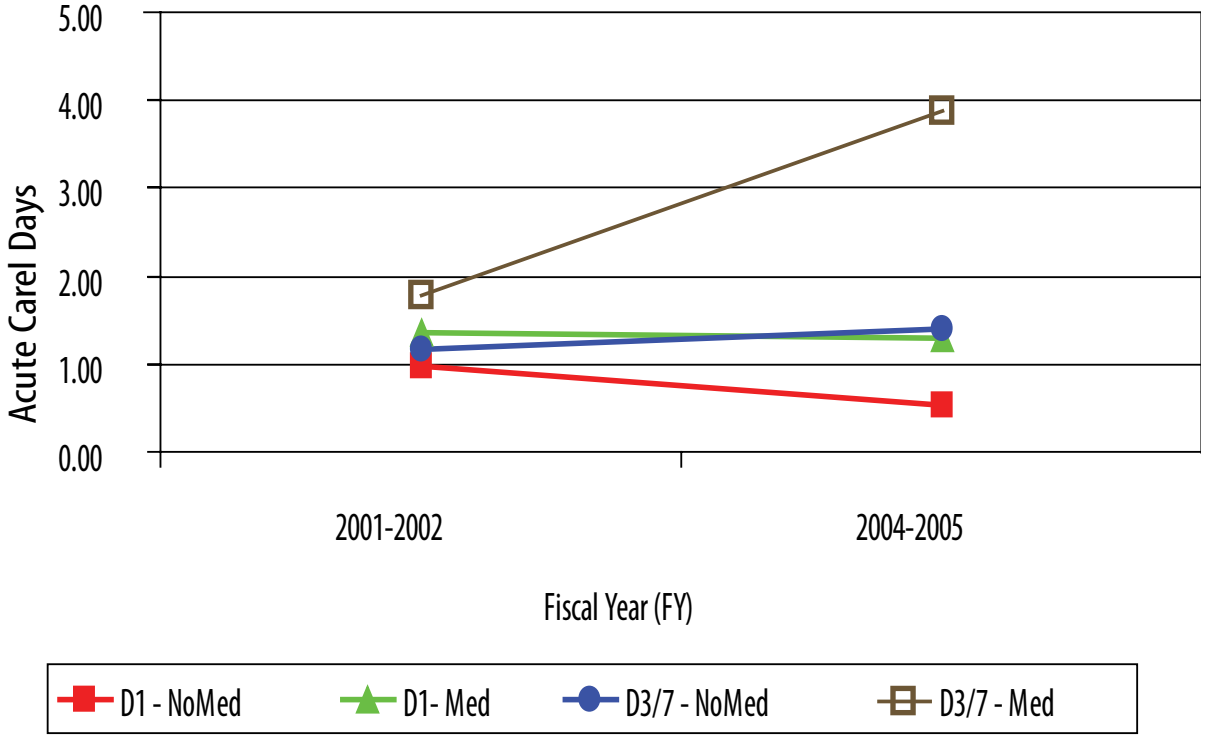
The rate of acute care utilization (percentage of people that used acute care) by District, Medicaid enrollment status and year are shown in Table 4. Inspection of this table shows that the rates differ by Medicaid enrollment status in a complex way. Overall, the rates of acute care utilization were higher in the comparison districts than in District 1. Further, the acute care utilization rates fell slightly in District 1 from baseline to follow-up (9.5% to 8.7%), whereas the rates actually increased somewhat in the comparison districts (13.2% to 15.2%).

A graph of the average number of days of acute care use by District, Medicaid enrollment status and year are shown in Figure 4. While an analysis of variance indicates that the effects of area, time, and Medicaid status, and all their interactions were significant at $p < .0001$, all these effects are due to the fact that there was a large increase in the average number of acute care days for persons on Medicaid in the comparison districts. The other groups stayed about the same or decreased slightly from baseline to follow-up.

Table 4. Number of Persons with Acute Care Service Utilization by District, Medicaid Status and Year

	District 1				District 3 & 7			
	Not on Medicaid		On Medicaid		Not on Medicaid		On Medicaid	
	No Acute Care	Used Acute Care	No Acute Care	Used Acute Care	No Acute Care	Used Acute Care	No Acute Care	Used Acute Care
FY 01-02	8197 (88.0%)	1120 (12.0%)	9204 (92.9%)	708 (7.1%)	25410 (84.0%)	4828 (16.0%)	24393 (89.9%)	2744 (10.1%)
FY 04-05	16365 (90.7%)	1672 (9.3%)	11806 (92.2%)	1003 (7.8%)	24892 (82.5%)	5282 (17.5%)	28083 (87.0%)	4215 (13.0%)

Figure 4. Average Number of Acute Care Days by District, Medicaid Status and Year



Thus, overall it appeared that acute care utilization increased from baseline to follow-up in the comparison districts, particularly for persons on Medicaid. In contrast, acute care utilization appeared to perhaps decrease slightly in District 1, particularly for persons not enrolled in Medicaid.

State Hospital Utilization

The rate of state hospital utilization (percentage of people that were served in the state hospitals) by District, Medicaid enrollment status and year are shown in Table 5. Inspection of this table shows that the rates differ by Medicaid enrollment status. Generally, the overall rate of state hospital utilization was higher in District 1 than in the comparison districts, and the rate increased slightly from baseline to follow-up. However, for Medicaid enrollees in District 1, the rate of state hospital utilization was significantly higher overall, but fell from baseline to follow-up.

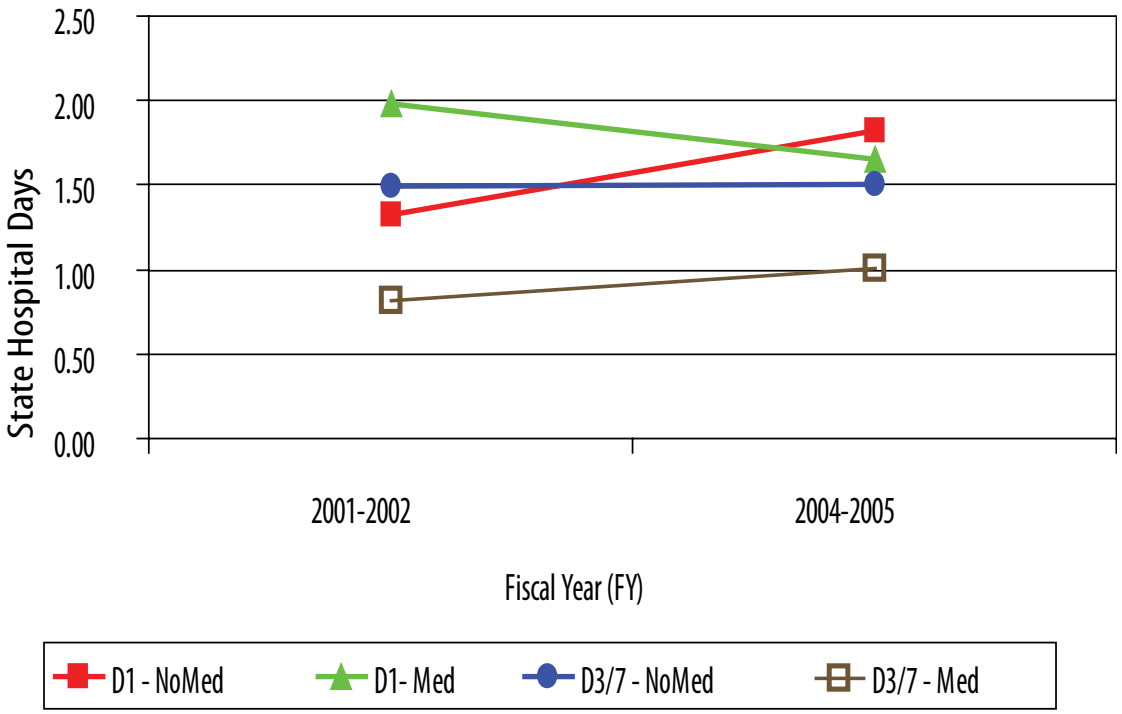
A graph of the average number of days of state hospital use by District, Medicaid enrollment status and year are shown in Figure 5. An analysis of variance indicates that neither the effect of time nor the interaction of time by area were significant, which means that overall, state hospitalization usage did not change over time and the areas did not differ in state hospital usage over time. The 3-way interaction of area, time and Medicaid status was marginally significant ($F(1,169914) = 5.99$, $p < .015$), and the pattern was similar to that for the utilization rate. That is, persons enrolled in Medicaid

Table 5. Number of Persons served in the State Hospitals by District, Medicaid Status and Year

	District 1				District 3 & 7			
	Not on Medicaid		On Medicaid		Not on Medicaid		On Medicaid	
	No SMH* Care	Used SMH Care	No SMH Care	Used SMH Care	No SMH Care	Used SMH Care	No SMH Care	Used SMH Care
FY 01-02	9233 (99.10%)	84 (0.90%)	9739 (98.25%)	173 (1.75%)	30067 (99.43%)	171 (0.57%)	26992 (99.47%)	145 (0.53%)
FY 04-05	17864 (99.04%)	173 (0.96%)	12638 (98.67%)	171 (1.33%)	29975 (99.34%)	199 (0.66%)	32097 (99.38%)	201 (0.62%)

*SMH=state mental hospital

Figure 5. Average State Hospital Days by District, Medicaid Status and Year



in District 1 had the highest usage at baseline, but their usage fell at follow-up; whereas the others groups' usage increased slightly from baseline to follow-up.

Arrest Data

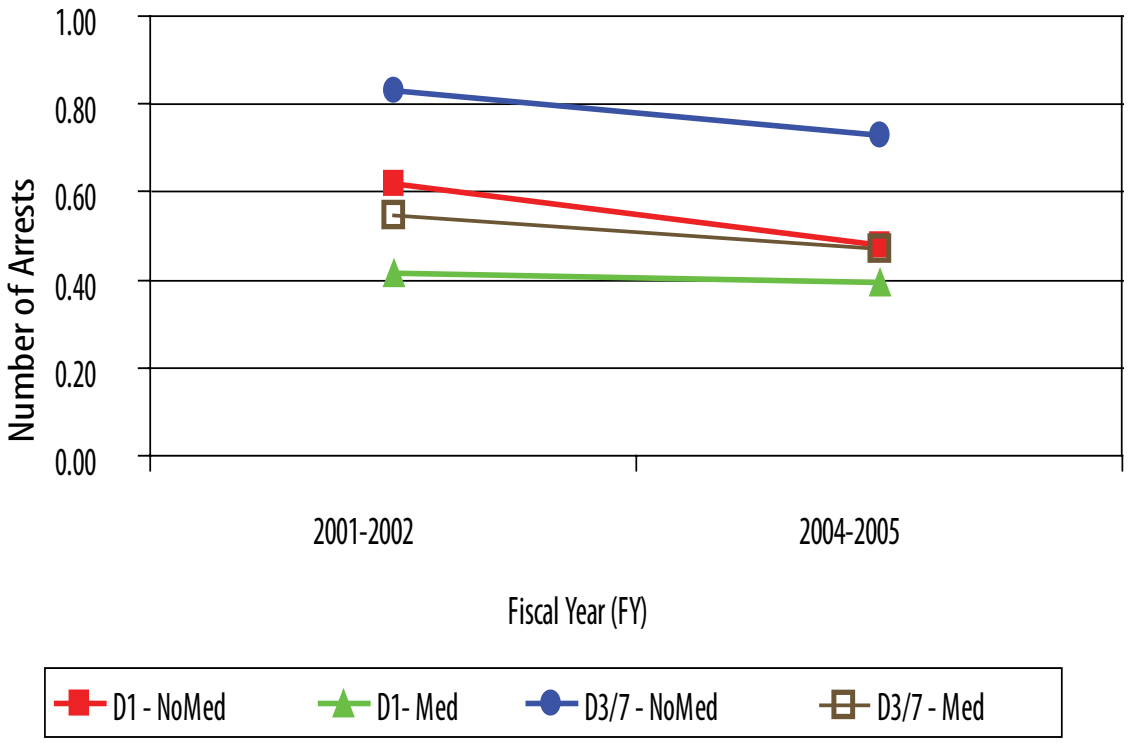
The rate of arrest (percentage of people that were arrested at least once) by District, Medicaid enrollment status and year are shown in Table 6. Inspection of this table shows that the rates differ only slightly by Medicaid enrollment status (the arrest rate for Medicaid enrollees in District 1 did not fall as much as the rate for the other groups). Overall, the arrest rate was slightly lower in District 1 than in the comparison districts, but the arrest rate decreased a little more in the comparison districts than in District 1.

A graph of the average number of arrests by District, Medicaid enrollment status and year are shown in Figure 6. This graph indicates that the average number of arrests parallels the data on arrest rates. The Medicaid enrollees in District 1 had the lower average number of arrests but also had the lowest decrease from baseline to follow-up. The interaction of area by time was not significant, meaning that the change in number of arrests from baseline to follow-up did not differ for District 1 and the comparison districts.

Table 6. Number of Persons with at least one Arrest by District, Medicaid Status and Year

	District 1				District 3 & 7			
	Not on Medicaid		On Medicaid		Not on Medicaid		On Medicaid	
	No Arrests	>= 1 Arrest	No Arrests	>= 1 Arrest	No Arrests	>= 1 Arrest	No Arrests	>= 1 Arrest
FY 01-02	7005 (75.2%)	2312 (24.8%)	8157 (82.3%)	1755 (17.7%)	22569 (74.6%)	7669 (25.4%)	22146 (81.6%)	4991 (18.4%)
FY 04-05	14553 (80.7%)	3484 (19.3%)	10672 (83.3%)	2137 (16.7%)	23599 (78.2%)	6575 (21.8%)	27567 (85.3%)	4731 (14.7%)

Figure 6. Average Number of Arrests by District, Medicaid Status and Year



Administrative Cost Analysis Results

As shown in Table 7, there appeared to be little change in the administrative cost percentage in District 1 over the five fiscal years shown (one year prior to implementation of the pilot project through the first four years of operation of the pilot project). However, when the additional administrative cost associated with the managing entity is factored in, the overall percentage of administrative cost appears to increase significantly with the implementation of the pilot project. In other words, the implementation of the pilot project did not appear to result in an associated decrease in administrative costs at the district level, the overall administrative expenditures including the managing entity were higher than the overall administrative costs before implementation. This is consistent with the report of the key stakeholders. Note that the overall administrative expenditure rates observed in District 1 are clearly lower than the 10% rate permitted by the legislation. The administrative expenditure rates observed in the comparison districts were essentially unchanged over the same five year period, and these rates were lower overall than the base administrative expenditure rate in District 1. Note, however, that the budgets for the comparison districts on average were much larger than that in District 1, thus, the lower administrative expenditures rate may be due to "economy of scale" issues.

Summary for District 1

Implementation of the financing strategies in District 1 appears to be well established. Contracting with a managing entity has yielded some important benefits, but it has taken time for the managing entity to fully assume its role of managing the service delivery system. In the initial years, organizational structures and relationships had to be developed and roles for the managing entity and the district DCF/SAMH office needed to be clarified. While some agencies argued that there is no need for both a managing entity and a District DCF/SAMH office, especially when considering the resources needed to support both, the DCF/SAMH staff have indicated that they are now more able to address system

Table 7. DCF/SAMH District Administrative Expenditures by Fiscal Year in District 1 and Comparison Districts

	FISCAL YEAR				
	2001-02	2002-03	2003-04	2004-05	2005-06
District 1					
Managing Entity Contract Total	$0.00	$13,531,085.44	$13,689,165.00	$13,634,258.00	$13,719,370.00
Services	$0.00	$13,192,808.30	$13,346,935.88	$13,293,401.55	$13,273,490.48
Administrative	$0.00	$338,277.14	$342,229.13	$340,856.45	$445,879.53
Services (non-ME)	$17,339,380.19	$5,298,943.62	$5,435,492.83	$5,792,489.99	$5,689,252.54
Administrative (non-ME)	$469,295.76	$457,768.33	$503,999.13	$525,955.68	$522,241.33
Other (OCO and Hurricane-related)	$1,842.00	$0.00	$4,116.84	$1,965,386.59	$2,930,858.51
Total	$17,808,675.95	$19,287,797.39	$19,628,656.96	$19,952,703.67	$19,930,863.87
Percent Administrative -- Base	2.64%	2.37%	2.57%	2.64%	2.62%
Percent Administrative -- Total (inc. ME)	2.64%	4.13%	4.31%	4.34%	4.86%
District 3 and 7 (averaged together)					
Managing Entity Contract Total	$0.00	$0.00	$0.00	$0.00	$0.00
Services	$0.00	$0.00	$0.00	$0.00	$0.00
Administrative	$0.00	$0.00	$0.00	$0.00	$0.00
Services (non-ME)	$30,492,922.19	$32,870,205.73	$32,904,090.80	$34,420,780.33	$37,049,926.21
Administrative (non-ME)	$523,262.56	$563,735.85	$557,029.08	$589,902.84	$543,406.88
Other (OCO and Hurricane-related)	$0.00	$0.00	$0.00	$489,723.06	$1,349,157.47
Total	$31,016,184.75	$33,433,941.58	$33,461,119.88	$35,010,683.17	$37,593,333.09
Percent Administrative -- Base	1.69%	1.69%	1.66%	1.68%	1.45%
Percent Administrative -- Total (inc. ME)	1.69%	1.69%	1.66%	1.68%	1.45%

* ME = managing entity

** OCO = operating capital outlay

development issues without having to deal with the daily operational issues for which the managing entity is responsible. Providers are also appreciative of the fact that the managing entity has a greater understanding of their issues, since they are part of a provider agency. Providers also appreciate the technical assistance and consultation they can access through the managing entity.

Stakeholders have indicated that there has been variable progress in meeting the 13 original goals established in the enabling legislation. However, there was some agreement that there have been improvements in the continuity of care across agencies, reducing hospitalizations, and using data for managing the service system. There are still some areas needing improvement, such as services to people who reside in assisted living facilities and children and families who are in the child welfare system. Most stakeholders did feel that access to services had improved and that they were serving more individuals than previously. However, stakeholders were quick to point out that there have been no increases in DCF funding.

Analysis of the administrative data indicates that the intervention was associated with a significant increase in the number of persons served in the DCF/SAMH system from the baseline period to the follow-up period. This increase was larger for persons not enrolled in Medicaid. The data also indicated a significant difference in the change in acute care usage (both in terms of number of persons and number of days) from baseline to follow-up in District 1 compared to Districts 3 and 7. District 1 had a decline in acute care usage, whereas the comparison districts had a increase in acute care usage. The intervention was associated with little or no change in Baker Act examinations, state hospital usage, or arrests from baseline to follow-up in District 1 compared to Districts 3 and 7. Overall, District 1 had lower rates of Baker Act examinations, acute care services, and arrests than the comparison districts, but had a higher rate of usage of the state hospitals.

There was little change in the base administrative expenditures rate in District 1 from the year prior to implementation of the pilot through the first four years of operation of the pilot project. When the administrative cost associated with the managing entity was factored in, however, the administrative expenditure rate increased significantly. However, the overall administrative expenditure rates observed were still clearly lower than the 10% rate permitted by the legislation.

District 8 Results

This year (FY2005-2006) nearly concludes the third year of implementation of the redesign strategy in District 8. Central Florida Behavioral Health Network, an administrative services organization (ASO), has been contracted by the District 8 DCF/ SAMH office to conduct a series of tasks to improve the District's behavioral health system. The District 8 DCF/ SAMH office continues to contract directly with providers for all general revenue funded mental health and addiction treatment services, using the standard unit-cost based financing as most other districts. The funding structure for behavioral health services in District 8 is depicted in Figure 2 (page 5).

Key Informant Results

Several themes emerged from interviews conducted with District 8 key informants, including ones that center on the accomplishments or value-added of the ASO experiment, challenges in the process, expectations people had for the project and how those were or were not met, recommendations for District 8 going forward, and recommendations to other Districts regarding managing entities or ASOs.

Accomplishments and the Value-Added

The majority of people interviewed feel that the District 8 project contributed to the Southwest Florida Behavioral Health Network becoming stronger and to the providers working together more. One person reported that provider communication is at an "all time high". Communication between the providers and the consumer advocacy group, National Alliance on Mental Illness, also increased. The Board of the Network meets monthly and the chair changes annually. A National Alliance on Mental Illness representative was added to the Board during the past year. A Central Florida Behavioral Health Network representative from their District 8 office has been attending these meetings, and the chief executive officer of the local community based care provider attended some of the meetings. Several of the key informants offered a recent example of their collaboration. The District is receiving a significant amount of new money for addiction treatment services (e.g., 45% increase or approximately $2 million dollars). The District Office asked the network for a plan on how to spend the money. The network worked together to create a plan to initiate some addiction treatment services in Charlotte County, and the plan was accepted by the District Office. The key informants that discussed this example seemed pleased with both the process and the outcome.

Several of the respondents noted that the trainings on evidenced-based practices conducted or sponsored by the ASO was value-added. The training on evidence-based care focused on services for people with co-occurring mental health and substance use disorders, motivational interviewing, person-centered planning, and supported employment. Some direct care staff and fewer supervisors from most of the five main centers participated in the trainings. ASO staff did the co-occurring disorders training, which was based on a curriculum, for about 40 people across all five centers. The supported employment online course by the University of Virginia took place over twelve weeks, for approximately 30 people. Baseline Recovery Assessments were completed to point where providers need to go in this area. Some of the respondents noted the ASO's work in these areas was a different focus than the "monitoring" they were used to receiving and appreciated the quality improvement focus.

Some reported that the consumer affairs staff member helped make the system more recovery-oriented and consumer-centered. She established advocacy groups in each county and helped them identify their priorities, taught advocacy skills and assisted with peer network development. She was involved in state activities in this area as well, and brought that information back to the District.

The data liaison employed by the ASO was seen as helpful and knowledgeable. She provided technical assistance to the providers regarding the required data reports. Perhaps as a result, the quality of the data improved. Performance on the state outcomes measures (e.g., completing treatment, employment at discharge, days in the community) improved for the district, and this was seen as a result of both the quality of the data improving, and at least one of the key informants attributed it to improved services.

Challenges

Key informants identified five challenges during the course of the project. Half of those interviewed said that the fact that the ASO never managed any contracts or contract funds in the district as part of its tasks was a significant challenge or barrier to the project developing more fully. This was mentioned several times by many of the respondents during the course of the interviews. Slightly less than half of the respondents said that there were not clear goals for the ASO; and/or they were not well communicated to the ASO and the other stakeholders; and that there was a lack of understanding of the role of the ASO. There was no "public decree" or other communication about its role and the goals. It was suggested by a couple of respondents that the contract language between the District Office and Central Florida Behavioral Health Network was not specific enough and the list of tasks not long enough, or that they were not written in a way that would lead to the accomplishment of the goals originally discussed.

Some of the respondents noted that there was turnover in the Director position of the ASO's District 8 office and that there were some issues with lack of experience, knowledge or specific skills of the staff they recruited. Some stakeholders reported that there was a "disconnect" between DCF and AHCA that presented a challenge. AHCA has been focusing on other statutory language regarding behavioral health services and procuring a separate managed care plan for the district, which was implemented in March 2007. Two other barriers mentioned included that core behavioral health services are under-funded (e.g., acute care services) and there was little focus on children's issues by the ASO (that they mostly focused on adults with severe mental illnesses and/or co-occurring disorders).

Expectations

Stakeholders mentioned several expectations for the ASO that they felt were not met. Besides the previously mentioned expectation that the ASO would manage contracts with the providers and manage funds, the next most common unmet expectation was that the five main providers, at least, would share a common management information system, so they could examine service utilization data and transfer people between their agencies more easily. Several thought the ASO activities would result in a single point of access, a better intake/assessment process, and increased access to care. Some expected that, as a district, there would be a system-wide approach to measuring quality and that they would measure outcomes in a better way than what is available at the state level. The ASO did some analyses of the personal outcomes measures data, but more was expected by the stakeholders. Some thought there would have been more done with the jail database that was developed. It was retrospective (not real-time), so it was not used to improve care for people in jail or for those being released. One expectation that at least some people had that was at least partially met involved increased quality of care. The exposure of some staff to evidence-based practices sets the stage for real implementation of those practices through the next Invitation to Negotiate that is expected in the future for quality improvement activities.

Progress Toward Goals

The thirteen goals that were included in the enabling statute for this pilot project were noted by respondents to be important goals to achieve and that they have collectively worked on them either with the ASO or separately to varying degrees. The goal about improving the quality of services was noted to have been worked on the most as a result of this pilot project. Stakeholders thought that the first goal regarding improved accountability was met given all the work done on improving the district's outcome data that is required by the state. The goals of improved assessment of local needs for behavioral health services, improved service integration with other systems, and improved use of data for planning and monitoring purposes were at least partially achieved.

The other eight goals (i.e., improved continuity of care, early diagnosis and treatment, flexible and creative funding, controlling costs, reduced admissions and lengths of stay for dependent children in inpatient or residential, treatment plans for abused and neglected children, coordination between admission and discharges from state hospitals, and work with assisted living facilities) were said to have not been addressed by this ASO project. Some stakeholders felt the two goals regarding dependent children were being addressed by the community based care provider. There are no assisted living facilities for people with behavioral health disorders in District 8.

It was anticipated by the legislature that these new pilot managing entities or ASOs would have a positive impact on the timeliness of service delivery, effectiveness of treatment services, cost effectiveness of service, and consumer satisfaction with services. In District 8, most of the key informants that were interviewed said the ASO did not have an impact on the timeliness of service delivery, but did note that other activities in the district during the past three years have increased timeliness of services. For example, one or more national grants were referenced that focused on increasing access to care and the timeliness of the access. Two respondents thought the ASO did have an impact in this area and two respondents said they did not know if the ASO had an impact on this aspect of care in their district.

In terms of the ASO impact on the effectiveness of treatment services, most said there was probably some improvement in this area as a result of the ASO. Some referenced the trainings done by the ASO on evidence based practices and that the state outcome data for their district had improved. Again, three respondents said they did not know whether this area had improved as a result of the ASO and one respondent noted it is too early to measure this. In terms of the ASO impact on the cost effectiveness of treatment services, most respondents said there was no impact. Two people said perhaps there might have been an impact because better quality services (as a result of the evidence based trainings) can translate into more cost effective care. One respondent suggested there had been a negative impact on cost effectiveness of care as a result of the ASO. In terms of ASO impact on consumer satisfaction with services, most respondents said there had been a positive impact by the ASO in this area. They referred to the work done by the person who holds the consumer affairs position at the ASO in District 8, including her focus groups with consumers, helping providers to be more consumer friendly, and generally getting consumers more involved in their care and in the system. Others mentioned the personal outcome measures as helpful and the ASO had some involvement in that initiative. Two respondents noted they did not know if there was any impact; one of said the state does not conduct a statewide consumer satisfaction survey that would give them this information.

Stakeholders Recommendations for District 8

Stakeholders were asked for their recommendations for District 8 going forward. The District Office reports that the special allocation for the ASO services will still be available to the District going forward. The most frequent recommendation was for the District Office to contract with the provider network for the ASO functions. Other recommendations for their district included:

- District Office should have the network/ASO do the contracting and manage funds;
- Continue with quality improvement activities;
- Continue with the self-directed care project and personal outcomes measures;
- Increase consumer and family education within the provider agencies; and
- Integrate DCF and Medicaid policies, procedures, and managing entities more.

Stakeholders Recommendations for Other Districts

Stakeholders were asked for their recommendations to other districts in the state given their experience over the past four years with this pilot project. The most common recommendation was to "get everyone on the

same page", to have clear goals for the ASO or managing entity, and ensure the state is a strong purchaser. It was recommended to do "due diligence" at the onset. Some recommended to have the ASO/ME manage contracts and funds, and others recommended not using this model. Other recommendations included:

- MEs are necessary to achieve system transformation goals, but there should be one managing entity per district, or at least there should be fewer MEs; there are too many "managing entities" (e.g., Medicaid Pre-paid Mental Health Plan, Medicaid health maintenance organizations (HMOs), commercial HMOs, DCF, Medicaid, ASO). There should be one single ME (e.g., some states have community service boards at the county level);
- Don't create additional layers of infrastructure in this under-funded system;
- Don't fund the ASO/ME with service dollars;
- Identify an ASO/ME that is from your community or is familiar with the demographics, providers, and other factors in your district;
- Identify what kinds of ME/ASO types of services your district needs and pick multiple vendors if needed to accomplish these; don't limit yourself to one vendor, especially if no one vendor has the experience or interest in the needed activities;
- Have a consumer affairs/ representative as part of the ASO; it is a "good home" for this position, especially since DCF only allows this position to be funded as "other personnel services" (OPS) in the District Offices;
- Implement self-directed care as part of the continuum of care;
- Focus on workforce development and follow through on the implementation of evidence-based care and best practices through the managing entity/ ASO;
- Establish data goals (e.g., common management information system) as one of the first activities; and
- Look at mergers or other economies of scale across providers.

Summary

Despite most stakeholders feeling disappointed with the process and outcome of this pilot project, they did note accomplishments in the important areas of strengthening the provider network, quality improvement (i.e., training on evidence-based practices), consumer advocacy and involvement, and improved outcome data reporting to Tallahassee. Systems change/ transformation/ redesign takes years and multiple strategies. There was progress and lessons learned through this ASO project that will eventually take the District "to the next level" as a system.

Administrative Data Analysis Results

Table 8 shows the number of persons served in the DCF/SAMH system in District 8 and in the comparison districts in the baseline year and the follow-up year. The comparison districts served a larger percentage of the districts' population overall; however, District 8 had a larger increase in the number and the percentage served from the baseline year to the follow-up year than the comparison districts.

Table 9 contains information on the number of persons enrolled in Medicaid in District 8 and in the comparison districts during the baseline and follow-up years. The comparison districts had a larger percentage of their service recipients enrolled in Medicaid overall. However, District 8 actually had a larger percentage increase in number of persons enrolled in Medicaid than the comparison districts. The percentage of service recipients enrolled in Medicaid during the year declined from baseline to follow-up in District because of the large increase in the number of persons served who were not enrolled in Medicaid.

Baker Act Examinations

The rate of Baker Act examination (percentage of people that had at least one Baker Act examination) by District, Medicaid enrollment status and year are shown in Table 10. Inspection of this table shows that the rates differ by only a small amount as a function of Medicaid enrollment status. Overall, the rates of having a Baker Act examination were slightly lower in the comparison districts than in District 8. Baker Act examination rates rose from the baseline period to follow-up in District 8, but the rates of having a Baker Act examination fell from baseline to follow-up in the comparison districts. Baker Act examination rates went from 16.3% at baseline to 14.9% at follow-up in the comparison districts (a 9% decrease), whereas, Baker Act examination rates went from 15.5% at baseline to 16.5% at follow-up in District 8 (a 7% increase).

Table 8. Persons using the DCF/SAMH system in District 8 and Comparison Districts

	District 8		District 15 & SunCoast Region	
	# of Persons	% of District Population	# of Persons	% of District Population
FY 02-03	13,619	1.39%	80,691	2.26%
FY 04-05	17,319	1.63%	89,041	2.38%

Table 9. Persons using the DCF/SAMH system in District 8 and Comparison Districts that were enrolled in Medicaid during each study period

	District 8		District 15 & SunCoast Region	
	Not on Medicaid (%)	On Medicaid (%)	Not on Medicaid (%)	On Medicaid (%)
FY 02-03	7,796 (57.2%)	5,823 (42.8%)	39,236 (48.6%)	41,455 (51.4%)
FY 04-05	10,532 (60.8%)	6,787 (39.2%)	43,174 (48.5%)	45,867 (51.5%)

A graph of the average number of Baker Act examinations by District, Medicaid enrollment status and year are shown in Figure 7. Inspection of this figure shows that the average number of Baker Act examinations differs only slightly as a function of Medicaid enrollment status (none of the effects involving Medicaid was more than just marginally significant in the analysis of variance). Overall, the people served in District 8 had a marginally lower average number of Baker Act examinations, than the persons served in the comparison districts ($F(1,200662) = 5.57$, $p < .02$). Overall, the average number of Baker Act examinations rose slightly from the baseline period to follow-up ($F(1,200662) = 7.55$, $p < .01$). And finally, the average number of Baker Act examinations decreased in the comparison districts, whereas it increased in District 8 ($F(1,200662) = 14.38$, $p = .0001$). The average number of examinations fell from 0.243 to 0.228 in the comparison districts (a 6% decrease), but it increased from 0.211 to 0.235 in the comparison districts (an 11% increase).

Thus, Baker Act examinations and rates appeared to increase somewhat in District 8, but decreased somewhat in the comparison districts.

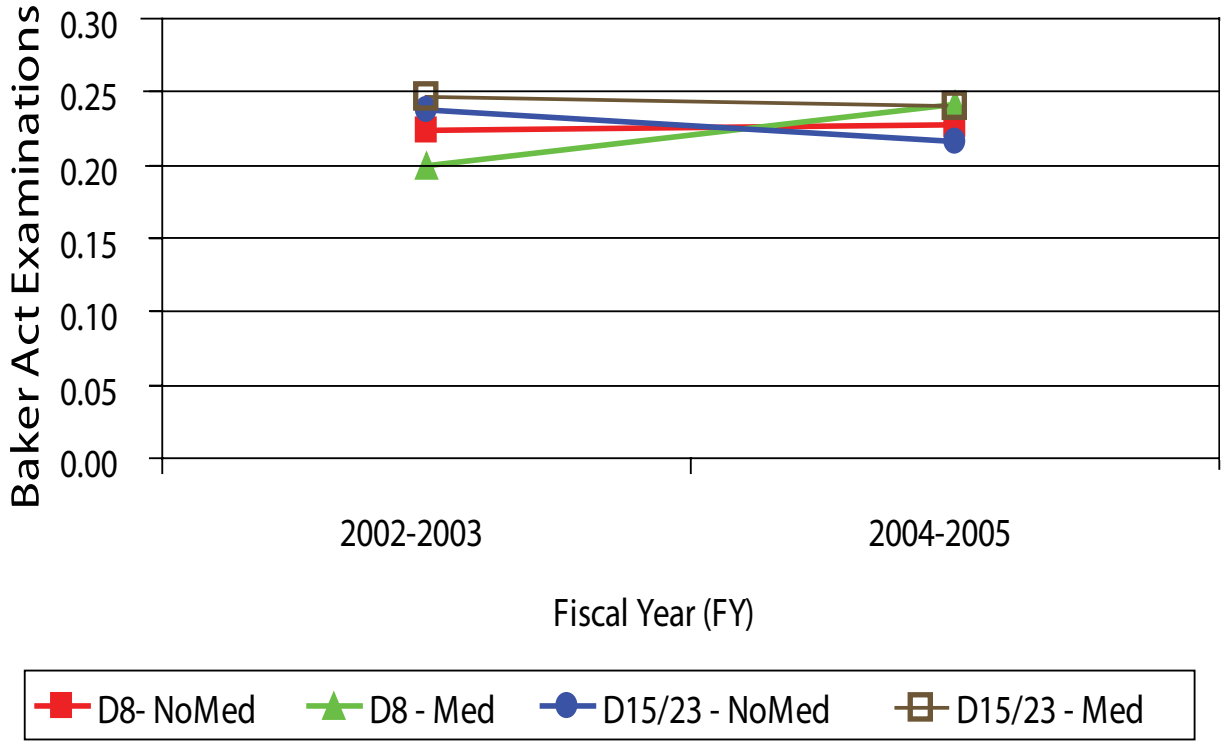
Acute Care Service Utilization

The rate of acute care utilization (percentage of people that used acute care) by District, Medicaid enrollment status and year are shown in Table 11.

Table 10. Number of Persons with a Baker Act Examination by District, Medicaid Status and Year

	District 8				District 15 & SunCoast Region			
	Not on Medicaid		On Medicaid		Not on Medicaid		On Medicaid	
	No Exams	>= 1 Exam	No Exams	>= 1 Exam	No Exams	>= 1 Exam	No Exams	>= 1 Exam
FY 02-03	6459 (82.8%)	1337 (17.2%)	5050 (86.7%)	773 (13.3%)	32211 (82.1%)	7025 (17.9%)	35294 (85.1%)	6161 (14.9%)
FY 04-05	9661 (82.2%)	1871 (17.8%)	5794 (85.4%)	993 (14.6%)	36243 (83.9%)	6931 (16.1%)	39523 (86.2%)	6344 (13.8%)

Figure 7. Average Number of Baker Act Examinations by District, Medicaid Status and Year



Inspection of this table shows that the rates differ somewhat by Medicaid enrollment status. Overall, the rates of acute care utilization were higher in District 8 than in the comparison districts. Further, the acute care utilization rates fell in the comparison districts from baseline to follow-up (14.1% to 12.6%) whereas the rates actually increased somewhat in District 8 (21.5% to 24.0%).

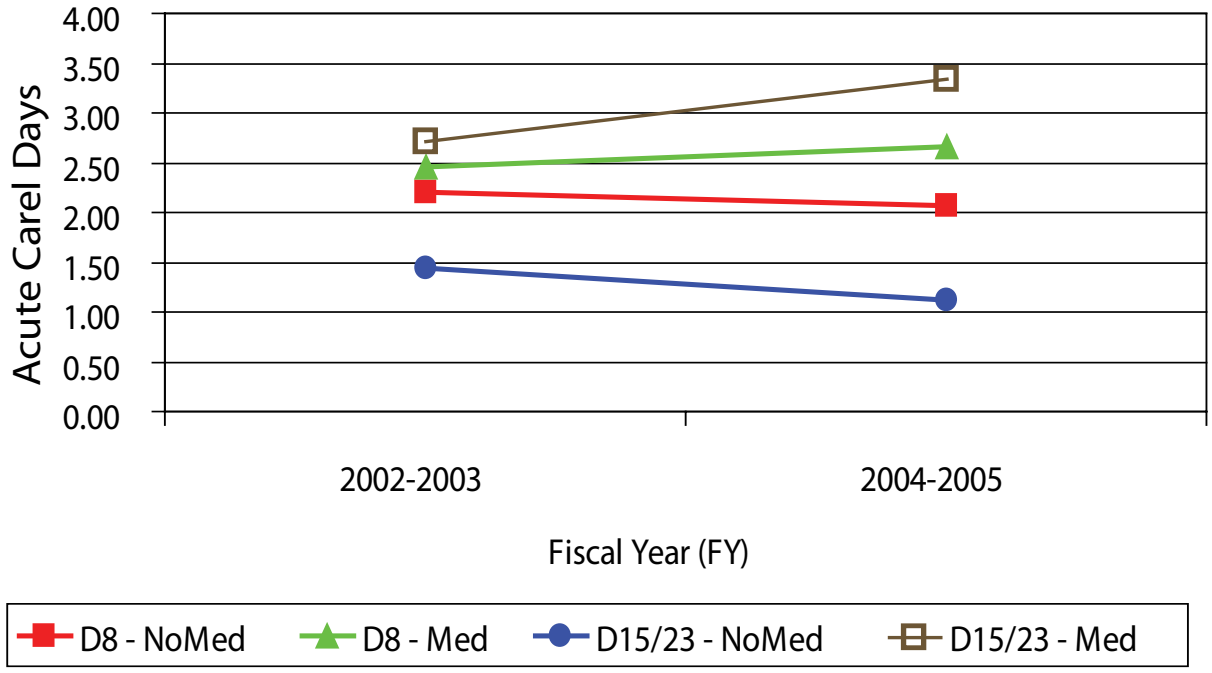
A graph of the average number of days of acute care use by District, Medicaid enrollment status and year are shown in Figure 8. This analysis produced a strikingly different result than the analysis of the penetration rates above. The average number of days of acute care did not differ by district, by time, or by district over time (i.e., the areas did not differ over time in the change in the average number of acute care days). However, Medicaid enrollees had higher average number of acute care days and this was more pronounced in the comparison districts than in District 8. Medicaid enrollees had higher numbers of acute care days in the follow-up year than in the baseline year, whereas, the persons not in Medicaid had lower numbers of acute care days from baseline to follow-up.

Thus, while there was a increase in the number of people who were in acute care in District 8 relative to the comparison districts, there did not appear to be any difference between District 8 and the comparison districts on the change in the average number of acute care days from baseline to follow-up. However, there were differences in the change in acute care days from baseline to follow-up associated with Medicaid enrollment.

Table 11. Number of Persons with Acute Care Service Utilization by District, Medicaid Status and Year

	District 8				District 15 & SunCoast Region			
	Not on Medicaid		On Medicaid		Not on Medicaid		On Medicaid	
	No Acute Care	Used Acute Care	No Acute Care	Used Acute Care	No Acute Care	Used Acute Care	No Acute Care	Used Acute Care
FY 02-03	5807 (74.5%)	1989 (25.5%)	4887 (83.9%)	936 (16.1%)	32295 (82.3%)	6941 (17.7%)	37042 (89.3%)	4413 (10.7%)
FY 04-05	7593 (72.1%)	2939 (27.9%)	5570 (82.1%)	1217 (17.9%)	36948 (85.6%)	6226 (14.4%)	40838 (89.0%)	5029 (11.0%)

Figure 8. Average Number of Acute Care Days by District, Medicaid Status and Year



State Hospital Utilization

The rate of state hospital utilization (percentage of people that were served in the state hospitals) by District, Medicaid enrollment status and year are shown in Table 12. Inspection of this table shows that the rates differ by Medicaid enrollment status. Medicaid enrollees were less likely to be served in the state hospitals and their utilization dropped more from baseline to follow-up than utilization for persons not enrolled in Medicaid. The overall rate of state hospital utilization was lower in District 8 than in the comparison districts, and the rate of utilization fell more in District 8 from baseline to follow-up (25%) than it did in the comparison districts (6%).

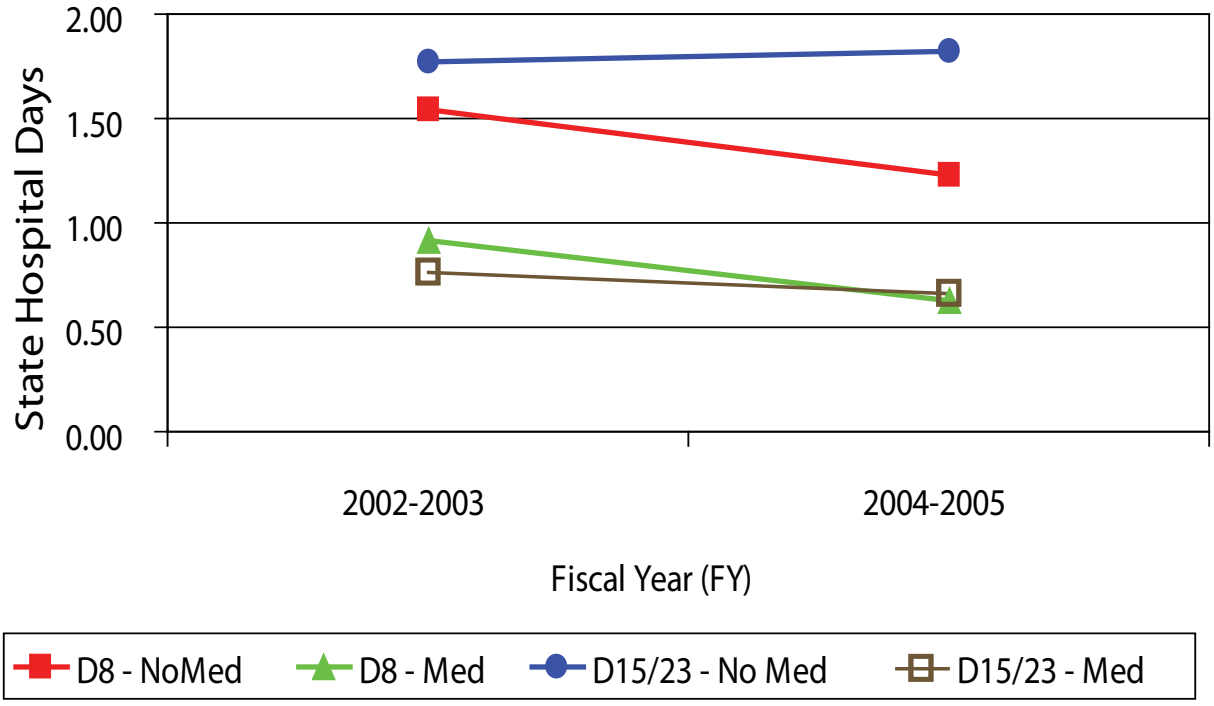
A graph of the average number of days of state hospital use by District, Medicaid enrollment status and year are shown in Figure 9. The analysis of variance indicates that only the effect of Medicaid enrollment was statistically reliable. Although not statistically significant, the average number of days of state hospital usage dropped by .30 days in District 8 from baseline to follow-up, but it dropped only .03 days in the comparison districts. (This effect may have failed to be reliable due to the large variability in the number of days in the state hospital in the data. For example, over 99% of the cases had 0 days in the state hospital, but for those that had more than 0 days, about one fourth of the cases were in the state hospital for the entire year).

Table 12. Number of Persons served in the State Hospitals by District, Medicaid Status and Year

	District 8				District 15 & SunCoast Region			
	Not on Medicaid		On Medicaid		Not on Medicaid		On Medicaid	
	No SMH* Care	Used SMH Care	No SMH Care	Used SMH Care	No SMH Care	Used SMH Care	No SMH Care	Used SMH Care
FY 02-03	7740 (99.28%)	56 (0.72%)	5788 (99.40%)	35 (0.60%)	38937 (99.24%)	299 (0.76%)	41253 (99.51%)	202 (0.49%)
FY 04-05	10470 (99.41%)	62 (0.59%)	6763 (99.65%)	24 (0.35%)	42853 (99.26%)	321 (0.74%)	45671 (99.57%)	196 (0.43%)

* SMH = state mental hospital

Figure 9. Average State Hospital Days by District, Medicaid Status and Year



Arrest Data

The rate of arrest (percentage of people that were arrested at least once) by District, Medicaid enrollment status and year are shown in Table 13. Overall, the arrest rate was slightly lower in District 8 than in the comparison districts, and the arrest rate decreased slightly more in District 8 (20.8% to 18.5% -- an 11% decrease) than in the comparison districts (23.3% to 21.3% -- an 8% decrease).

A graph of the average number of arrests by District, Medicaid enrollment status and year are shown in Figure 10. This graph indicates that arrests went down in both areas and that persons enrolled in Medicaid had fewer arrests than those not on Medicaid. Persons in District 8 had fewer arrests than those in the comparison districts. And most importantly, the average number of arrests fell more for persons in District 8 than it did in the comparison districts.

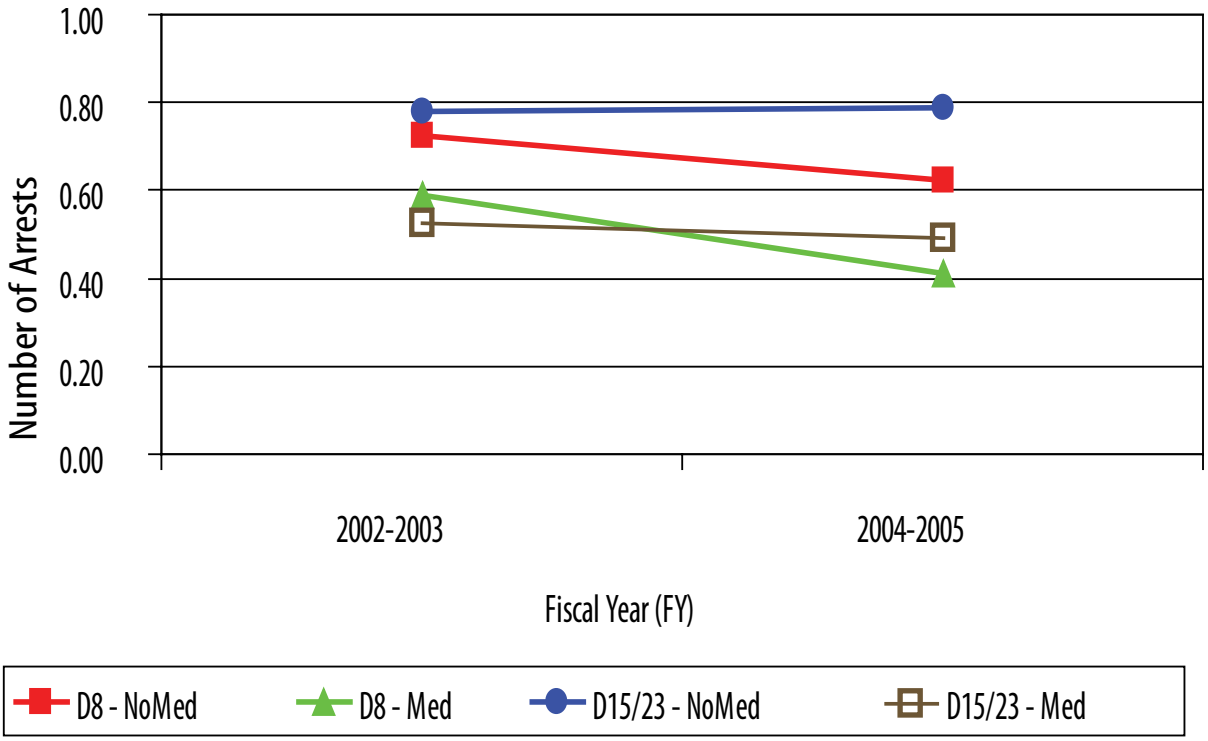
Administrative Cost Analysis

As shown in Table 14, there appeared to be little change in the base administrative cost percentage in District 8 over the five fiscal years shown (two years prior to implementation of the pilot project through the first three years of operation of the pilot project). However, when the additional administrative cost associated with the ASO is factored in, the overall percentage of

Table 13. Number of Persons with at least one Arrest by District, Medicaid Status and Year

	District 8				District 15 & SunCoast Region			
	Not on Medicaid		On Medicaid		Not on Medicaid		On Medicaid	
	No Arrests	>= 1 Arrest	No Arrests	>= 1 Arrest	No Arrests	>= 1 Arrest	No Arrests	>= 1 Arrest
FY 02-03	5999 (76.9%)	1797 (23.1%)	4790 (82.3%)	1033 (17.7%)	28648 (73.0%)	10588 (27.0%)	33282 (80.3%)	8173 (19.7%)
FY 04-05	8283 (78.7%)	2249 (21.3%)	5834 (86.0%)	953 (14.0%)	32118 (74.4%)	11056 (25.6%)	37951 (82.7%)	7916 (17.3%)

Figure 10. Average Number of Arrests by District, Medicaid Status and Year



administrative cost appears to increase significantly with the implementation of the pilot project. In other words, the implementation of the pilot project did not appear to result in an associated decrease in administrative costs at the district level, the overall administrative expenditures including the managing entity were higher than the overall administrative costs before implementation. This is consistent with the report of the key stakeholders. Note that the overall administrative expenditure rates observed in District 8 are clearly lower than the 10% rate permitted by the legislation. The administrative expenditure rates observed in the comparison districts increase somewhat over the same five year period, but these rates were still lower overall than the administrative expenditure rate in District 8. The larger comparison district (the SunCoast Region) utilizes a managing entity (District 15 does not utilize a managing entity); however, the budgets for the comparison districts on average (and for the managing entity in the SunCoast Region) were much larger than the budgets in District 8. Thus, the lower administrative expenditures rate may be due to "economy of scale" issues.

Summary for District 8

Despite most stakeholders feeling disappointed with the process and outcome of this pilot project, they did note accomplishments as a result of the ASO pilot in the important areas of strengthening the provider network, quality improvement (i.e., training on evidence-based practices), consumer advocacy and involvement, and improved outcome data reporting to the DCF data warehouse. The challenges seemed to stem from a lack of clarity among the key stakeholders about the goals and role of the ASO at the initiation of the project coupled with an ASO that did not have experience functioning as the unique kind of managing entity model that was being sought in District 8 (i.e., that does not manage contracts).

The District 8 pilot was a pioneer in the sense of trying a very different kind of "managing entity" model than what is currently being used in other districts. This pilot reminds us of the importance of being clear about the goals, communicating the goals continuously to all stakeholders, translating the goals carefully into contract language, matching expectations and services sought with a vendor that has experience and interest in delivering those services, and holding contractors accountable.

In terms of the thirteen goals and four areas of improvement that the Legislature designated for these pilots, there was some progress. Thirteen disparate goals are probably too many for this kind of a managing entity to realistically accomplish given the challenges posed by our under-funded and fragmented system. Nevertheless, the goals regarding quality, accountability, improved assessment of local needs, integration with other systems and improved use of data were thought by the key informants to have been impacted positively by the ASO. The other eight goals were either not seen as relevant for their community (e.g., there are no assisted living facilities in District 8) or the strategies used by the ASO ultimately did not impact the goals (e.g., improved continuity of care). Consumer satisfaction was thought to have improved because of the consumer affairs staff member at the ASO, timeliness of service and effectiveness of services were thought to have improved somewhat, but cost effectiveness of care was said to not have been affected by the ASO.

Key informants made several recommendations for their district going forward and for other districts. For their district, several of the key informants suggested discontinuing the ASO as it currently exists and to use the provider network, Southwest Florida Behavioral Health Network, as the contractor to conduct the quality management functions that the District DCF/SAMH Office would like done. They would also like contracting flexibility with the network possibly managing some contract funds. For other districts, their recommendations focused on coming to consensus on what the services are that the District Office wants to purchase and not limiting themselves to one vendor. It might be better to contract with multiple entities that perform distinct tasks given their experience, interest, and knowledge of the community rather than contracting with one entity to perform a wide variety of tasks that does not have experience or interest in some of them.

Systems change, systems transformation, or systems redesign takes years and multiple strategies. There was progress and lessons learned through this ASO project that will help them to get "to the next level" as a system. Several recommendations are offered for the next iteration of their systems change strategy.

Analysis of the administrative data for the District 8 pilot project indicates that the intervention was associated with a significant increase in the number of persons served in the DCF/SAMH system from the

Table 14. DCF/SAMH District Administrative Expenditures by Fiscal Year in District 8 and Comparison Districts

	FISCAL YEAR				
	2001-02	2002-03	2003-04	2004-05	2005-06
District 8					
Managing Entity Contract Total	$0.00	$0.00	$513,000.00	$513,000.00	$488,663.00
Services	$0.00	$0.00	$0.00	$0.00	$0.00
Administrative	$0.00	$0.00	$513,000.00	$513,000.00	$488,663.00
Services (non-ME)	$25,989,902.45	$30,159,709.21	$30,810,932.37	$30,983,519.50	$31,322,796.87
Administrative (non-ME)	$469,066.98	$465,530.28	$526,693.82	$599,370.62	$593,124.13
Other (OCO and Hurricane-related)	$0.00	$750,000.00	$0.00	$0.00	$1,960,231.06
Total (exc. OCO and Hurricane-related)	$26,458,969.43	$30,625,239.49	$31,850,626.19	$32,095,890.12	$32,404,584.00
Percent Administrative -- Base	1.77%	1.52%	1.65%	1.87%	1.83%
Percent Administrative -- Total (inc. ME)	1.77%	1.52%	3.26%	3.47%	3.34%
District 15 and 23 (averaged together)					
Managing Entity Contract Total	$1,908,124.00	$1,177,254.00	$3,524,393.50	$14,622,846.00	$17,135,654.50
Services	$1,640,986.64	$1,012,438.44	$3,101,466.28	$13,745,475.24	$16,107,515.23
Administrative	$267,137.36	$164,815.56	$422,927.22	$877,370.76	$1,028,139.27
Services (non-ME)	$46,253,211.17	$59,169,663.31	$56,251,202.58	$46,472,044.01	$45,184,290.90
Administrative (non-ME)	$554,723.38	$587,277.37	$645,403.73	$652,022.29	$639,229.31
Other (OCO and Hurricane-related)	$144,549.50	$1,056.50	$0.00	$626,554.54	$1,533,468.19
Total (exc. OCO and Hurricane-related)	$48,716,058.54	$60,934,194.68	$60,420,999.81	$61,746,912.30	$62,959,174.71
Percent Administrative -- Base	1.14%	0.96%	1.07%	1.06%	1.02%
Percent Administrative -- Total (inc. ME)	1.69%	1.23%	1.77%	2.48%	2.65%

* ME = managing entity
** OCO = operating capital outlay

baseline period to the follow-up period relative to the number of persons served in the comparison districts. This increase was larger for persons not enrolled in Medicaid. The data analysis indicated a significant difference in the change in arrest rates (both in terms of number of persons and number of arrests) from baseline to follow-up in District 8 compared to District 15 and the Suncoast Region. Both areas experienced a decrease in arrests and arrest rates, but District 8 had a larger decrease in both the number of arrests and the proportion of persons arrested than the comparison districts. Similarly, state hospital usage declined more in District 8 than in the comparison districts, however, this finding was not statistically reliable (probably due to extreme variability in the data). The data analysis indicated a significant difference in the change in Baker Act examination rates (both in terms of number of persons and number of arrests) from baseline to follow-up in District 8 compared to District 15 and the Suncoast Region. Baker Act examinations and rates went up in District 8, but declined in the comparison districts. The intervention was associated with little or no change in acute care services from baseline to follow-up in District 8 compared to District 15 and the Suncoast Region. Overall, District 8 had lower rates of arrest and state hospital usage than the comparison districts, but had a higher rate of usage of the acute care services.

There was little change in the base administrative expenditures rate in District 8 from the two years prior to implementation of the pilot through the first three years of operation of the pilot project. When the administrative cost associated with the managing entity was factored in, however, the administrative expenditure rate increased significantly. However, the overall administrative expenditure rates observed were still clearly lower than the 10% rate permitted by the legislation.

Overall Conclusions and Recommendations

Although the two pilot projects involved very different models, both projects were able to implement their models, and the projects have operated for several years. In District 1, the roles and responsibilities of the managing entity (relative to the DCF/SAMH district office) evolved over time, but the general expectations for the role of the managing entity was fairly well established from the outset. In contrast initially in District 8, there was considerable ambiguity regarding the role and future of the ASO resulting in some key participants being reluctant to support the project. This underscores the importance of establishing a clear role for the managing entity or ASO at the outset of the project.

Both pilot projects were able to at least partially meet a subset of the goals that were set forth in the legislation. However, in both cases several goals were not met. Overall, the goals that were set forth in the legislation appear to have been overly ambitious, particularly in light of the level of resources available to accomplish them. In some cases, goals were not relevant to the local district in which the project was established. In future projects prior to implementation, it will be very important to establish consensus on clear, reasonable, and measurable goals that are relevant to the local community in which the project is being established.

It was clear that administrative cost and administrative effort were increased as a result of the implementation of the projects. In District 8, some positive results were observed, but there seems to be some consensus among key stakeholders that the system had not benefited in proportion to the increase in administrative cost. In District 1, there continues to be concerns about the cost of supporting both a managing entity and a district office. In future projects, managing entities should have to demonstrate adequate value added to the system or be discontinued.

Initially, data systems were very problematic in both districts. However, over time significant progress was made in this area, both in the reporting of data and use of data to manage the system. More improvement is needed in this area, but the improvements to date are encouraging.

The Agency for Health Care Administration was only minimally involved in these demonstrations. The management, oversight, and funding of these projects were essentially entirely supplied by DCF. Little progress has been made on the integration of resources at the district level. Ongoing requirements related to state and federal funding continue to limit the capacity for managing entities to integrate these resources.

The addition of a consumer affairs position in the project in District 8 was seen as very positive by the key stakeholders in that District. In District 1, there is a consumer advisory council in place that has increased level of consumer involvement in the system. Future projects should develop ways to similarly increase consumer involvement.

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