A Quality Management System for Mental Health Professionals

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IOM Recommendations
A comprehensive quality-management system for all mental health professionals

• Well-defined scopes of practice and clinical privileging of all mental health-care providers
• Promotion of evidence-based practices for treatment and monitoring of results
• Focused training in the particular mental and related general medical conditions in TRICARE population and in military cultural competence
• A systematic process for continued professional education and training
• Development and application of quality measures to assess performance of providers
• Systematic monitoring of process and outcomes of care at all levels of health-care system and application of effective quality-improvement strategies
"Structural components have a propensity to influence the process of care . . . changes in the process of care, including variations in quality, will influence the outcomes of care, broadly defined. Hence, structural effects on outcomes are mediated through process."

--Donabedian A (1980)
“Crossing the Quality Chasm”

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October 13, 2010; Washington, DC
Studies Documenting the “Quality Gap”

• Literature reviews conducted by RAND
  – Over 70 studies documenting quality shortcomings
• Large gaps between the care people should receive and the care they do receive
  – true for preventive, acute and chronic
  – across all health care settings
  – all age groups and geographic areas
• Only 55% chance of getting appropriate care

“Quality problems occur typically not because of failure of goodwill, knowledge, effort or resources devoted to health care, but because of fundamental shortcomings in the ways care is organized”

The American health care delivery system is in need of fundamental change. The current care systems cannot do the job. *Trying harder* will not work: Changing systems of care will!
Six Aims of Quality Health Care

1. **Safe** – avoids injuries of care

2. **Effective** – provides care based on scientific knowledge and avoids services not likely to help

3. **Patient-centered** – respects and responds to patient preferences, needs, and values
Six Aims of Quality Health Care
(continued)

4. **Timely** – reduces waits and sometimes harmful delays for those receiving and giving care

5. **Efficient** – avoids waste, including waste of equipment, supplies, ideas and energy

6. **Equitable** – care does not vary in quality due to personal characteristics (gender, ethnicity, geographic location, or socio-economic status)
Ten Rules for Achieving the Aims

Old Rules
1. Care is based on visits.
2. Professional autonomy drives variability.
3. Professionals control care.
4. Information is a record.
5. Decisions are based upon training and experience.

New Rules
1. Care is based upon continuous healing relationships.
2. Care is customized to patient needs and values.
3. The patient is the source of control.
4. Knowledge is shared and information flows freely.
5. Decision making is evidence-based.
Ten Rules for Achieving the Aims

**Old Rules**

6. “Do no harm” is an individual clinician responsibility.
7. Secrecy is necessary.
8. The system reacts to needs.
9. Cost reduction is sought.
10. Preference for professional roles over the system.

**New Rules**

6. Safety is a system responsibility.
7. Transparency is necessary.
8. Needs are anticipated.
9. Waste is continuously decreased.
10. Cooperation among clinicians is a priority.
Four Levels of Care

• Level A: the experience of patients
• Level B: the functioning of small units of care delivery ("microsystems" such as a cardiac surgical team, ACT team)
• Level C: the functioning of organizations that house or support microsystems (such as clinics and hospitals)
• Level D: the environment of policy, payment, regulation, accreditation, and other factors that influence the organization at Level C
Evidence-Based Chronic (Planned) Care Approaches for Treating Depression Are Effective

Community

Resources and Policies

Health System

Health Care Organization

Clinical Information Systems

Delivery System Design

Decision Support

Self-Management Support

Health Care Organization

Improved Outcomes

Prepared, Proactive Practice Team

Productive Interactions

Patient-Centered Coordinated

Timely and Efficient Evidence-Based and Safe

Evidence-Based Chronic (Planned) Care Approaches for Treating Depression Are Effective

Informed, Empowered Patient and Family

Prepared, Proactive Practice Team

Improved Outcomes

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Improved Outcomes
Improving the Quality of Health Care for Mental and Substance-Use Conditions
Two Phenomena Central to the Committee’s Work and Findings

• Co-occurrence of mental, substance-use, and general health conditions (and substantial societal burden)

• The differences in M/SU health services delivery compared to general health care
Six Problems in the Quality of M/SU Health Care

• Problem 1: Obstacles to patient-centered care
• Problem 2: Weak measurement and improvement infrastructure
• Problem 3: Poor linkages across MH/SU/GH
• Problem 4: Lack of involvement in National Health Information Infrastructure
• Problem 5: Insufficient workforce capacity for QI
• Problem 6: Differently structured marketplace
Overarching Recommendation 1

The aims, rules, and strategies for redesign set forth in *Crossing the Quality Chasm* should be applied throughout M/SU health care on a day-to-day operational basis but tailored to reflect the characteristics that distinguish care for these problems and illnesses from general health care.
CONCLUSION

Improving care delivery and outcomes for anyone depends upon improving care and outcomes for the others.

OVERARCHING RECOMMENDATION 2

Health care for general, mental, and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind / brain and the rest of the body.
Problem 2: Weak Measurement and Improvement Infrastructure

1. Clinical assessment and treatment practices not yet standardized and classified for use in administrative datasets
2. Outcome measurement not widely applied in spite of reliable and valid instruments (“measurement-based care”)
3. Dissemination of advances often fails to use effective strategies
4. Performance measurement for M/SU health care has not received sufficient attention in private or public sector
5. QI methods not yet permeating day-to-day operations
Preparing for the Future

Consumer Participation

Standardize Practice Elements
- Clinical assessment
- Interventions
- IT infrastructure

Develop Guidelines
- Mental health
- Substance use
- General health

Measure Performance
- For each “6P” level
- Across silos

Improve Performance
- Learn
- Reward

Strengthen Evidence Base
- Document stakeholder value
- Evaluate effective strategies
- Translate from bench to bedside to community

Leadership (PCP/MH/SUD) Support

Clinical (PCP/MH/SUD) Perspectives

Integrative Processes

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Create/Engage/Integrate Leadership

• Consumers/Users
• Clinicians
• Administrators
• Policy makers
• Across MH/SU/GH
Standardize Practice Elements

- Clinical assessment
- Interventions
- IT infrastructure
Develop Guidelines

- Mental health
- Substance use
- General health
"According to an article in the upcoming issue of 'The New England Journal of Medicine,' all your fears are well founded."
• Evidence-Based Practices
  – specific interventions
  – medications, psychotherapies, team-based, etc.
  – appropriateness/fidelity measurement
  – training, supervision

• Measurement-Based Care
  – clinical measures (e.g. HA1c, PHQ-9)
  – systematic, consistent, longitudinal
  – action-oriented

• Best Practices/Context
  – accessibility
  – patient centeredness
  – cultural competence
Measure Performance

- “You can’t improve what you don’t measure”
- Develop quality metrics (indicators)
  - Structure
  - Process
  - Outcomes
- Across silos of MH/SU/GH
- At each “P” level
- Multiple activities/No stewardship
“6 P” Conceptual Framework

Patient / Consumer
- Enhance self-management/participation
- Link with community resources
- Evaluate preferences and change behaviors

Providers
- Improve knowledge/skills
- Provide decision support
- Link to specialty expertise and change behaviors

Practice / Delivery Systems
- Establish chronic care model and reorganize practice
- Link with improved information systems
- Adapt to varying organizational contexts

Plans
- Enhance monitoring capacity for quality/outliers
- Develop provider/system incentives
- Link with improved information systems

Purchasers (Public / Private)
- Educate regarding importance/impact of BH
- Develop plan incentives/monitoring capacity
- Use quality/value measures in purchasing decisions

Populations and Policies
- Engage community stakeholders; adapt models to local needs
- Develop community capacities
- Increase demand for quality care enhance policy advocacy
Improve Performance

- Guideline Dissemination
- Provider Training/Education/CME
- Certification/Accreditation/Licensure
- Provider Reminder Systems/Decision Support
- Patient Education/Reminders
- Quality Measurement
- Quality Improvement- PDSA/Six Sigma/IHI
- Public Reporting
- Financial Incentives/P4P
Strengthen Evidence Base

- **Document stakeholder value**
  - Get on radar screen

- **Evaluate effective strategies**
  - Measurement
  - Improvement Strategies
  - Implementation/Dissemination/Organizational Learning Strategies

- **Translate innovations from bench to bedside to community**
  - Knowledge Transfer

- **Fill gaps in the evidence base via:**
  - Alternate study designs
  - Administrative data sets
  - Outcome measures
  - Coordination of initiatives analyzing the evidence
  - Stewardship of field
Most Prevalent Treated Diagnoses in TRICARE Population

- Mood Disorders
- Anxiety Disorders
- Substance Use Disorders
- Adjustment Disorders
- *Post-Traumatic Stress Disorder
- *Military Sexual Assault
- *Traumatic Brain Injury
- *Suicidality
- Comorbidity
Examples of Evidence-Based Psychological Interventions for Selected Disorders Relevant to the TRICARE Beneficiary Population (cont’d)

| Major depressive disorder | Cognitive behavioral therapy (APA, 2000; VA/DOD, 2009a)  
Interpersonal therapy (VA/DOD, 2009a)  
Dialectical behavioral therapy (VA/DOD, 2009a)  
Behavior couples therapy (VA/DOD, 2009a)  
Problem-solving therapy (APA, 2005c; VA/DOD, 2009a) |
|---------------------------|---------------------------------------------------------------------|
| Schizophrenia             | Cognitive behavioral therapy (APA, 2004b; NIMH, 2009e)  
Social-skills training (APA, 2004b)  
Family intervention (APA, 2004b; NIMH, 2009e)  
Assertive community treatment (APA, 2004b)  
Supported employment (APA, 2004b; NIMH, 2009e; Lehman et al., 2004) |

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Examples of Evidence-Based Psychological Interventions for Selected Disorders Relevant to the TRICARE Beneficiary Population (cont’d)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute stress disorder, posttraumatic stress disorder</strong></td>
<td>Cognitive behavioral therapy (APA, 2009a; APA, 2004a; NIMH, 2009d; VA/DOD, 2004)</td>
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<tr>
<td></td>
<td>Exposure therapy (APA, 2009a; APA, 2004a; IOM, 2008; NIMH, 2009d; VA/DOD, 2004)</td>
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<td>Eye-movement desensitization and reprocessing (APA, 2004a; VA/DOD, 2004)</td>
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<tr>
<td><strong>Bipolar disorder</strong></td>
<td>Cognitive behavioral therapy (APA, 2005a; APA, 2002; NIMH, 2009b)</td>
</tr>
<tr>
<td></td>
<td>Interpersonal therapy (APA, 2005a; APA, 2002; NIMH, 2009b)</td>
</tr>
<tr>
<td></td>
<td>Family-focused therapy (APA, 2005a; APA, 2002; NIMH, 2009b)</td>
</tr>
</tbody>
</table>
Examples of Evidence-Based Psychological Interventions for Selected Disorders Relevant to the TRICARE Beneficiary Population (cont’d)

| Substance-use disorders       | Cognitive behavioral therapy (CBT) (APA, 2006b)  
|                               | Motivational interviewing (APA, 2006b; VA/DOD, 2009b)  
|                               | Behavioral couple therapy (APA, 2006b; VA/DOD, 2009b)  
|                               | Cognitive behavioral skills training (VA/DOD, 2009b)  
|                               | Contingency management (APA, 2006b; VA/DOD, 2009b)  
|                               | Community reinforcement approach (APA, 2006b; VA/DOD, 2009b)  

| Generalized anxiety disorder | Cognitive behavioral therapy (DH, 2001; NIMH, 2009a) |
Examples of Evidence-Based Psychological Interventions for Selected Disorders Relevant to the TRICARE Beneficiary Population (cont’d)

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<td>Panic disorder</td>
<td>Cognitive behavioral therapy (APA, 2009b)</td>
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Strategies for Measuring the Quality of Care

• Conceptualize aspects of care to be measured based on evidence – based on guidelines/evidence
• Translate concepts/recommendations into performance measure specifications
• Pilot-test performance measures to determine validity, reliability, feasibility, and cost
• Ensure calculation of performance measures and submission to a performance measure repository
• Audit to ensure that performance measures are calculated accurately in accordance with specifications
• Analyze and display the performance measures in formats suitable for understanding by multiple audiences – “Six P’s”
• Maintain performance measures and policies and provide stewardship for the field
Issues in Quality Measurement

- Adequacy of data sources
- Agreement/development of clinical measures (mental health “vital signs”)
- Codifying assessments in administrative data (visit v. lab test v. lab value)
- Codifying interventions in administrative data (e.g. specific psychotherapy, fidelity)
- Determining benchmarks
- Risk adjustment
- Linking process and outcome
Structure

- Are providers trained in evidence-based practices (incorporated in certification, credentialing, and licensing)?

- Are providers trained in applying evidence-based practices to different M/SU conditions and competences assessed?

- Do clinicians or organized care settings have mechanisms to ensure patients receive evidence-based care and to measure and improve quality (e.g., as incorporated in provider agreements with TRICARE contractors)?

- Do military care providers have mechanisms to measure and improve the quality of care (including the provision of evidence-based care) of their providers/contractors?
Process

- Are providers using evidence-based practices for assessment, diagnosis, and treatment
  - at a level of fidelity that meets accepted standards?
  - for appropriate conditions presenting in the treatment setting?
  - Among mental health-clinician categories?

- Are clinics and other organized settings
  - assessing whether patients are receiving evidence-based care
  - and using the data to improve care?

- Are contractors
  - assessing whether patients are receiving evidence-based care
  - And using the data to improve performance of providers in their network?
Outcomes

- Are providers, clinics, and care contractors systematically utilizing appropriate measures of clinical outcomes on a coordinated, longitudinal basis?

- Are they using the data to improve outcomes of individual patients and population as a whole?

- Are the outcomes improving?
“Crossing the Quality Chasm”

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