Behavioral Health Clinical Quality in the MHS: Past, Present and Future

Experience of Care: Improving Quality and Safety

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**Behavioral Health Clinical Quality in the MHS: Past Present and Future**

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Objectives

- Gain knowledge of historical context of Behavioral Health (BH) clinical quality in the MHS
  - Dichotomized direct and purchased care systems
  - Evolution of the national focus on health care quality and legislative requirement history
  - Policy and alignment with Quadruple Aims

- Identify present activities and future opportunities for MHS BH clinical quality
MHS is made up of two systems with key differences:

- The Direct Care (DC) system is the Services run system of hospitals, clinics and providers (MTFs)
  - Closed system
- Purchased Care (PC) system is the partnership with civilian health care systems in which the MHS purchases health care services for TRICARE beneficiaries in the civilian network
  - Open system
- Opportunities exist for increased coordination of BH Quality initiatives in both DC and PC Systems
- Need to balance projects that are response to local quality issues with MHS wide projects that promote standardization and benefit system as a whole.
Data on MHS Beneficiaries Receiving Behavioral Health Care

Meeting Demand by Increasing Access

Behavioral Health Staffing at MTFs

- Personnel Assigned
- 2007: 5000
- 2008: 5500
- 2009: 6000
- 2010: 7000

Purchased Care Behavioral Health Providers

- Services
- 2007: 39587
- 2008: 45215
- 2009: 49807
- 2010: 53080

- Patients
- 2007: 47%
- 2008: 26%
- 2009: 40%
- 2010: 40%

RADM C.S. Hunter, “Clinical Quality in Behavioral Health: A TRICARE Perspective” (15 October 2010)
Overview

- National Focus on Quality Health Care
- Legislative Requirements under NDAA
- Quadruple Aims
- BH Clinical Quality Management
- Implications
- Summary
- Discussion
<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1952</td>
<td>The Joint Commission (TJC) created by AMA, AHA, American College of Physicians and Canadian Medical Assn- originally for acute general hospitals</td>
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<td>1952</td>
<td>Medicare established-conditions of participation and UR</td>
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<tr>
<td>1953</td>
<td>TJC-Move from Subjective Peer Review to Standardized Audits of surgical cases, blood &amp; antibiotic use and medical support</td>
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<td>1954</td>
<td>TJC- Hospital-wide Quality Assurance Programs</td>
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<td>1955</td>
<td>TJC Agenda for Change: adopted Continuous Quality Improvement</td>
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<td>1956</td>
<td>TJC adds Community Mental Health</td>
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<td>1965</td>
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<tr>
<td>1966</td>
<td>Health Care Quality Improvement Act of 1966 operational: NPDB</td>
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<td>1967</td>
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<td>1968</td>
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<td>1969</td>
<td>IOM, “To Err is Human”</td>
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<td>1970</td>
<td>DODD 6025.13, “Clinical Quality Management Program (CQMP) in Military Health Services System”</td>
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<td>1971</td>
<td>IOM 2001, “Crossing the Quality Chasm”</td>
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Institute of Medicine (IOM) projects

- IOM 1999, *To Err Is Human: Building a Safer Health System*
  - Patient safety- 44-98,000 hospital deaths per year from errors

- IOM 2001, *Crossing the Quality Chasm*
  - Designing an innovative and improved health care delivery system
    - Six Aims of Care - Safe, Effective, Patient Centered, Timely, Efficient, Equitable
    - “The difference between what we know and what we do is not just a gap, but a chasm”

- IOM 2002, *Reducing Suicide: A National Imperative*
  - Explores what is known about the epidemiology, risk factors, and interventions for suicide and suicide attempts

- IOM 2003, *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality*
  - Congress directed HHS to contract IOM to study quality enhancement processes in Medicaid, Medicare, the State Children’s Health Insurance Program, DoD and TRICARE & VA

- IOM 2006, *Improving the Quality of Health Care for Mental and Substance-Use Conditions*
  - Promoting patient centered care and scientific findings of effective care

- IOM 2010, *Provision of Mental Health Counseling Services Under TRICARE*
  - Study of the credentials, preparation, and training of licensed mental health counselors with recommendations for their independent practice under TRICARE and recommendations for a BH CQMS

- **FY 2000 § 701**
  - Allow AD SMs in remote areas to see civilian providers (expanded pool of network providers)

- **FY 2006 § 742** on the Quality of Health Care furnished by DoD program measures:
  - Timeliness & access, population health, patient safety, patient satisfaction, use of CPGs, biosurveillance

- **FY 2006 § 723**
  - Establish a task force to improve efficacy of mental health services in the Armed Forces
    - Included recommendation to increase the # of mental health providers

- **FY 2008 § 717**
  - Licensed mental health counselors and the TRICARE program
    - Will add another BH provider category to provide therapy

- **FY 2009 § 733**
  - Establish a task force on the prevention of suicide by Armed Forces members

- [www.armed-services.senate.gov](http://www.armed-services.senate.gov)

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**Topic Area 1 – Brief examination of BH clinical quality through the lens of the NDAA requirements and the IOM studies**
Legislative Requirements 2010


- FY 2010 § 596
  - Plan for Prevention, Diagnosis, and Treatment of Substance Use Disorders and Dispositions of Substance Abuse Offenders in the Armed Forces
- FY 2010 § 708
  - Required person-to-person mental health evaluations as part of evidence-based assessments
- FY 2010 § 712
  - Administration and prescription of psychotropic medication for Armed Services
    - Deployment limiting psychiatric conditions
- FY 2010 § 714
  - Plan to increase mental health capabilities of DoD AD Mental Health Personnel
- wwwarmed-services senate.gov

Topic Area 1 – Brief examination of BH clinical quality through the lens of the NDAA requirements and the IOM studies
DoD Policy: Overarching Guidance for the MHS

- **DoD 6025.13-R** *(MHS Quality Assurance Program Regulation)* is the policy guidance that regulates the principles of accountability, continuity of care, quality improvement, and medical readiness.

- **MHS Definition of Quality** "the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

- **DoDD 6025.13 and DoD 6025.13-R (2011-awaiting)** the IOM six Aims for a quality management system, as introduced in the Quality Chasm and adopted per **HA POLICY: 02-016 (2002)** "More specifically, the services provided will be:
  - Safe
  - Effective
  - Patient-centered
  - Timely
  - Efficient
  - Equitable

  [https://www.mhs-cqm.info/Open/QualityDirectives.aspx](https://www.mhs-cqm.info/Open/QualityDirectives.aspx)

**Topic Area 4 – Aligning BH clinical quality with the MHS CQMS to achieve the Quadruple Aims**
The Quadruple Aims & BH Quality Initiatives Currently In Progress

**Readiness**
- Behavioral Health
- Professional Competency & Currency
- Current Credentialing & Scope of Practice System (LMHCs)

**Experience of Care**
- Patient & Family-centered Care, Access & Satisfaction
- Behavioral Health in Primary Care
- Use of CPGs/Evidenced Based Practices (EBPs)

**Population Health**
- Healthy Service members, families & retirees
- Quality health care outcomes
- Structure, Process & Outcome Measures
- CPGs/EBPs

**Per Capita Cost**
- Responsibility Managed
- Focused on value
- Information Technology to enhance efficiency
- Focus on effective EBP

Topic Area 4– Aligning BH clinical quality with the MHS CQMS to achieve the Quadruple Aims
Opportunities for MHS BH Quality

Readiness
- Professional Competency
- Scope of Practice
- Credentialing
- Patient Satisfaction Review
- Enhanced Peer Review
- Review of Competency-Based Training
- Military Cultural Competency

Population Health Measurement
- Structure, Process & Outcomes
- HEDIS 2011
- HBIPS
- Screening Tools
- CPG Usage
- BH Patient Satisfaction Surveys
- Case & Disease Management

Experience of Care
- Behavioral Health Care Delivery
- Competency Training for Providers
- Tools to assist in CPG/EBP use
- Patient Feedback on Treatment to Providers
- Patient Satisfaction Surveys
- Case & Disease Management

Per Capita Cost
- Behavioral Health Care Delivery
- Access to Care
- Provider Productivity
- Service Delivery Models
- Information Technology
- Program Evaluation

Topic Area 4 – Aligning BH clinical quality with the MHS CQMS to achieve the Quadruple Aims
Implications of a BH CQMS from the Perspective of a New MTF Provider: Scenario

- Credentialing/Scope of Practice for competent BH providers
- Orientation/Competency Training per IOM recommendations
- Patient Encounter- Intake
- The Patient Experience
- Quality Measures- Structure, Process and Outcomes

Topic 3- How dialogue on the essential elements of BH clinical quality, credentialing, and scopes of practice are the first steps for improving behavioral health clinical quality in the MHS
Summary

- **Key Points**
  - BH initiatives alignment with Quad Aims and MHS CQMS
  - Focus on standardization and consistency of BH quality across system
  - Focus on measurement of effectiveness of programs and treatments (Outcomes)
  - Continuation of dialogue
QUESTIONS