SMIAdviser
A Clinical Support System for Serious Mental Illness

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Measurement-Based Care in Community Behavioral Health

August 16, 2019

An APA and SAMHSA Initiative

AMERICAN PSYCHIATRIC ASSOCIATION

SAMHSA Substance Abuse and Mental Health Services Administration

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CSS-SMI INITIATIVE

The Clinical Support System for Serious Mental Illness (CSS-SMI) is a Substance Abuse and Mental Health Services Administration (SAMHSA) funded initiative implemented by the American Psychiatric Association (APA).

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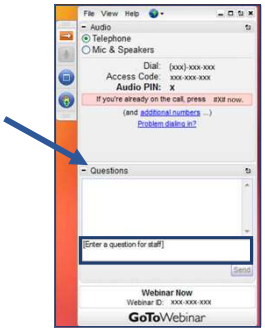

Instant Join Viewer: Click the "?" to display the "Questions" area

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HEALTH MANAGEMENT ASSOCIATES

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Disclosure

No relationships or conflicts of interest related to the subject matter of this presentation

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Today's Agenda

- Contrast the core processes of effective measurement-based care with ineffective approaches.
- List common, validated measurement tools for assessing behavioral and physical symptoms in community mental health populations
- Discuss how a registry can be used to monitor individual patients and improve population health with aggregated data.

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Measurement-based Care (MBC)

"Measurement-based care involves the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient. Aggregated symptom rating scale data can be used for professional development at the provider level and for quality improvement at the clinic level and to inform payers about the value of mental health services delivered at the health care system level."

Fortney et al Psych Serv Sept 2016

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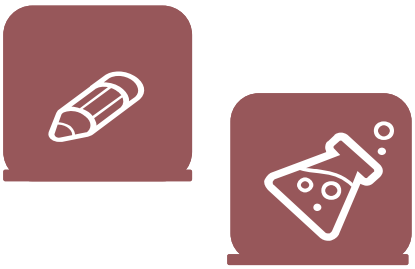
Common Provider Questions and Concerns



IS MEASURMENT SUITABLE IN COMMUNITY MENTAL HEALTH?

+ Measurement tools can't replace clinical judgement
+ These tools don't work for individuals with serious mental illness
+ We don't need tools because we provide thorough clinical interviews

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Provide Perspective

- ✓Know there is value and but how to demonstrate nuanced human impact
- ✓Feel undervalued in healthcare (sometimes David and Goliath)
- ✓Concern about missing out on important alternative payment structures because of ability to demonstrate outcomes/value
- ✓Therapists can experience burnout and hopelessness when they don't see progress
- ✓Rely on productivity standards in absence of quality metrics
- ✓Concern about loss of unique individual level in data driven system

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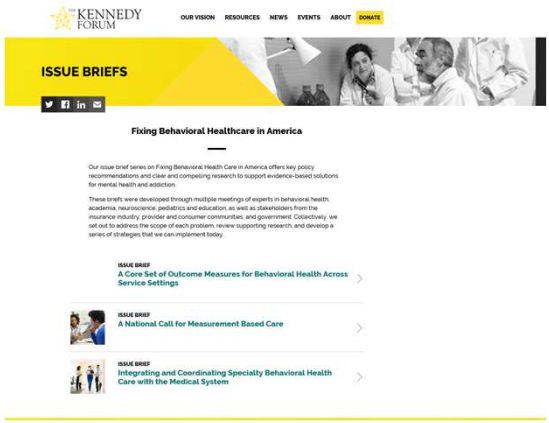
Missing Important Clinical Outcomes



- Research shows that BH providers only detect 19% of patients who are worsening with judgement and standard practice
- Detection is even lower for those whose symptoms are not improving as expected. We don't know that people aren't improving.

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CCBHC and Additional State Metrics Reporting; Accreditation

- BMI
- Control high blood pressure
- Tobacco screen and cessation

- Diabetes screening schizophrenia and bipolar disorder on SGAs
- Diabetes care for SMI with poor control HbA1c>9
- Cardiovascular health screening SMI
- Health monitoring for SMI and cardiovascular disease

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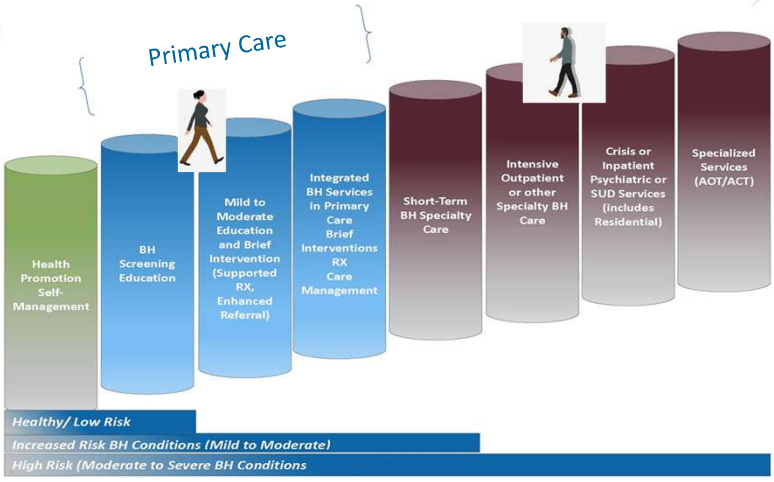
Use to Determine Best Place Using Stepped Care

- Uses limited resources to their greatest effect on a population basis
- Different people require different levels of care
- ***Finding the right level of care often depends on monitoring outcomes***
- Increases effectiveness and lowers costs overall



Van Korff et al 2000

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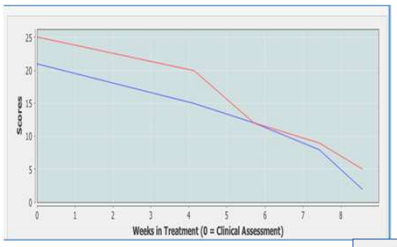
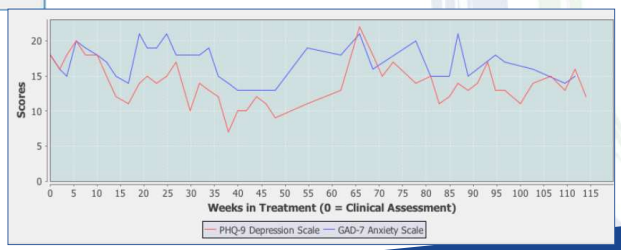
Who Needs Higher Level of Care?





www.aims.edu

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Payer Perspective

"Behavioral health is a black hole: we pour money into it and we don't get anything in return"

Payers are expecting outcomes especially as we lobby them to open more codes – the rest of the medical field provides them (A1c, BP, etc)

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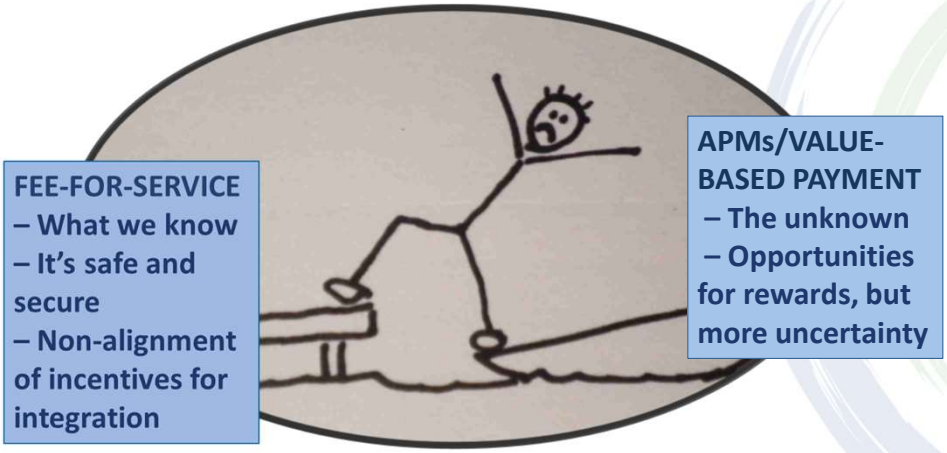
Value-based Payment (VBP) is Coming to a Clinic Near You



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Win-Win

MBC IS A WIN AT ALL LEVELS

PAYER
Demonstration of value with consistent outcomes

PROVIDER
Clinical data on what's working and when people are not improving.

PERSON
Improved outcomes more rapidly, education, engagement.

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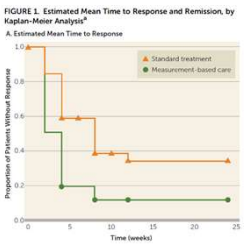
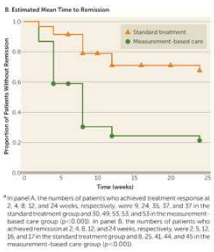
Things That Get Measured Get Better; and Better Faster

Response 62.7% vs 86.9%

Remission 28.8% vs 73.8%



8.1 vs 4.5 weeks



14.8 vs 8.4 weeks

- HAM-D 50% or <8
- Paroxetine and mirtazapine
- Greater response
- Shorter time to response
- More treatment adjustments (44 vs 23)
- Higher doses antidepressants
- Similar drop out, side effects

Quo T, Correll, et al. American Journal of Psychiatry, 172 (10), Oct, 2015

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A Tipping Point for Measurement-Based Care

John C. Fortney, Ph.D., Jürgen Unützer, M.D., M.P.H., Glenda Wrenn, M.D., M.S.H.P., Jeffrey M. Pyne, M.D., G. Richard Smith, M.D., Michael Schoenbaum, Ph.D., Henry T. Harbin, M.D.

Objective: Measurement-based care involves the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient. This literature review examined the theoretical and empirical support for measurement-based care.

Methods: Articles were identified through search strategies in PubMed and Google Scholar. Additional citations in the references of retrieved articles were identified, and experts assembled for a focus group conducted by the Kennedy Forum were consulted.

Results: Fifty-one relevant articles were reviewed. There are numerous brief structured symptom rating scales that have strong psychometric properties. Virtually all randomized controlled trials with frequent and timely feedback of patient-reported symptoms to the provider during the medication management and psychotherapy encounters significantly improved outcomes. Ineffective approaches included one-time screening, assessing symptoms infrequently, and feeding back outcomes to providers outside the context of the clinical encounter. In addition to the empirical evidence about efficacy, there is mounting evidence from large-scale pragmatic trials and clinical demonstration projects that measurement-based care is feasible to implement on a large scale and is highly acceptable to patients and providers.

Conclusions: In addition to the primary gains of measurement-based care for individual patients, there are also potential secondary and tertiary gains to be made when individual patient data are aggregated. Specifically, aggregated symptom rating scale data can be used for professional development at the provider level and for quality improvement at the clinic level and to inform payers about the value of mental health services delivered at the health care system level.

Psychiatric Services 2016; 00:1–10; doi: 10.1176/appi.ps.201500439

https://www.thekennedyforum.org/a-national-call-for-measurement-based-care
https://www.thekennedyforum.org/a-supplement-to-our-measurement-based-care-issue-brief

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Ineffective Approaches to MBC

- One-time screening
- Assessing symptoms infrequently
- Feeding back outcomes outside the context of the clinical encounter

Fortney, et al. The Tipping Point for Measurement-based Care Psychiatric Services 2016; 00:1–10; doi: 10.1176/appi.ps.201500439

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What is Needed for Effective Measurement

- Systematic administration of symptom rating scales – specific intervals to maximize opportunities to adjust treatment if needed
- Measurement Based Care is NOT a substitute for clinical judgement
- Use of the results to drive clinical decision making at the patient level – overcome clinical inertia
- Patient rated scales are equivalent to clinician rated scales
- Best choice may be brief, easy to score, good uptake by clinicians, limited additional administration or clinician time needed to score/administer and non-proprietary
- Good to find screening tool that can serve as measurement tool also
- Cheaper if non-proprietary

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Commonly Used Measurement Tools

Mood Disorders	Anxiety Disorders	Psychotic Disorders	Substance Use Disorders
PHQ-9 Depression	GAD-7: Anxiety	Brief Psychiatric Rating Scale	AUDIT-C
CIDI Bipolar Disorder	PCL-5: PTSD	Positive and Negative Syndrome Scale	BAM
Mood Disorder Questionnaire	SCARED		DAST
EPDS: Postnatal Depression	Mini Social Phobia: Social Phobia		CRAFFT

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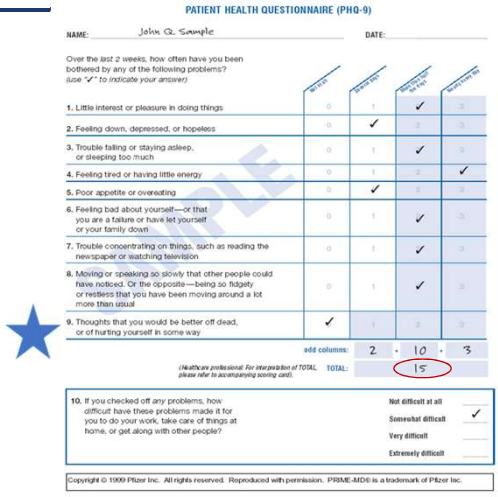
PHQ-9



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: John Q. Sample DATE:

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use ✓ to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓	3
2. Feeling down, depressed, or hopeless	0	✓	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓	3
4. Feeling tired or having little energy	0	1	2	✓
5. Poor appetite or overeating	0	✓	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	✓	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓	1	2	3
add columns:	2	+ 10	+ 3	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:		15		

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ✓ / Somewhat difficult / Very difficult / Extremely difficult

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PHQ 9 > 9

- < 5 – none/remission
- 5 - mild
- 10 - moderate
- 15- moderate severe
- 20 - severe

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SMI Measurement Tools

- Bipolar Disorder (new study: Systematic Review of Symptom Assessment Measures for Use in Measurement-based Care of Bipolar Disorders. Cerimele et al. Psych Serv 70:5, May 2019)
  - Mania – Altman Self-Rating Mania Scale – brief and easy to score, self-administered
  - Depression – PHQ9
  - Both – Bipolar Inventory of Symptoms Scale
- Schizophrenia
  - Brief Psychiatric Rating Scale (BPRS)
  - Positive and Negative Symptom Scale (PANSS)
  - Functional assessments
- Substance Use Disorders
  - Brief Addiction Monitor (BAM)
- Physical – cardiovascular risk
  - BMI, A1c, BP, lipids

"While there are many different scales available to assess positive and negative symptoms of schizophrenia, a scale that is simpler, accessible, user-friendly, incorporates a multidimensional model of schizophrenia, addresses the psychosocial and cognitive component, and helps us better understand the severity and psychopathology of schizophrenia has yet to be developed." Kumari et al
J Addict Res Ther. 2017; 8(3): 324.

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Physical Health Measures – Cardiovascular Disease

- Cholesterol – Risk Factor calculation and tracking
- Hypertension – systolic/diastolic blood pressure
- Obesity - BMI
- Diabetes – HgA1c
- Smoking

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HEDIS Metrics

Standard	National Quality Forum Number
BMI Screening and Follow-up Adults	NQF 0421
BMI Screening and Follow-up Children	NQF 0024
Controlling High Blood Pressure	NQF 0018
Tobacco Use Screening and Cessation Intervention	NQF 0028
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications	NQF 1932
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NQF 2607
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NQF 1933
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NQF 1933

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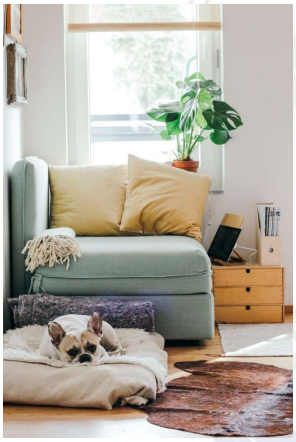
Functional Measures

- Identifying tools that support functional assessment including recovery factors:
  - SF-20 (12 proprietary)
  - Daily Living Activities (DLA 20)
  - Illness Management & Recovery Scale (Dartmouth)
  - WHO Disability Assessment Schedule (WHODAS)
  - Mental Health Recovery Measure
  - Employment Ratings
  - Housing Stability
  - Quality of Life

Behavioral health is better suited for helping to define measurement of social determinants of health.



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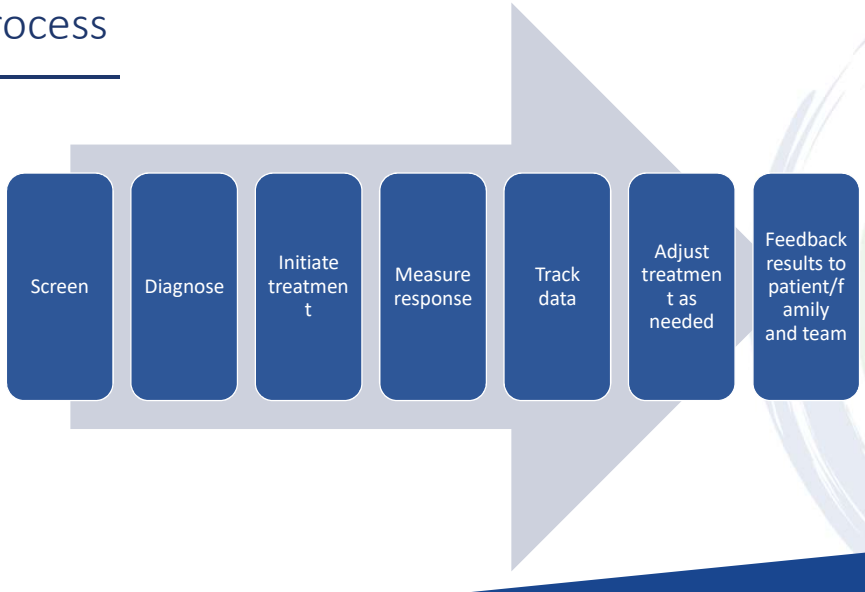
MBC Process



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Workflow and Data Entry into the EHR

- Which tools to use
- How often will they be repeated and how will this be monitored
- Who on the staff will administer the tool and by what means
- Who will enter into EMR and where will it be located
- How will data be used with individual patient and family
- Who will be responsible for aggregating data for specific needs

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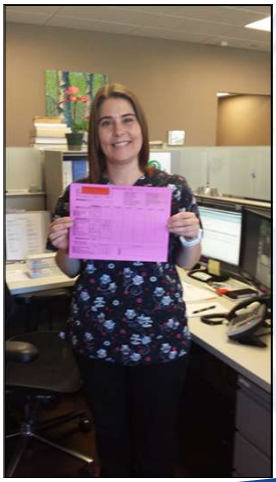
Workflow: Medical Assistants Do Vitals, Measurement Tools and Enter into EMR



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Set Goals

The Expanded Work for the Health Home Team

Medical Treatments Targets

- Glucose control
- Blood pressure
- Cardiac risk reduction

Health Behavior Change Targets

- Inactivity
- Smoking cessation
- Improving dietary habits

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Commit to Targets

Goal	Target
Improve tracking of health outcomes	90 % of eligible clients will have documented BMI, Hgb A1c, LDLc, and blood pressure in the last 6 months.
Improve health outcomes	Reduce by 25 % the number and % of eligible clients with a Hgb A1c > 7, a blood pressure > 140/90, or LDLc > 100.
Improve health behaviors	Reduce by 25 % the number and % of clients who are smoking.
	Increase by 25 % the number and % of clients who are physically active (30 minutes or more of aerobic activity such as walking at least 4 times/ week)

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What is a Registry?

- Systematic collection of a clearly defined set of health and demographic **data** for patients with specific health characteristics
- Held in a central **database** for a predefined purpose
- Medical registries can serve **different purposes**—for instance, as a tool to monitor and improve quality of care including risk stratification, or as a resource for epidemiological research.

J Am Med Inform Assoc. 2002 Nov-Dec; 9(6): 600–611

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What Can a Registry Do for Patient Care?

- Keep track of all clients so no one "falls through the cracks"
  - Up-to-date client contact information
  - Referral for services
- Tells us who needs additional attention
  - High risk individuals in need of immediate attention
  - Clients who are not following up
  - Clients who are not improving
  - Reminders for clinicians & managers
  - Customized caseload reports
- Facilitates communication, specialty consultation, and care coordination
- Helps to stratify risk
  - Concentrate resources where needed most
- Choose the initiative most likely to have significant impact and use to focus educational efforts

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Measuring Change

			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
			! Indicates that the most recent contact was over 2 months (60 days) ago				✓ Indicates that the last available PHQ-9 score is at target (less than 5 or 50% decrease from initial score) ! Indicates that the last available PHQ-9 score is more than 30 days old				✓ Indicates that the last available GAD-7 score is at target (less than 10 or 50% decrease from initial score) ! Indicates that the last available GAD-7 score is more than 30 days old					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Consultant Note
View	Active	Susan Test	9/5/2015	2/23/2016	10	26	22	14	-36%	2/23/2016	18	17	-6% !	1/23/2016	Flag for discussion & safety risk	1/27/2016
View	Active	Albert Smith	8/13/2015	! 12/2/2015	7	29	18	17	-6%	12/2/2015	14	10	-29% !	12/2/2015	Flag for discussion	
View	Active	Joe Smith	11/30/2015	2/28/2016	6	14	14	10	-29%	2/28/2016	10	✓ 6	-40%	2/28/2016	Flag for discussion	2/26/2016
View	Active	Bob Dolittle	1/5/2016	3/1/2016	3	9	21	19	-10%	3/1/2016	12	10	-17%	3/1/2016	Flag as safety risk	2/18/2016
View	Active	Nancy Fake	2/4/2016	2/4/2016	0	4	.	No Score			.	No Score				
View	RP	John Doe	9/15/2015	3/6/2016	10	25	20	✓ 2	✓ -90%	3/6/2016	14	✓ 3	✓ -79%	3/6/2016		2/20/2016

Two crucial data points:
50% reduction PHQ-9
Remission (PHQ 9 < 5)

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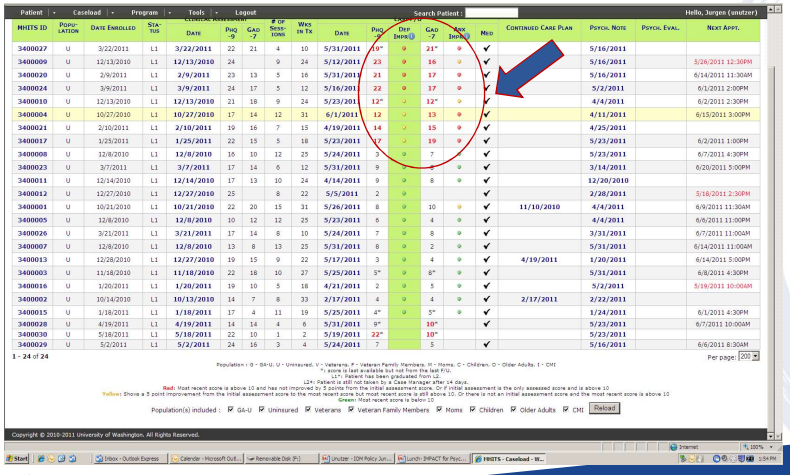
Registries to Track Progress, Change Treatment



AIMS Center: http://aims.uw.edu

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Outpatient Metrics Example

- **Process Metrics**
  - Percent of patients screened for depression – NQF 712
  - Percent with follow-up with care manager within 2 weeks
  - Percent not improving that received case review and psychiatric recommendations
  - Percent treatment plan changed based on advice
  - Percent not improving referred to specialty BHP
- **Outcome Metrics**
  - Percent with **50% reduction PHQ-9 – NQF 184 and 185**
  - Percent reaching **remission (PHQ-9 < 5) – NQF 710 and 711**
- **Satisfaction** – patient and provider
- **Functional** –work, school, homelessness
- **Utilization/Cost**
  - ED visits, 30 day readmits, med/surg/ICU, overall cost

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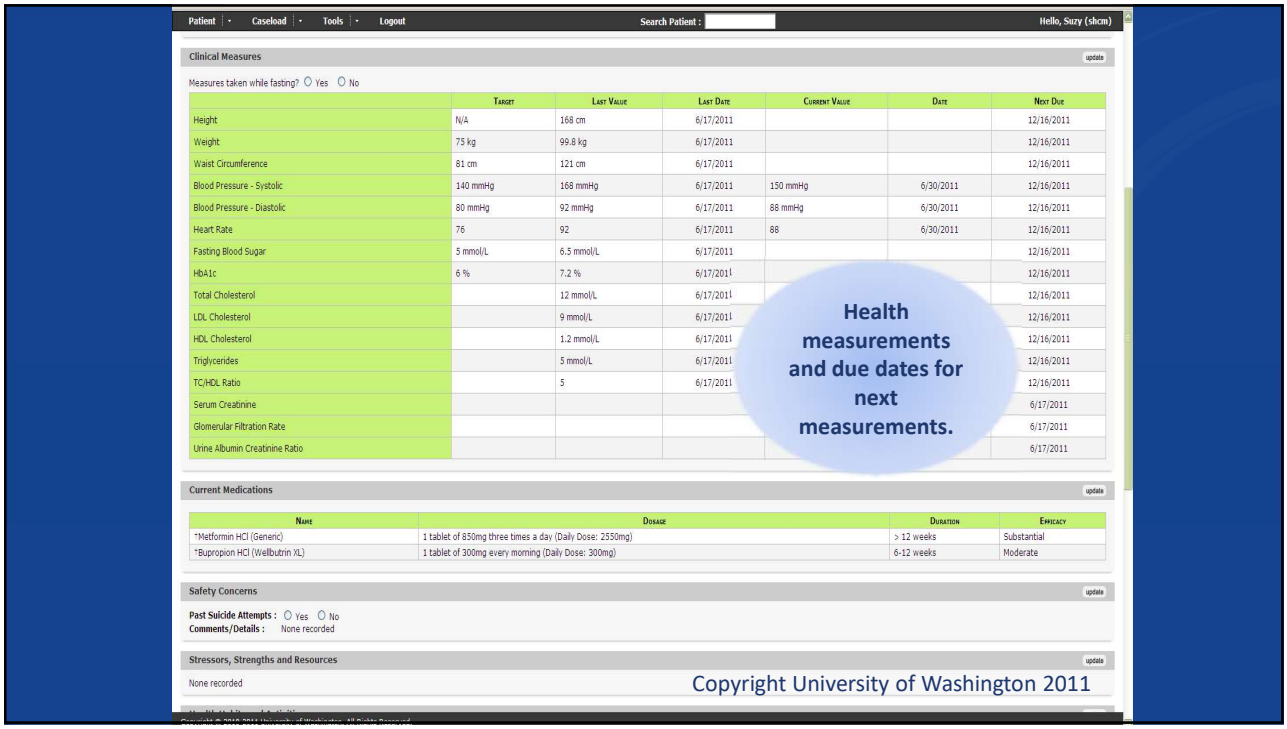

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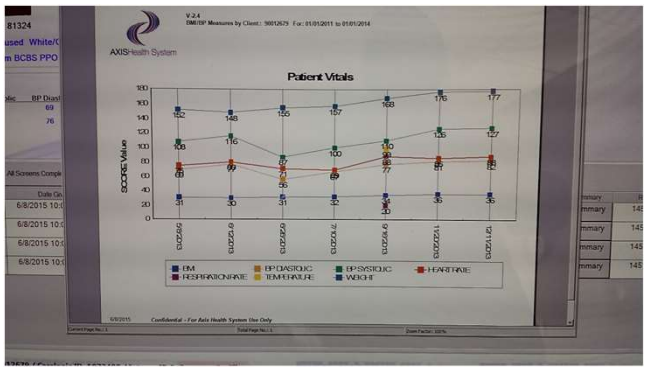
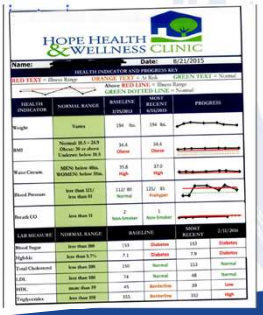
Using Dashboards For Patient Education





Wellness Report Card

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Sharing Aggregate Results

- Blinded or not
- Reward staff
- Carrot approach
- Stick approach
- Set new benchmarks

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Using Data to Identify Gaps in Care

	DM PATIENTS						
	ALL PROVIDERS	Provider A	Provider B	Provider C	Provider D	Provider E	All providers Aug-08
DM Pt's A1C <7.0, **GOAL 40%**	48%	51%	41%	43%	61%	0%	47%
DM Pt's A1c <9.0, **GOAL 68%**	75%	80%	72%	78%	70%	100%	
DM Pt's, BP <130/80, **GOAL 25%**	35%	41%	32%	47%	21%	0%	
DM Pt's, LDL <100 mg/dl, **GOAL 36%**	42%	42%	44%	35%	42%	100%	27%
DM Pt's Annual Dilated Eye exam, **GOAL 40%**	7%	9%	3%	4%	9%	100%	0%
DM Pt's Annual Foot Exam, **GOAL 80%**	96%	93%	95%	100%	91%	100%	24%
DM Pt's Annual Nephropathy, **GOAL 80%**	95%	93%	92%	100%	94%	100%	24%
DM Pt's Smoking Status documented and/or advised Treatment, **GOAL 80%**	93%	96%	92%	96%	94%	100%	55%

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Using Data to Identify Gaps in Care

	Goal	All Providers	PCP 1	PCP2	PCP 3	PSY 1	PSY 1
Smoking Assessment	100 %	38%	25%	60%	50%	0%	0%
Cessation Advised	50%	23%	5%	50%	20%	0%	0%

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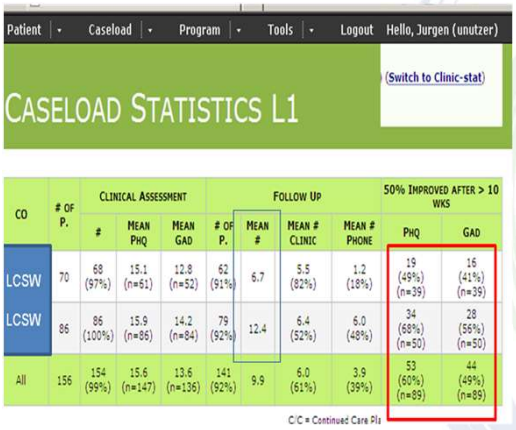
Aggregate Data for Staff Improvement

- Professional development at the provider level – MACRA, MIPS
- Quality improvement at the clinic level
- Inform reimbursement at the payer level



CO	# OF P.	CLINICAL ASSESSMENT			FOLLOW UP				50% IMPROVED AFTER > 10 WKS	
		#	MEAN PHQ	MEAN GAD	# OF P.	MEAN #	MEAN # CLINIC	MEAN # PHONE	PHQ	GAD
LCSW	70	68 (97%)	15.1 (n=51)	12.8 (n=52)	62 (91%)	6.7	5.5 (82%)	1.2 (18%)	19 (49%) (n=39)	16 (41%) (n=39)
LCSW	86	86 (100%)	15.9 (n=86)	14.2 (n=84)	79 (92%)	12.4	6.4 (52%)	6.0 (48%)	34 (68%) (n=50)	28 (56%) (n=50)
All	156	154 (99%)	15.6 (n=147)	13.6 (n=136)	141 (92%)	9.9	6.0 (61%)	3.9 (39%)	53 (60%) (n=89)	44 (49%) (n=89)

C/C = Continued Care Pts

SOURCE: Fortney et al Psych Serv Sept 2016

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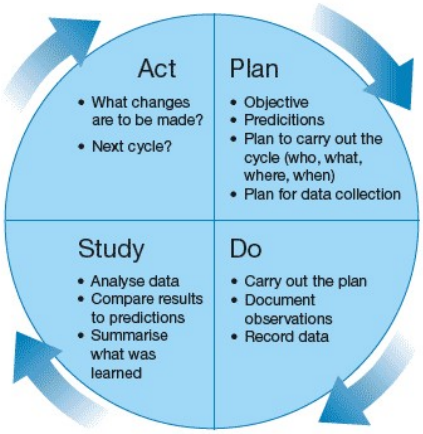
PDSA Cycle for Continuous Quality Improvement



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MBC and VBP

- Upside and downside risk
- Performance bonus
- Shared savings
- Total capitation of all health care expenditures
- Case rate (particularly for SMI, FEP example)

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Thank You!

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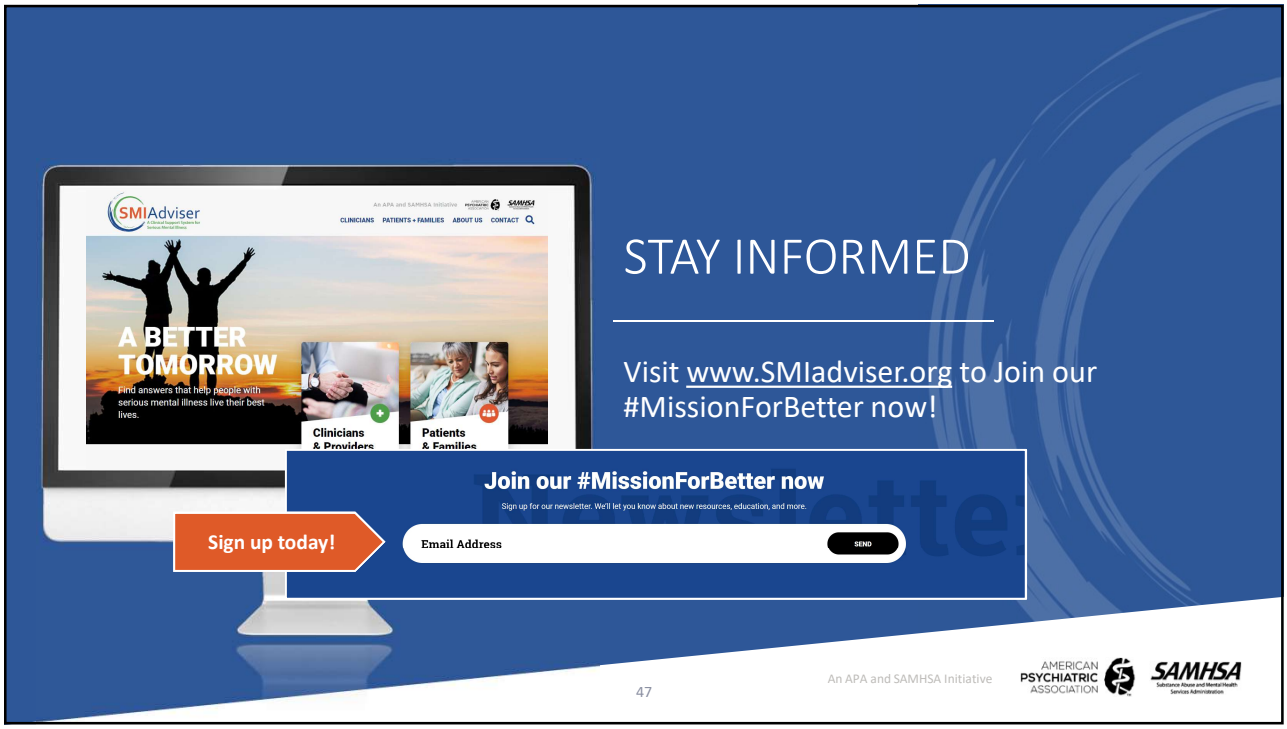
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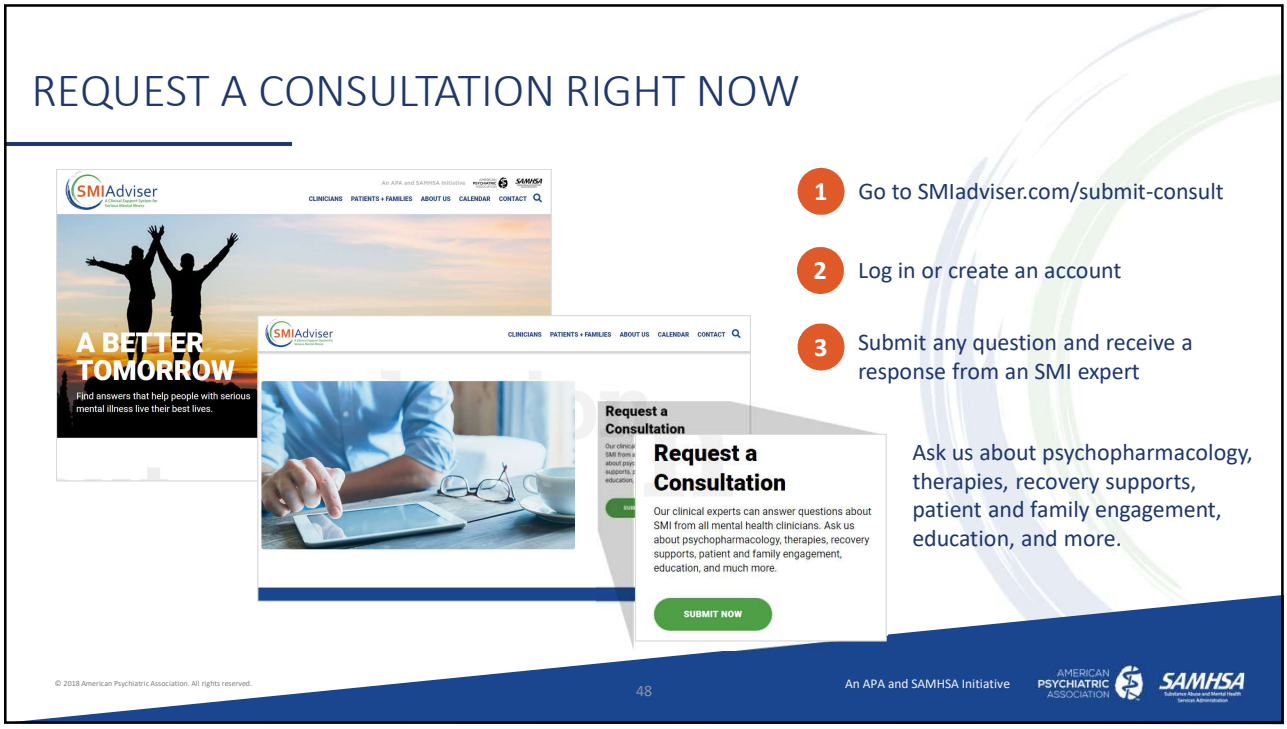
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National Alliance on Mental Illness

Ken Duckworth, MD
National Alliance on Mental Illness

Engaging the Individual and the Family in Treatment Planning

August 22| 3-4pm ET

An overview of the importance of including the patient in all levels of the assessment and treatment process and suggestions on how to incorporate this approach into practice.

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