• Both Dr. Raney and Dr. Lasky receive royalties from American Psychiatric Publishing Inc for books they have edited on Integrated Care
LEARNING OBJECTIVES

• Define best practices for measurement-based care to be successful

• List the most frequently used validated measurement tools for assessing outcomes for common behavioral health conditions.

• Understand the common performance metrics associated with behavioral health conditions and how to utilize them in your practice for value-based payment
AGENDA

- Review of validated screening tools: adults and pediatrics
- Using a registry to track results
- Process of measurement-based care
- Tracking individual patient response
- Tracking practice performance on process and outcomes measures
- Considering challenges to MBC
FEE-FOR-SERVICE
– What we know
– It’s safe and secure
– Non-alignment of incentives for integration

APMs/VALUE-BASED PAYMENT
– The unknown
– Opportunities for rewards, but more uncertainty

NAVIGATING TWO WORLDS – THE CHALLENGING FINANCES OF BEHAVIORAL HEALTH INTEGRATION
CASH FLOW IN FFS VS. A VALUE-BASED ENVIRONMENT

**Fee-for-Service World**

- Provider performs a service and receives payment for it in a quantifiable period of time (30 – 90 days)
- Reimbursement is certain if billing requirements are met
- Steady cash flow throughout the year
- Traditionally no payment for care coordination, integration, quality

**Value-Based Payment World**

- Provider performs a service and may receive a FFS payment for some portion of the service
- Payments based on contract performance (managing total cost of care and quality measures) are received after the measurement period, and cannot be quantified at the time service is rendered
  - Some payments may be PMPM
- Uncertain cash flow with delays from time service delivered
- Providers/systems rewarded for quality and metrics that integrated care addresses
  - Alignment of incentives around achieving better outcomes
“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)
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
• 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.
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
PROCESS OF MEASUREMENT-BASED CARE

- Systematic administration of symptom rating scales – use huddle or registry
  - 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

**SOURCE:** Fortney et al Psych Serv Sept 2016
AGGREGATE DATA

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

SOURCE: Fortney et al Psych Serv Sept 2016
INEFFECTIVE APPROACHES

✚ One-time screening
✚ Assessing symptoms infrequently
✚ Feeding back outcomes outside the context of the clinical encounter
**PROCESS:** SCREEN, TREAT, TRACK, FEEDBACK

- Screen
- Diagnose
- Start treatment
- Measure treatment response
- Track outcomes
- Adjust treatment if needed
- Feedback results to team
**STEPPED CARE APPROACH**

+ 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

**SOURCE:** Van Korff et al 2000
Changing from reacting to the ad hoc needs of individual patients to proactive management of a practice’s patient panel.

**CHOOSE A POPULATION TO TREAT AND TRACK**

+ Define a population based on clinical data
  + Depression
  + Anxiety
  + Depression or Anxiety and > 1 chronic illness
  + ADHD
  + Adolescent depression
  + Post partum depression

---

*Health Management Associates*
SCREENING: USE VALIDATED TOOLS

Mood Disorders
- PHQ-9 Depression
- MDQ: Bipolar Disorder
- CIDI: Bipolar Disorder
- EPDS: Postnatal Depression

Anxiety Disorders
- GAD-7: Anxiety
- PCL-C: PTSD
- SCARED
- Mini Social Phobia: Social Phobia

Psychotic Disorders
- Brief Psychiatric Rating Scale
- Positive and Negative Syndrome Scale

Substance Use Disorders
- CAGE-AID
- AUDIT-C
- DAST
- CRAFFT
- Alcohol Screening and BI for Youth

Developmental Screening
- ASQ
- SWYC
- CHAT
- PEDS
VALIDATED SCREENING AND MEASUREMENT TOOLS

**PHQ 9 > 9**

- < 5 – none/remission
- 5 - mild
- 10 - moderate
- 15- moderate severe
- 20 - severe
**Generalized Anxiety Disorder 7-item (GAD-7) scale**

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by the following problems?</th>
<th>Not at all sure</th>
<th>Several days</th>
<th>Over half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious, or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it's hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Add the score for each column**

<table>
<thead>
<tr>
<th></th>
<th>+</th>
<th>+</th>
<th>+</th>
</tr>
</thead>
</table>

**Total Score (add your column scores) =**

Score $\geq 10$ indicates possible diagnosis
### NICHQ Vanderbilt Assessment Scale—PARENT informant

**Today’s Date: **

**Child’s Name: **

**Date of Birth: **

**Parent’s Name: **

**Parent’s Phone Number: **

**Directions:** Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child’s behaviors in the past 6 months.

**Is this evaluation based on a time when the child:**

- [ ] was on medication
- [ ] was not on medication
- [ ] not sure

**Symptoms**

<table>
<thead>
<tr>
<th>Symptom Description</th>
<th>Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does not pay attention to details or makes careless mistakes with, for example, homework</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Has difficulty keeping attention to what needs to be done</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Does not seem to listen when spoken to directly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Has difficulty organizing tools and activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Is easily distracted by noises or other stimuli</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Is forgetful in daily activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Fidgets with hands or feet or squirms in seat</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Leaves seat when remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Runs about or climbs too much when remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Has difficulty playing or beginning quiet play activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Is “on the go” or often acts as if “driven by a motor”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Talks too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Blurs out answers before questions have been completed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Has difficulty waiting his or her turn</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Interrupts or intrudes in others’ conversations and/or activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Argues with adults</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Loses temper</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. Actively defies or refuses to go along with adults’ requests or rules</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. Deliberately annoys people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. Blames others for his or her mistakes or misbehaviors</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. Is touchy or easily annoyed by others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25. Is angry or resentful</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26. Is spiteful and wants to get even</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27. Bullies, threatens, or intimidates others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Health Management Associates**

20
A Core Set of Outcome Measures for Behavioral Health Across Service Settings

Supplement to Fixing Behavioral Health Care in America: A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services

https://www.thekennedyforum.org/a-supplement-to-our-measurement-based-care-issue-brief/
Identifying tools that support functional assessment including recovery factors:

- SF-12, 24,
- DLA-20,
- Illness Management & Recovery Scale (Dartmouth)
- Employment Ratings
- Housing Stability
- Quality of Life

Behavioral health is better suited for helping to define measurement of social determinants of health.
SCREENING, DIAGNOSTIC, OR MEASUREMENT TOOL?

- Some tools are for *screening* – examples:
  - PHQ2/9/A
  - GAD2/7
  - Vanderbilt
  - CIDI
  - PTSD – PC
  - AUDIT

- *None of these are diagnostic* – need to add a dose of clinical judgement and make a diagnosis

- Some of these tools are *validated measurement tools* – examples:
  - PHQ9
  - GAD7
  - Vanderbilt
  - SCARED (children)
  - BAM – Brief Addiction Monitor
SCREENING VERSUS MEASUREMENT

Common Questions and Concerns

IS SCREENING APPROPRIATE IN COMMUNITY MENTAL HEALTH?

+ Screening 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
Reminder About These Tools

Payers and quality regulators who are requiring outcomes tools need to:
1) use ones that are clinically useful, time efficient, and enable monitoring of aggregate data on quality and population health; and
2) be aware of the need to address the case mix of the targeted populations based on severity and diagnosis.
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.
HOW CAN A REGISTRY HELP?

+ 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
## MEASUREMENT DATA

<table>
<thead>
<tr>
<th>View</th>
<th>Record</th>
<th>Treatment Status</th>
<th>Name</th>
<th>Date of Initial Assessment</th>
<th>Date of Most Recent Contact</th>
<th>Number of Follow-up Contacts</th>
<th>Weeks in Treatment</th>
<th>Initial PHQ-9 Score</th>
<th>Last Available PHQ-9 Score</th>
<th>% Change in PHQ-9 Score</th>
<th>Date of Last PHQ-9 Score</th>
<th>Initial GAD-7 Score</th>
<th>Last Available GAD-7 Score</th>
<th>% Change in GAD-7 Score</th>
<th>Date of Last GAD-7 Score</th>
<th>Psychiatric Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>View</td>
<td>Active</td>
<td>Albert Smith</td>
<td>8/13/2015</td>
<td>12/2/2015</td>
<td>7</td>
<td>29</td>
<td>18</td>
<td>17</td>
<td>-6%</td>
<td>12/2/2015</td>
<td>14</td>
<td>10</td>
<td>-29%</td>
<td>12/2/2015</td>
<td>Flag for discussion</td>
<td></td>
</tr>
<tr>
<td>View</td>
<td>Active</td>
<td>Nancy Fake</td>
<td>2/4/2016</td>
<td>2/4/2016</td>
<td>0</td>
<td>4</td>
<td>- No Score</td>
<td>- No Score</td>
<td></td>
<td></td>
<td>- No Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## PSYCHIATRIC REVIEW, SAFETY FLAGS

<table>
<thead>
<tr>
<th>View Record</th>
<th>Treatment Status</th>
<th>Name</th>
<th>Date of Initial Assessment</th>
<th>Date of Most Recent Contact</th>
<th>Number of Follow-up Contacts</th>
<th>Weeks in Treatment</th>
<th>Initial PHQ-9 Score</th>
<th>Last Available PHQ-9 Score</th>
<th>% Change in PHQ-9 Score</th>
<th>Date of Last PHQ-9 Score</th>
<th>Initial GAD-7 Score</th>
<th>Last Available GAD-7 Score</th>
<th>% Change in GAD-7 Score</th>
<th>Date of Last GAD-7 Score</th>
<th>Psychiatric Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>View</td>
<td>Active</td>
<td>Susan Test</td>
<td>9/5/2015</td>
<td>2/23/2016</td>
<td>10</td>
<td>26</td>
<td>22</td>
<td>14</td>
<td>-36%</td>
<td>2/23/2016</td>
<td>18</td>
<td>17</td>
<td>-6%</td>
<td>1/21/2016</td>
<td>Flag for discussion &amp; safety risk</td>
</tr>
<tr>
<td>View</td>
<td>Active</td>
<td>Albert Smith</td>
<td>8/13/2015</td>
<td>12/2/2015</td>
<td>7</td>
<td>29</td>
<td>18</td>
<td>17</td>
<td>-6%</td>
<td>12/2/2015</td>
<td>14</td>
<td>10</td>
<td>-29%</td>
<td>12/2/2015</td>
<td>Flag for discussion &amp; safety risk</td>
</tr>
</tbody>
</table>

**Notes:**
- Indicates the most recent contact was over 2 months (80 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.

**Psychiatric Consultation Options:**
- Flag for discussion & safety risk.
Two crucial data points:
50% reduction PHQ-9
Remission (PHQ 9 < 5)
SHARE RESULTS WITH PATIENTS AND STAFF

Used with permission UW AIMS
AGGREGATE DATA TO MEASURE PERFORMANCE ON A CLINICIAN LEVEL

<table>
<thead>
<tr>
<th>CO</th>
<th># OF P.</th>
<th>#</th>
<th>MEAN PHQ</th>
<th>MEAN GAD</th>
<th># OF P.</th>
<th>MEAN #</th>
<th>MEAN #</th>
<th>MEAN #</th>
<th>50% IMPROVED AFTER &gt; 10 WKS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LCSW</td>
<td>70</td>
<td>68</td>
<td>15.1</td>
<td>12.8</td>
<td>62</td>
<td>6.7</td>
<td>5.5</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(97%)</td>
<td>(n=51)</td>
<td>(n=52)</td>
<td>(91%)</td>
<td>(82%)</td>
<td>(18%)</td>
<td>(18%)</td>
<td></td>
</tr>
<tr>
<td>LCSW</td>
<td>85</td>
<td>86</td>
<td>15.9</td>
<td>14.2</td>
<td>79</td>
<td>12.4</td>
<td>6.4</td>
<td>6.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(100%)</td>
<td>(n=85)</td>
<td>(n=84)</td>
<td>(92%)</td>
<td>(52%)</td>
<td>(48%)</td>
<td>(48%)</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>156</td>
<td>154</td>
<td>15.6</td>
<td>13.6</td>
<td>141</td>
<td>9.9</td>
<td>6.0</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(99%)</td>
<td>(n=147)</td>
<td>(n=136)</td>
<td>(92%)</td>
<td>(61%)</td>
<td>(39%)</td>
<td>(39%)</td>
<td></td>
</tr>
</tbody>
</table>

C/C = Continued Care Pls

HEALTH MANAGEMENT ASSOCIATES
PERFORMANCE MEASURES

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
OTHER METRICS

- **Anxiety**
  - 50% reduction in GAD-7
  - Remission in anxiety GAD-7 < 5

- **Depression and chronic medical conditions**
  - % with depression and 2 or more chronic conditions who had improvements in HbA1c/DBP/Lipids, etc

- **Alcohol use**
  - % of patients with AUD who reduced intake to NIAAA safe drinking limits
  - % of patients with AUD who are abstinent

- **ADHD**
  - % of patients with reduction in score of items 1-18
TRANSPARENCY: CELEBRATE SUCCESSES!

- Blinded or not
- Reward staff
- Carrot approach
- Stick approach
- Set new benchmarks
When P4P arrangements were in place, median time to depression treatment response was reduced by half.

Unützer et al. 2012
EXERCISE

PERSONAL REFLECTION

WHAT IS THE BIGGEST CHALLENGE TO MBC IN MY ORGANIZATION?

FIND A PARTNER - WORK IN PAIRS

Discuss the challenges in a pair and provide each other with ideas or refine the challenge.

JOIN A GROUP OF THREE - NEW PARTNERS!

Discuss the challenges and also spend some time brainstorming solutions or ideas for addressing the challenge.

DISCUSS WITH THE GROUP

Share your thoughts and experience and what you heard from your colleagues as solutions.
CONTACT US

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