CCBHC-E National Training and Technical Assistance Center

CCBHC Optimizing Data through Measurement Informed Care (MIC) Learning & Action Series

June 18, 2024

CCBHC-E National Training and Technical Assistance Center
Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

Acknowledgements and Disclaimer

This session was made possible by Grant Number 1H79SM085856 from the Substance Abuse and Mental Health Services Administration (SAMHSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views, opinions, or policies of SAMHSA, or the U.S. Department of Health and Human Services (HHS).

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Logistics

- **Please rename yourself so your name includes your organization.**
  - *For example:*
    - **Roara Michael, National Council**
  - *To rename yourself:*
    - Click on the **Participants** icon at the bottom of the screen
    - Find your name and hover your mouse over it
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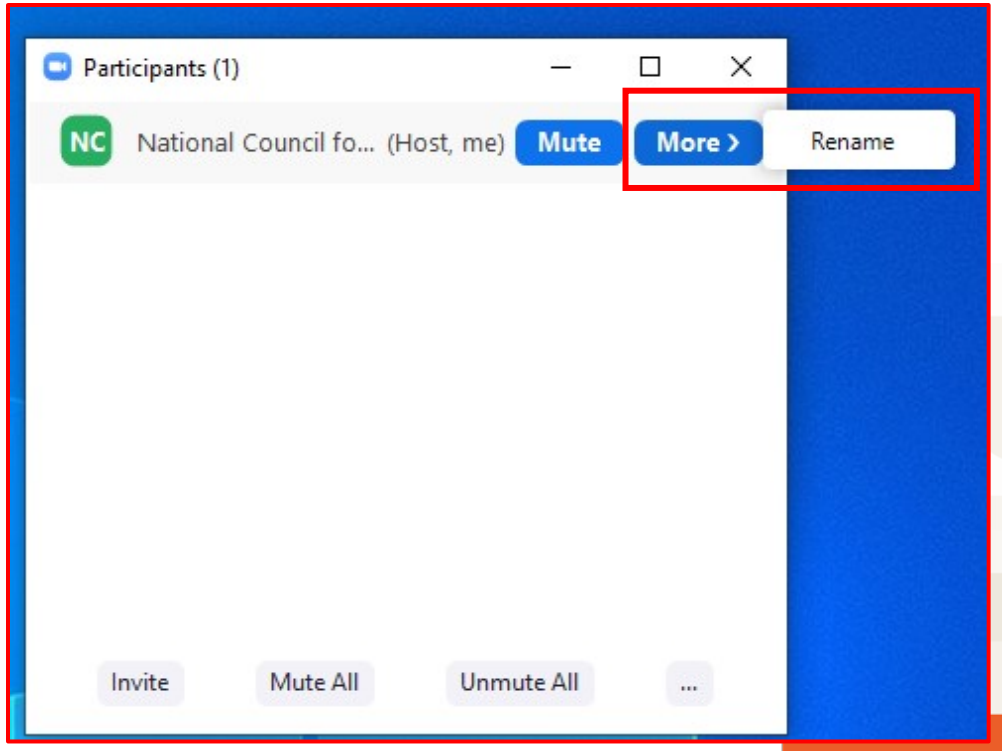

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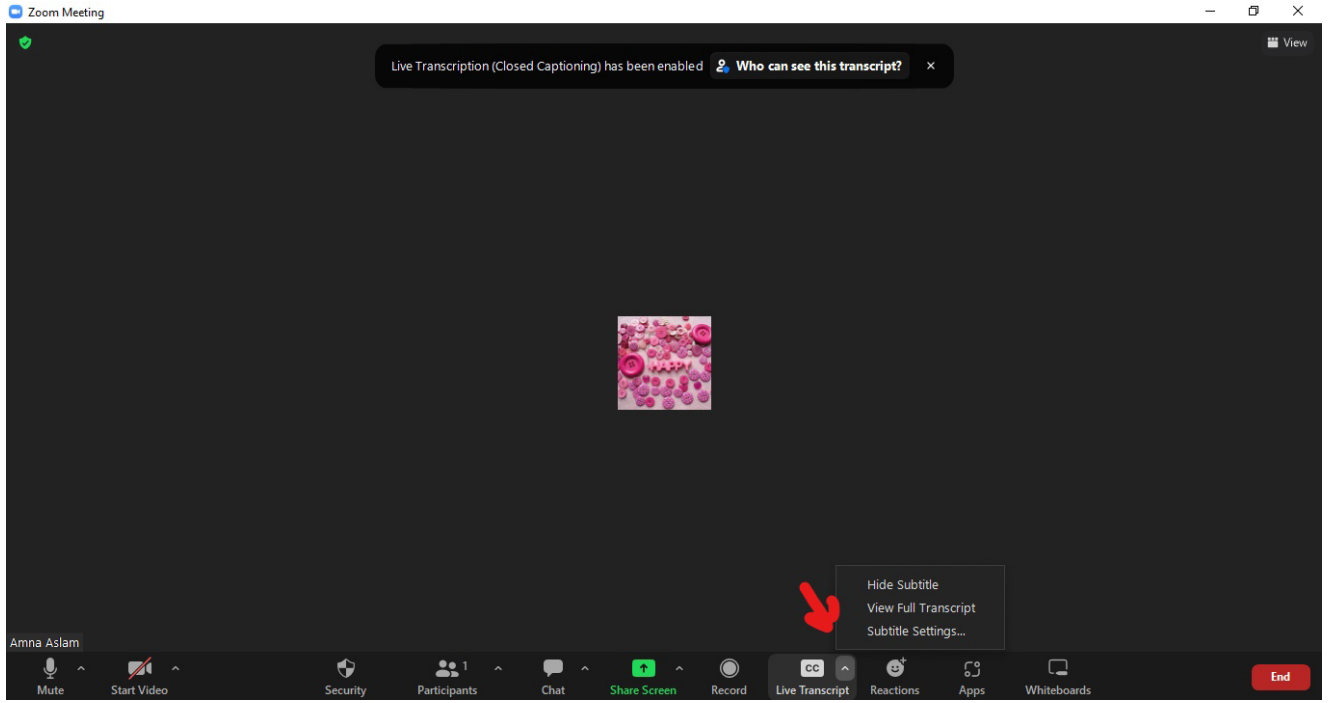

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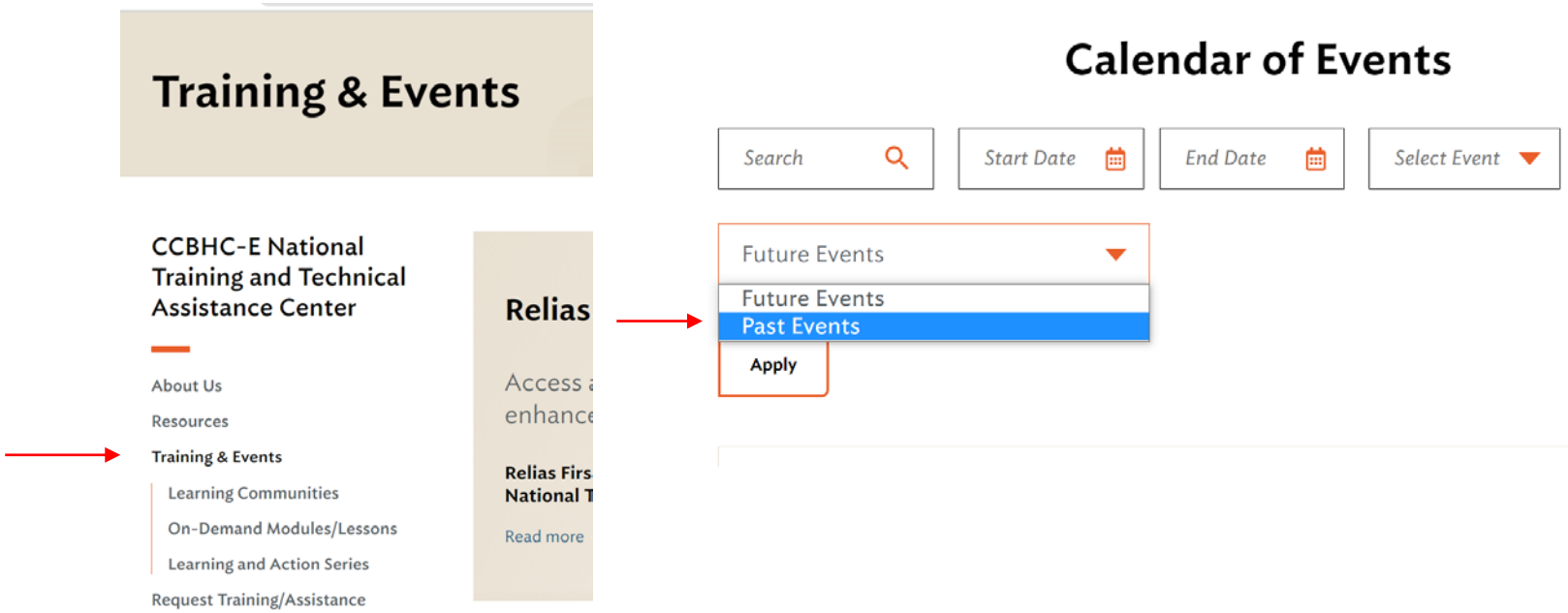
Today's Session: Slides and Recording

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.



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Learning Series Curriculum

Date	Topic
May 14	Understanding Measurement-informed Care
June 18	Implementing and Optimizing Measurement-informed Care
July 16	Sustaining Measurement-informed Care

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Today's Agenda

- Review Purpose of Optimizing Data Learning Series
- Key processes and structures necessary to begin MIC
- Important considerations in selecting measures
- Common challenges and associated solutions MIC Implementation
- Group Discussion

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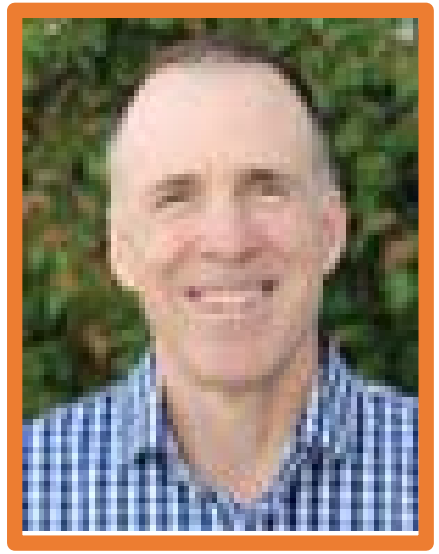
Learning Series Faculty

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



Jim Zahniser, PhD
Partner and Chief Leadership Officer
TriWest Group

TriWest Health + Human Service Evaluation + Consulting

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Today's Guest Presenters

Josh Cantwell, MBA, LCSW, CPRSS
Chief Operating Officer
GRAND Mental Health

Matthew Spencer, MA, LPC, CPRSS
Chief Clinical Officer
GRAND Mental Health

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Organizations are made-up of People! People are made-up of this:

- **Cultural Norms** are "how we do things here…"
- **Behaviors** are how these internalized systems (principles, attitudes, beliefs & values) are expressed!
- **Principles** are the guidelines we use to live our values (e.g., Honesty = don't tell lies).
- **Attitudes** are core values & beliefs we hold internally.
- **Beliefs** are assumptions and convictions we hold to be true based on past experiences.
- **Values** are abstract conceptions of what is important and worthwhile (e.g., honesty). It's what we care about!

Why is the Use of Data for Clinical & 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

Dept. of Labor Organizational Data Maturity Model

Organizational mechanisms that reinforce, communicate, and share the importance of data informed decision making.

Analytical techniques to gain insights from data and inform decision-making.

Management and governance of data and metadata.

Applications, data platforms and infrastructure to support data management, data governance, and analytics.

Human capital programs required to develop talented and trained data personnel.

Dept of Labor Data Maturity Model: https://www.dol.gov/agencies/odg/data-management-maturity-model

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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 i n 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.

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1. Important Considerations in Selecting Measures

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 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)

- Kennedy Forum Issue Brief
- Fixing Behavioral Healthcare in America: A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services https://www.thekennedyforum.org/app/uploads/2017/06/KennedyForum-MeasurementBasedCare_2.pdf

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Common Measures and Tools

- The specific tools chosen do, indeed, 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.**

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. (example: AUDIT-C)

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)

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)
- Child & Adolescent Functional Assessment Scale (CAFAS) (includes. school, home, community)

National Council Research Project

- **Goal:**
  - Direct the concepts and content for consideration that will improve and align behavioral health MIC with HEDIS/NCQA and other measures endorsement bodies.
- **Methods:**
  - Literature and measures review (16 data sets, 215+ measures)
  - Expert panel process (12 interdisciplinary experts)
  - Input from interested parties, including many of you (500+ session attendees)

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Expert Panel Recommendations

Utilize existing measures that are:

- Outcome-focused
- Patient self-report
- Low burden
- Sensitive to change

If you add, focus on:

- Transdiagnostic measures
- Functional measures

Tier 1 Measures Criteria

Inclusion

- Required reporting for Medicaid or CCBHC
- Measures highly prevalent conditions screened and assessed in primary care
- Outcome focused
- User self-report scales or biometric indicator
- Low burden (≤15 items)
- Sensitive to clinical change
- Psychometrically sound (reliable, valid)
- Scales with established norms and clinical severity thresholds
- Adult
- Outpatient
- Suitable for community behavioral health
- Free and in the public domain
- Eligible for reimbursement

Exclusion

- Process focused
- Epidemiological (counts only)

Tier 1 Measures

Name	Specs	Source	Items	Proposed Modifications
Depression response/ remission at 6 months	% adults w/ MD or dysthymia who reached response (PH-9 50% reduction) or remission (PHQ-9 <5) in 6 months (+/- 60 days after an index event.	APA-MBHR, NCQA	10	Monthly assessment; Consider categorical cut-point for response; Episode-based time interval should be revised to last score in calendar year
Anxiety response at 6 months	% adults with anxiety disorder who demonstrated response to treatment (GAD-7 <25% than at index event) at six months (+/- 60 days) after an index event.	APA-MBHR	8	As above.
Alcohol use disorder outcome response	% adults who reported problems w/ drinking alcohol (AUDIT-C, DAST, TAPS etc.) and demonstrated response to treatment at 3 months (+/- 60 days after index visit.	APA-MBHR	3	Consider categorical cut point to indicate alcohol treatment response indicating drinking within NIAAA (or other) safe limits.

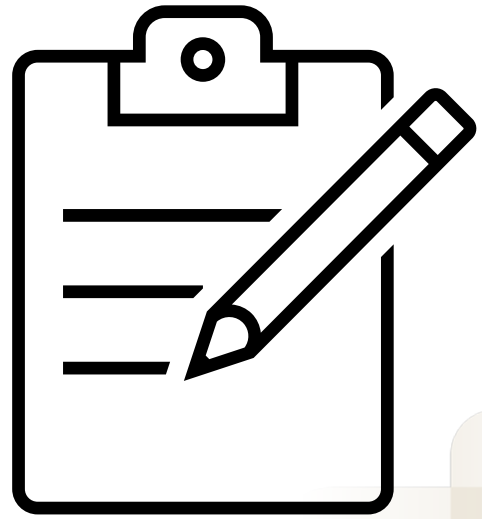
Continued on next slide

Tier 1 Measures (cont.)

Name	Specs	Source	Items	Proposed Modifications
Comprehensive Diabetes Care for Ppl w/ SMI: HbA1c Poor Control (>9.0%)	Adults w/ 1(+) acute inpatient visit or 2 outpatient visits for schizophrenia or bipolar I disorder, or at least 1 inpatient visit for major depression during the measurement year *and* diabetes (type 1 and type 2) and whose HbA1c > 9.0%, missing or not tested.	Medicaid (Adult Core Set 2022); ASPE	1	Align HBA1c outcome w/ NCQA diabetes screening of bipolar and schizophrenia patients receiving atypical antipsychotic meds; Freq of assessment is 2(+)/year when stable at target; frequency is greater at 2-3 months when HBA1c not at target.
Comp. Diabetes Care for Ppl W/ SMI: Blood Pressure Control (<140/90 mm Hg)	Adults w/ 1(+) acute inpatient visit or 2 outpatient visits for schizophrenia or bipolar I disorder, or 1(+) inpatient visit for major depression during the measurement year *and* diabetes (type 1 and type 2) and whose most recent blood pressure screening result was <140/90mm Hg.	NQF	1	Cut point could be updated with new guidance (130/65 mm Hg).
Diabetes Monitoring for Ppl w/ Diabetes and Schizophrenia	Adults 18-64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	NCQA, APA-ADA	2	Create outcome consistent w/ the recommendations of the joint consensus APA/ADA statement on anti-psychotic medication; Create a cut point to indicate LDL-C treatment response

Tier 2 Measures Criteria

- Transdiagnostic (i.e., informative for clinical care across diagnoses)
- Outcome focused
- Patient self-report
- Low burden (≤ 20 items)
- Sensitive to change
- Suitable for adult community behavioral health



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Tier Two Examples

Concept	Candidate Scale(s)	Cost	Items	Modifications
Disease Self-Management	PAM scores at 12 Months (Hibbard et al., 2004)	Free for research only	10 or 13	Reassess every 3 months. Specify target change in score (e.g., move up one level).
Functioning	PROMIS v1.2 – Global Health Physical 2a and PROMIS Scale v1.2 – Global Health Mental 2a (Hays et al., 2017)	Free	4	Create categorical cut point to indicate treatment response. Reassess every three months.
Goal Attainment	Goal Attainment Scaling (GAS)(NCQA, 2023).	Free	2	Format for unsupported patient self-report.
Patient Experience of Care	CAHPS Experience of Care and Health Outcomes (ECHO) (AHRQ, 2004)	Free	31, or individual subscales	Shorten scale or limit to particular subscales.
Quality of Life	World Health Org. Disability Assessment Schedule (WHODAS 2.0) (Ustün et al., 2010)	Free	12	Create categorical cut point to indicate treatment response. Reassess every 3 months. Limit reporting to select domains.
Recovery	Hearth Hope Index (HHI) (Nayeri et al., 2020)	Free	12	Create a more stable factor solution

Additional Considerations

- So many good measures! What's a CCBHC to do?
  - Start focused with measures that have been proven to work well in MBC – e.g., PHQ9 and PHQ-A, then
  - Build from there, being sure to include measures that address prevalent concerns in the population you serve, and
  - Equipping clinicians to use the measures clinically
- Aid clinicians in the use of MIC:
  - 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
  - Train on how to talk with clients about measurement findings
  - Build off of treatment algorithms and clinical guidelines, matching stage of change to treatment provided (train in motivational interviewing, etc.)

The GRAND Experience and Developmental Path

29,385
unique clients served statewide in 2023

Increased number of adult clients served by
362%
(from 4,326 in 2015 to 19,973 in 2023)

Reduced inpatient hospitalizations at any Oklahoma hospital by
93.1%
(from 959 in 2015 to 66 in 2021)

Creating and establishing best practices that prioritize the community's mental health through innovation and transparency

2,200+
clinical + administrative staff

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Measurements Informing Change

Following a CCBHC Outcome-Driven Model	*Leading Change, Advancing Care*
Identify Need	Lean heavily on the community / partnerships
Develop Informed Pathways	https://www.thenationalcouncil.org/resources/toolkit-for-designing-and-implementing-care-pathways/
Implement with resources	Strategic Roll Out with sense of agency
Continuous Quality Improvement	https://www.thenationalcouncil.org/resources/quality-improvement-toolkit-2/

Progress in Motion - EXAMPLE

Identify Need	Develop Informed Pathways	Implement with resources	Continuous Quality Improvement
841 GRAND adult clients were inpatient at contracted psychiatric hospital in 2015.	Development of the GRAND Model for Crisis Services •Urgent Recovery Centers •Community iPads for immediate Access to Care	24/7 URC for Crisis Stabilization opened in January 2016. 5,302 mental health devices assigned by 2020.	2021/2022 - NRI conducts and publishes findings of an independent evaluation that show strong evidence that the GRAND Model reduces hospitalizations (93%), increases outpatient services, and saves law enforcement time and money.

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Incorporating in Clinical Workflow

Care Pathways

Development of policy, protocol, care pathways, and learning materials.

Learning and Development

Investing time and resources into the enrichment of clinical staff.

Outcome-Based Treatment Plan

Each service is an encountered opportunity to measure the current impact of treatment with the person served.

Person Served provides informed feedback on their progress towards milestones.

- Living, breathing treatment planning for actionable steps in providing care.

Feedback Informs Outcomes

Outcomes drive an argument for resources towards best practices.

- Does the current practice work for the Person Served?

GRAND utilizes Feedback Informed Care to help direct resources towards clients.

- Struggles with direction of services may require further attention to health literacy, community resources, or shifts in modality.
- Follow the equation of screening/ assessment, service direction/ modality decisions, client response and outcomes.
  - Example – PHQ9 score informs service direction, but client response informs next steps towards positive outcomes.

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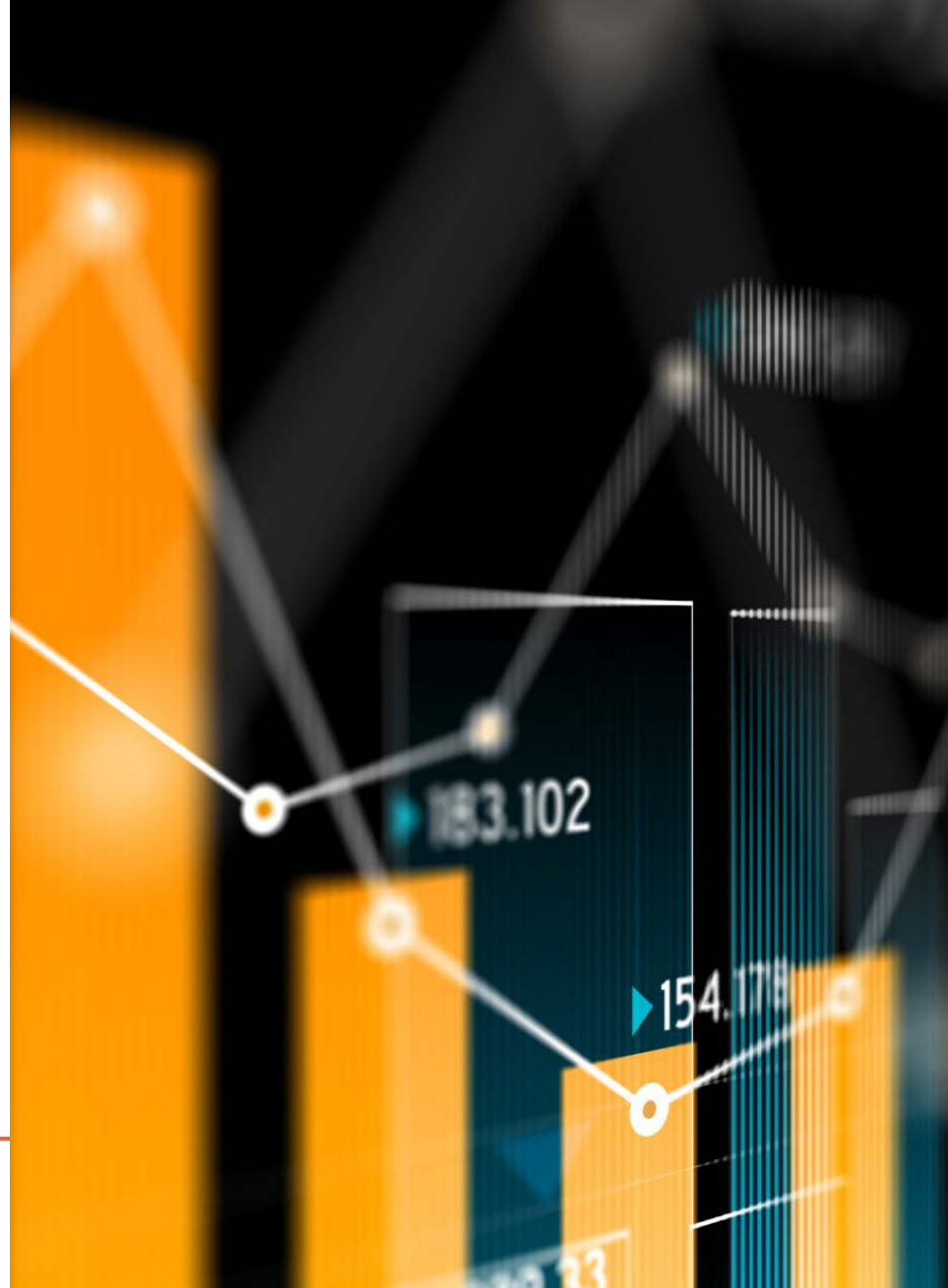
Organizational Level Use

- Oklahoma implemented Managed Care Organizations in April 2024.
- The importance of progress and results is amplified.
  - Using Outcome driven data to display the necessity of CCBHC services.
- The combination of outcomes and feedback leads to an inarguable data set.
  - Data collected by clinical staff will match the progression of milestones in completing services.
- We are equipped to thrive in a Values Based Care system.
  - Prepared to offer visual results.



Interview Questions for GRAND

- What challenges did you encounter, if any, in selecting measures – e.g., in knowing which would be best to include and which you needed to exclude? Or, in combining standardized patient-reported outcomes with other types of outcomes (individually-specific or outcomes that are not client-reported like the PHQ-9)?
  - How did you address this challenge?
- What challenges have you encountered, if any, in obtaining clinician buy-in?
  - How did you address these challenges?
- What challenges did you face, if any, in integrating the measures into your electronic record or into your clinical documentation and billing processes?
  - How did you address these challenges?

Interview Questions for GRAND

- What challenges did you face, if any, in aggregating findings and using them for program enhancement (vs. at the individual client-level)?
  - How did you address this challenge?
- What challenges have you encountered, if any, in explaining the use of measures and MIC in general to clients?
  - How did you address these challenges?
- What challenges you have faced, if any, in sharing and explaining the use of MIC and its results to constituents, such as funders, Board members, etc.?
  - How did you address these challenges?

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Questions and Comments from Participants

- What questions or comments do you have for Josh and Matthew?

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Resources:

- 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.
- Very recent paper on the "quality of quality metrics" – helpful in thinking about program-level MIC. Narayan et al. 2024 Health Affairs, March 19, 2024. https://www.healthaffairs.org/content/forefront/improving-quality-quality-metrics
- Implementing Measurement-Based Care in Behavioral Health: A review by Lewis et al. in JAMA Psychiatry, 2019. https://pubmed.ncbi.nlm.nih.gov/30566197/ (among other things defines MIC fidelity and it addresses typical implementation barriers and solutions to overcoming them; proposes a 10-point research agenda, also relevant for considering implementation)
- Dept of Labor Data Maturity Model: https://www.dol.gov/agencies/odg/data-management-maturity-model

New MIC Report

Advancing Measurement-informed Care in Community Behavioral Health

Authors: Henry Chung, MD, Deborah Scharf, PhD, Joe Parks, MD, Jeff Capobianco, PhD, Vamika Mann, MA, Alexandra Plante, MA, and Sarah Neil, PhD

Corresponding Author: Henry Chung, HChung@Montefiore.org

Available now! https://www.thenationalcouncil.org/resources/advancing-measurement-informed-care-in-community-behavioral-health/

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Closing: Next Session

- **July 16, 2024, 3pm – 4:00pm EST**
  - The session will discuss what constitutes a useful measure for both staff and clients, considerations for choosing valid and clinically useful measures. How to reliably integrating measurement in staff workflows and clients' interactions. Time will be spent reviewing common challenges. A model of assessing your CCBHC's level of data use will be introduced to help CCBHC's design a path for scaling their MIC current state.

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CCBHC-Expansion Grantee National Training and Technical Assistance Center

We offer CCBHC grantees…

Virtual Learning Communities, Webinars and Office Hours

Regular monthly offerings that are determined based on grantees expressed needs.

Opportunities for Collaboration with Other Grantees

Monthly Peer Cohort Calls for CCBHC Program Directors, Executives, Evaluators and Medical Directors.

Direct Consultation

Request individual support through our website requesting system and receive 1:1 consultation.

On-demand Resource Library

Includes toolkits, guidance documents, and on-demand learning modules.

TheNationalCouncil.org

Access our website to register for upcoming events, submit a consultation request or scan our on-demand resource library:
https://www.thenationalcouncil.org/program/ccbhc-e-national-training-and-technical-assistance-center/

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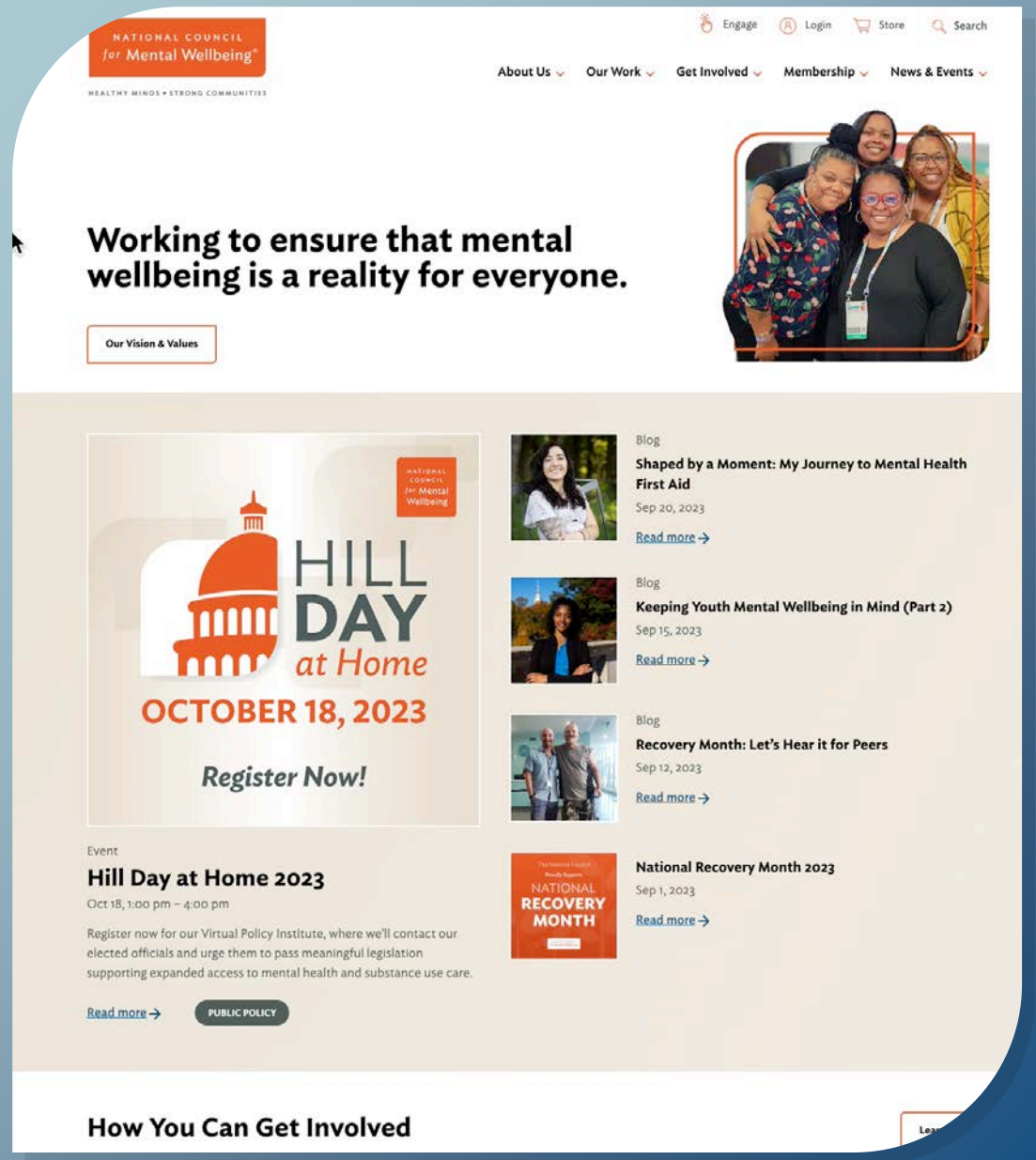

Questions or Looking for Support?

Visit our website
and complete the CCBHC-E NTTAC Request Form

Slides, recordings and session resources will be available on our New Grantee Learning Community webpage approximately 2 days following each session

thenationalcouncil.org/program/ccbhc-e-national-training-and-technical-assistance-center/request-training-assistance/

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