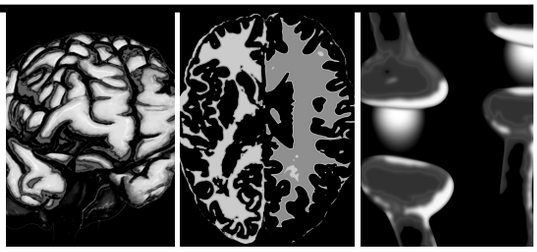
ASK THE EXPERTS



Quality of mental healthcare

Harold Alan Pincus*: Harold Alan Pincus is Professor and Vice Chair of the Department of Psychiatry at Columbia University's College of Physicians and Surgeons, Director of Quality and Outcomes Research at New York-Presbyterian Hospital and Co-Director of Columbia's Irving Institute for Clinical and Translational Research. He also serves as a Senior Scientist at the RAND Corporation. Previously, he was Director of the RAND-University of Pittsburgh Health Institute and Executive Vice Chairman of the Department of Psychiatry at the University of Pittsburgh. He is the National Director of the Health and Aging Policy Fellows Program and directed national programs for the Robert Wood Johnson Foundation and the John A Hartford Foundation. He was also the Deputy Medical Director of the American Psychiatric Association (APA) and the founding director of the APA's Office of Research, Special Assistant to the Director of the National Institute of Mental Health (NIMH) and served in the White House and Congressional staffs. He was Vice Chair of the Task Force on the DSM-IV and has been appointed to the editorial boards of ten major scientific journals. He has edited or coauthored 23 books and over 300 scientific publications on health services research, science policy, research career development and the diagnosis and treatment of mental disorders. Among other projects, he has led the national evaluation of mental health services for veterans, the redesign of primary care/behavioral health relationships in New Orleans and a national study of research mentoring. He has also been a consultant to multiple federal agencies and private organizations, including the US Secret Service and the MacArthur Foundation. He has chaired or served on national and international committees, including those for the US Institute of Medicine, and committees on quality for the Medicaid and Medicare programs, Affordable Care Act, National Quality Forum and the WHO's International Classification of Disease 11th Edition. For over 22 years, he worked one night a week treating the severely mentally ill at a community clinic.

Brigitta Spaeth-Rublee: Brigitta Spaeth-Rublee is a research associate and program coordinator in Columbia University's psychiatry department, as well as at the Research Foundation for Mental Hygiene, a private, not-for-profit corporation whose goal is to enhance research and training for the New York State Department of Mental Hygiene and its component agencies.

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New York State Psychiatric Institute, Department of Psychiatry, 1051 Riverside Drive, New York, NY, USA
*Author for correspondence: pincush@pi.cpmc.columbia.edu

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Q Why is it becoming so important to measure the quality of mental healthcare?

A series of reports from the US Institute of Medicine in the early part of this century identified serious and widespread problems with regard to the quality and safety of the healthcare system [1,2]. These reports not only identified problems but laid out a framework for improving quality, built around six aims – safe, effective, timely, efficient, equitable and patient-centered healthcare – and a set of rules and strategies for redesign of the healthcare 'system'.

A subsequent committee examined the state of the quality of healthcare with regard to mental health and substance abuse care and found the "chasm" between the quality of behavioral health that should be provided compared with the care that is provided to be just as large, if not larger, than the chasm that exists in general medical care [3]. Specific quality problems include:

- Failure to provide care that is consistent with scientific evidence;
- Unnecessary variations in the care (including regional and racial/ethnic disparities);
- Lack of access to care;
- Unsafe care.

In addition, the committee found that the field was not well poised to improve the situation, with a quality measurement and improvement infrastructure that is well behind that of general medical care. Now, 6 years later, mental health has still not kept pace with the rest of medicine [4].

The situation has become more acute with the advent of the Affordable Care Act (ACA; i.e., healthcare reform). The ACA incorporates a range of 'value-based' initiatives and strategies that promote and incentivize the provision of care with greater efficiency and quality. To implement these strategies, the capacity to measure and improve mental healthcare must be accelerated. Extensive efforts to develop and apply quality metrics are currently underway throughout all areas of medicine. Importantly, behavioral health will need to be well-integrated with these efforts, given the high level of comorbidity and cost associated with mental illness and substance use conditions [5]. Furthermore, the impetus for enhancing quality measurement in mental health is not limited to the USA, but is present at the international level as well [6].

> "...it is important to note that there is substantial variation across countries and across regions/states within countries along multiple dimensions of care..."

Q How does one go about measuring the quality of mental healthcare?

More than a generation ago, Donabedian described a framework for evaluating the quality of healthcare that incorporated three domains: structure, process and outcomes [7]. Structure measures assess characteristics of the treatment setting's services, including program fidelity, staffing, supervision and infrastructure (i.e., are quality services available?). Process measures examine interactions between consumers and the structural elements of the healthcare system (i.e., are patients actually receiving quality services in a way that conforms to the evidence base?). Outcome measures assess the results of patient care in terms of symptoms/remission, functioning, mortality, quality of life, patient/family experience and costs (i.e., is the care making a difference?).

At its base, the process of developing quality measures flows from the evidence base of what are the characteristics of care that are most likely to result in better outcomes for patients, individually and at a population level. Each of the domains – structure, process and outcomes – have their own strengths and limitations, and individual measures vary in the strength of their evidence bases (and by how that evidence base is assessed and by whom).

In practice, quality measures are vetted through a consensus process that evaluates their:

- Clinical importance – in other words, will it make a big difference? Can providers/clinical organizations improve performance on the measure?
- Validity – in other words, is the measure scientifically sound? Can it be manipulated or affected by the severity/complexity of the population being treated (and if so, are there methods to risk-adjust the measure)?

- Feasibility – in other words, how difficult or costly is it to collect the data?

Most measures are defined in terms of well-specified denominators and numerators (e.g., percentage of individuals discharged from hospital who have an outpatient visit within 7 days). The data may come from insurance claims, medical record reviews, electronic medical records, patient surveys or other sources.

A variety of government agencies and private organizations such as the National Quality Forum, the National Committee on Quality Assurance and the Joint Commission, as well as various professional societies, think-tanks and consulting firms are involved in the development, testing approval and application of these measures.

Q Are there different approaches across countries, regions or healthcare sectors & are there any models that are especially successful?

First, it is important to note that there is substantial variation across countries and across regions/states within countries along multiple dimensions of care, such as utilization, cost and quality, as well as how care is organized. For example, the USA spends more than twice as much per person on healthcare as other industrialized countries [101], yet healthcare in the USA repeatedly falls short of expected results. For instance, a 2011 Commonwealth Fund Report ranked the US healthcare system last or next to last on five dimensions of a high-performance health system (quality, access, efficiency, equity and healthy lives) compared with that of five other developed nations – Australia, Canada, Germany, New Zealand and the UK [102].

Within the USA, the Dartmouth Atlas has documented the extensive variation in costs and quality of healthcare [103]. Even within a 'single payer', nationally organized system (e.g., the US Veterans Health Administration), Watkins *et al.* have documented extensive variations in quality across regions and demographic groups in mental healthcare [8]. At the same time, it is difficult to reach clear conclusions as to what is the 'best' system. Culture, tradition, variation in data availability/quality and actual prevalence limit both the ability to make inferences with regard to quality comparisons and the opportunities to change the system.

Q What are the different approaches to improving the quality of mental healthcare?

Improvement approaches can be organized at three different levels:

- At the clinical level, introducing and applying standardized longitudinal measurement-based care for clinical evaluation and treatment is a key strategy to improve the quality of mental healthcare ("you cannot improve what you cannot measure") [9]. While this approach has been routinely used in psychiatric research and for the management of many chronic conditions such as diabetes, hypertension and asthma, measurement-based care has not yet been applied in a consistent manner for the treatment of chronic mental disorders (i.e., major depression, bipolar disorder and alcohol abuse, among others).

- At the organizational level, approaches adapted from industrial re-engineering processes, such as Six Sigma or Plan-Do-Study-Act (PDSA), provide useful continuous quality-improvement methods that can be applied to the medical care cycle through continuous small-scale experimentation and data collection, feedback and practice. These approaches have been widely applied in healthcare for over a decade (especially in hospitals), but have barely penetrated the psychiatric field.

- It is important, however, to have policy-level mechanisms in place that are carefully designed to encourage and reinforce the application of quality-improvement activities at clinical and organizational levels. Two major motivating strategies have been applied: shame and money. Public reporting of quality metrics engages providers and organizations to improve performance and enhance their reputation (for an example, see [104]). Pay-for-performance programs (sometimes termed 'value-based purchasing') are

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intended to augment traditional price/volume financial incentives with payment based on achieving quality and efficiency goals. There has been some limited early experience in behavioral health [10] (e. g., the DIAMOND project in Minnesota [105]).

Overall, the 'chronic care model' developed by Wagner *et al.* offers a useful conceptual framework for improving health and mental health treatment outcomes by enhancing interactions between patients/families and practice teams through developing an infrastructure and a set of policies that support patient-centered, coordinated, longitudinal, efficient, safe and evidence-based care [11].

Q Are there specific areas that are not sufficiently addressed?

The mental health field needs to move ahead on a number of fronts, all of which will require involvement of a broad range of stakeholder–clinicians, academicians, policy makers and, importantly, patients and families. First, a robust, valid and feasible portfolio of quality metrics needs to be developed, tested and applied in order to bring the field into the mainstream of healthcare. This requires both the investment of resources and careful stewardship of the field. In addition, we need to broaden the availability (and systematic, longitudinal application) of standard measurement tools at a clinical level (i.e., a set of 'mental health vital signs') [3].

Mental health is also lagging behind other areas of healthcare when it comes to information technology development and implementation. Expanding use of electronic health records that incorporate key data elements relating to the quality of care would enable systematic coordination, tracking and evaluation of patient care.

Training of mental professionals and organizing them to adopt measurement-based care provides a basis for change not only with regard to clinical practice at the individual level, but it will also allow organizations to make the shift towards adopting the best practices and effective care delivery and improvement strategies at the organizational level.

Q What changes do you envision occurring with regard to the impact of these changes on healthcare policy & its implications for clinicians?

The pace of change for the mental healthcare system is accelerating rapidly and inexorably, accompanied by key themes of quality, value, coordination, integration, efficiency, incentives and patient-centered care. Psychiatrists and other mental health providers will be swept along with these changes and need to prepare for the future by:

- Eliciting patient preferences and involving consumers at every level of decision-making. Paternalism is out, shared decision-making is in.
- Practicing evidence-based care and learning and applying measurement-based care and quality-improvement strategies. The healthcare provider will be accountable and compensated, in part, based on quality.
- Screening for comorbid conditions, applying systematic follow-up and routinely assessing treatment outcomes. Systematic, longitudinal, action-oriented measurement is essential.
- Learning how to use new technology. Providers and organizations will need to go beyond simply electronic health records and utilize clinical registries, decision aids, predictive modeling, population health management technology and more.
- Affiliating with organizations in order to access the infrastructure needed to keep pace with scientific advances and policy change. There will be increasing pressures on isolated solo practices.
- Enhancing links between mental health, general health, substance use care and social services. Behavioral health providers must become comfortable in the mainstream of medicine (and *vice versa*); do not split the mind and body.

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