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ABSTRACT

The National Health Planning and Resources Development Act of 1974 (PL 93-641) grants review authority to Health Systems Agencies (HSAs) which seek to improve the quality of health care and insure the rational expenditure of financial resources. Their review process necessitates the development of adequate mental health standards and criteria and better communication between community mental health centers (CMHCs) and HSAs. The Arthur D. Little (ADL) study which sought to determine the feasibility of developing guidelines, criteria, and standards for PL 93-641, identifies few of the mental health standards and review criteria developed by HSAs. Because CMHCs face data demands from multiple sources, HSAs should coordinate their data needs with other major mental health planning and review processes. The federal site visit process, the Joint Commission on Accreditation of Hospitals survey, and state licensing and review boards also request data from CMHCs. HSAs could use the National Standards for their standards and criteria, an approach which would reduce overlapping and conflicting CMHC assessment and monitoring procedures. (Author/MLT)

ISSUES RELATED TO REVIEW CRITERIA AND STANDARDS FOR MENTAL HEALTH PROJECTS

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FOREWORD

The National Health Planning and Resources Development Act of 1974 (PL 93-641) mandates project review responsibilities to three types of health planning agencies. These include Health Systems Agencies (HSAs), State Health Planning and Development Agencies (SHPDAs), and State Health Coordinating Councils (SHCCs). Mental Health Services are subject to all three review functions as outlined in the legislation.

Strengthening the mental health aspects of health planning and review under PL 93-641 has been a major goal of a grant to the Southern Regional Education Board (SREB) from the Continuing Education Branch of the National Institute of Mental Health (Grant #1-T15-MH14703). This publication is one activity of that project.

Special thanks are due to the participants of the SREB Task Force on The Use of Guidelines, Criteria, and Standards for Review of Mental Health Services Under PL 93-641, which met in Atlanta during February, 1979. Many of their comments and suggestions have been incorporated into the text. We are also grateful to NIMH and to the Regional ADAMHA staff for their assistance.

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INTRODUCTION

BACKGROUND

Health Systems Agencies (HSAs) need guidance in arriving at review decisions so that they can meet the mandate set forth by PL 93-641. In addition to the technical aspects of standards and criteria development, it is important that the HSA planning and review process be in harmony with the other processes that relate to community mental health centers. The HSA is one of many agencies that have been established for the improvement of quality of health care and the rational expenditure of financial resources. Roles and responsibilities of HSAs and other parties to this larger process will be considered in more detail later.

To understand the current situation, it is helpful to consider some of the intended purposes of the HSA review. One of the committees responsible for health legislation in the United States Congress provided insight into the purpose of HSA review:

> It has often been charged that the Department of Health, Education, and Welfare makes its health funds available in communities in a manner which is inconsiderate of or ignores the community's real needs.[1]

The Committee went on to say that HSA review authority should be provided to assure appropriate coordination of the Department's health activities with the planning activities of local agencies.

There are other reasons for conducting project reviews. The review of projects facilitates the implementation of health plans by assuring that projects meet the criteria and standards for needs and the appropriate delivery of services. Other benefits stem from the fact that the process may stimulate the responsiveness of institutions to the needs of the community. Prior knowledge of the necessity of undergoing review often stimulates requests for technical assistance which may strengthen the quality of the proposal.

Other effects of project review should be considered. According to the Health Planning and Development Center, Inc., project review has three additional benefits:

1. It aids accessibility of health care. The review process may affect size, location, and the variety of services in the community.

2. It stimulates communication among the various portions of the health care system -- the proposer, the reviewer, the funding agencies, and the public.

3. It helps in cost containment -- by reducing unnecessary duplication of facilities and equipment.[2]

STATEMENT OF THE PROBLEM

Mental health planning had a rather low priority in the early development of health systems and annual implementation plans. Part of the reason for this is because few professionals seem to have a good understanding of the mental health field from a systems' point of view. Numerous books, articles and other documents describe therapies, services, types of clinical organizations, staffing patterns, etc. and there is a whole field of literature that relates directly to the community mental health center movement.

Unfortunately, there is still quite an information gap, and the planning and review process often suffers as a result. The exception seems to be those HSAs where a staff member has had previous experience as a mental health provider or in those agencies which have active, knowledgeable mental health representatives on their project review committees.

Considerable progress has been made toward the implementation of the health planning legislation. However, there are several basic problems which remain. This publication is directed primarily toward the following objective:

> To increase the consistency in, and improve the quality of standards and criteria for mental health services that are developed by HSAs.

There has been a great diversity among the HSAs in terms of their interest and abilities to develop adequate mental health standards and criteria and to conduct the review process as mandated by law. The problem is compounded because community mental health centers frequently do not understand the new health planning system, its potential impact on their services, and appropriate ways to access that system to assure adequate attention to mental health needs. Decision makers in each system must have clearer understandings of the roles and functions performed by the other, opportunities for interagency communications in the planning and review process, and opportunities to review and utilize materials and approaches that have been developed in other areas. As the health planning system moves toward exercising review and approval/disapproval authority, the need for mutual understanding and coordination will become critical.

The second objective of this publication is to:

> Provide an opportunity for the replication and transfer of "model" or successful approaches in mental health project review and the development of criteria and standards.

This objective is particularly applicable for Health Systems Agencies that are just beginning to develop standards and criteria specific to mental health. They must be able to share some of the knowledge of HSAs with prior experience in this area.

Local Imperative

One of the greatest sources of confusion on the part of CMHCs relates to the development of mental health standards and criteria by HSAs. This confusion is shared by many HSAs facing the prospect of developing review criteria specifically for mental health.

The Health Planning legislation, the National Health Planning Guidelines, and the Health Systems Agency Performance Standards Guidelines are all clear on one point -- the HSA must adopt procedures and criteria for use in carrying out its review responsibilities:

- Proposals for new institutional health services to be offered or developed within the health service area (certificate of need reviews).
- Applications for certain federal funds (review and approval/disapproval).
- Periodic review of all institutional health services offered within the health service area (appropriateness review).
- Any other reviews of proposed or existing health services.

The HSA must conduct all of the above reviews in accordance with the adopted procedures. The criteria, as adopted, must be used in making a determination on an application, proposal, or service. Procedures and criteria must be adopted as a prerequisite for full designation, and they must be reviewed and revised as necessary.

This publication will not be concerned with the procedural aspects of the review process, but rather the criteria and standards that are used. The legislation and supporting documents state that the minimum requirements for the criteria to be used:

> shall be consistent with and supportive of the goals, objectives, priorities, and recommendations contained in the agency's Health Systems Plan (HSP) and Annual Implementation Plan (AIP);
>
> shall address the general considerations to be used in the criteria specified in Section 1532(c) of the Act and the implementing regulations (42 CFR 122.308);
>
> shall also address the specific nature and characteristics or unique aspects of the proposed services or projects.

In spite of these minimum requirements, HSAs really have a great deal of flexibility in developing and applying their standards and criteria. This kind of flexibility, while in accord with the concept of local decision making, opens the door to a wide variety of problems. There is little consistency among HSAs in the mental health criteria that have been adopted. In fact, just the opposite is the case. Many HSAs have kept things simple -- perhaps a two-page check-list which outlines the minimum criteria. Other HSAs have developed a complex set of standards and criteria, some of which ask for over 100 review questions. Some of these questions appear to be

inappropriate placing an undue burden on the applicant and there is often a great deal of duplication between the HSA review and the other levels of review to which CMHC programs are subjected. Such in-depth approaches could result in serious loss of credibility for the HSA or a misconception that the HSA is a regulatory agency, when, actually, its authority is clearly limited by state and federal law to health planning and review.

Need for Consistency and Quality

This publication will stress the need for consistency and quality in the development and application of standards and criteria for the review of mental health programs. One of the initial problems in the review process relates to the lack of understanding of the definitions of the primary review terms. For the purposes of this publication, the following basic terms and definitions will be used. Where there are conflicting definitions of these terms, this publication will use PL 93-641 for clarification.

The following terms will be used:

- o Review Consideration. This is a general category of concern which is applied to all proposals under review. These are the factors which must be considered in the development of review criteria. (For example, quality, continuity, cost, availability.)

- o Standard. The value, either quantitative and/or qualitative, assigned to a particular criterion, or measurable level of excellence recognized either by the community, or by an agency or person considered to be an "authority," which is used as a measure of whether a specific criterion has been achieved. (For example, mental health services shall be accessible at all times.)

- o Criterion. A measurable characteristic of a health service, or a test, role, or principle established by a community against which it judges the value or suitability of a service or facility. (For example, mental health services shall be located within a reasonable distance.)

- o Indicator. (Optional in HSA Review Process) A specific method or characteristic which is correlated with or reflective of a criterion. It is a form of documentation and/or justification which may be used to meet the criterion. (For example, percentage of all mental health services available within one-hour driving time.)

It should be noted that the HSA is mandated to consider a proposal in relation to all of the other services or facilities in the health service area. Although the criteria and standards used in the process may address individual services, a "systems viewpoint" must be taken.

Although the guidelines, standards, and criteria which are developed by an HSA serve many functions, their primary purpose is to provide a basis for making consistent and credible review decisions. By establishing written criteria which are consistently applied, a review can be fair and objective to all applicants. Maintaining a constant set of review criteria can also benefit applicants, since it will speed the development of program proposals. Potential applicants will be able to know what is expected by their local Health Systems Agency, and should be able to write their proposals accordingly. The community benefits because a larger percentage of program proposals will reflect the community's broader health care concerns.

SOURCES OF CRITERIA AND STANDARDS

This chapter will consider the sources of criteria and standards in terms of PL 93-641 and, in broader terms, the general "state of the art." A review of the literature will quickly reveal an overwhelming variety of mental health criteria and standards that have been developed and applied by various levels of government and by voluntary organizations. An initial reaction is that for a criterion or standard to be valid, it must have some kind of documentation as to its origin. A standard that appears to have been pulled out of the air has little credibility compared to one which has its origin firmly documented in legislation or in usage by a respected professional organization.

PL 93-641 AND IMPLEMENTING REGULATIONS

As stated in the previous chapter, the HSA must adopt criteria for use in carrying out its review responsibilities. The criteria must then be formally adopted by the governing body and be utilized in making a determination on an application, proposal, or service.

The Health Planning Act can serve as a starting point for the development of mental health review criteria for HSA use. Three sets will be considered: minimum legislative criteria, application of health systems characteristics, and other criteria.

Minimum Legislative Criteria

Section 1532(c) of the National Health Planning and Resources Development Act of 1974 (PL 93-641) establishes nine minimum considerations for the development of specific criteria that should be used by an HSA in conducting mental health reviews. These are:

1. The relationship of the health project being reviewed to the applicable Health Systems Plan (HSP) and Annual Implementation Plan (AIP).

2. The relationship of projects reviewed to the long-range development plan, if any, of the person providing or proposing such services.

3. The need that the population served or to be served has for such a project.

4. The availability of alternative, less costly, or more effective methods of providing such services.

5. The relationship of projects reviewed to the existing health care system of the area in which services are provided or proposed to be provided.

6. In the case of health services proposed to be provided, the availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of such services and the availability of alternative resources for the provision of other health services.

7. The special needs and circumstances of those entities that provide a substantial portion of their services or resources, or both, to individuals not residing in the health service area. Such entities may include medical and other health professions, schools, multidisciplinary clinics, specialty centers, and such other entities as the Secretary (of HEW) may by regulation prescribe.

8. The special needs and circumstances of Health Maintenance Organizations for which assistance may be provided under Title XIII of the Public Health Service Act.

9. In the case of a construction project, (a) the costs and methods of the proposed construction, and (b) the probable impact of the construction project reviewed on the costs of providing health services by the person proposing such construction project.

The legislative considerations were intended to be applied to all HSA reviews: projects proposing to use federal funds, new institutional services, and appropriateness review.

Application of Health Systems Characteristics

In addition to the nine legislative criteria referred to above, Section 1513(a) of PL 93-641 specifies six desired characteristics of any health service system. These are as follows:

1. Availability. A measure of the appropriate supply and mix of health services and the capacity of resources for providing care.

2. Accessibility. A measure of the degree to which the system inhibits or facilitates the ability of an individual or group to gain entry and to receive appropriate services, including geographic, architectural, transportation, social time, and financial considerations.

3. Acceptability. An individual's (or group's) overall assessment of medical care available to him or her in terms of such factors as cost, quality, outcome, convenience of care, and provider attitudes.

4. Continuity. A measure of the degree of effective linkages and coordination in providing a succession of services over time, regardless of whether care is provided in one setting or multiple settings.

5. Cost. The total economic value of resources required to provide services, including all financial expenditures, especially expenditures for capital and operating requirements.

6. Quality. A measure of the degree to which health services delivered meet established professional standards and judgments of value to the consumer. Quality is frequently described as having three dimensions: quality of input resources

(e.g., certification and/or training of providers -- both manpower and facility factors); quality of the process of service delivery (e.g., the use of appropriate procedures for a given condition); and quality of outcome of service use (actual improvement in condition or reduction of harmful effects).

The legislation describes the functions of the HSA with regard to each of the above characteristics (e.g., "improving" the health, "increasing" the accessibility, "restraining" increases in cost).

Other Sources

The use of the legislative criteria and the application of the desired health systems characteristics are also described in the National Health Planning Guidelines and in the Performance Standards Guidelines that were written for HSAs. As of this date, final regulations have not been issued for two of the HSA review functions: review and approval/disapproval and appropriateness review. Arthur D. Little, Inc. suggests that the additional review considerations will be similar to the Certificate of Need (CON) regulations.[3] These were issued and printed in the Federal Register, Part II on January 21, 1977:

1. The immediate and long-term financial feasibility of the proposal as well as the probable impact of the proposal on the costs of and charges for providing health services by the person proposing the new institutional health service.

2. The relationship, including the organizational relationship, of the health services proposed to be provided to ancillary or support services in the health service area in which the proposed health service will be provided.

3. Special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

4. The contribution of the project in meeting the needs of minorities, women, and handicapped individuals in the health service area.

It needs to be emphasized that an application for a proposed service does not have to meet all of the considerations.

ARTHUR D. LITTLE "STATE OF THE ART" STUDY

The National Institute of Mental Health (NIMH) recognized the need for technical assistance regarding the review requirements of PL 93-641. About the same time, the other Alcohol, Drug Abuse and Mental Health Administration's Institutes -- the National Institute of Drug Abuse and the National Institute of Alcoholism and Alcohol Abuse -- contracted with outside organizations to develop criteria and guidelines to assist HSAs in planning and project review. Both of these documents have been completed and delivered to health planning agencies.

NIMH took a different approach by funding a comprehensive study to determine the feasibility of developing guidelines, criteria, and standards for the PL 93-641 review of mental health services. This contract, awarded to Arthur D. Little, Inc., was completed in August, 1978, and up to this point has not been distributed to HSAs. One of the central purposes of this study was to look for answers to the following questions:

- What guidelines, criteria, and standards for mental health have been developed to date? Who has developed them? How? For what purpose? What problems are associated with their development?[4]

The bulk of the completed study consists of a "state of the art" paper which documents all relevant guidelines, standards, criteria, and methodologies pertaining to mental health. In addition, the paper identifies gaps and

makes recommendations regarding the adequacy of available information, the areas in need of further development, and possible next steps for NIMH to take regarding technical assistance to HSAs.

Current Progress in Mental Health

The Arthur D. Little study described the state of the art of the development of criteria and standards by health planning agencies as "emergent but rapidly changing."[5] The study concluded, as to be expected, that attempts to develop such criteria have been made at just about every level: national, state, regional, and local.

The primary concern of this publication is the development of standards and criteria by HSAs for mental health reviews. Up to this point, there has not been a formal survey of HSAs to determine the actual criteria used for this purpose. The Southern Regional Education Board, through its Improving Mental Health Centers and Mental Health Planning Project, did conduct a survey of the HSAs in 14 states during 1977. At that time, 24 percent of the HSAs had developed some sort of criteria to assist mental health agencies in preparing grant applications. "Facilities and programs" accounted for 21 percent, "Facilities only" for three percent (figures based on 62 responding HSAs).

The Arthur D. Little study was based on a survey of 19 of the total 205 HSAs in the country. Whether this cross-section of current activities and approaches adequately represents the state of the art or not, this is without

a doubt the most comprehensive study of mental health standards and review criteria that is currently available. This publication will draw from it in an appropriate manner.

Figure 2, on the following page, presents an excellent overview of the state of the art as presented in the Arthur D. Little study. It shows the 13 considerations addressed in PL 93-641 and lists the availability of guidance appropriate to HSA use for criteria, quantitative standards, and methodologies. It can be seen that criteria are available for all of the considerations, even though the level of detail varies a great deal. Four considerations have criteria that are especially well developed:

- o relationship to health system/continuity
- o accessibility
- o acceptability
- o financial feasibility

The study points out considerable contrasts in the level of development. For example, the greatest amount of work in quantitative standards development has been in the needs assessment area. By contrast, the area of quality has specific standards that address only the length of stay. It is important to note that quantitative standards are completely absent in terms of the cost of mental health service.

Degree of Comprehensiveness

The Arthur D. Little study found that the degree of comprehensiveness of quantitative standards was very limited. None of the 13 considerations addressed in PL-93-641 (or its implementing regulations) was adequately

Figure 2

Overview of the State of the Art:
Availability of Guidance Appropriate to HSA Use

Consideration	Criteria	Quantitative Standards*	Methodologies
1. Relationship to HSP and AIP	Available	N/A	N/A
2. Relationship to Long-Range Plans	Available	N/A	N/A
3. Need for Services and Resources			
Services	Available, but more for inpatient than outpatient services	Available: Bed/population Occupancy rates/ Utilization/population (admissions, days, visits, census, episodes) Incidence rates Unit size	Available: Quantitative need prediction o Incidence/population o Sociodemographic o Utilization o Health status survey Bed need estimation o Linear attrition o Utilization/occupancy o Functional level analysis o Waiting times Impressions Ranking of relative need Balanced service system
Resources	Available	Available: Staff/population Staff/visit Staff/patient	Available: Area need o Manpower ratios o Health needs o Demand Institutional need
4. Availability of Services and Resources	Available	N/A	Available: Resource inventories
5. Availability of less costly or more effective alternatives	Available	Mostly unavailable	Available: Cost-effectiveness analysis Cost-benefit analysis
6. Relationship to System/ Continuity	Available; comprensive within MH system	Indicators only for transfer time and follow-up time; not primarily for HSA use	Review questions available
7. Accessibility	Available and comprehensive	Available: Travel time Linguistic standards	Available
8. Acceptability	Available and comprehensive	Indicators only, standards N/A	Available: Surveys and questionnaires
9. Quality	Available, but more for inpatient than outpatient services	Available: Length of stay Otherwise mostly N/A.	Available, but primarily not for HSA use
10. Costs	Available	Mostly unavailable	Mostly unavailable
11. Financial Feasibility	Available and comprehensive	Mostly unavailable but N/A	Available: Financial feasibility analysis
12. Construction Projects: Space	Available	Available	Available
13. Special Needs: HMOs Providers serving multiple areas	Developing, some included under other considerations such as numbers 3, 4, 6 and 7	Unavailable except when included in other considerations	Unavailable

addressed by standards. In fact, very few standards were found to be in wide use. Standards developed within a particular geographic setting or within a specific service area, in most cases, were not "exportable."

Other findings in the Arthur D. Little study were:

- o There is a paucity of outpatient standards compared to inpatient service standards.
- o Some standards have been developed within a specific conceptual framework or system of mental health services and require collection and analysis of information that exists only within that system.
- o The fact that a standard exists and may be used does not guarantee its merit. Some standards are based on existing utilization of services while others may be judgments that are not soundly based.[6]

The study did conclude that many of the available standards are useful as long as they are not used "blindly and mechanically or in isolation." Modification by the use of other criteria, as well as consideration of local realities, will probably be necessary for them to be most useful.

Choice of Methodology

It has already been explained that HSAs have a considerable amount of latitude or flexibility in the methodology that they choose for mental health project review. There is not one "right" way to go about setting standards and criteria. The Arthur D. Little report concluded that the choice of methodology must be based on the data and resources available to the agency. For example, many of the methodologies require primary data collection which would not be feasible for smaller HSAs. Such agencies would probably have to concentrate on methodologies that could be implemented with readily available secondary data.

Complex quantitative analysis is also required for some of the techniques. Others, by contrast, can be used with reviewer judgments. The most important point is that whatever methodology is chosen, it must be consistently applied.

IMPLEMENTATION/APPLICATION OF CRITERIA AND STANDARDS

GENERAL CONSIDERATIONS

One of the biggest problems associated with standards development in the past has been the lack of a systems approach. A typical procedure is to develop standards on a service-by-service basis starting with inpatient, outpatient, day care, and so forth. Although this approach is easy to administer, there are several serious shortcomings; the most noteworthy is that such standards are subject to manipulation. It is easy to meet any specific standard, such as reducing beds, if there is no simultaneous accountability for meeting other standards that relate to alternative services.

The Health Planning and Resources Development Act places a high priority on a systems approach. In this case, the standards developed would reflect an overview of the entire mental health system. The Balanced Service System, which is used as the conceptual base of the Joint Commission on Accreditation of Hospitals standards for community mental health centers, is an example of this kind of broad perspective. A variation of this approach could be the area-specific development of systemwide standards. In fact, there are several ways that mental health needs can be met through attempts at comprehensiveness.

One of the problems that was brought out in the A. D. Little study relates to the danger of a rigid application of criteria and/or standards. There are many reasons why this danger exists. However, the fact that very

complex questions continue to exist about the very nature of the mental health field (the scope, the mix, and the substitutability of services) should be enough reason to approach this task with caution. The situation is further complicated because of the fact that standards can be expressed in at least five different forms:

- o Ceilings (maximum)
- o Floors (minimum)
- o Guidelines (which can be modified as needed)
- o Ranges (an acceptable level within a maximum and minimum)
- o Absolute/Optional (desired goal)

There are many individuals who feel that general goals or objectives should be used as review criteria. This opinion makes sense but a more careful examination of the problem is warranted. There are many examples of criteria being applied too blindly, with little or no flexibility. Quantitative criteria are most often cited as examples of that problem. For example, a 90 percent occupancy rate may be listed as a minimum to obtain funding for a psychiatric inpatient unit. The question could easily arise as to why 89 percent is too low, particularly if the inpatient unit shows signs of soon attaining the 90 percent rate. Quantitative criteria, strictly applied, would not allow funding, even though there may be signs that funding would be appropriate in the near future.

In spite of the above considerations, project reviews based on general objectives and goals could present more serious problems. Often it is difficult to relate a proposal to general goals. It also may be difficult to derive a proper rationale for approval or disapproval. This could make

review decisions seem inconsistent or arbitrary. It is possible that proposals submitted at different times could be similar in all respects and yet be given different review decisions.

The threat to fair and objective reviews, and the likely inability to provide documented justification, must argue against the sole use of generalized goals. At the same time, care must be taken to avoid the inflexible use of specific criteria. Thus, an approach is needed which combines the two extremes.

QUALITIES OF GOOD CRITERIA AND STANDARDS

It is important that HSAs follow some kind of guidelines in adopting and implementing their criteria and standards for community mental health programs. There are at least three major qualities that are necessary to have valid criteria and standards: accuracy, precision, and legitimacy. The descriptions of these have been excerpted from Project Review Procedures and Criteria - A Manual for HSAs which was prepared by the Health Planning and Development Center.

Accuracy

> The appropriateness of criteria and accuracy of standards can and will be challenged by members of review committees, the public and the proposers.
>
> Criteria used in review must be relevant to the project reviewed; the criteria must fit the facts of the proposal and not need to be manipulated to apply to the proposal.
>
> The standards used in review must fit the health need within the time frame of "now" and perhaps 3 to 5 years from now based on plans and accurate projections. Standards which are based on old data (even though they may have been valid at the time) must not remain a basis for review.

Transfer of criteria or standards from one community to another or from one review situation to another is often tricky, and care should be taken before adopting final criteria and standards.

Precision

It is observed that the more general the criteria the easier it is for almost any proposals to conform to them. On the other hand, criteria that are so precise that they set up "nitpicky" situations do not assist the Review and Comment process either. Some kind of balance needs to be achieved.

Historically, one of the best track records for a legislative program in the health field was the Hill-Burton hospital and health facilities construction program. Some of the criteria to determine eligibility were precise (4 beds per 1000 population served), and yet the program gave considerable latitude as to the design, location, administration and medical staff of the hospital.

Legitimacy

Criteria will be challenged if there is not a weight of historical use, study, research, expert "input," and "administratability" built into them.

Again, the Hill-Burton program with its 20-30 year history gained a great deal of its "legitimacy" on the basis of public acceptance, workability and demonstrated results.

The program did in fact meet its major objective, that of providing good new hospital facilities and diagnostic services in rural communities. One basis of its accomplishments was public acceptance of its rules and principles.

Legitimacy of criteria is also developed if conceived through individual and group research either independently, on university campuses, or by foundations or governmental research efforts. If criteria are so developed, and stand the test of public criticism and inspection and survive, such criteria and standards become "legitimate."

Another method for developing criteria is by the expert consensus method. Examples: (1) the hospital administrators, radiologists and onocologists agree on the number and location

of radiation therapy centers in a given community; and (2) the Heart Association develops criteria and standards for cardiac catheterization laboratories.

Other studies have noted that there are as many as nine technical requirements: validity, reliability, sensitivity, comprehensiveness, verifiability, practicality, explicitness, transferability, and currency.

Philosophical Issues

Another area that must be considered relates to the philosophies that underlie the mental health service delivery system as well as the review activities that are carried out by HSAs. One of the problems with mental health reviews is that, in the past, philosophies of mental health programs have not been made explicit. Developing a statement of philosophies is essential if good criteria and standards are to be adopted. Such statements must reflect the expectations of agency leaders, legislators, clients and families, citizen support groups and professional societies, agency employees, and third party payers. This would probably be the case if the HSA drew upon a broad cross section of consumers and providers in its task forces and governing boards to come up with adequate criteria and standards.

The Southern Regional Education Board has conducted a good deal of research in the area of state mental health standards and emphasis was placed on the importance of explicitly stating the agency's philosophies before developing standards for mental health programs. Many of the points that were raised are directly relevant to HSAs in their project review activities. For example, it was found that:

> .....a great deal of the ultimate interpretation of whether a program is judged to be in conformance with a specific standard will depend on how well the activity conforms with the philosophy that underlies the standard.[8]

Standards which call for flexible judgments would be the primary ones affected. Without such a statement of philosophies, two different observers could arrive at completely different judgments about an activity's compliance based on their different personal philosophies.

Other philosophical issues underlie the setting and monitoring of standards. The most fundamental philosophical differences lie between the philosophy of standards as a means of control versus the philosophy of standards as a means of facilitation. It would seem that the HSA should fall into a middle ground.

HSA RELATIONSHIP WITH OTHER MENTAL HEALTH PLANNING AND REVIEW PROCESSES

It has already been stated that the HSA is one of many agencies that has been established for a variety of positive functions. It is important that the HSA planning and review process occur in harmony with the other processes to which community mental health centers are subjected. It is no secret that there has been a great deal of concern on the part of mental health providers that the HSA represents another layer of bureaucracy which may interfere with the real reason for the center's existence -- service delivery. This feeling may be somewhat justified due to the fact that there are approximately 20 organizations or agencies to which centers must be accountable.[9]

A recent article in Hospital and Community Psychiatry considered the problem of escalating data demands made on community mental health centers.[10]

The authors began with the premise that the gathering of structured data about the provision of mental health services is an essential part of sound program administration. However, they point out a paradox which is caused, in part, by the present mood toward cost containment. The paradox is the inverse correlation between the availability of resources for patient care and the demand for data about that care. In reality, the fulfillment of the demand for data consumes even more of the diminishing resources.

A public institution, such as a community mental health center, is faced with data demands from multiple sources, including HSAs. Unfortunately, few if any of these demands seem to show any concern for coordinating or integrating their requests. The article mentioned above points out that the data required by many of the major surveys or reviews are "agonizingly troublesome to produce." The problem of duplication of efforts is acute because, in general, all of the data requests cover much of the same territory. Examples are age groupings, ethnic breakdowns, criteria for defining a program, and definitions of types and units of service provided. Other problems caused by such data demands include:

- o possibilities for ambiguity;
- o pressure on administrators to produce "estimates";
- o dollar value of professional time; and
- o frustration and other morale costs.

It is imperative that the mental health planning and review staff of Health Systems Agencies consider what their process means in terms of the above.

This chapter will briefly consider the major mental health planning and review processes and suggest ways that the HSA might become involved.

Emphasis will be placed on the similarities and differences between the two major processes with which an HSA should be concerned: the federal site visit and the JCAH survey. Other considerations, including state licensing and review will also be discussed.

Federal Site Visit Process

The federal site visit process was designed to facilitate the review, evaluation, and monitoring of NIMH-funded programs. Purposes include determining compliance with the grant, assisting the grantee in service development, and investigating allegations of special problems. Reviews are conducted initially 90 days after the commencement of operations and annually thereafter. The two- to three-day visit is usually performed by a team of from two to 12 professionals who represent federal, state, and local government and/or service agencies.

There is a great deal of flexibility in the federal review process at two conceptual levels. First, the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) has published a CMHC Monitoring Package (Basic) which outlines review criteria in three major categories: management, direct service, and community relations.[11] In practice, however, the regional ADAMHA divisions have a great deal of latitude in carrying out the process and in developing their own review criteria. And, the site visit review criteria in the monitoring package are primarily subjective in nature. This leaves validity and reliability as a function of the review team's expertise.

The HSA should be concerned with the federal site visit reports which follow the format adopted by that particular regional office. In general,

the site visit report for program review goes to the state mental health authority, to be incorporated into a combined federal/state report. As an alternative, it may go directly to the chairman of the board of the CMHC governing body. The second site visit report deals with the management capability of the federal grantee and would only be completed when an audit report card or a managerial letter are not on file at the center.

It is very important that the appropriate HSA staff contact their regional ADAMHA office so that they can become familiar with the site visit process. In some areas, HSA staff with mental health planning and/or review responsibility have been asked to accompany the site review team. This can foster understanding on the part of the HSA and, perhaps, answer many questions that could have come up during a regular HSA review.

This publication suggests that an HSA consider the adoption of a two-sided approach. A set of review criteria/standards for CMHCs could have two levels of detail:

A. Initial or new application. The need for an in-depth HSA review seems greater at this point and could entail a more detailed set of review criteria. Overlap with the state and federal process would be understandable.

B. Continuation grant application. The need for an in-depth review by the HSA seems to be less and the HSA could request all of the site visit materials from the previous year. This would include visits from both the regional offices of ADAMHA and the state offices, where applicable.

The point needs to be made that the HSA does have a unique review responsibility -- to consider the project from a systems' point of view. No other review process or authority can offer this local perspective and be able to consider the relationship of mental health to other services and/or resources in the community. Therefore, HSAs should focus on the review elements which cannot be adequately addressed by others.

There are at least two different ways that HSAs can relate to applicants during the grant application process. The HSA can encourage a proactive approach -- an attempt by the applicant to work with the review staff as the application is being developed. By contrast, the HSA could do little or nothing and allow the applicants to take a reactive approach. In this method, the applicant pretty much ignores the HSA review process until the actual review takes place. Usually, by that time, the HSA is seen as an adversary or an obstacle and the potential for conflict is great.

The JCAH Survey Model

The Joint Commission on Accreditation of Hospitals (JCAH) has developed an accreditation program for community mental health centers and services. The accreditation program is founded in the manual, Principles for the Accreditation of Community Mental Health Service Programs, developed by the Accreditation Council for Psychiatric Facilities and published by JCAH in 1976. The procedures are similar in some respects to the federal site review process. The major difference is that the JCAH survey is voluntary -- it is conducted only after being requested by the center; it too usually takes two to three days.

There has been a great deal of confusion and misunderstanding concerning the process -- primarily because of the balanced service system which is the theoretical framework. This could best be described as an "umbrella" under which a common review can be conducted without regard to the wide range of titles and terms used by various mental health providers. Unfortunately, the new language and the structure introduced in the balanced service system were confusing to many professional staff. In spite of this problem, the program has been successful in many ways.

The primary interest of community mental health centers seeking JCAH accreditation lies with third party reimbursement. There is a great deal of hope that the credentialing offered by this program will hasten the process of reimbursement which will be a boost to centers that are constantly faced with obtaining funds.

HSAs should be aware of the issues which concern the accreditation process. Dr. Donald Langsley, Chairman of the Department of Psychiatry at the University of Cincinnati College of Medicine, points out in a recent appraisal of the JCAH process that the major issue is whether the CMHC is part of the health care delivery system, with necessary linkages to source services and other community support, or is primarily a social service function.[12] Others have stated their view that the JCAH model seems more appropriate for social services than for health.

The objective of an accreditation survey is to determine the extent of a mental health program's compliance with certain standards of performance. The JCAH system is based on 95 principles. For each principle, there are

subprinciples, indicators, sources, and standards. Subprinciples express explicit or implicit ideas; indicators for each are the units of performance used to measure compliance. The source indicates where information required by each indicator is found. Each indicator then has one or more standards indicating the required level of performance. This relationship is shown in Figure 3.

Figure 3

EXAMPLE OF THE JCAH REVIEW FORMAT
FOR THE ACCREDITATION OF
COMMUNITY MENTAL HEALTH CENTERS

PRINCIPLE: Each consumer shall be provided with an individualized service plan that is collaboratively developed, implemented and updated.

SUBPRINCIPLE: Service plans shall reflect the precise nature of the consumer's problems, the portion of the problem being dealt with by the service, the expected goals, prior and anticipated services, and the relationship of the services to expected goals.

INDICATOR: Percent of service plans specifying precise nature of consumer's problem.

SOURCE: Service records

STANDARD: 100

(Source: Accreditation Council for Psychiatric Facilities, JCAH, 1976.)

It should be noted that there are 95 principles, but over 700 indicators. Not all of the indicators would be applicable to every organization applying

for accreditation. For example, some indicators are applicable only to children, while others are applicable only to services provided in a protective environment.

HSAs may find the review format used by JCAH useful while they are trying to set up their own mental health specific review criteria. However, caution must be taken so that the HSA does not include many of the detailed measures called for by JCAH. An example of this would be standards which call for "measures of the percentage of floors with non-slip surface.". This would be totally irrelevant to the purpose of the HSA review.

Unlike the federal site visit report, the JCAH survey is confidential. However, there are several ways that HSAs can get involved. Under JCAH requirements, each program must publicly announce an impending survey and advise interested individuals and agencies, such as HSAs, that they may schedule an interview with a JCAH surveyor. JCAH cannot release the contents of the report, but the HSA can request copies of the findings directly from the center. The key here is the HSA's attitude: If it is consistent with JCAH's non-punitive approach, there should be no problem.

A final source of confusion of which HSAs should be aware relates to the relationship between the JCAH principles and the NIMH National Standards for Community Mental Health Centers. The existence of two sets of standards has caused problems. NIMH has no plans to make its standards function as an operational program, however, NIMH is currently engaged in an effort to reduce the confusion by clarifying the content of the two sets of standards.[13]

State Licensing and Review

State licensing and review is another process with which HSAs should be familiar. Licensing regulations vary from state to state and are often applied with varying reliability from locality to locality. The facility-oriented inspections generally emphasize life safety code requirements and pay little attention to the service being delivered. Many states have no specialty licensing regulations for mental health programs, which means that compliance with hospital regulations is usually required.

In addition to the licensing process, each state generally carries out a program review process to ensure quality of services. Each state mental health authority either develops its own set of review criteria or uses the national standards for CMHCs that were developed by NIMH. The state review may be held separately from the federal site visit or it may be held at the same time.

OTHER CONSIDERATIONS

President's Commission on Mental Health

The task panel on planning and review of the President's Commission on Mental Health was concerned with many of the issues that relate to the implementation of the project review process by HSAs. The panel focused on three primary areas:

- Governmental legislation and regulations which impact on mental health services;
- Mental health planning processes as they are currently being carried out; and

- Accountability and regulatory mechanisms used to assure the quality and measure the outcome of mental health services.

One of the most important findings of the panel was that federal initiatives and mandates are frequently in conflict with one another. This conflict is intensified when interpretation and implementation take place at the state, regional, and local levels. The panel found that the most effective and efficient delivery of mental health services at the local level is severely inhibited -- especially due to the multiplicity of standards, requirements and reviews. The HSA is caught right in the middle of all of this because of its legally mandated review functions.

On a positive note, the panel did take the attitude that the HSA planning and review process was legitimate. In several places, they recommended that activities of the state mental health authority be coordinated with those of the local HSAs.

One of the most interesting recommendations of the panel was to call for a national board for quality assurance in mental health. The development of model standards would be one of the board's primary objectives. These standards would be responsive to the views of professional groups, the needs of state and federal agencies, and the concerns of consumer organizations. It is significant that linkages with health planning agencies established under PL 93-641 were called for in the report.

Emphasis was also placed on the peer review process -- the kind of review that is called for under the PSRO legislation and the CMHC amendments. It was brought out that in order for peer review to be effective, it would have to involve the HSAs and provide feedback to the planning process.

Information from these reviews would be sent to the committees of the local HSAs which have the authority for local health service planning and review. The panel called for appropriate linkages between peer review teams and the HSAs. This feedback would be invaluable to the HSA in assessing needs and promoting reallocation of resources.

Quality Assessment Methodologies

It is very important that Health Systems Agencies have a good understanding of the foundation of standards and criteria as appropriate to quality assessment. In one form or another the foundation of all health care standards employed today rests with these three approaches.

- o Structural. Standards and criteria designed to assess the impact of organization and setting upon the quality of care.
- o Process. Standards and criteria designed to assess the processes of rendering care.
- o Outcome. Standards and criteria designed to assess the outcomes of treatment.

An excellent description of these concepts is contained in National Standards for Community Mental Health Centers - A Report to Congress, January, 1977. This document points out that structural standards have long been favored since many of their criteria assess quantifiable data, most of which are readily accessible. Structural standards comprise the largest portion of licensure, certification, and accreditation programs. Historically, these have been the primary elements of the various facility standards established by JCAH.

Opinions on the relative merits of process or outcome measures depend, to a great degree, on the objectives of those who make the appraisals. Individuals who focus on process feel that they have a responsibility to see to it that "the best" medical care is provided and would not be very concerned with evaluating the effectiveness of health services. Those who focus on the outcomes of health care place primary significance on the causes of failure to achieve health objectives and the means of taking corrective actions.

It would seem that HSAs should be concerned only with structural aspects in their project reviews. They have the responsibility to examine the capacity of a CMHC to render care in three broad areas:

- Activities which directly support the delivery of services;
- General requirements which are applicable to all CMHC services, for example, accessibility and availability;
- Specific elements of care, for example, requirements directed at emergency outpatient services.

The responsibility for process and outcome measures of evaluation will rest primarily with Professional Standards Review Organizations (PSROs) as established by Title XI of the Social Security Act. PSROs were set up to function as peer review groups on the quality, medical necessity, and the opportunities of health and mental health services under Medicare, Medicaid, and maternal and child health programs.

Elements To Which Standards Are Applied

There are many ways that standards and criteria can be applied to a mental health program. It is useful to review some of the elements to which standards are commonly applied:

Facilities. These standards deal with the physical plant, buildings, and equipment. These are the standards that speak to space requirements, fire protection, and other line safety items.

Programs. These apply to the overall programs, such as community mental health, alcohol treatment, or children's programs. They include attention to needs assessment, admission and patient movement procedures, staffing, and program evaluation.

Administrative services. These apply to the administrative organization and include standards for operating boards, advisory boards, staff organization, accounting and personnel procedures.

Professional or clinical services. These standards apply to the specifics of diagnosis and treatment. They include all of the matters that Professional Standards Review Organizations address.

Support services. These standards deal with program support activities, such as clinical records, pharmacy and volunteer services.[14]

It would be helpful to prospective applicants if HSAs attempted to group their standards and criteria according to the above elements.

MODEL APPROACHES TO MENTAL HEALTH STANDARDS AND REVIEW CRITERIA

The degree of comprehensiveness of standards and criteria in present use has been considered. Figure 2, reprinted from the Arthur D. Little study (ADL), gives an overview of the guidance that is available to HSAs in the use of criteria, quantitative standards, and methodologies for each of the 13 considerations addressed in PL 93-641. There is no question that the ADL material is comprehensive and that it is probably the best study of mental health standards and review criteria ever done. In fact, it is almost too comprehensive in that it includes several experimental and pilot efforts which would not be appropriate for general use. (A limited number of copies of the report were printed, and are not generally available.)

What HSAs really need, in addition to the relevant reference material provided by the ADL study, is an opportunity to share work on criteria and standards among themselves. In general, mental health planning has been somewhat slow to produce a widely circulated "body of knowledge." For example, Volume VI, Mental Health Planning: An Annotated Bibliography, of the Bureau of Health Planning's Health Planning Bibliography Series, was only recently published. It is significant that neither this publication nor earlier publications in the series deal with mental health project review. Even the ADL study is somewhat limited in identifying mental health standards and review criteria that have been developed by HSAs and only three

references (R-66, R-67, R-74) are listed for HSAs which have already completed such a document. Two of these are in Florida; one is in Missouri.

A need for such a compilation was seen in September, 1978, when the Division of Intergovernmental Coordination in the Office of Program Coordination asked each of the 10 regional ADAMHA offices to identify which HSAs in their region had actually developed specific mental health criteria and standards. The results of this request, as of February, 1979, are shown in Figure 4.

At that time, only eight HSAs reported having developed the kind of standards and criteria that are needed. While this figure is probably low because of under-reporting, it still seems to indicate that relatively few of the 203 HSAs have advanced their level of expertise in mental health reviews.

There is no single way to develop mental health specific standards and criteria. This publication can only suggest that HSAs use the National Standards for Community Mental Health Centers as a basis for their reviews. Perhaps the greatest benefit of this approach would be the reduction in overlapping and conflicting CMHC assessment and monitoring procedures.

National standards can serve as a starting point for the systematic review of the many overlapping, and at times conflicting, requirements to which CMHCs are subjected by various agencies and organizations. National standards which have general acceptance can serve as a reference point for the other standards. They can also raise the quality and consistency of individual sets of standards developed by each Health Systems Agency.

Figure 4

STATUS REPORT: HSAs THAT HAVE DEVELOPED MENTAL HEALTH SPECIFIC CRITERIA AND STANDARDS FOR PROJECT REVIEW, AS OF FEBRUARY, 1979

DHEW Regional Office Responding to Request	Name and Location of HSAs with Applicable Criteria & Standards	Title
I (Boston)	None	---
II (New York)	None	---
IV (Atlanta)	Mid-South Medical Center Council (Memphis)	Community Mental Health Center Project Review Guidelines
	HSA of South Florida (Miami)	Draft Criteria and Standards for CMHC Services
	Florida Panhandle HSA (Tallahassee)	Criteria and Standards for CMHCs
	Florida Gulf HSA (St. Petersburg)	Criteria and Standards for CMHCs
	North Central Georgia HSA (Atlanta)	Community and Hospital Mental Healt Services and Facilities Review Criteria
V (Chicago)	Suburban Cook/Dupage Counties HSA, Inc.	Review Criteria for Mental Health, Alcohol Abuse, and Drug Abuse Services
VI (Dallas)	None	---
VII (Kansas City)	Greater St. Louis HSA	Criteria and Standards for Communit Mental Health Services
	Health Planning Association of Western Kansas (Hays)	Criteria and Standards for Communit Mental Health Services

SOURCE: Survey by Jack Katz, Director Division of Inter-Governmental Coordination, ADAMHA

HSAs should focus on the unique review responsibility that they have -- to consider mental health projects from a systems' point of view. Close communication and understanding can help reduce some of the conflicting demands that often are placed on centers for data.

There is no question that HSAs need immediate technical assistance in the development and application of mental health criteria and standards. The Arthur D. Little study should be reprinted as soon as possible and distributed to HSAs throughout the country. It would be invaluable as a reference document. It is hoped, however, that this publication also will help orient mental health providers, laypersons involved in the HSA planning and review process, and HSA staff who may lack mental health experience.

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