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  - *For example:*
    - Blaire Thomas, National Council
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- If you are having any issues, please send a Zoom chat message to **Kathryn Catamura, National Council**
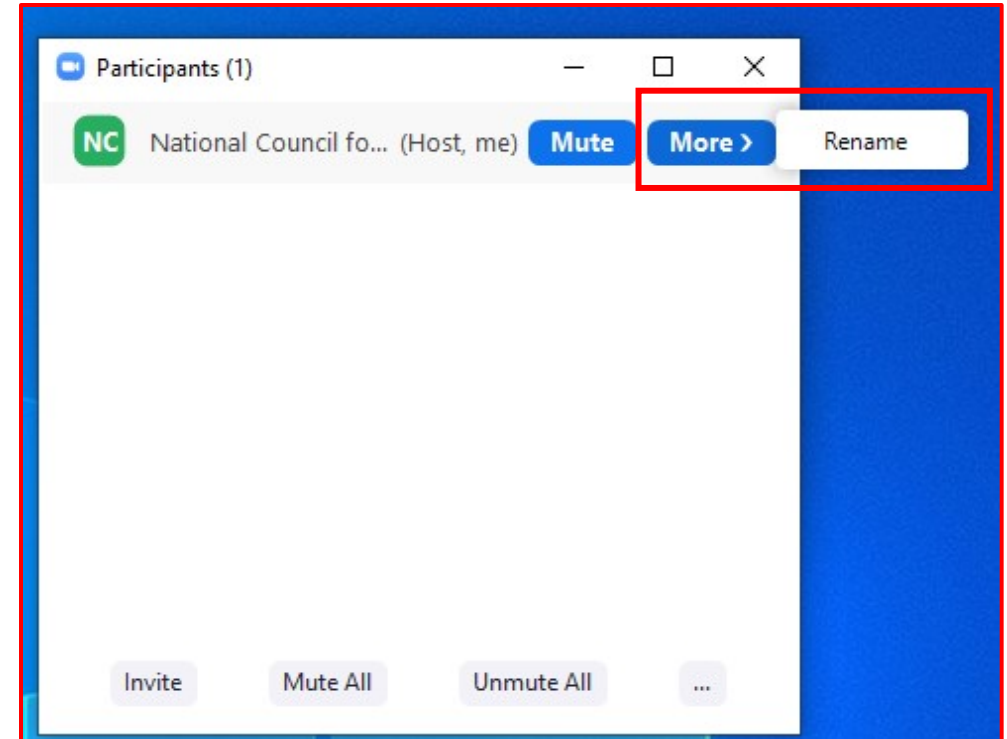
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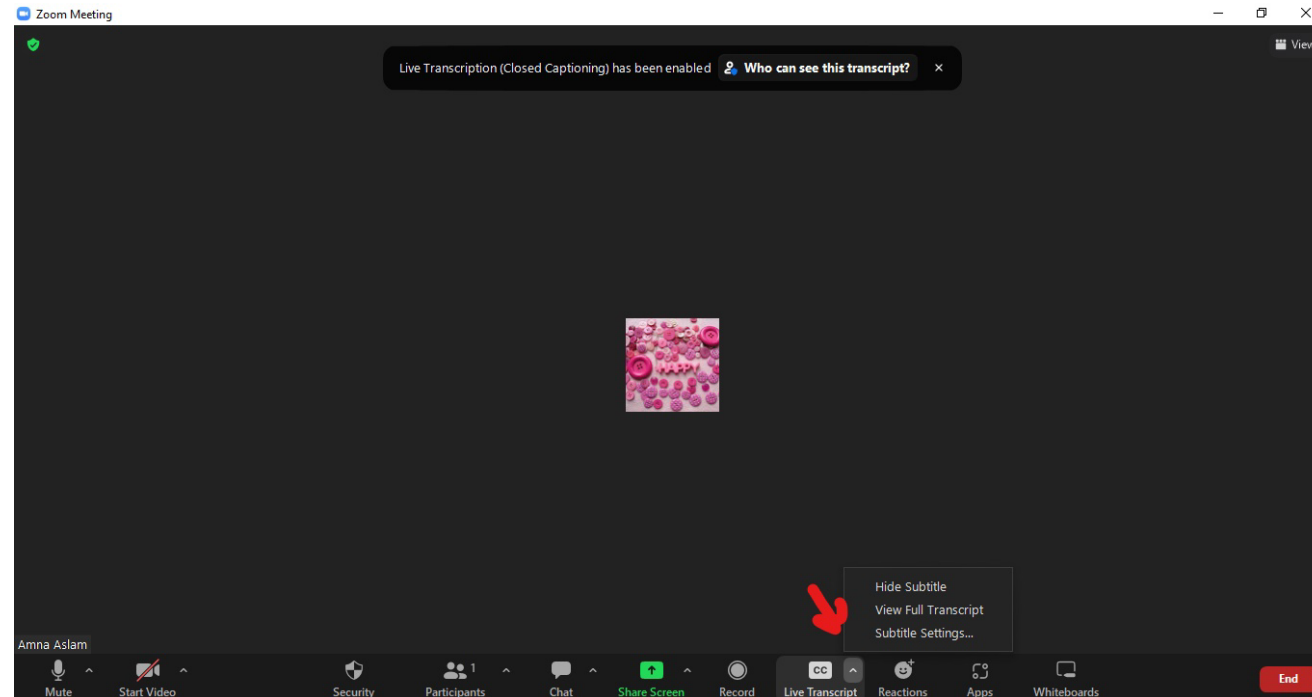
Today's Session: Slides and Recording

Slides and the session recording link will be available on the CCBHC-E NTTAC website under "Training and Events" > "Past Events" within 2 business days.

Today's Agenda

- Review Purpose of Optimizing Data Learning Series
- Provide Overview of Measurement-Informed Care
- Describe How to Implement Measurement-Informed Care for Clinical Decision Making and Practice Improvement
- Group Discussion

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CCBHC Advanced Optimizing Data Learning Series

Purpose

Designed for CCBHC grantees interested in learning about the advanced principles of leveraging data to advance consumer health outcomes, the four-session CCBHC Advanced Optimizing Data Learning Series will explore applying data to identify disparities, operationalizing data to expand screening, and integrating data to improve practice activities.

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Learning Series Topics
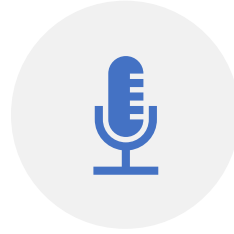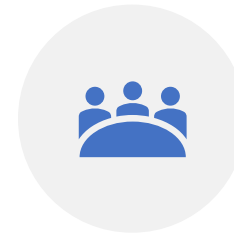
Date	Topic	Summary
May 16	Application of Data	Provide overview of National Standards for Culturally and Linguistically Appropriate Services (CLAS) and discuss how to use data to identify and address disparities.
June 20	Integrating Data Systems	Increase knowledge of data to support chronic disease management and identify opportunities for improved health outcomes.
July 18	Operationalizing Data	Increase understanding of screening tools and opportunities to address social determinants of health.
August 15	The Role of Data in Practice Improvement	Provide overview of measurement-informed care (MIC) and discuss how to build organizational readiness to implement MIC.

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Your Learning Series Team

Jeff Capobianco, PhD,
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Matter Expert

Clement Nsiah, PhD, MS
Director

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Project Manager

Kathryn Catamura, MHS
Project Coordinator

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Today's Presenters

Jeff Capobianco, PhD
Consultant and Subject Matter Expert
National Council for Mental Wellbeing

Jim Zahniser, PhD
Partner and Chief Leadership Officer
TriWest Group

Measurement-Informed Care

- An approach to healthcare that integrates the regular use of patient-reported outcome measures (PROMs) and other clinical measures to inform treatment decisions and monitor progress over time.

- Repeated, systematic use of validated measures that are utilized at each clinical encounter to inform decision-making about treatment.

- Utilized in conjunction with weighing multiple factors to arrive at individualized treatment plans and continually optimizing outcomes.

Bickman, L., Kelley, S. D., Breda, C., de Andrade, A. R., & Riemer, M. (2011). Effects of routine feedback to clinicians on mental health outcomes of youths: results of a randomized trial. Psychiatric Services, 62(12), 1423-1429. DOI: 10.1176/appi.ps.002052011

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Impact of Measurement-Informed Care

Clinical - Researchers analyzed 51 randomized controlled trials exploring how frequently providers collected feedback on patient-reported symptoms during medication management and psychotherapy encounters and found that almost all the trials that consistently used MIC showed significantly improved patient outcomes, while one-time screenings and assessing symptoms infrequently were less effective (Fortney, J. C., et al., 2017).

Value Proposition - Effective and efficient care pathways that lead to achieving recovery/treatment targets can be leveraged into value-based payment arrangements.

Workforce - Can support staff who are experiencing increased behavioral healthcare demand with engagement, health literacy provision and clinical decision support.

In the absence of MIC, research demonstrates that clinicians struggle to identify the patients who are at a higher risk for nonresponse, or even deterioration in functioning (Constantino et al., 2019; Walfish et al., 2012).

Why is the Use of Data for Clinical and Administrative Decision Support So Difficult?

"The main reason seems to be a lack of integration of (data) health IT into clinical workflow in a way that supports the cognitive work of the clinician and the workflows among (network/partner) organizations, within a clinic and within a visit."

Source: Carayon & Karsh, (2010). AHRQ Publication No. 10-0098-EF

Collecting, Using, and Sharing Data

BARRIERS

1. **Lack of leadership**
2. **Lack of strategic plan for data use & health IT**
3. Costs of EHR implementation
4. Cost of establishing and maintaining links between EHRs and HIE networks
5. Security and privacy issues
6. Liability Provider's concern to be held liable for information from outside sources/labs
7. Misaligned incentives (who pays and who benefits)
8. Provider reluctance to relinquish control of patient information to competing systems
9. Technical barriers (e.g. lack of EHR interoperability)
10. Lack of IT training and support

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Collecting, Using, and Sharing Data

BENEFITS

1. More efficient workflow
2. Improved access to clinical data
3. Streamlined referral processes
4. Improved quality of care--Better health outcomes
5. Improved patient safety, including fewer prescribing errors and fewer hospital readmissions
6. Cost savings (e.g. eliminating costs of storing paper records)
7. Increased revenue (e.g. government incentives for use of health IT)
8. Pay-for-performance incentives

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Analytics at Work: Smarter Decisions Better Results

by Davenport, Harris & Morison

D for accessible, **high-quality Data**

E for an **Enterprise** orientation

L for analytical **Leadership**

T for strategic **Targets**

A for **Analytical talent**

Analytical Maturity Model (DELTA)

		DATA	ENTERPRISE	LEADERSHIP	TARGETS	ANALYSTS
↑	STAGE 5 Analytical Competitors	Relentless search for new data and metrics	All key analytical resources centrally managed	Strong leadership passion for analytical competition	Analytics support the firm's distinctive capability and strategy	World-class professional analysts and attention to analytical amateurs
	STAGE 4 Analytical Companies	Integrated, accurate, common data in central warehouse	Key data, technology and analysts are centralized or networked	Leadership support for analytical competence	Analytical activity centered on a few key domains	Highly capable analysts in central or networked organization
	STAGE 3 Analytical Aspirations	Organization beginning to create centralized data repository	Early stages of an enterprise-wide approach	Leaders beginning to recognize importance of analytics	Analytical efforts coalescing behind a small set of targets	Influx of analysts in key target areas
	STAGE 2 Localized Analytics	Data useable, but in functional or process silos	Islands of data, technology, and expertise	Only at the function or process level	Multiple disconnected targets that may not be strategically important	Isolated pockets of analysts with no communication
	STAGE 1 Analytically Impaired	Inconsistent, poor quality, poorly organized	n/a	No awareness or interest	n/a	Few skills, and these attached to specific functions

Adopted from the Five Stages of Analytics Maturity developed by Tom Davenport and Jeanne Harris in their book, Competing on Analytics: The New Science of Winning, and the DELTA Model developed in 2010 by Tom Davenport, Jeanne Harris and Bob Morison in their book, Analytics at Work: Smarter Decisions, Better Results.

Common Measures and Tools

- Meadows Mental Health Policy Institute white paper provides a thorough review of recommended MIC measures and tools (https://mmhpi.org/wpcontent/uploads/2021/03/MBC_Report_Final.pdf)

- The specific tools chosen do matter (some are required), but more important is the commitment to and use of MIC, both for direct clinical-level purposes and for program-level purposes.

Three reasons:

1. **Outcome improvements from merely using MIC are in the range of 20% to 75%.**
2. Organizations like The Joint Commission and the Utilization Review Accreditation Commission are incorporating MIC into their **accreditation standards.**
3. Use of MIC is increasingly considered a fundamental aspect of **mental health parity.**

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Measures and Tools – Further Considerations

- There are **different *types* of measures**: e.g., condition-specific measures, co-occurring physical health measures, and assessment of functioning (including recovery-oriented issues like employment, education, level of independent living, and such).
  - The "Holy Grail" of MIC: Using all of the above for people receiving integrated care - e.g., adults with SMI in a PIPHBC program or CCBHC.

- **Patient-reported outcome measures**, which some tend to think of as "soft" measures, are arguably the most useful and helpful in behavioral health. Much evidence for their utility.

- A good *screening* measure is not necessarily a good measure for MIC. It also must be sensitive to change and useful for outcome measurement.

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Examples of Adult Measures

Most common:

- PHQ-9 (depression, suicidal thoughts and behaviors)

- GAD-7

Others to consider:

- Alcohol and SUDs: *AUDIT-C (has 3 or 10 item versions); *Brief Addiction Monitor (17 items – longer but more sensitive to change over time)

- Columbia Suicide Severity Rating Scale (17 items; often used if screen on PHQ-9 is positive or if client discloses suicidality to the clinician)

- Positive and Negative Syndrome Scale-6 (PANSS-6) – for people experiencing psychosis; Altman Self-Rated Mania Scale (ASRM) – 5 items

- WHO Disability Assessment Scale 2.0; Recovery Assessment Scale (20 items)

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Examples of Child/Youth Measures

Most common:

- PHQ-A (9 items; depression, suicidality)

- Pediatric Symptom Checklist (17 or 35 items)

Others to consider:

- PROMIS Anxiety (8 items; parent and youth versions; PROMIS has a lot of other good measures)

- Screen for Child Anxiety Related Emotional Disorders (SCARED; 41 items)

- Brief Addiction Monitor (17 items)

- Vanderbilt Attention Deficit Hyperactivity Disorder Rating Scale (parent and teacher version; lengthy; covers more than just ADHD)

- CAFAS (incls. school, home, community)

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Building Organizational Readiness to Use MIC

- "... the key to MIC is helping providers implement sufficiently reliable and valid measurement tools needed to accurately assess symptoms, conditions, treatment progress, and functional outcomes." (MMHPI, 2021)

- Aid clinicians in the use of MIC:
    o Train on the meaning (but also the limitations) of scores on the measures they are using. (Analogous to "risk levels" for blood pressure, cholesterol, etc.). Example: PHQ-9
    o Train on how to talk with clients about measurement findings
    o Build off of treatment algorithms and clinical guidelines, matching stage of change to treatment provided (train in motivational interviewing, etc.)

Building Organizational Readiness to Use MIC

- *Get clinicians and program managers involved* in all decision-making.

- Consider *getting clients involved* in helping to design an optimal MIC program – e.g., where and when and how would it be best to complete the measures? Can a patient-facing portal in the EHR be used?   iPad in the waiting room?

- Many EHRs now incorporate common measures and have capacity to incorporate repeated measures.
  - Check out the EHR to see what it can support, in terms of clinicians reviewing an individual client's history and performing program-level outcome analyses.

Building Organizational Readiness to Use MIC

- Examine ways in which aggregated analyses of client outcomes can be used to assess and demonstrate quality to monitoring organizations or to support value-based payments.

- Bill for MIC – clarify the use of reimbursement codes.

- Ensure the data are readily available to clinicians and can be used in real time or close to it.

Discussion: Sharing with Your Peers

- How have you used MIC to inform clinical decision-making and practice improvement?

- What lessons have you learned in implementing measurement-informed care?

- What suggestions do you have for building organizational readiness?

- Do you have any remaining questions?

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Thank You!

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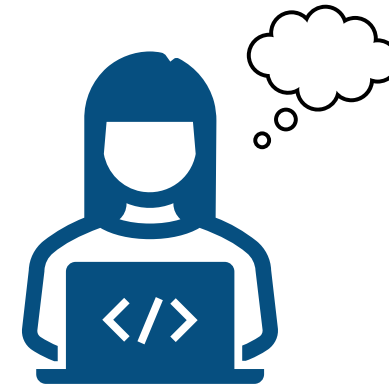
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