Can Child Mental Health Cross the Quality Chasm?

Children's Behavioral Health, Healthcare Reform and the "Quality Measurement Industrial Complex"

Harold Alan Pincus, MD
Professor and Vice Chair, Department of Psychiatry
Co - Director, Irving Institute for Clinical and Translational Research
Columbia University
Director of Quality and Outcomes Research
NewYork-Presbyterian Hospital
Senior Scientist, RAND Corporation

IOM C-CAB Meeting
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A Reality Check

- How do YOU choose a doctor for yourself, your children, your parents?
- How do YOU choose a mental health provider for your children or suggest one for a friend or a family member?
- How do YOU determine whether your children are receiving high quality medical care?
- High quality mental health care?
- What DATA do you examine to answer these questions? What data do you WISH you had?

Affordable Care Act

- Expanded Insurance Access/Provider Revenue Reductions
  - Mandates/Medicaid expansion/Insurance exchanges
  - MH/SUD parity
- System/Payment Redesign
  - Accountable Care Organizations (ACOs)
  - Patient-Centered Medical Homes/Health Homes
  - Bundling
  - Health Information Technology
- Quality Measurement/Accountability
  - “Triple Aim”- Quality/Affordability/Population Health
  - National Quality Strategy
- New research/demonstration opportunities-PCORI/CMMI

Examples of Quality Reporting/Payment Programs in ACA

- National Quality Strategy
- Core Hospital Safety Measures
- Meaningful Use
- Physicians Quality Reporting System
- Value-Based Purchasing Modifier
- Value Based Inpatient Psychiatry Quality Reporting Program
- PhysicianCompare.Gov
- HospitalCompare.Gov
- NursingHomeCompare.Gov

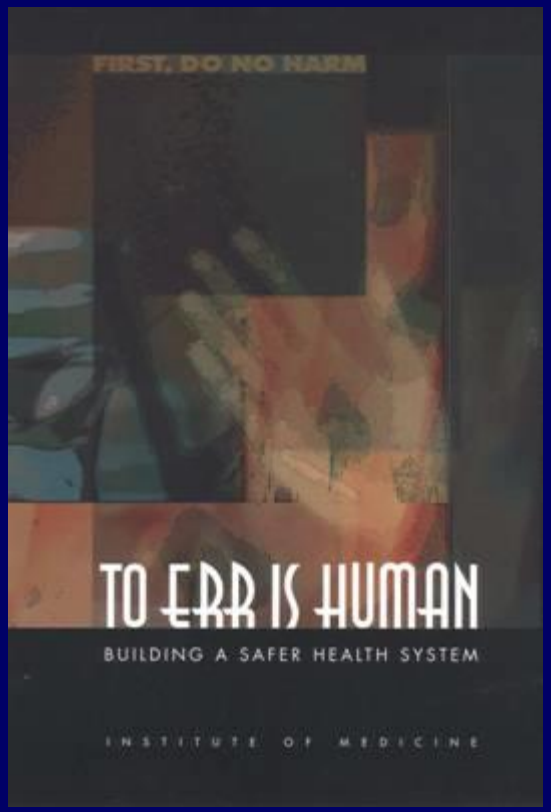
The Boston Globe

Care of mentally ill faulted in report

US survey reviews patient follow-up; state well below national average

Medicare data on hospitalcompare.gov highlights poor performance of individual hospitals

To Err Is Human: Building A Safer Health System

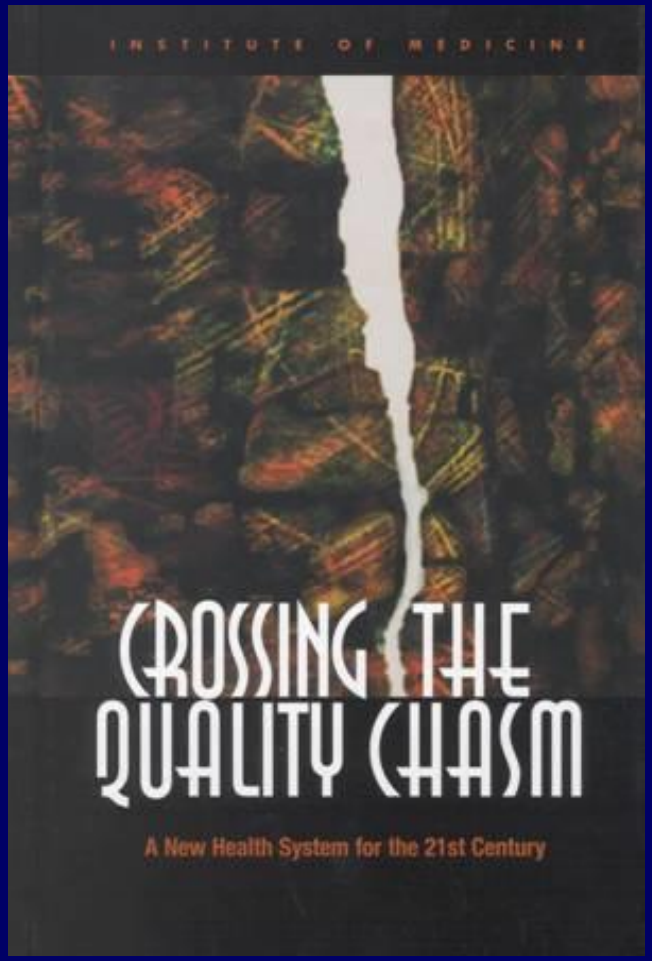


First Report

Committee on
Quality of Health Care
in America

To order: www.nap.edu

Crossing the Quality Chasm



"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/Quality Domains 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

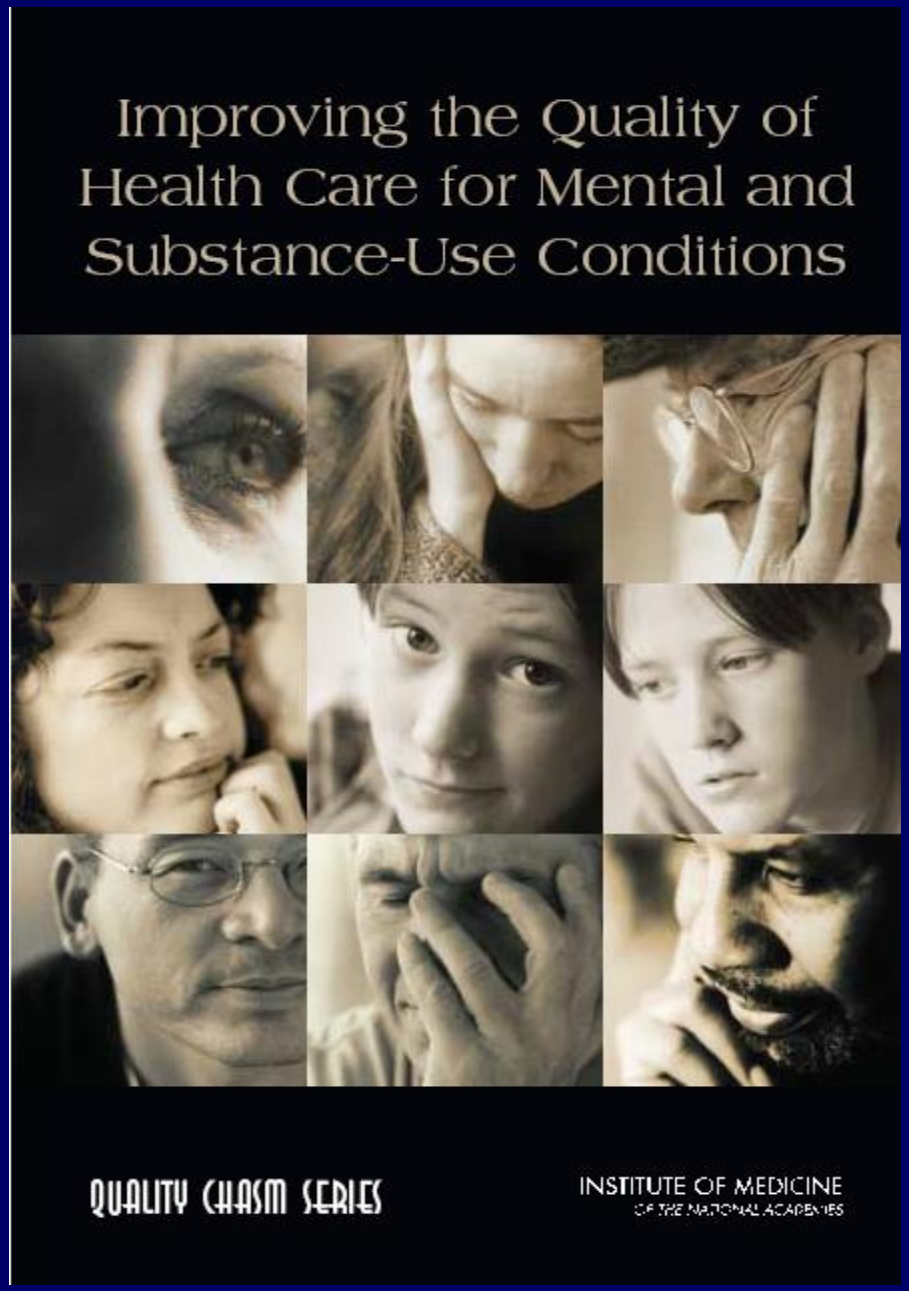
3. **Patient-centered** – respects and responds to patient preferences, needs, and values

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)


Improving the Quality of Health Care for Mental and Substance-Use Conditions
QUALITY CHASM SERIES
INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

“Crossing the Quality Chasm”

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 (NHII)
- Problem 5: Insufficient workforce capacity for QI
- Problem 6: Differently structured marketplace

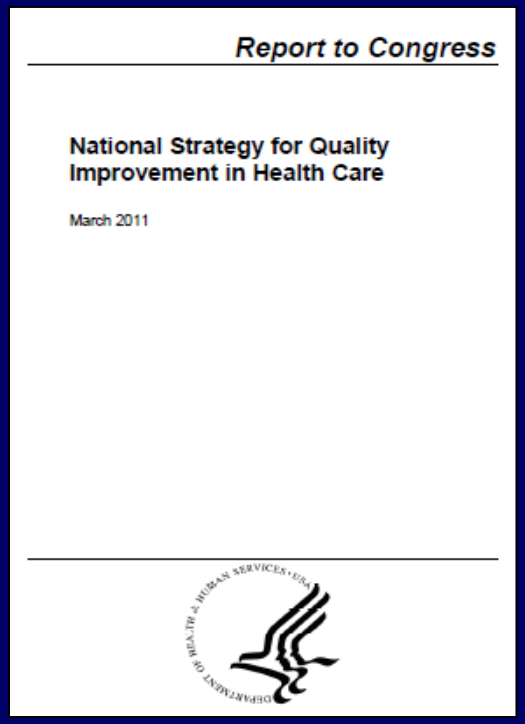
Problem 2: Weak Measurement and Improvement Infrastructure

- Clinical assessment and treatment practices not standardized and classified for use in administrative datasets
- Outcomes measurement not widely applied despite reliable and valid instruments (“measurement-based care”)
- Insufficient attention to development or implementation of performance measures
- QI methods not yet permeating day-to-day operations
- Work force not trained in quality measures and improvement
- Policies do not incentivize quality/ efficiency

Quality of Publicly Funded Child SMH Care in California (ADHD, CD, MD) (Zima, et al, JAACAP, 2005)

Indicators	Weighted % Passing Indicator
Initial clinical Assessment	
Probable Acceptable care	37.8%
All Indicators	37.8%
Linkage to other service sectors	
Probable Acceptable care	34.4%
All Indicators	17.6%
Basic treatment principles	
Probable Acceptable care	35.0%
All Indicators	12.1%
Psychosocial treatment	
Probable Acceptable care	78.2%
All Indicators	18.6%
Patient Protection	
Probable Acceptable care	51.3%
All Indicators	51.3%
Safety: Informed medication decision	
Probable Acceptable care	39.8%
All Indicators	39.8%
Safety: Medication monitoring (monthly)	
Probable Acceptable care	56.0%
All Indicators	56.0%
Safety: Medication-specific monitoring	
Probable Acceptable care	26.1%
All Indicators	7.3%

National Quality Strategy promotes better health, healthcare, and lower cost



The **Affordable Care Act (ACA)** requires the Secretary of the Department of Health and Human Services (HHS) to establish a ***national*** strategy that will improve:

The delivery of health care services

Patient health outcomes

Population health

CMS Quality Programs

Hospital Quality Reporting	Physician Quality Reporting	PAC and Other Setting Quality Reporting	Payment Model Reporting	"Population" Quality Reporting
• Medicare and Medicaid EHR Incentive Program • PPS-Exempt Cancer Hospitals • Inpatient Psychiatric Facilities • Inpatient Quality Reporting • Outpatient Quality Reporting • Ambulatory Surgical Centers	• Medicare and Medicaid EHR Incentive Program • PQRS • eRx quality reporting	• Inpatient Rehabilitation Facility • Nursing Home Compare Measures • LTCH Quality Reporting • ESRD QIP • Hospice Quality Reporting • Home Health Quality Reporting	• Medicare Shared Savings Program • Hospital Value-based Purchasing • Physician Feedback/Value-based Modifier*	• Medicaid Adult Quality Reporting • CHIPRA Quality Reporting • Health Insurance Exchange Quality Reporting • Medicare Part C • Medicare Part D


recognizing
medication
analysis
capture
definitions
disability
program
incorporating
considerations
Availability
Alignment
centric
endorsed
beneficiaries
Address
population
transparency
accountability
Disparities
Promote
cost
duals
private
ideal
outcomes
providers
reporting
coordination
specific
criteria
status
mechanism
sources
cross
care
Add
unintended
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comprehensiveness
Need
plans
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Patient
consequences
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Appropriateness
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supports
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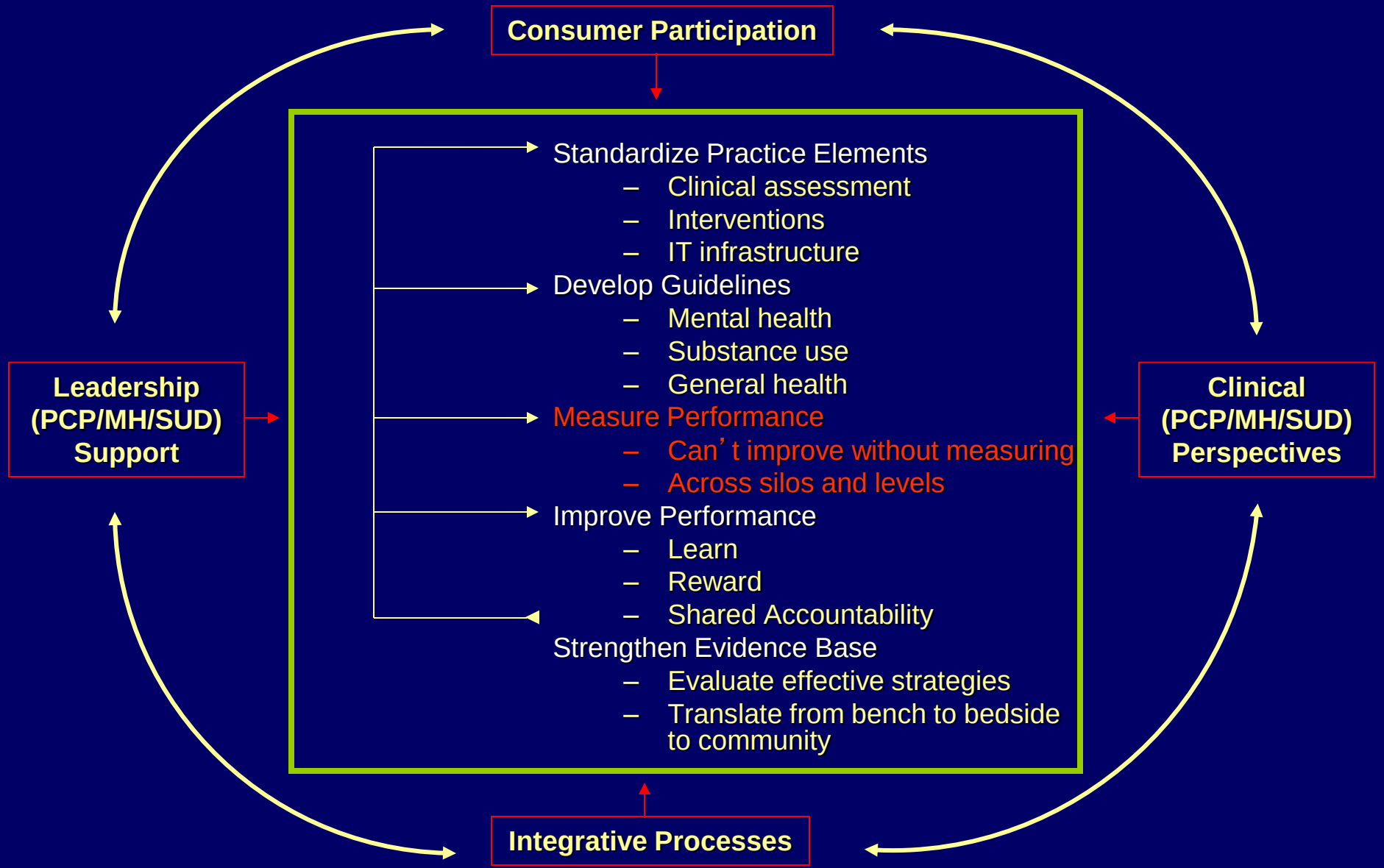
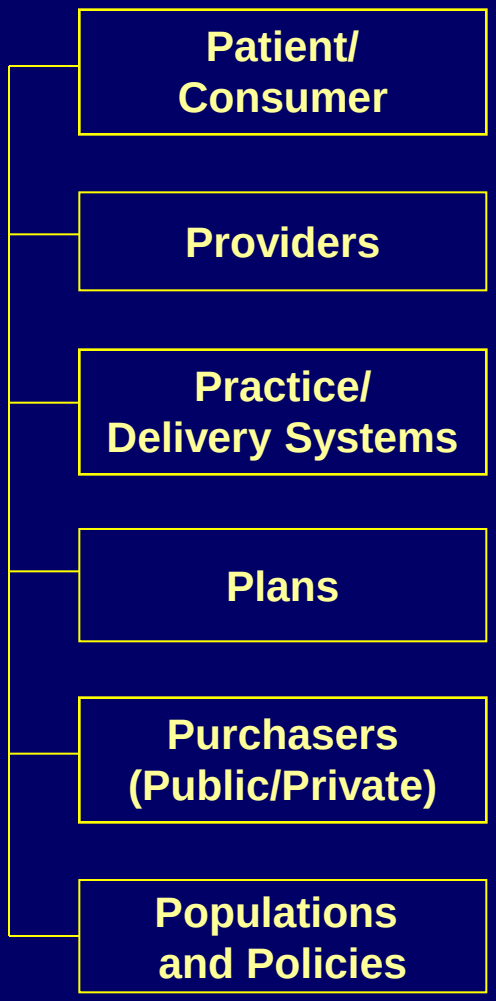
Preparing for the Future



Measure Performance

- "You can't improve what you don't measure"
  - Deming
- Develop quality metrics (indicators)
- Across IOM domains
  - Safety, Effectiveness, Equity, Efficiency, Patient-Centeredness, Timeliness
- Improvement v Accountability Measures
- Across silos of MH/SU/GH
- At each "P" level
- "Not everything that counts can be counted, and not everything that can be counted counts"
  - Einstein

"6 P" Conceptual Framework



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

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

- *Establish chronic care model and reorganize practice*
- *Link with improved information systems*
- *Adapt to varying organizational contexts*

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

- *Educate regarding importance/impact of BH*
- *Develop plan incentives/monitoring capacity*
- *Use quality/value measures in purchasing decisions*

- *Engage community stakeholders; adapt models to local needs*
- *Develop community capacities*
- *Increase demand for quality care enhance policy advocacy*

Types of Measures

- Structure
  - Are adequate personnel, training, facilities, security, QI infrastructure, IT resources, policies, etc. available for providing care?
- Process
  - Are evidence-based processes of care accessible? Are they delivered with fidelity?
- Outcome
  - Does care improve clinical outcomes?
- Patient Experience
  - What do users and other stakeholders think about the system's structure, the care they have received, and their outcomes?
- Resource Use
  - What resources are expended for the structure, processes of care and outcomes?

Developing Indicators

- Establishing an evidence base
- Translating evidence to guidelines
- Translating guidelines to measure concepts
- Operationalizing concepts to measure specifications (numerator/ denominator)
- Testing for reliability, validity, feasibility
- Aligning measures across multiple programs
- Stewardship/Updating measures over time

Components of Quality Measures

- Numerator
- Denominator
- Exclusion criteria
- Standardization
- Risk adjustment

Gathering Data for Indicators

- Data sources
  - Administrative (e.g., insurance claims)
  - Chart reviews
  - EHRs
  - Registries
  - Patient surveys
- Data collection/ submission
- Auditing for accuracy
- Analysis and display/ benchmarks
- Allocating resources/costs

"Players" in the Measurement Process

- Evidence Developers
  - Researchers, NIH, PCORI
- Guideline Developers
  - Professional Associations, Organizations
- Measure Developers/Stewards
  - NCQA, TJC, CMS, Contractors, Researchers, AMA?
- Measure Endorsers
  - NQF
- Measure Selectors/Advisers
  - NQF/MAP/CMS
- Measure Users
  - CMS, Plans, Organizations, Media, Public

Choosing Measures

Stage of Evaluation	National Quality Forum Endorsement Criteria
Conditions to be met prior to measure consideration	Measure is in the public domain or measure steward agreement is signed •Measure is updated on a schedule commensurate with the rate of clinical innovation •Measure includes both accountability applications and performance improvement to achieve high-quality, efficient healthcare •Measure is fully specified and tested for reliability and validity •Measure has been harmonized with competing measures
Measures are evaluated for their suitability based on four sets of standardized criteria [listed in order of importance]	• ***Importance of measure***: Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high impact) aspect of healthcare where there is variation in or overall less-than-optimal performance • ***Scientific acceptability*** *of measure properties*: Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented • ***Usability***: Extent to which potential audiences are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations • ***Feasibility***: Extent to which the required data are readily available or could be captured without undue burden and can be implemented for performance evaluation

Using Indicators to Improve Quality

- **Use at Clinical Level (Standardization)**
  - Measurement based, patient-centered care
- **Use at Organizational Level (Improvement)**
  - Audit/ profiling/ feed back
  - PDSA/ checklists/ six sigma
  - Reducing unwanted/inappropriate variation
- **Use at Policy Level (Accountability)**
  - Public reporting
  - Value-based purchasing / P4P

Issues in Developing/Using Behavioral Health Measures

- Adequacy/Specificity of evidence base!
- Agreement/development/HIT integration of clinical measure for “Measurement-Based Care”
- Codifying psychosocial interventions in administrative data (psychotherapy/“90806” v. CBT v. CBT with fidelity)
- Adequacy of data sources--Documentation or Reality
- Determining benchmarks/Risk adjustment
- Linking S-P-O (e.g. ACCORD)
- Who is stewarding/funding measure development?
- Far behind in implementation of HIT/(exclusion from HITECH)
- Heterogeneity of providers/training/certification
- Who is accountable for performance? Shared accountability?

Measurement-Based Care (MBC)

- Systematically Apply Appropriate Clinical Measures
  - e.g. HA1c, PHQ-9, Vanderbilt Assessment Scales
  - Create a measurement tool kit
- Assure Consistent, Longitudinal Assessment
  - “Ruthless” Follow-Up/Care Management
- Maintain Action-Oriented Menus of Evidence-Based Options
  - Treatment intensification/“Stepped Care”
- Establish Practice-Based Infrastructure
  - Build IT/Registry Capacity
- Enhance Connectivity among Systems
  - MH/PC/SUD/Social Services/Education
- Incentivize Structures that Produce Outcomes

IOM Committee on Developing Evidence-Based Standards for Psychosocial Interventions for Mental Disorders

Sponsors

National Institutes of Health

Department of Veterans Affairs

Substance Abuse and Mental Health Services Administration

HHS / Office of the Assistant Secretary for Planning and Evaluation

American Psychological Association

American Psychiatric Association

American Psychiatric Foundation

National Association of Social Workers

Association for Behavioral Health and Wellness

Charge to the Committee

The IOM committee will **develop a framework from which to establish efficacy standards for psychosocial interventions** used to treat individuals with mental disorders (inclusive of addictive disorders). The committee will explore strategies that different stakeholders might take to help establish these standards for psychosocial treatments.

Specifically, the committee will:

- Characterize the types of scientific evidence and processes needed to establish the effectiveness of psychosocial interventions.
- Identify the elements of psychosocial treatments that are most likely to improve a patient's mental health and can be tracked using performance measures. In addition, identify features of health care delivery systems involving psychosocial therapies that are most indicative of high quality care that can be practically tracked.
- Report to be released in Spring 2015