



Consumer Quality Initiatives, Inc.
197 Ashmont Street
Dorchester, MA 02124
phone (617) 929-4400 fax (617) 929-4128
www.cqi-mass.org

CQI Quality Management White Paper #1, 1/29/04
Crossing the Mental Health Care Quality Chasm in Massachusetts

The 2001 Institute of Medicine Report, *Crossing the Quality Chasm: A New Health System for the 21st Century* states that: “Between the health care we have and the care we could have lies not just a gap but a chasm.”¹ Numerous recent journal articles and reports², including the report of the President’s New Freedom Commission³, describe the application of the “quality chasm” to the public mental health system. These reports note consistently that a reliance on “traditional approaches” to providing services, workforce training, and conducting quality management is the bedrock of this problem.⁴ Reoccurring themes include:

- Fragmented systems, treatment, and financing models;
- A training gap that leaves graduate students, working professionals, and other direct care providers inadequately prepared for practice in the current health care environment;
- Licensing, accreditation, and complaints processes that do not assure effective care;
- A field that is very resistant to change in service delivery methods, such as those that are evidenced based or promising practices;⁵
- A lack of focus on recovery and rehabilitation oriented practices;⁶
- Insufficient consumer/family input into planning and policy-making.⁷

In five years of assessing the consumer experience with mental health services, Consumer Quality Initiatives, Inc. (CQI) has observed the “quality chasm” phenomenon in Massachusetts to a remarkable degree. The purpose of this White Paper is to build the case that the Department of Mental Health is ready and able to lead the development of a total quality management (“TQM”) approach that will breach this quality chasm.

I. CQI’s General Conclusions on the Quality Chasm in Massachusetts

Consumer Quality Initiatives, Inc. (“CQI”) is a mental health consumer-led, non-profit organization whose mission is to “give consumers a greater voice and a integral role in evaluating the effectiveness of their treatment” through “honest and

balanced” reports on consumer perceptions of quality and satisfaction. This mission also permits CQI “to hope to initiate changes to improve the system for all, consumers and providers alike.”

In five years of existence, CQI has engaged in numerous survey research projects, primarily those funded by the Massachusetts Department of Mental Health (“DMH”) and the Massachusetts Behavioral Health Partnership (“MBHP”), but also on behalf of the Center for Health Care Strategies, SAMHSA, and individual providers.⁸ As such, CQI has had the rare opportunity to observe the operations of the public mental health system throughout Massachusetts, primarily through the eyes of consumers⁹, but also through discussions and meetings with providers, family members, and policy makers. The scope of CQI’s work in Massachusetts can be quantified in part:

- ❖ Approximately **3450** Quality Improvement interviews¹⁰: 2500 about specific services offered within the MBHP network and 850 about specific DMH funded services;¹¹
- ❖ About **202** Written Reports:
 - **185** Single Entity Quality Improvement reports, 115 for MBHP and its network providers, 37 for DMH and its funded providers, and 33 for individually contracted providers;¹²
 - **12** Level of Service Aggregate Quality Improvement reports of between 80 and 500 clients each, interviewed across a level of service, with detailed analysis and recommendations:¹³
 - Day Treatment Report (twice)
 - Acute Inpatient (MBHP) Report
 - Outpatient Therapy Report (twice)
 - State Hospital (DMH) Report
 - Structured Outpatient Addiction Program Report
 - DMH Case Management Report
 - CRS (Metro Boston) Report
 - Housing services offered by a provider agency (three times)
 - **5** Qualitative Needs Assessment Reports:
 - Vocational Assistance Needs of Western Mass DMH clients,
 - The Experience of Youth Aging Out of Public Mental Health Services in Massachusetts,
 - Quality and Length of the Community Tenure of MBHP members (2 reports),
 - The Better World report: Key Areas of Systems Change Desired by DMH clients.

A review of CQI’s specific findings and its work in total is beyond the scope of this paper.¹⁴ But based on the large scope of its work, CQI has found that the quality chasm exists in Massachusetts in three distinct ways:

- 1) Many of the services are offered in accordance with “traditional standards” that are often not responsive to the specific needs of persons/families and are not “evidence-based”;
- 2) The service system does not provide for an effective continuity of care for many of those in need and yet is highly resistant to change;
- 3) Programs (egs., hospitals, PACT) and staff are often not prepared, able, and/or willing to engage in a person-centered approach, the cornerstone of a therapeutic alliance with a recovery orientation.

A good illustration of how CQI findings demonstrate these quality concerns is hereunto described: CQI has found that high majorities of clients are satisfied overall with their outpatient programs primarily because they are treated respectfully and feel better as a result of the treatment/service.¹⁵ Even limited probing, however, exposed several client frustrations, often confirmed by providers themselves. For example, many clients who had seen improvements in their mental health and coping abilities had not felt more involved in daily activities outside of their program/service or better about their vocational capacities and hopes. And while many clients expressed a desire for more guidance in their vocational pursuits, providers were often confused about their role in providing that guidance and were often frustrated in locating and connecting clients to appropriate referrals.

II. Quality Management in Massachusetts today, a CQI view

While CQI has been collecting valuable data, writing reports with programmatic and systematic recommendations, and offering some technical assistance, we have found that the barriers to translating findings into practice have been high. Some of the reasons appear to be:

- The collection of client perceptual data (large amounts) is new to our system of care, so that MBHP and DMH have not been prepared to either integrate such data with other relevant data sets or to incorporate the data into the development of practice guidelines;
- There has been some institutional rejection of the data’s validity, as well as some fear of how the data might be used;
- CQI has not always been able to deliver its work product to providers and key stakeholders in the most efficient and effective way and CQI has not generated sufficient discussion among stakeholders about its findings.
- With the mental health system itself being fragmented, quality improvement efforts have not been carried out in a coordinated fashion. Quality management responsibilities and efforts have

operated within “silos”: within DMH, MBHP, and the Medicaid HMOs respectively, within the departments of DMH and MBHP, and within the regional offices of DMH and MBHP;

- Providers sometimes receive mixed messages as to what quality initiatives to prioritize;
- Technical assistance and training is not coordinated and is often unavailable to programs that require quality improvement assistance;
- Available resources for mental health administration have been reduced over the last few years, taking the focus off quality improvement and onto maintenance.

As a result, while valuable data is being collected, much of it is not being put to the most effective use. And yet, we see a unique opportunity to begin to cross the “quality chasm.” Over the last decade, DMH has had direct oversight for rehabilitation and long-term services, and the Division of Medical Assistance (DMA) has overseen acute services (MassHealth- Medicaid) through contracts with managed care companies, most notably MBHP and several Medicaid HMOs. Under the Romney administration, acute Medicaid funded services have been placed under the *direct* authority of DMH. This move has created the potential for both administrative savings and authoritative quality management

III. Embracing a Total Quality Management (“TQM”) Framework

“Quality Management” can be thought of as a “framework for assessing and improving clinical, operational and financial performance within a health care organization.”¹⁶ It includes the collection, coordination and assessment of data; the development of measures, benchmarks, and practice guidelines; the prioritization of issues and development of action plans; and the coordination of technical assistance and training.

Total Quality Management (“TQM”) “seeks to actively shape a culture that sustains routine self-evaluation and ongoing improvement... [and] integrates clinical improvement with operational and financial performance.”¹⁷ This approach is necessary when managing a system that faces rapid technological change as well as staff turnover. Ultimately, TQM can succeed only with strong and committed leadership.¹⁸

Based on CQI’s findings and a review of the literature, we strongly encourage the Department of Mental Health, as the mental health authority¹⁹, to take the lead in establishing standards of practice for TQM within the Massachusetts public mental health system. One approach would be to establish a single division that has direct oversight of Quality Management within our public mental health

system with the mission of enforcing a methodology that *insures* a culture of regular self-assessment, ongoing improvement based on data integration, and an openness to varieties of technical assistance. Some of the specific duties of this division might be to:

- Coordinate the establishment of core measures and benchmarks;
- Be a central repository for all data collected by state-funded mechanisms (measures are meaningful only in comparison with results from other programs that treat similar populations, assuming risk adjustment).
- Coordinate the establishment of practice standards that are based on outcomes-based research, the expressed desires of consumers and families, and on promising and best practices;
- Coordinate technical assistance and training to meet those standards and benchmarks.

Of course, movement to a model that encourages proactive engagement and change will face challenges and must be gradual.²⁰ Therefore, our first step in crossing the quality chasm should be to bring together an invested team of stakeholders with a clear mandate from DMH leadership for change. As Richard Hermann states, “Leadership is needed to establish priorities, negotiate realistic goals, and maintain consistent focus and follow-up.”²¹

IV. Current Case Examples

DMH, often at the appeal of consumer/family groups, has established several TQM projects. Below I will summarize two of them as illustrations of TQM in its infancy with the real potential to create effective and ongoing change.

A. Program for Assertive Community Treatment (PACT)

PACT was rolled out in Massachusetts a few years ago with funding for five privately run programs.²² According to Professor Gary Bond, ACT is evidence-based in producing at least two outcomes that many clients would not otherwise achieve: 1) reduced time spent in the hospital, and 2) increased time spent in stable housing. Another critical feature of PACT is that the team is capable of delivering all services in an organized and stress reducing manner. The overall result can be an increased quality of life for people who have had a lot of difficulties.

PACT, by all accounts, is a new way of doing business for many providers. For example, it is dependent on a great deal of teamwork and planning and is very person-centered. Early on, there were numerous complaints from the consumer community about the quality of care provided by some programs, in particular, the use of coercive measures. When M-POWER and the Northeast Independent Living Center (“NILP”) brought these concerns to DMH Deputy Commissioner of Mental Health Services Ann Detrick, she decided to include CQI in its audit process, primarily to obtain the client perspective through structured interviews. The audit team also included DMH regional staff and national PACT consultant Gloria Mazza.

The initial audits were rough for both the PACT team and the audit team. Interestingly, consensus among the audit team members was almost always reached, but often in disappointing ways. For example, we observed that the treatment planning did not integrate the consumer’s expressed wishes very well, in some cases not bringing the consumer’s voice to the planning meeting at all.

At follow-up meetings, the PACT teams varied in their capacity to receive critique and be open to change. Because of the breadth of data and stakeholder perspectives, recommendations were heartfelt by certain teams, which made immediate quality improvements. For those programs that have resisted the audit team’s recommendations, DMH is making attempts to hold them accountable. CQI and M-POWER have been working on technical assistance materials to aid all of the teams in benchmarking their progress.²³ While this first attempt at audits was often clumsy and no team appeared to feel good about this mode of oversight, DMH is already convening meetings of participants to gather feedback on how to improve the process.

B. Youth in Transition

In 2000, two separate groups independently began to address concerns about the public health care system’s incapacity to address the needs of older adolescents and young adults with a serious mental health condition.²⁴ Members of the DMH State Planning Council formed a Youth Development Committee (“YDC”), with DMH Assistant Commissioner of Child/Adolescent Services, Joan Mikula, as the Council liaison. Almost simultaneously, based on the encouragement of Donna Welles, Director of the Parent/Professional Advocacy League (PAL), CQI decided that “youth in transition” was an area worth researching. CQI obtained a grant to develop the Youth in Transition Citizenship Project: to conduct a needs assessment based on qualitative interviews with young adults who had aged out of services and also to hire young adults to assist in this process.²⁵ When the projects learned of each other, collaboration began immediately. CQI’s Executive Director, Jon

Delman, and youth trainees, Jessel Smith and Sarah Entemann, joined the YDC, which came to include state administrative, provider and parent representatives of other organizations, as well as national expert, Maryann Davis, PhD, of the University of Massachusetts Medical School.

The YDC has been persistent in building the case that traditional methods of addressing the needs of “youth in transition” have been insufficient.²⁶ While progress has been slower than hoped for, the group’s accomplishments include, but are not limited to:

- Raising awareness among multiple stakeholders through presentations potentiated by the testimony of young adult leaders, Jessel Smith and Sarah Entemann;
- DMH’s, CQI’s, and M-POWER’s establishment of a peer mentoring project for youth at the Worcester IRTP (Intensive Residential Treatment Program);
- DMH’s establishing a data base of DMH clients between the ages of 16-25, including data on how DMH vocational programs work with youth in transition;
- DMH’s bringing its adult division directly into the YDC’s policy and planning processes;
- The completion of “Inspirational Stories of Young Woman,” edited by Sarah Entemann, sponsored by CQI, and funded by DMH’s Office of Consumer and Ex-Patient Relations;
- YDC’s completion of a document highlighting recommendations to DMH for improving the system’s capacity to work with youth in transition.

C. **Keys to Current Success**

While these projects each have a different focus, the goals have been similar- to change an entrenched approach in order to improve the quality of care. Keys to their current success include:

- Direction from and engagement of mental health authority leadership, (ie, Ann Detrick and Joan Mikula of DMH);
- A coordinated teamwork approach where the youth and adult consumer voices are not only valued, but emphasized;
- The mental health authority’s recognition of the concerns about quality and its willingness to specify practice standards that invoke person-centered treatment;
- A movement to coordinate and centralize data collection with regard to these subject areas;
- The inclusion and technical assistance of experts, including the nationally recognized expertise of Maryann Davis and Gloria Mazza;
- Attempts to involve all interested stakeholders.

V. Conclusion

The climate is right for our mental health community to address quality management from an overall systems perspective. A Total Quality Management approach will require direct leadership from DMH and time for stakeholders to adjust to this new approach. CQI looks forward to working in conjunction with all stakeholders to bring this approach to the forefront, maximizing the value of all data collected, translating that research into high quality care, and ultimately increasing access and improving outcomes.

Submitted,

Jonathan Delman,
Executive Director

For reprints, contact Jonathan Delman at (617) 929-4400 or jdelman@cqi-mass.org, or see Consumer Quality Initiatives website: www.cqi-mass.org.

¹ Institute of Medicine, Committee on Quality Health Care in America, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, DC, National Academy Press (2001).

² See egs., Hyde, PS, Falls, K, et al, *Turning Knowledge into Practice: A Manual for Behavioral Health Administrators and Practitioners about Understanding and Implementing Evidence-based Practices*, The Technical Assistance Collaborative (2003); Torrey, WC, Drake, RE, et al, *Implementing Evidence-based Practices for Persons with Severe Mental Illness*, Psychiatric Services, 52(1), 45-50 (2001); NAMI TRIAD report (2003).

³ “The lag between discovering effective forms of treatment and incorporating them into routine patient care is unnecessarily long, lasting about 15 to 20 years. Even when these discoveries become routinely available at the community level, too often the clinical practice is highly uneven and inconsistent with the original treatment model that was shown to be effective....” Commission report at 67.

⁴ Huey, LY, *Problems in Behavioral Health Care: Leap-Frogging the Status Quo*, Administration and Policy in Mental Health 29 (4, 5) 403-419, 404 (2002): “...despite research supporting the effectiveness of various approaches and innovations in treatments for individuals with chronic psychiatric disorders, routine clinical practice settings do not readily incorporate these advances, leading to the disturbing assessment that these patients are highly unlikely to receive effective services... Traditional approaches to change clinician (and therefore system) performance through continuing education strategies have shown to be largely ineffective as well... [O]rganizing health care around discrete, disconnected service events clouds our vision of how such a model negatively impacts the health status of individuals with chronic disease and disability... For other time-honored approaches believed to be associated with quality and competence such as licensing and accreditation which purportedly ensure effectiveness, there is either weak or nonexistent research to support the idea that licensure predicts effectiveness or that there is more than a weak or insignificant relationship between accreditation and quality-of-care indicators.”

⁵ “Evidence-based practices are those clinical and administrative practices that have been proven to consistently produce specific intended results” with specific populations. Evidence-based medicine is grounded in [the] concept of **person-centeredness**... [meaning] acknowledging individual differences and characteristics, including different biology, culture, beliefs, values, preferences, history, abilities and interests. (emphasis added)” Hyde, PS, Falls, K, et al, *Turning Knowledge into Practice: A Manual for Behavioral Health Administrators and Practitioners about Understanding and Implementing Evidence-based Practices*, Pgs 15, 23, The Technical Assistance Collaborative (2003).

⁶ Ibid.

⁷ From the President’s New Freedom Commission Report at 37: “Local, State, and Federal authorities must encourage consumers and families to participate in planning and evaluating treatment and support services. The direct participation of consumers and families in developing a range of community-based, recovery-oriented treatment and support services is a priority.”

⁸ The Center for Health Care Strategies, funded by the Robert Wood Johnson Foundation, is a funding source that promotes best practices in Medicaid managed care. SAMHSA is a federal agency- the Substance Abuse and Mental Health Services Authority.

⁹ The term “consumers” here refers to people directly receiving services, and includes adolescents, children and their parents/guardians.

¹⁰ “Quality Improvement” interviews focus on a particular level of service, with interviewers using semi-structured surveys developed by CQI. CQI has developed and used surveys to interview clients of acute inpatient hospitals, day treatment programs, outpatient therapy/medication management services, Structured Outpatient Addiction Programs, State Hospitals, Community Rehabilitation Services (CRS), DMH Case Management services, Program for Assertive Community Treatment (PACT) services and outpatient child/adolescent services.

¹¹ These numbers do not account for approximately 240 interviews completed for private providers about specific community residences.

¹² These reports were conducted for specific programs/services, such as a day treatment program, a state hospital or a regional case management office. As few as five and as many as seventy clients have been interviewed, with a median of 20, based on the number of clients in the program and the time required to complete the project.

¹³ The reports were based on interviews to assess “single entities,” but data were aggregated across a level of service, usually statewide, but sometimes regionally or within an agency, to provide a look at the defined system and provide for comparisons across and recommendations for that system.

¹⁴ Contact the author for more information at jdelman@cqi-mass.org or (617) 929-4400. CQI has developed a range of research methodologies, including a “**consumer directed program (qualitative) evaluation**” model, which provides stakeholders with an opportunity to provide project feedback through qualitative interviews and focus groups. CQI has used this approach with a DMH funded evaluation of the Trauma Center’s training program in Boston. CQI is also implementing it with the SAMHSA funded, Boston Medical Center directed Safe Haven project (person-centered congregate living for chronically homeless mentally ill in Roxbury).

¹⁵ Up to this point, CQI has interviewed people only while they are in the program being assessed. CQI is now conducting some of its interviews, such as those about Family Stabilization Teams, several weeks after the client has left the program.

¹⁶ Hermann, RC, Regner, JL, et al, *Developing a Quality Management System for Behavioral Health Care: The Cambridge Health Alliance Experience*, Harvard Review of Psychiatry 2000x 251- 260, 251.

¹⁷ Hermann at 253. Hermann notes the aligning principles of “Continuous Quality Improvement”:

- Health care is a series of processes in a system leading to outcome
- Quality problems can be seen as the direct result of defects in the process
- Quality Improvement efforts should draw on the knowledge and efforts of individuals involved in these processes, working in teams
- Quality improvement is grounded in measurement, statistical analysis and scientific method
- The focus of improvement efforts should be on the needs of the customers (eg., patients, but also referrers, payers and other components of the health care system)
- Improvement should concentrate on the highest priorities (ie, those having the greatest impact patient outcomes, costs, and other critical areas)

(Consumer Quality Initiatives, Inc. emphasizes the implicit significance of qualitative inquiry as a means of encouraging consumers to think critically and beyond their normal expectations of quality (which is often low), as well as an adjunct and critical method of explaining the quantitative information.)

¹⁸ Presidents Advisory Commission on Consumer Protection and Quality in the Health Industry (1998) <http://www.hcqualitycommission.gov/>, Chapter 12.

¹⁹ See MGL c. 123, sec. 2; 104 CMR 25.02

²⁰ Hermann at 257-259.

²¹ Hermann at 259.

²² Both M-POWER and CQI offered input to the RFR and a number of recommendations were adopted, including the requirement of a peer counselor on each team.

²³ While the NAMI PACT manual provides technical guidelines, it does not provide guidance about the basics of operational start-up and how to develop a person-centered culture. Nor does it give ample information about the requirements and qualifications of personnel. Under the auspices of DMH, M-POWER and the Northeast Independent Living Center have been working on establishing

the proper role of the peer advocate. CQI has established job qualifications and expectations of the PACT team leader and is working on other materials, including 1) the use of motivational interviewing in discussing medications, and 2) providing support for PACT workers who face traumatic situations.

²⁴ Commonly called “Youth in Transition.”

²⁵ CQI’s final report is called *Voices of Youth in Transition: The Experience of Aging out of Public Mental Health Services in Massachusetts, Practice and Policy Implications*, and can be obtained at www.cqi-mass.org/Youth-in-Transition-Final-Report.pdf.

²⁶ Ibid.