

Improving the Quality of Health Care for Mental and Substance-Use Conditions

A Report in the Quality Chasm Series

The *Crossing the Quality Chasm* Series

To Err is Human (1999)

Crossing the Quality Chasm - A New Health System for the 21st Century (2001)

Leadership by Example (2002)

Fostering Rapid Advances in Health Care (2002)

Priority Areas for National Action (2003)

Health Professions Education (2003)

Keeping Patients Safe – Transforming the Work Environment of Nurses (2004)

Patient Safety – Achieving a New Standard for Care (2004)

Quality through Collaboration – the Future of Rural Health (2005)

Improving the Quality of Health Care for Mental and Substance-use Conditions (2005)

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IOM's Six Aims of Quality

1. **Safe** – avoids injuries from care
2. **Effective** – provides care based on scientific knowledge to all who could benefit and avoids services not likely to help
3. **Patient-centered** – respectful and responsive to patient preferences, needs, values; includes patient values in clinical decision making
4. **Timely** – reduces waits and sometimes harmful delays for those who receive and give 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

Ten New Rules for Achieving the Aims

1. Care is based upon continuous healing relationships.
2. Care customized to patient need and value.
3. Patient is the source of control.
4. Knowledge is shared and information flows freely.
5. Decision making is evidence-based.
6. Safety is a system responsibility.
7. Transparency is necessary.
8. Needs are anticipated.
9. Waste continuously decreased.
10. Cooperation among clinicians is a priority.

Achieving Aims and Rules Requires

- Payment methods conducive to good quality
- Effective use of information technology (IT)
- Managing the clinical knowledge, skills, and deployment of the workforce
- New ways of delivering care Evidence Based Care

Improving the Quality of Health Care for Mental and Substance-Use Conditions

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Charge to the IOM

Explore the implications of the Quality Chasm report for the field of mental health and addictive disorders;

Identify the barriers and facilitators to achieving significant improvements along all six dimensions examining both environmental factors such as payment, benefits coverage and regulatory issues, as well as health care organization and delivery issues.

Based on a review of the evidence, develop an “agenda for change.”

Two Phenomena Central to the Committee's Work and Findings

- Co-occurrence of mental, substance-use, and general health conditions
- The differences in M/SU health services delivery compared to general health care

Consequences of the status quo

- M/SU conditions the leading cause of disability /death for American women; the second for American men
- Considerable workplace burden from absenteeism, “presenteeism,” disability days, and “critical incidents”
- > 9,000 children placed in juvenile justice system solely to receive MH care

Mental and substance-use conditions

Pervasive

- More than 33 million Americans treated annually
 - 20 % of all working age adults (18-54)
 - 21 % of adolescents
- Millions more fail to receive care

Frequently intertwined and affect general health

- 15 - 40 % co-occurrence of M/SU illnesses
- M/SU conditions frequently accompany chronic illnesses; e.g., cancer, diabetes, and heart disease
- 20% of heart attack patients suffer from depression, tripling risk of death
- Depression and anxiety associated with leading causes of outpatient visits

Mental, substance-use, & general health

CONCLUSION

Improving care delivery and outcomes for any one area depends upon improving care and outcomes for the others.

OVERARCHING RECOMMENDATION

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.

Overarching Recommendation

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.

Supporting Patient Decision-making and Preferences

- Stigma and discrimination impede patient-centered care
- Evidence refutes stereotypes of impaired decision making and dangerousness
- Patient-centered care still relevant when coercion is unavoidable

Stereotypes and Stigma:

1. Lessen patient ability to manage their illness and achieve recovery;
2. Encourage non-therapeutic clinician attitudes and behaviors that hamper patients' illness self-management efforts; and
3. Promote discriminatory public policies that create barriers to recovery.

Actions for patient-centered care

- Combat stigma and support decision making at the locus of care;
- Involve consumers in design, administration and delivery of care;
- Provide decision making support to consumers;
- Support illness self-management programs and practices;
- Make transparent policies for determining decision-making capacity and dangerousness;
- Preserve patient decision-making in instances of coercion.

Stronger evidence base and QI infrastructure: a 5-part strategy

1. *more coordinated strategy for filling gaps in the evidence base;*
2. *stronger, more coordinated, and evidence-based approach to disseminating evidence;*
3. *improved diagnostic and assessment strategies;*
4. *stronger infrastructure for measuring and reporting the quality of M/SU health care; and*
5. *support quality improvement practices at the locus of health care.*

Coordinating care across multiple separations

Effective linking mechanisms needed to bridge:

1. the greater separation of M/SU health care from general health care;
2. the separation of mental and substance-use health care from each other;
3. society's reliance on the education, child welfare, and other non-health care sectors to secure M/SU services for many children and adults; and
4. the location of services needed by individuals with more severe M/SU illnesses in public sector programs apart from private sector health care.

Mechanisms for Coordinating Care

- Routine sharing of patient information between providers with patient knowledge and consent.
- Screening of patients for comorbid mental, substance-use, and general medical problems and reliable monitoring of their progress.
- Evidence-based coordination–linkage mechanisms
- High level policy coordination mechanism that achieves and models collaboration at the Federal level.

Ensure the NHII benefits M/SU care

- Coordinate the activities of the NHII and public sector M/SU IT initiatives
- Bring M/SU expertise to the development of the NHII
- Support individual clinicians' use of IT

Increasing workforce capacity for QI must provide sustained attention to:

- Greater variation in the M/SU workforce
- Problems in professional education
- Variation in licensing and credentialing
- Inadequate continuing education
- More solo practice
- Use of the Internet and other communication technologies for service delivery

Sustained attention to the workforce through

- A public-private Council authorized and funded by Congress - similar to COGME and NACNEP;
- Federal support for faculty development
- Complementary activities by institutions of higher education, accrediting bodies, licensing boards and purchasers.

Marketplace leverage

- Use tools to reduce adverse selection of consumers
- Give greater weight to quality in state procurement processes
- Use measures of quality in procurement in accountability
- Reduce reliance on grants not linked to quality

Improving M/SU health care requires action by:

- Clinicians
- Health care organizations
- Health plans
- Purchasers
- State policy officials
- Federal policy officials
- Accrediting bodies
- Institutions of higher education
- Funders of research

Chapter 9

Individual clinician actions

- Support consumer decision-making and treatment preferences;
- Use illness self-management practices;
- Have effective linkages with community resources;
- When coercion unavoidable, make the process transparent;
- Screen for co-morbid conditions;
- Routinely assess treatment outcomes;
- Routinely share clinical information with other providers;
- Practice evidence-based care coordination; and
- Be involved in designing the National Health Information Infrastructure (NHII).

Chapter 9 Actions from organizations providing care:

- Have policies to enable and support all actions required of clinicians (on prior slide);
- Involve patients / families in design, administration, and delivery of services;
- If serving a high-risk population (e.g., child welfare, criminal and juvenile justice) screen all entrants for M/SU problems
- Involve leadership and staff in developing the National Health Information Infrastructure (NHII).

Chapter 9

Health plan and purchaser actions

- For consumers with chronic M/SU illnesses, pay for peer support and illness self-management programs that meet standards;
- Use and provide consumers with comparative info on the quality of M/SU services to select providers;
- Remove payment, service exclusion, benefit limits and other coverage barriers to accessing effective screening, treatment and coordination;
- Support development of a quality measurement and reporting infrastructure;

Health plan / purchaser action (cont.)

- Require all contracting organizations to appropriately share patient information;
- Provide incentives for the use of electronic health records and other IT;
- Use tools to reduce adverse risk selection of M/SU treatment consumers; and
- Use measures of quality and coordination of care in purchasing / and oversight.
- Associations of purchasers work to reduce variation in reporting / billing requirements.

Chapter 9 Actions by state policy-makers

- Make coercion policies transparent, use info on comparative quality of providers and evidence-based treatment, and afford consumers choice;
- Revise laws and other policies that obstruct communication between providers;
- Create high level mechanisms to improve collaboration and coordination across agencies;
- Use purchasing practices that incentivize use of EHRs and other IT;
- Enact parity for coverage of M/SU treatment;
- Reorient state procurement processes toward quality; and
- Reorient state purchasing to give more weight to quality and reduce emphasis on grant-based mechanism

Chapter 9 DHHS to charge or create entities to:

- Identify evidence–based practices;
- Develop procedure codes for administrative data sets;
- Use evidence–based approaches to disseminate and promote uptake of evidence-based practices;
- Assure use of general health care opinion leaders (e.g., CDC, AHRQ) in dissemination;
- Fulfill essential quality measurement and reporting functions;
- Provide leadership in quality improvement activities; and
- Improve coordination among federal agencies.

Chapter 9 Federal Government also should

- Revise laws, rules, other policies that obstruct sharing of information across providers;
- Fund demonstrations to transition to evidence-based care coordination;
- Ensure that the emerging NHII addresses M/SU health care;
- Authorize and fund an ongoing Council on the Mental and Substance-Use Health Care Workforce similar to the Council on Graduate Medical Education (Congress);
- Support M/SU faculty leaders in health profession schools;
- Provide leadership, development support and funding for R&D on QI in M/SU health care.

Chapter 9 Actions for accreditors of M/SU health care organizations

Adopt standards requiring:

- Patient-centered decision-making throughout care;
- Involvement of consumers in design, administration, and delivery of services;
- Effective formal linkages with community resources; and
- Use of evidence-based approaches to coordinating mental, substance-use and general health care.

Chapter 9

Actions by higher education

- Increase interdisciplinary teaching and learning to facilitate core competencies across disciplines; and
- Facilitate the work of the Council on the Mental and Substance-Use Health Care Workforce.

Chapter 9

Funders of research should support:

- Development and refinement of screening, diagnostic, and monitoring instruments to assess response to treatment;
- A set of M/SU “vital signs”: a brief set of indicators—for patient screening, early identification of problems and illnesses, and repeated use to monitor symptoms and functional status.
- Research approaches that address treatment effectiveness and quality improvement in usual settings of care.
- Research designs in addition to randomized controlled trials, that involve partnerships between researchers and stakeholders, and create a “critical mass” of interdisciplinary research partnerships involving usual settings of care.