Report From Institute of Medicine Focuses on Use of Quality Measures to Improve Behavioral Health Care

A recent report from the Institute of Medicine of the National Academy of Sciences explores how better quality control measures can be developed to ensure that Americans who are enrolled in managed behavioral health care plans receive the most effective services.

The report, *Managing Managed Care: Quality Improvement in Behavioral Health*, notes that at the end of 1995 some 142 million Americans had managed behavioral health care benefits, through either specialty programs or health maintenance organizations. Each year an estimated 52 million Americans have some kind of mental health or substance abuse problem.

The report is based on a study by the Institute of Medicine's committee on quality assurance and accreditation guidelines for managed behavioral health care, chaired by Jerome H. Grossman, M.D., chairman and chief executive officer of Health Quality LLC in Boston. The study was funded by the Substance Abuse and Mental Health Administration.

The committee was asked to develop a framework to guide the development, use, and evaluation of performance indicators, accreditation standards, and quality improvement mechanisms that would lead to the most effective managed behavioral health care in both the public and the private sectors.

The Institute of Medicine has defined quality of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." In addressing quality issues, the committee relied on the framework developed by Avedis Donabedian to understand and measure quality: structure, process, and outcome. Structure relates to the types of services available, the qualifications of practitioners, staffing patterns, and other administrative issues. Process involves the procedures and course of treatment, the appropriateness of care, and ongoing efforts to maintain quality. Outcome involves health status changes after treatment and consumer satisfaction with treatment.

The study found that efforts to assess quality of behavioral health care services have been hampered by a complex patchwork of approaches that reflect the fragmented service delivery system and the wide variety of evidence and opinions about quality of care. Quality assessment measures currently include accreditation by independent organizations, licensing and certification by states and other jurisdictions and agencies, credentialing and privileging by professional groups and service providers, practice guidelines aimed at ensuring that diagnostic assessment and treatment meet certain standards, performance indicators designed to measure treatment outcome, and report cards assessing consumer satisfaction.

The report recommends that accreditation organizations focus on areas associated with effective treatment, such as whether a patient experiences fewer symptoms or returns to work or school. The report says that most accreditation agencies now primarily assess the structure and process of care, rather than the results.

The report also recommends that the federal government monitor the effectiveness of quality assurance and accreditation and promote improvements in the tools used to measure health care quality. Federal and state governments should encourage the development of report cards or other materials to help inform consumers and their families about the quality of specific plans.

Managed care organizations should provide consumers with a clear description of a plan's benefits and create straightforward grievance proce-

Health Plans Modify Practice Guidelines to Meet Local Needs

A study of 19 managed health care plans by the General Accounting Office found that most plans modify clinical practice guidelines published by federal agencies and professional organizations to meet local needs. Plan managers reported that guidelines adopted by a consensus of local physicians are more likely to be accepted.

In addition to increasing physician acceptance, other reasons given for modifying the guidelines included cost considerations, resource constraints, demographic characteristics of the patient population, the desire to simplify the guidelines, and the need to update information in the published guidelines.

In general, health plans customized the guidelines by modifying their scope or recommendations or by emphasizing one of several therapy options. Few had documentation on the methods they used to adapt the guidelines. However, some described their approach as typically including some combination of physician consensus and a review of outcomes of clinical studies.

About 75 organizations have developed more than 2,000 guidelines to date, according to the study report. Single copies of the report, entitled *Practice Guidelines: Managed Care Plans Customize Guidelines to Meet Local Interests* (GAO/HEHS-96-95) are available free from the General Accounting Office, P.O. Box 6015, Gaithersburg, Maryland 20884; phone, 202-512-6000; fax, 301-258-4066.

dures, the report declares. They should also take steps to maintain patient confidentially and eliminate so-called "gag clauses" or other limitations that may prevent a clinician from discussing treatment options or providing appropriate care.

In addition, the report recommends that primary care clinicians be trained to better recognize patients with mental health and substance abuse problems and either treat them or refer them to specialty providers such as psychiatrists, psychologists, or social workers.

The committee was particularly concerned with the problems arising from having two distinct financing arrangements for behavioral health care—one for publicly funded state programs, as well as Medicaid and Medicare, and another for private health insurance. Critics of managed care fear that market forces could allow health plans to transfer an increasing share of costs to the consumer, to effectively screen out all but the healthiest enrollees from participating in the plan, or to shift costly care that might not be covered by managed care to the underfunded public system. The committee concluded that there is no way to judge whether any of these practices are taking place. Their report recommends that accreditation agencies and purchasers of care in the public and private sectors each develop criteria and guidelines to identify and correct potential problems.

The report recommends that purchasers of managed care, and especially of behavioral health care, involve consumers and their families in treatment decisions and in measurements of patient satisfaction and treatment effectiveness. Accreditation agencies should evaluate the extent to which consumers are involved in treatment decisions; managed care companies should include consumers and their families as well as practitioners and researchers in their review of quality.

Managing Managed Care is available from National Academy Press, 2101 Constitution Avenue, N.W., Washington, D.C. 20418, for $45 plus shipping; phone, 800-624-6242.

Corrections

An incorrect telephone number was listed for the American Psychiatric Association's AIDS Project in the November 1996 issue (page 1282). The correct number is 202-682-6143. E-mail should be sent to csvoboda@psych.org.

In the December 1996 People & Places (page 1406), the wrong degree was listed for Gilbert Honigfeld. Dr. Honigfeld has a Ph.D.

NEWS BRIEFS

Medicaid waiver for Maryland: Maryland became the 14th state to receive approval from the Clinton Administration for a comprehensive Medicaid reform demonstration project. The project includes a mental health program delivered through a partnership of public and private agencies. The state expects to enroll about 80 percent of its current Medicaid population, some 280,000 people, into managed care plans during the first six months of 1997. Currently 25 percent of Maryland Medicaid beneficiaries are voluntarily enrolled in health maintenance organizations, while another 50 percent participate in the state's fee-for-service case management system.

Refining outcome measures: The Health Care Financing Administration has awarded a four-year, $2 million contract to the Rand Corporation to refine clinical measures of health care outcomes and test them in both managed care and fee-for-service medicine. The project will refine and test outcome measures for breast cancer, diabetes, and depression that were developed in early 1996 by FAcct, the Foundation for Accountability. The Rand investigators will focus on how to use outcome measures to actually improve quality of care. Working with FAcct and third-party payers, they will convene expert clinical panels to review and refine the measures, the data collection instruments, and methods to adjust for relevant risk factors.

PEOPLE & PLACES

Appointments: ***Steven M. Mirin, M.D.,*** has been selected as incoming medical director of the American Psychiatric Association. He will assume his new post no later than January 1, 1998, following the retirement of ***Melvin Sabshin, M.D.,*** who has served as APA medical director since 1974. Dr. Mirin is president and psychiatrist-in-chief at McLean Hospital in Belmont, Massachusetts, and professor of psychiatry at Harvard Medical School.

W. Walter Menninger, M.D. resigned as president of the Menninger organization in Topeka, Kansas, effective January 1 of this year. He will be succeeded by ***Efrain Bleiberg, M.D.,*** a child psychiatrist who has been executive vice-president and chief of staff since 1994.

Patrick Cody has joined the staff of the National Mental Health Association in Alexandria, Virginia, as director of media relations. He previously was editor of the biweekly newsletter *Mental Health Report.*