THINK **BIGGER** DO **GOOD**
POLICY SERIES

Toward Greater Accountability in Mental Health Care

Richard G. Frank, Ph.D., and Ruth S. Shim, M.D., M.P.H.

Summer 2022

Dear Reader,

Now is the time to solve the growing behavioral health needs in our country by advancing public policies that transform the delivery of mental health and substance use disorder services and address outdated funding mechanisms.

This paper is part of Think Bigger Do Good, a series of papers launched in 2017 through the support and leadership of the Thomas Scattergood Behavioral Health Foundation and Peg's Foundation. While the paper topics continue to evolve, our goal to develop a policy agenda to improve health outcomes for all remains constant.

In partnership with national experts in behavioral health, including our editors, Howard Goldman and Constance Gartner, we identified seven critical topics for this third series of papers. Each paper identifies the problem and provides clear, actionable solutions.

We hope you join us in advocating for stronger behavioral health policies by sharing this paper with your programmatic partners, local, state, and federal decision makers, advocacy organizations, and voters. To learn more about Think Bigger Do Good and to access the other papers in the series, visit **www.thinkbiggerdogood.org**.

Sincerely,

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Toward Greater Accountability in Mental Health Care

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1 Introduction

Despite significant breakthroughs in the management and treatment of behavioral health conditions, much clinical practice fails to engage "best practices," and as a result, realized outcomes fall short of what is possible to achieve (1–3). Lack of accountability contributes to this gap between best practices and potential outcomes (4). Thus accountability is critical to ensure that the mental health care system applies what it knows—the effective implementation of the best available science in the equitable treatment and management of mental illnesses and substance use disorders.

Lack of accountability contributes to this gap between best practices and potential outcomes.

Accountability in mental health care typically involves institutions that establish a set of goals, objectives, and standards for insurers, providers, and professionals participating in the delivery of care and support for people with mental illnesses and substance use disorders. The establishment and oversight of performance relative to the goals, objectives, and standards can emanate from professions in the form of norms, the marketplace through consumer responses to the quality and cost of services, and government institutions working in the public interest.

Accountability in the support and care of people with mental illnesses involves two classes of judgment and performance. The first are matters of clinical science, management, and other forms of technical expertise. These matters include the most effective treatments for specific conditions, the proper amount of time necessary to diagnose a patient's condition and develop a treatment plan, and the clinical expertise needed to effectively deliver the chosen treatment. The second set comprises normative matters that involve structural-level factors—the sociocultural context within which a patient lives, the use of language, the cost of and access to care, and the resources of a community, among others. These classes are distinct, and how these criteria are formulated in accountability standards is important. That is, accountability standards cannot be structured and enforced based on technical or expert judgments alone and must also carefully incorporate issues of structural and cultural competence and expertise.

2 Why Is Accountability Important?

Although behavioral health conditions are highly prevalent in society and a major source of disability worldwide (5), there are no national standards for tracking the management of these conditions. Specific tools for measurement-based care measure severity and response to treatment, but few psychiatrists and other mental health professionals use these tools to track outcomes (6).

Furthermore, few mental health providers routinely practice evidence-based care (1). In fact, within the mental health field, there is significant controversy over the use of evidence-based practices (7). In some cases, skepticism and mistrust of evidence-based treatments stem from the fact that "evidence" is often gathered and examined in nondiverse, homogeneous populations in terms of gender identity, race and ethnicity, socioeconomic status, and education. Resistance also stems from beliefs that treatment of most mental illnesses is highly individualized, depends solely on the relationships between clinician and patient, and does not lend itself to measurement and oversight (those beliefs are not grounded in evidence).

The lack of care for the value of people whose lives are affected by mental illness and substance use disorders is evident in the policy choices made by society—and the disinterest that society has in holding the mental health care system accountable. This lack of accountability has impacts on individuals receiving care at the patient level, provider level, and systems level. At the patient level, poor quality of care and discrimination cause people to distrust or avoid services, leading to greater severity of illness when they finally do seek care—often in crises, a situation that further complicates treatment. At the provider level, many providers carry negative implicit bias and stigma toward people with substance use disorders and mental illnesses, resulting in failures in respectful care and reduced patient engagement. At the systems level, health plans seldom face consequences for weak performance on behavioral health or failure to comply with parity laws and regulations.

3 Barriers to Accountability

Several barriers impede accountability in behavioral health care. Lack of a diverse, well-trained workforce, challenges in measurement, misalignment of payment incentives, and misguided regulations are all contributing factors.

Training and Education

Because many mental health providers' educational and training practices still operate in apprenticeship models, effective teaching is often limited to the extent of what these teachers know. Too often, education on clinical advances is not built into standard practice. For example, the Accreditation Council for Graduate Medical Education requires resident physicians to be educated in concepts related to cultural competence, even though the field has evolved to consider structural competence and cultural humility as equally if not more important skills for psychiatric trainees. Structural competence is defined as the trained ability to understand how clinical presentations of disease are influenced by upstream social determinants of mental health (8), and cultural humility is the lifelong practice of self-reflection and self-critique in the examination of cultural identities (9). Moreover, few psychiatrists, psychologists, and social work trainees have received specialized training in evidence-based psychotherapies, because most required trainings in these programs are not in evidence-based therapies (10).

Structural competence is defined as the trained ability to understand how clinical presentations of disease are influenced by upstream social determinants of mental health.

Lack of workforce diversity also limits accountability.

Lack of workforce diversity also limits accountability. For example, despite long-standing data highlighting that patients from minoritized backgrounds receive poorer quality of care, compared with White populations (11), no specific accountability metrics have been put in place to monitor, let alone improve, this specific care inequity, because those most responsible for implementing these accountability metrics are often not directly affected by this lack of diversity and the resulting disparate outcomes.

Measurement Challenges

The use of metrics is highly uneven and inconsistent across the mental health delivery system, and as a result, performance improvement has lagged behind the rest of health care (12). Metrics that assess quality of care exist, including the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures and the federal government's Healthy People 2030 Goals, which provide basic benchmarks for monitoring mental health outcomes; however, these are limited to a small number of mental health outcomes (i.e., suicide, depression screening, and access to care). These metrics fail to capture the full breadth of mental illnesses and substance use disorders.

A recent analysis of quality measures for behavioral health care in federal government programs, such as Medicare, Medicaid, and the health insurance marketplaces, concluded that "standardized BH [behavioral health] quality measures used in federal programs focus on narrowly specified conditions or processes and are misaligned and used variably across programs" (13). The authors reported that four measures are commonly used across federal programs: screening for depression, outpatient follow-up after hospitalization, initiation and engagement in substance use disorders treatment, and screening and intervention for tobacco use. Notably, none of these metrics report on the patient experience. Measures of patient experience are used in various programs, such as Medicare Advantage, but elsewhere in Medicare, patient experiences, such as in inpatient psychiatric care, are explicitly excluded from quality measurement. These measures also rarely include measures that examine discrimination or inequities in outcomes. Furthermore, these measures typically do not reflect a strategic view of the sources of quality failures that occur in behavioral health care.

Payment Incentive Misalignment

In some health care circumstances, choosing appropriate metrics and reporting them publicly can serve to create economic consequences for strong or weak performance based on market responses. The capitated health plan model that is prevalent in commercial insurance is based on combining high-powered financial incentives to spend less with quality metrics reported publicly, which in theory drives consumers to plans that best balance quality and cost of care. However, in many cases, relying on consumer choices based on cost and quality in health care does not serve to discipline the performance of health plans or providers. Moreover, the behavioral health quality measures tend to be crude and relatively few. The Medicare Advantage program recognizes such limitations by paying bonuses to health plans achieving high scores on quality metrics, in addition to publicly reporting quality measures. However, the weight given behavioral health indicators in the bonus scheme is minimal, compared with weights given to other indicators, such as those for diabetes care, and thus the consequences for performance in treating mental illnesses and substance use disorders are minimal (14).

Because relatively few psychiatrists take insurance (operating cash-only private practices), accessing mental health treatment can be challenging for people from lower socioeconomic status backgrounds (15). This is in part due to reimbursement rates that are quite low and administrative processes that can be cumbersome (16).

Misguided Regulations

Regulations affecting treatment facilities and providers are frequently relics of outdated clinical science. As a result, they permit program structures and practices that are ineffective and sometimes harmful. Perhaps most exemplary is the licensure and accreditation of programs that permit the continued use of seclusion and restraints that extend beyond the minimal "last resort" standard. Likewise, hospitals that provide simple inpatient detoxification-only services for people with opioid use disorder are licensed and accredited despite offering a treatment that elevates mortality risk (17). The risk is elevated because patients are discharged with lower resistance to opioids, and without active engagement in postdischarge treatment, they are at risk of using opioids and overdosing.

4 A Framework for Accountability

Accountability arrangements typically consist of several elements: a clear articulation of goals, objectives, or standards; metrics so that progress toward achieving goals can be tracked; and consequences for insurers, providers, and professionals for achieving or failing to achieve objectives. Setting out the goals, objectives, and standards for individuals and organizations involved in behavioral health care is necessarily complex. They are typically formed at the level of a participating organization or contractual arrangement. That is, clinics, health plans, and professionals establish systems of accountability. Individuals and organizations providing care and support for people with mental illnesses must commonly satisfy the economic demands of budgets or competitive markets, the community needs of improved health and well-being, and the provision of high-quality services. These competing demands result in uncontested sets of goals, objectives, and standards. As a matter of public policy, the fundamental challenge of accountability is to create incentives (consequences), rules, and metrics that align various private and social goals and objectives.

Individuals and organizations providing care and support for people with mental illnesses must commonly satisfy the economic demands of budgets or competitive markets, the community needs of improved health and well-being, and the provision of high-quality services.

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A vision of national goals, objectives, and standards for the care and support of people with mental illnesses was first articulated by President Kennedy in 1963. He called for a community-based approach that would promote recovery. Some specifics about services delivery were added by Surgeon General David Satcher in 1999 in *Mental Health: A Report of the Surgeon General*, which focused on access to care and support, care processes, mental health outcomes, and community well-being (2). In 2003, President Bush's New Freedom Commission further amplified these values (18). Together, these national goals outlined a call to action for the nation to implement treatments that work, ensuring that people with mental illnesses can avail themselves of high-quality services and that those services are appropriately designed for the ethnic, racial, and cultural backgrounds of the treated individuals.

5 Accountability Tools

To advance these goals, the full complement of accountability tools should be consistently applied to all sources of behavioral health care and supports. We focus on three sets of tools: performance metrics, payment incentives, and regulatory standards. These apply differently across the delivery system. For example, payments are traditionally set by public and private health insurance programs and public health agencies—and not by providers. Quality metrics can be and are used throughout the system, but professionals must respond to provider organization metrics and provider organizations must respond to payer metrics. Regulatory standards are typically set by federal and state governments. These regulations most often involve state licensing of insurers, providers, and professionals and federal accreditation and establishment of conditions of participation in public programs. Accreditation is commonly implemented by quasi-public organizations, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the NCQA, and the Commission on Accreditation of Rehabilitation Facilities (CARF). Therefore, our policy focus on promoting accountability takes aim at the major public insurance and payment systems, the federal links to accreditation bodies, and state licensing arrangements.

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Performance Metrics

Performance metrics must include patient-reported experiences to be appropriately inclusive and accountable. Given that key federal programs that pay for mental health care, such as Medicare, Medicaid, and the health insurance marketplaces, also support the range of other medical services, practical management concerns require that the measures used for behavioral health are quite circumscribed. Therefore, selecting measures that would reveal unwanted conduct where the incentives to do so are greatest might serve as an appropriate basis for measure selection. For instance, in identifying ineffective treatment for bipolar disorder, measuring the number of people treated for bipolar disorder and the percentage that received an antidepressant without a mood stabilizer would serve as an indicator of how attentive a health plan or a provider organization is in maintaining the minimum standard of appropriate clinical care.

Nevertheless, this type of "poor performance" metric represents a process measure. Some measures of the outcomes produced are important to include. Outcome measures come with additional complexity—if not carefully designed they risk creating incentives for plans and providers to choose the patients likely to yield the best outcomes (19). Thus attention to patient selection must accompany the use of outcome metrics.

There is strong evidence of the effectiveness of dialectal behavior therapy (DBT) for the treatment of borderline personality disorder. However, few public mental health systems have DBT services available for their patient populations.

An example of a strategically selected process-based quality indicator would focus on the treatment of borderline personality disorder, a debilitating mental health condition often characterized by chronic suicidality. There is strong evidence of the effectiveness of dialectal behavior therapy (DBT) for the treatment of borderline personality disorder. However, few public mental health systems have DBT services available for their patient populations (20). In addition, there are no Food and Drug Administration–approved pharmacological indications for borderline personality disorder, and although evidence shows that few medications have any beneficial effect, 96% of people with a diagnosis of borderline personality disorder take at least one psychotropic medication, and 20% take four or more such medications (21). This polypharmacy is often independent of comorbid psychiatric diagnoses (22). Therefore, a performance metric could include measuring the percentage of people with a diagnosis of borderline personality disorder who receive high-fidelity DBT services (a marker of "good care") coupled with a measure of polypharmacy (a poor-performance marker). Together, these two performance elements would reflect a provider system's appropriate use of evidence-based psychotherapy alongside the ability to appropriately manage the use of pharmacotherapies. Such a performance measurement approach would likely correlate with the provision of high-quality care for other illnesses. Incorporating patient experience, such as satisfaction with DBT services, would be an important additional performance metric.

Payment Incentives

In promoting high-quality care for people with mental illnesses, concern that reliance on market forces would promote quality is especially salient. Because of experiences of historical and current oppression and discrimination, people with mental illnesses have had challenges advocating for their needs when dealing with insurers and providers (23). The implication is that policy cannot count on market mechanisms alone to create appropriate incentives for good-quality mental health care. This means finding a way to couple payments and performance metrics. One approach is so-called pay for performance (P4P). P4P typically works by paying bonuses to health plans or providers that meet certain outcome standards for their enrolled or patient populations. The available evidence typically demonstrates small gains that are quite costly (24, 25). This is because P4P arrangements frequently pay based on the provider's exceeding a threshold value on a quality index. However, in many cases, most of the payments are made to providers that were already above the threshold, thus greatly increasing the cost per provider that improved its quality rating. Moreover, some experiences highlight the potential for gaming of P4P schemes that use outcome measures, such as abstinence for people with substance use disorders, allowing providers to "cherry-pick" patients who are more likely to improve (19).

Another approach is gain sharing. Gain sharing is a payment system that establishes cost targets for providers or networks of providers in which financial gains or losses are shared between payer and provider.

Another approach is gain sharing. Gain sharing is a payment system that establishes cost targets for providers or networks of providers in which financial gains or losses are shared between payer and provider. However, the provider would only realize the available gains if quality standards for key metrics are met. Several evaluations of various types of gain sharing arrangements in health care have shown realization of savings with no declines in access to or quality of care (26). The application of gain sharing to behavioral health in the context of Medicare accountable care organizations has shown little change, in part because the weight given to behavioral measures in the overall set of quality measures was small and the potential savings modest (27). In addition, several state-shared saving programs have shown mixed results for both spending and quality measures (28).

Finally, in some cases, risk-based capitation payments are constructed from historical data on utilization and spending. If, however, historical levels of utilization were low (because of benefit design or care management processes), then the capitation rate will reflect a situation in which the money available for mental health care is inadequate to achieve the desired clinical outcomes. Thus, in such programs, the behavioral health functions are subject to strong resource constraints that affect the size of the provider network and the ability to pay competitive fees for some professionals.

The behavioral health capacity must be based on an up-to-date assessment of the resources necessary to appropriately serve an enrolled population, and that capacity must take contextual factors, such as the social determinants of mental health of communities, into consideration.

To effectively tie payments to performance, the levels of payment must be consistent with the ability to produce strong performance. The behavioral health capacity must be based on an up-to-date assessment of the resources necessary to appropriately serve an enrolled population, and that capacity must take contextual factors, such as the social determinants of mental health of communities, into consideration. Payment structures that allow flexibility to combine resources to treat most patient and community circumstances are likely to produce environments most conducive to high-value behavioral health care.

Flexibility, however, typically is accompanied by significant incentives to spend less. Existing quality measures are limited in their ability to identify substandard care and are typically given little weight in bonus schemes or gain sharing arrangements. Thus the rewards and penalties linked to the quality of behavioral health care are minimal and not given programmatic attention. Payment should be linked to performance via mechanisms such as shared savings or penalties for poor performance and bonuses for strong performance, among other approaches, in ways that create substantial consequences—both financially and in public perception related to performance in serving people with mental illnesses and substance use disorders. Additionally, payment and risk adjustment should consider various social determinants of mental health affecting patients and their communities, including area-level poverty, residential segregation, and food insecurity. This ensures appropriate access to care and provides "fair" payment to providers that must address more complex and likely more costly treatment circumstances.

Regulatory Standards

The supply and structural characteristics of providers, along with the workforce that delivers care and supports for people with mental illnesses and substance use disorders, are subject to state regulations. Providers serving people covered by Medicare and Medicaid are also subject to reviews and conditions by accrediting organizations such as JCAHO and CARF. State regulations are typically slow to be updated, so they frequently reflect standards of care that are decades out of date. Likewise, accrediting bodies seldom incorporate evidence about structural features that drive quality in behavioral health providers (12). Recent evidence on residential substance use disorder programs showed that 29% of programs that did not use evidence-based, medication-assisted therapy to treat opioid use disorders and frequently engaged in practices that were financially exploitive of consumers were accredited by JCAHO or CARF (29). An analysis of the overall performance of accredited versus nonaccredited hospitals showed no significant differences in quality (30). The Government Accountability Office reported that JCAHO missed the identification of a substantial portion of hospitals with serious safety deficiencies in 2004 (31). Thus regulatory oversight must be provided in ways in which outcomes and the recovery of patients are central goals.

The establishment of regulatory standards for licensing and accreditation that are undergirded by modern clinical science and are regularly updated would represent an important step in promoting higher-quality behavioral health care. A second step would involve enforcement of standards through quality improvement processes and sanctions when necessary. These are fundamental steps to ensure consumer protections and adequate quality.

An analysis of the overall performance of accredited versus nonaccredited hospitals showed no significant differences in quality.

4 Conclusion

When implemented thoughtfully, accountability tools, in the form of performance metrics, payment incentives, and regulatory standards, have the potential to help move the field toward more positive outcomes in behavioral health. Some steps that would advance improved accountability involve adopting a consistent set of performance standards that are supported by evidence and have the potential to affect the behavior of key sector participants, such as clinicians, hospitals, and insurers; linking performance to consequences through mechanisms such as gain sharing and bonus schemes; and implementing regulatory and accreditation standards for clinicians, providers, and insurers that reflect "best practices" and clinical evidence. A higher standard of accountability, coupled with robust evaluation of implemented recommendations, could lead to improved and more equitable outcomes and to the hope of recovery from mental illnesses and substance use disorders for all people in the future.

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1 / **Send the paper to your local, state, and federal policy- and decision-makers**

2 / **Share the paper with mental health and substance use advocates and providers**

3 / **Endorse the paper on social media outlets**

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The Scattergood Foundation believes major disruption is needed to build a stronger, more effective, compassionate, and inclusive health care system — one that improves well-being and quality of life as much as it treats illness and disease. At the Foundation, we THINK, DO, and SUPPORT in order to establish a new paradigm for behavioral health, which values the unique spark and basic dignity in every human.

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