Quality Improvement in Mental Healthcare: The Measures Matter

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Overview

- Quality of mental healthcare in the US
- Movement toward measurement-based quality improvement (MBQI)
- Implications for patient care & clinical practice

U.S. Institute of Medicine
Crossing the Quality Chasm, 2001

Quality problems are everywhere...

Between the health care we have and the care we could have lies not just a gap, but a chasm.

IOM Crossing the Quality Chasm (2005): Adaptation to Mental Health/Addictive Disorders

- Many with severe illness receive no treatment
- Inappropriate variation from provider to provider
- Inconsistent use of evidence-based practices
- Medical errors threaten patient safety
- Opportunities for prevention often missed

Quality of Mental Health Care

Evidence-based Guidelines	Conformance Rate
Depression	
medication management	31-35% (Wells,1999)
psychotherapy / counseling	16-24% (Wells,1999)
Schizophrenia	
medication management	29-92% (Lehman, 1999)
psychosocial treatment	10-45% (Lehman, 1999)
Bipolar disorder – med. mgmt.	36-39% (Unutzer, 2000)
Severe mental illness – evid. based care	4-19% (Wang, 2002)

Gaps in Other Processes of Care

Prevention

- 30-50% primary care pts w/ MDD not detected

Assessment

- Among pts. hospitalized for MDD, only 46% had documented assessment for SI, 50% for psychosis

Continuity

- Among pts. hospitalized for SPMI, btw 33-53% lacked an ambulatory follow-up visit w/in 30 days

Coordination

- 29-84% of patients hospitalized for a psychiatric disorder lacked a scheduled OP appt. at discharge

IOM Crossing the Quality Chasm (2005): Adaptation to Mental Health/Addictive Disorders

Recommendations:

Clinicians & provider organizations should measure and continuously improve the quality of the care they provide.

- consensus-based development of core measures
- validation of measures
- models for their use in QI

Why QI, Why Now?

- Accumulation of quality of care research
- Concerns of business community
  - rising costs
  - absence of information on value
  - “accountability”
- Concerns of consumers & clinicians
  - impact of cost-containment, managed care
- Rise of the machine
  - integrated health systems
  - information systems

A ‘March’ toward Empiricism?

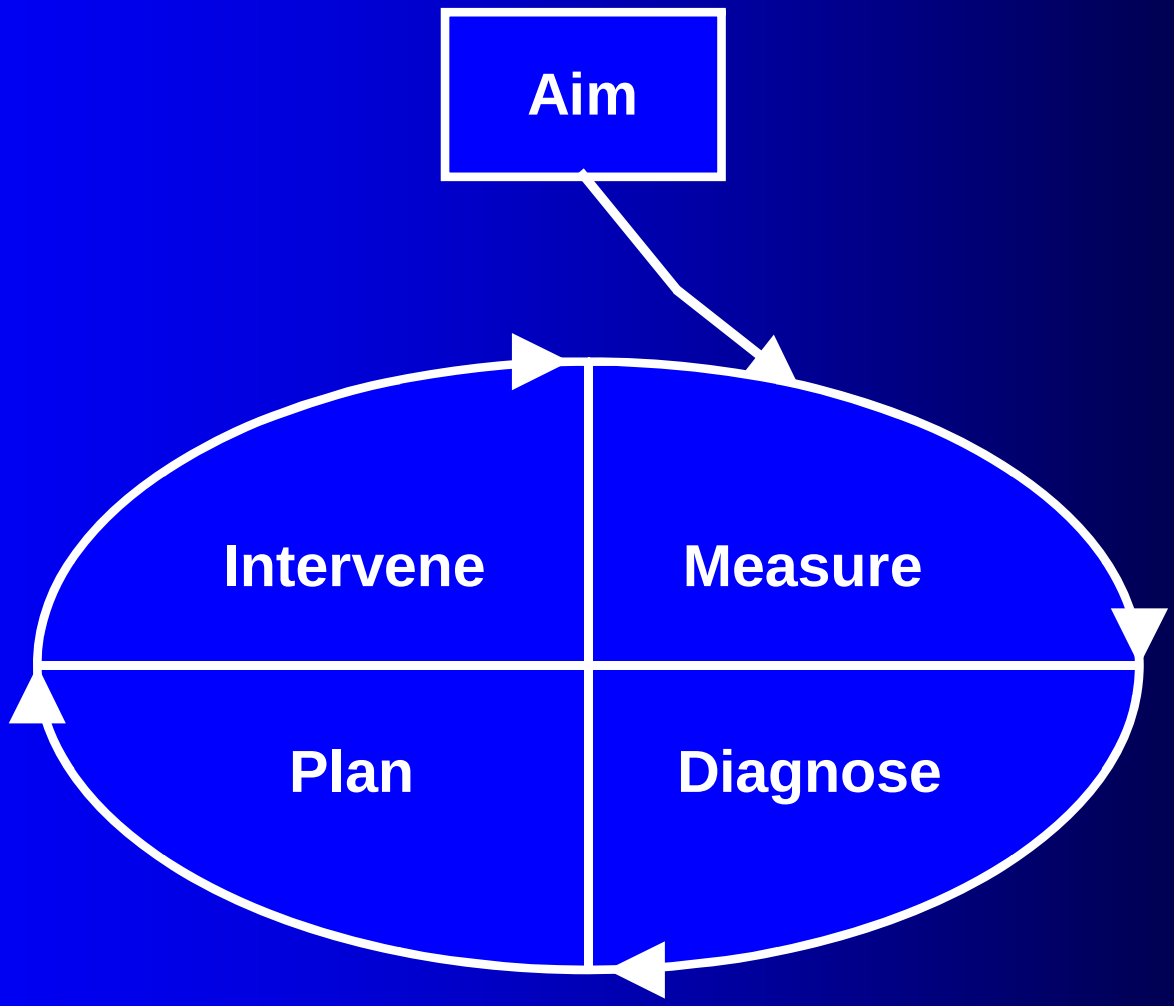
- Criteria-based diagnosis
- Controlled trials of interventions
- Practice guidelines
- Measuring guideline conformance
- Narrowing gaps between actual & guideline-based care

What is Measurement-based QI?

Principles of Measurement-Based QI

- Health care as series of processes
- Quality as problems in processes
- Use of measurement & statistical analysis
- Focus on improving process & outcomes
- Organization-wide involvement

Model for Measurement-based QI



Role of Measurement in Quality Improvement

- Internal quality improvement
  - incremental MBQI
  - system redesign
- External quality improvement
  - reporting and feedback
  - collaborative partnerships
  - consumer & purchaser choice
  - contractual goals
  - accreditation standards

"Pay for Performance"

Goal: align payment incentives w/ higher quality

Mechanisms:

- higher payments for meeting quality standards
- incentives for improvement
- "tiered co-payments" for consumers

Status:

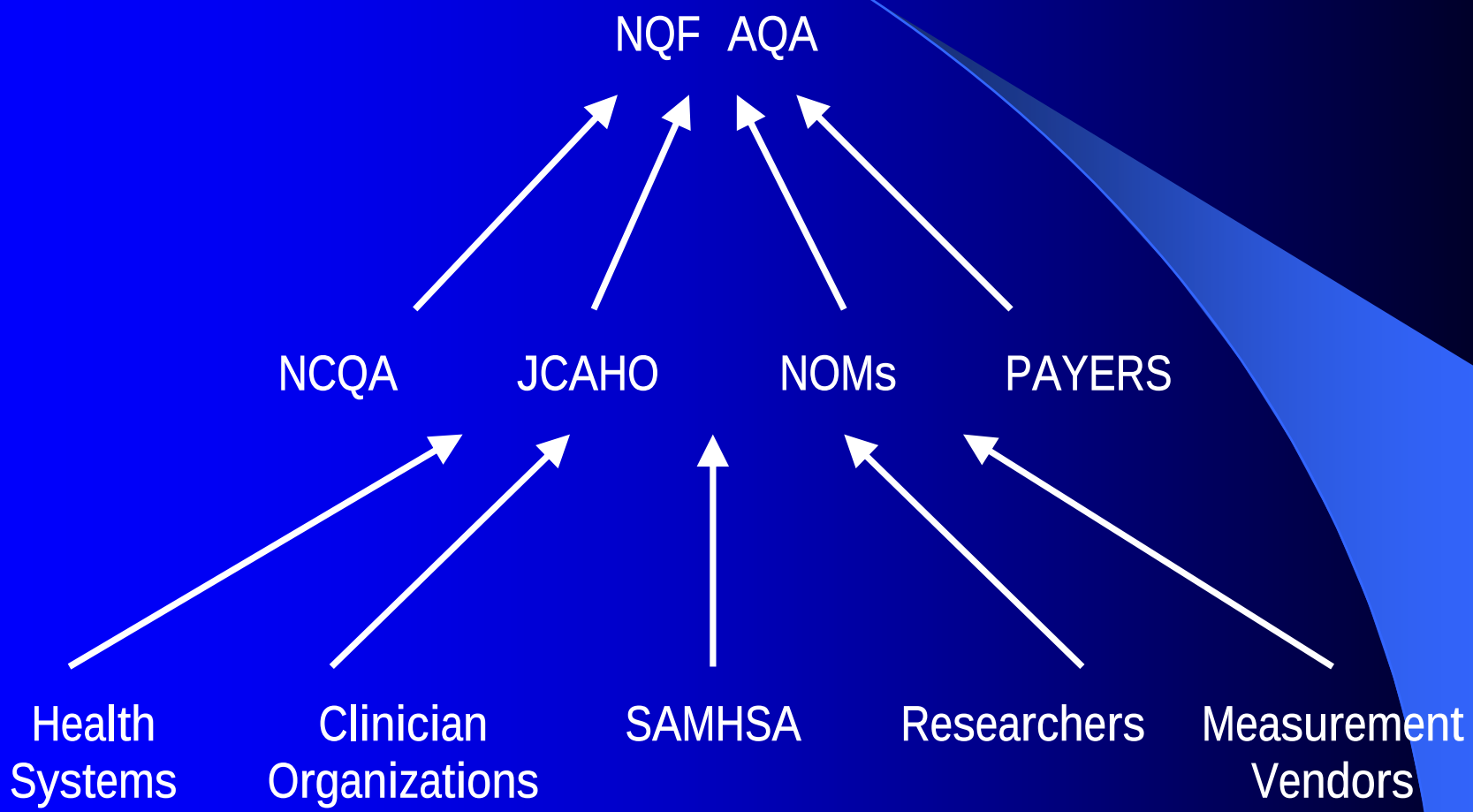
- hundreds of programs nationwide
- federal demonstration projects; legislation pending
- broader use expected

Concerns about Measurement-Based QI

- Regulatory compliance or real work?
- QI or cost containment?
- Are we measuring what's important?
- Are the measures & data adequate to the task?
- Is what's measured under our control?
- My patients are sicker…

Meanwhile…

Standardization of Quality Measures



Measure Selection: Why it Matters

- What problems will be addressed?
- Where will resources be directed?
  - Direct cost of QI to hospitals: $200,000 / year
  - Indirect costs: clinician & administrative time
  - Opportunity costs: other QI, clinical care, other
- How will we be reimbursed, accredited, credentialed?

Measurable, Improvable Components of Care

Structure

Clinicians
Facilities
Plans
Financing
Communities
Patients
Illnesses

Technical Process

Prevention
Access
Assessment
Treatment
Coordination
Continuity
Safety

Interpersonal Process

Communication
Decision-making
Interpersonal style

Outcome

Δ in symptoms
Δ in functioning
Δ in quality of life
Satisfaction
Adverse effects
Mortality

NCQA's HEDIS Measures for Health Plans

Major Depression: % of patients with…

- ≥12-week continuation after antidepressant initiated
- ≥ 6-month continuation after antidepressant initiated
- 3 follow-up visits during 12-week acute phase

ADHD: % of children with…

- ≥ 1 follow-up visit w/in 30-day after initiation of medication
- ≥ 2 additional follow-up visits w/in subsequent 9 months

Aftercare Post-Hospitalization:

- % patients with a follow-up visit within 7 & 30 days

JCAHO Candidate Core Measures for Inpatient Psychiatry

% of hospitalized patients with:

- assessment of risk, substance abuse, trauma & strengths
- discharged on multiple antipsychotic medications
- hospital data provided to their OP clinician after discharge

Per Inpatient Stay:

- hours of restraint use
- hours of seclusion use

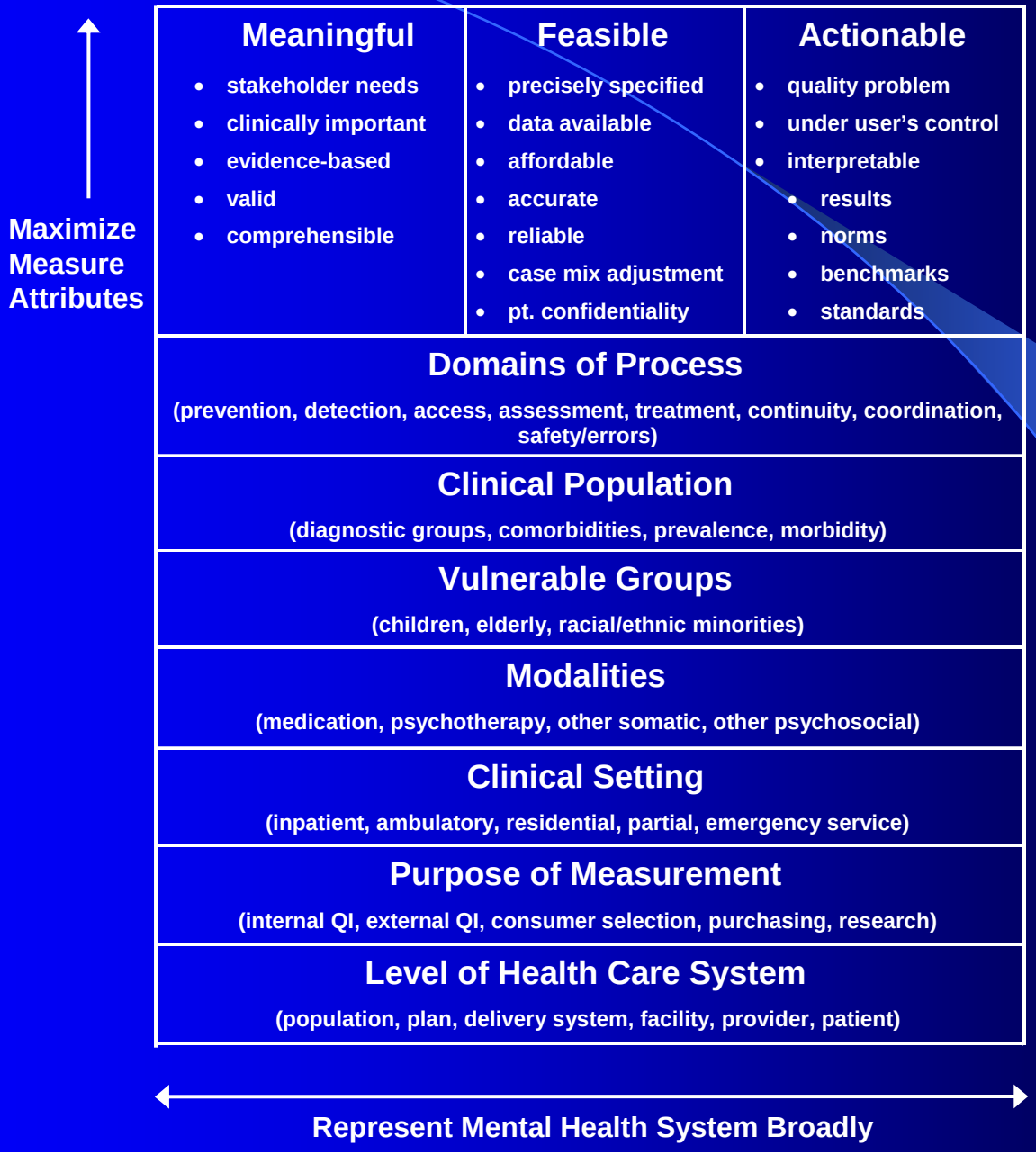
Surveys of Patient Experience

- Experience of Care & Health Outcomes Survey (ECHO)
- MHSHIP Consumer Survey
- Perceptions of Care Survey
- Press-Ganey Survey

Outcome Measures in Use in Massachusetts

- Brief Psychiatric Rating Scale (BPRS)
- Treatment Outcomes Package (TOP)
- Behavior & Symptom Identification Scale (BASIS)
- Life Status Questionnaire (LSQ)
- Patient Health Questionnaire (PHQ)

Attributes Informing Measure Selection



Hermann and Palmer, Psychiatric Services, 2002

CQAIMH

center for quality assessment and improvement in mental health

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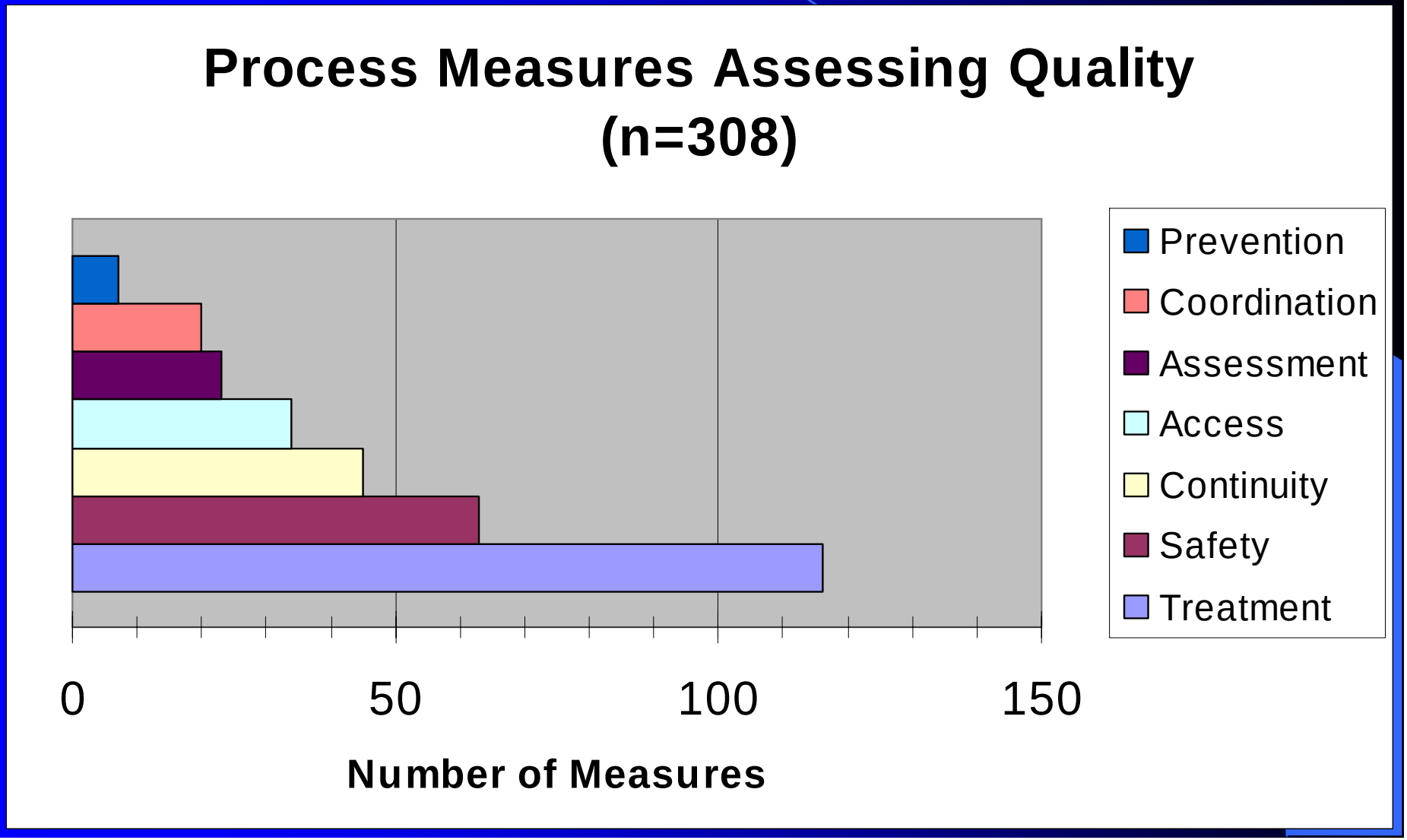
Overview | Instructions | Search for Measures | Report Measures | Sign In | Glossary | Toolkit

To search for measures, please select at least two of the following search criteria.

Diagnosis:	Not Specified
Special Populations:	Not Specified
Data Source:	Not Specified
Evidence Level:	Not Specified
Treatment:	Not Specified
Domain of Quality:	Not Specified
Clinical Setting:	Not Specified

Search for Quality Measures | Reset

National Inventory of Mental Health Quality Measures



Treatment Modalities Assessed

	N	%
Medication	81	26
Psychosocial	97	32
Psychotherapy	9	
Assertive community treatment	11	
Substance abuse counseling	22	
Other psychosocial	12	
Other modality	43	14
Not applicable	121	39

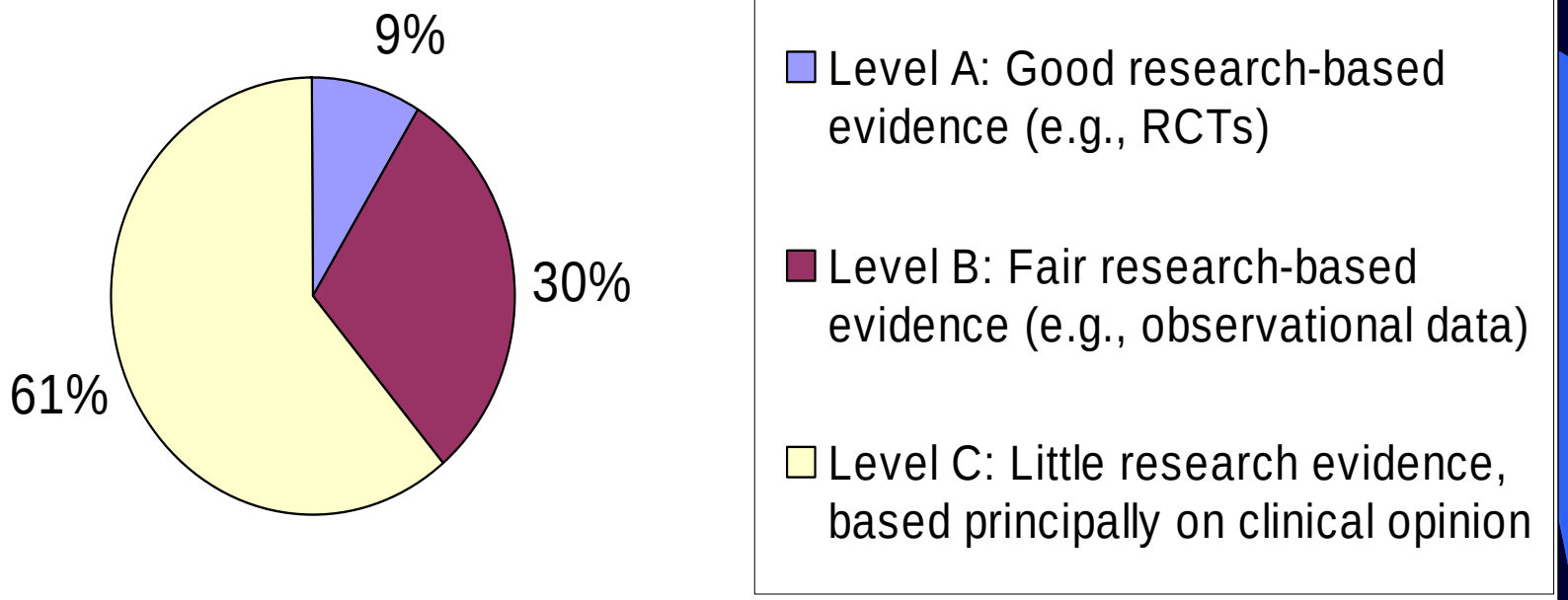
Diagnostic Groups Addressed

	N	%
Schizophrenia	35	11
Depressive disorders	43	14
Substance abuse / dependence	24	8
Bipolar disorder	3	1
Dementia	1	<1
Personality disorders	1	<1
Across diagnoses	119	39

Vulnerable Populations Addressed

	N	%
SPMI	35	11
Elderly	23	7
Children & adolescents	49	16
Dual diagnosis	7	2
Comorbid medical conditions	4	1

Most Measures Lack Supporting Research



Testing of Measures

	N	%
Reliability testing	21	7
Validity testing	34	11
Cost assessment	53	17

Evidence for Measurement-based QI

Efficacy

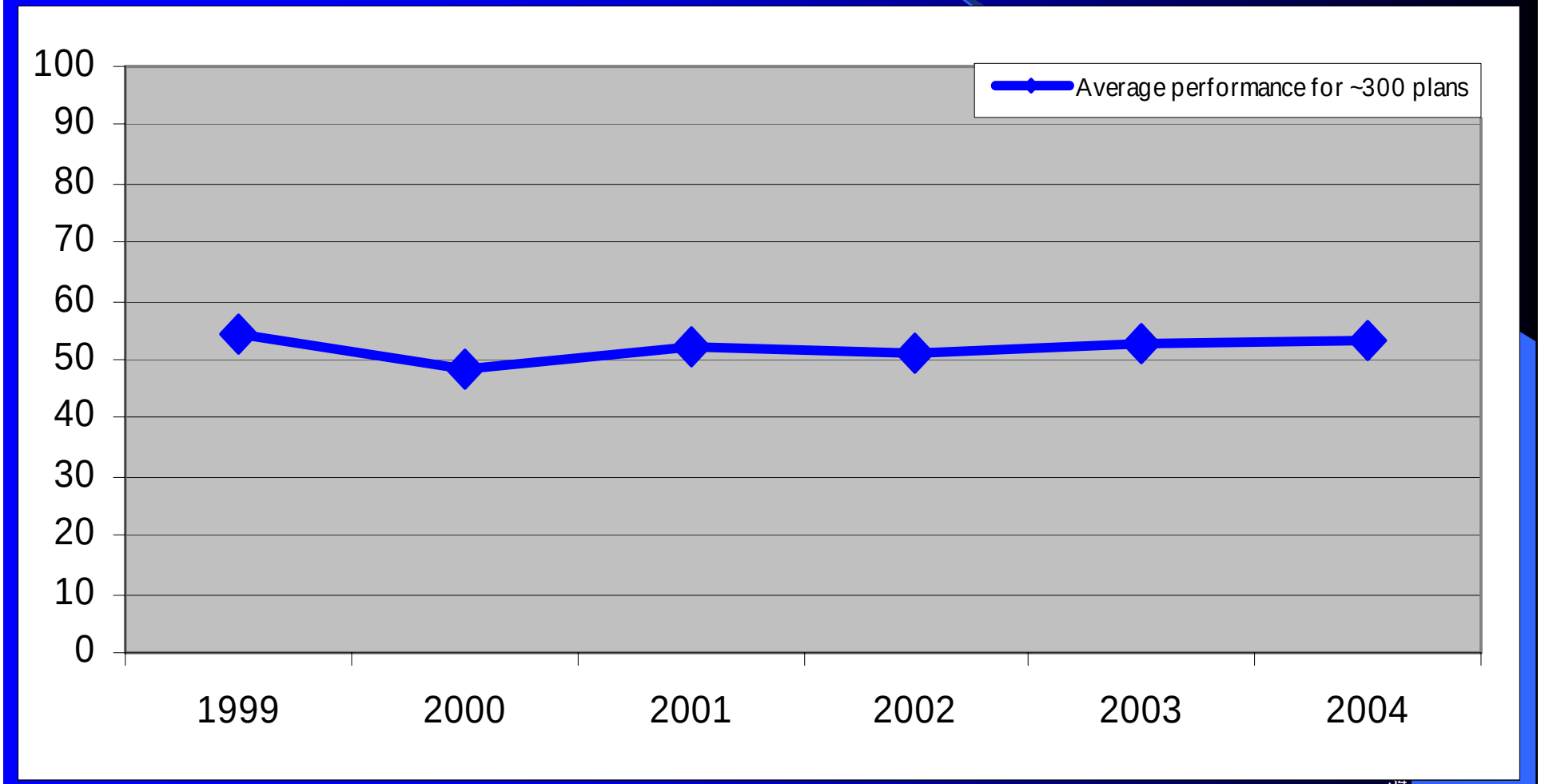
- Review of 55 controlled trials of QI showed "pockets of improvement" rather than widespread change across hospitals and QI objectives (Shortell, 1998)

Evidence for Measurement-based QI

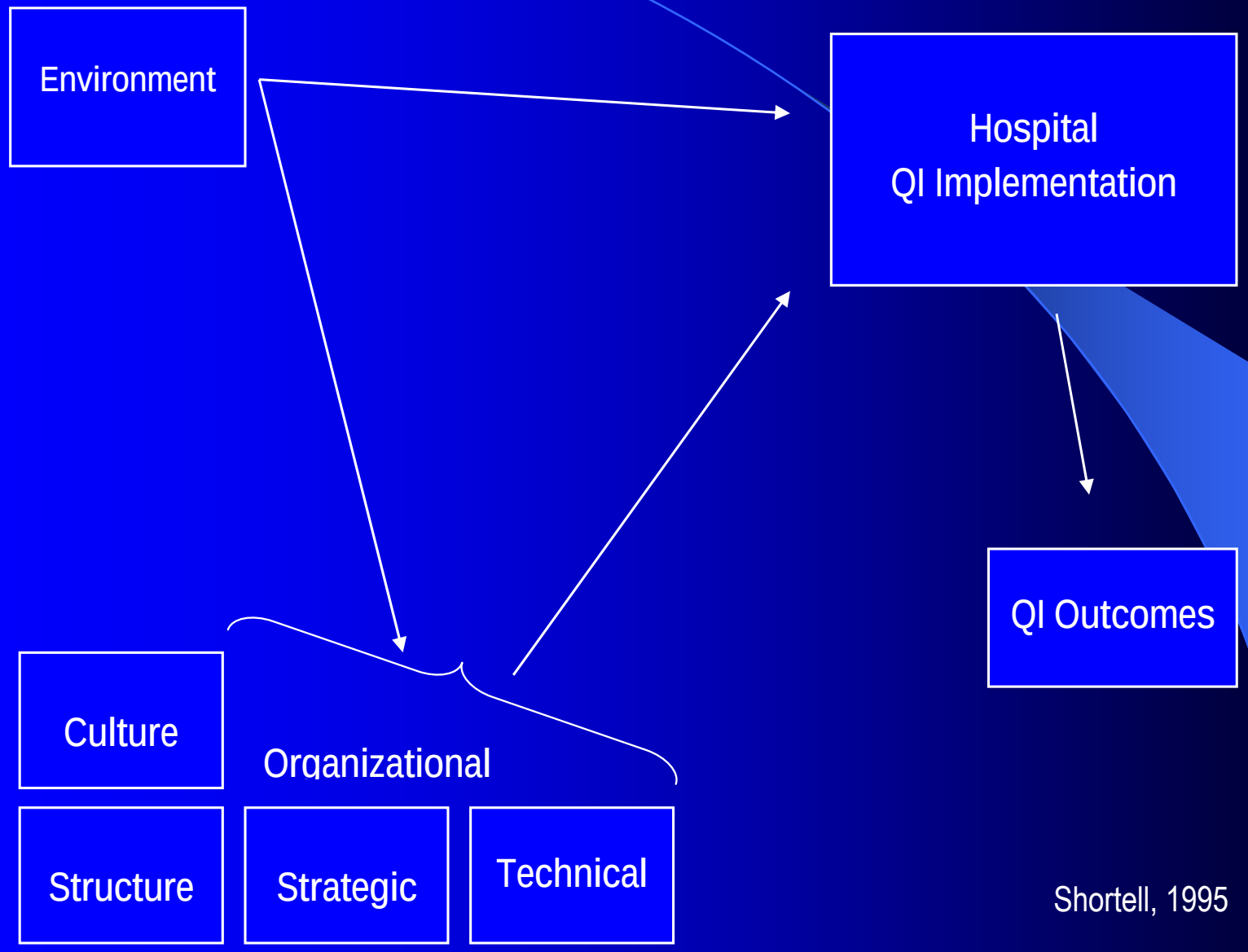
Effectiveness

- Routine QI is not well studied
- Published case reports of successful initiatives
- Little improvement seen in results of national measurement initatives

National HEDIS Results: Acute-Phase Antidepressant Adherence



Determinants of QI Effectiveness: Prior Research

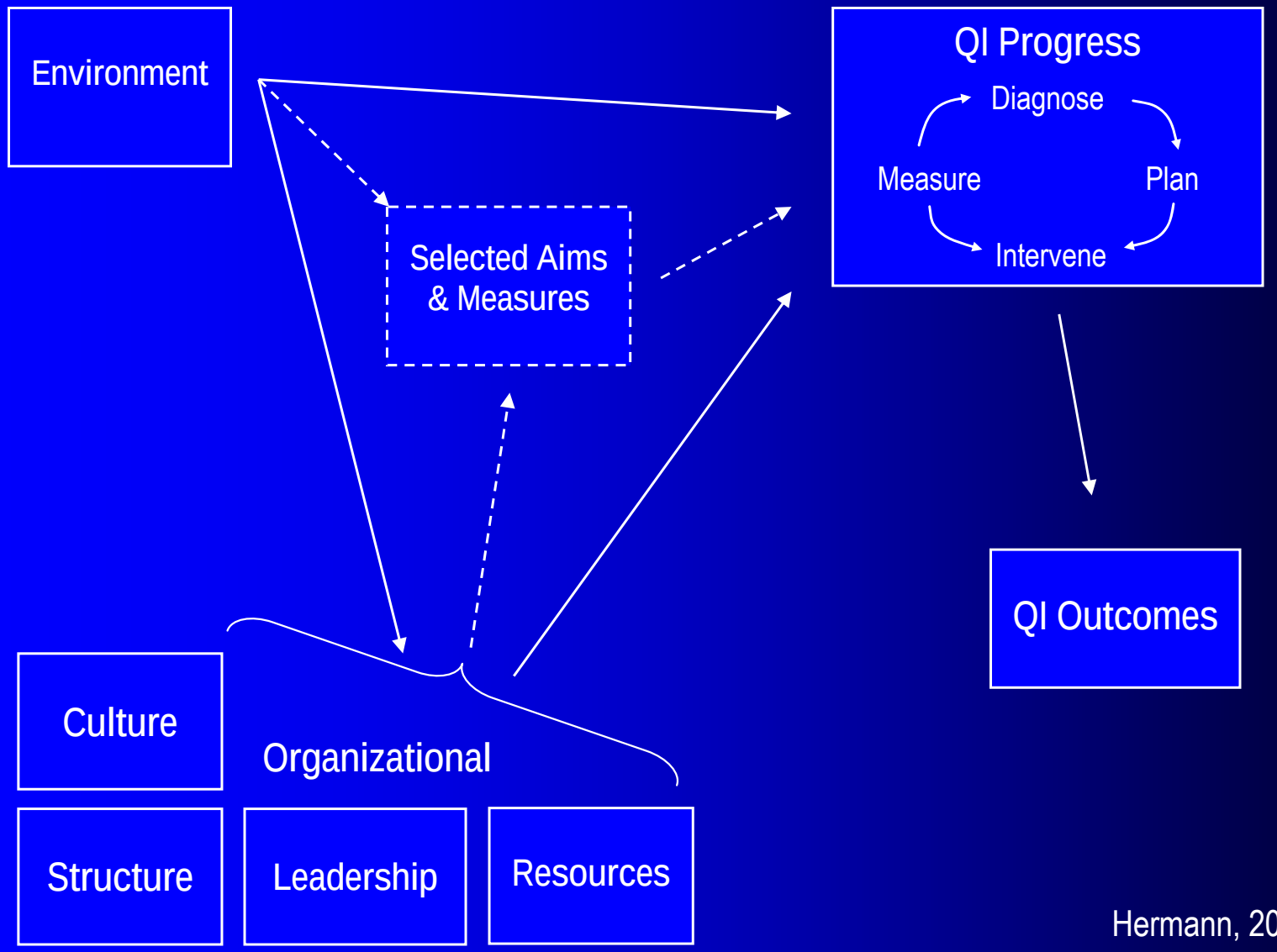


Shortell, 1995

The Mental Health QI-Fit Study

- NIMH-funded study of 32 hospitals in MA & CA
- What are hospitals' QI objectives for inpatient psychiatry?
  - EBPs -- patient-centered care
  - effectiveness -- equity
  - access -- efficiency
  - safety
- Are hospitals achieving improvement?
- Hypothesis: effectiveness is influenced by the fit between the hospitals & their QI objectives

Determinants of QI Effectiveness: QI-Fit Study



Hermann, 2005

Evidence-based Improvement Interventions

- Audit & feedback
- Local opinion leaders in guideline implementation
- Academic detailing
- Reminders & prompts
- Multimodal programs for improving depression care
  - Collaborative management
  - Chronic disease model
  - Partners in Care training model
- Relapse prevention programs for schizophrenia
- Open access for ambulatory care

Conclusion

Current Status

- 100s of measures–need for further development & testing
- MBQI not proven—need to improve effectiveness

Meanwhile…

- need for the "good enough" measure
  - trade-offs
  - combined approaches
- measure selection is a political process
  - educate, advocate, negotiate
  - can't beat something with nothing
  - need for clinician input & leadership
- accountability works both ways