From PORT to Policy to Patient Outcomes: Crossing the Quality Chasm

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The reports from the Schizophrenia Patient Outcomes Research Team (PORT) represent an enormous accomplishment. Building on the initial report in 1998 and a first revision in 2003, the team not only evaluated the evidence base that had accumulated over the past 5 years but expanded their focus to incorporate areas beyond mental health, i.e., smoking cessation, weight loss, and substance abuse.

As important as this work is in providing guidance on evidence-based clinical practice, these reports by themselves do not ensure an impact on policy and practice. The Institute of Medicine (IOM) Quality Chasm1 report documented the enormous gaps between the health care that Americans should be receiving and the care they actually receive. The subsequent IOM report on Improving the Quality of Healthcare for Mental and Substance Use Conditions2 documented these same gaps in behavioral health and provided a set of aims, principles, and strategies for fundamentally altering the mental health care system to improve the quality of care (which, as indicated by the PORT, is particularly problematic for individuals with schizophrenia).

An overall framework for applying these elements is depicted in figure 1 and suggests a series of additional steps:

- Consumers, policy leaders, administrators, clinicians (across mental health and substance abuse and general health) as well as researchers must be part of this process. While the PORT articles did not indicate the extent to which perspectives from all these stakeholders were incorporated, ensuring participation of these groups in the process from the outset increases the likelihood of obtaining broad acceptance of practice recommendations and achieving patient-centered outcomes. They will all need to be centrally involved in each of these following stages.
  
  - Guidelines need to be transformed into valid performance measures that can be feasibly measured. This translational step requires that guideline recommendations be operationalized into denominators and numerators that can be reliably quantified with specified inclusion/exclusion rules. Ideally, measures should be derived from data gathered during routine processes of care (e.g., insurance claims, electronic health records) rather than through a separate data collection process. Standardizing the practice elements in the denominator and numerator of performance measures enhances the ability to develop measures that will actually be used. Unfortunately, current coding systems, Diagnostic and Statistical Manual/International Classification of Diseases for diagnosis, and Current Procedural Terminology for procedures do not necessarily capture sufficiently refined clinical information that can reflect what guidelines are recommending (e.g., smoking status, suicidality). Strategies have been suggested to enhance these classifications.3
  
  - Once measures are developed, they must be applied at multiple levels: consumer, clinical, clinic/hospital, health plan/system, and population/community. The National Quality Forum (NQF), a private nonprofit consortium of stakeholders at all these levels, reviews and approves measures. Once transformed into quality measures, the PORT recommendations would need to be submitted through the NQF process. NQF approval by itself does not ensure actual use of these measures. Advocacy will be necessary to have health plans, and regulatory and accreditation organizations add the PORT measures to their measure sets and require that providers and health care organizations use and report them.
  
  - Strategies to improve performance need to be applied more widely at the point of care. While the performance improvement mantra of “you can’t improve what you don’t measure” is true, simply measuring quality will not improve quality.4 Measurement is a tool to effect change. There are many different approaches, most derived from industrial engineering,
that utilize measurement as an essential element of the change strategy. While these tools (eg, Plan/Do/Study/Act, Six Sigma, Toyota Production System, and LEAN) have been widely applied in health care, the mental health field has lagged behind the rest of medicine in their adoption. The IOM has recommended that public and private entities (Department of Health and Human Services, professional organizations, philanthropy) join forces in providing leadership on dissemination of effective quality improvement practices in mental health.2

**Finally, at every step of this process, we need to evaluate how effective our guidelines, measures, and quality improvement strategies are in actually improving the care of patients with schizophrenia.**

The Schizophrenia PORT is to be congratulated for taking a major step toward improving the quality of care for individuals with schizophrenia. Multiple other groups (both public and private) must now move much more forcefully through these additional steps to assure that better outcomes of care are realized: National Institute of Mental Health, Substance Abuse and Mental Health Services Administration, Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, NQF, the Joint Commission, American Psychiatric Association, National Committee for Quality Assurance, Department of Defense, Department of Veterans’ Affairs, as well as the PORT, all have a role. The blueprint has been well specified in the IOM reports, but it has largely not been implemented in mental health. Perhaps the opportunity presented by health care reform will be a stimulus to action. As noted by the quotation from Goethe on the title page of each Institute of Medicine Quality Chasm reports “To know is not enough; we must apply. Willing is not enough; we must do.”

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