The Measurement Based Care (MBC) in Mental Health Initiative in VHA

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What is Measurement Based Care?

MBC is the use of Veteran self-reported outcome measures to individualize and improve mental health care.
Veterans complete reliable, validated, clinically appropriate measures at intake and at regular intervals as one part of routine care.

Results from the measures are immediately shared and discussed with the Veteran and other providers involved in the Veteran’s care.

Together, providers and Veterans use outcome measures
- to develop treatment plans
- assess progress over time
- inform shared decisions about changes to the treatment plan over time.
Why MBC in VHA?
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Evidence-Based Care

Improved outcomes:
- Depression care
- Primary care
- Psychotherapy
Why MBC in VHA?

Evidence-Based Care

Improved outcomes:
- Depression care
- Primary care
- Psychotherapy

Veteran-Centered Care

Veteran’s voice
Shared decision-making
Increases engagement

act now
The MBC initiative is VHA’s effort to implement the use of measures for individualized treatment planning and shared-decision making throughout VA mental health as a **standard of care**.
VHA Mental Health Strategic Goal

Call to Action for Suicide Prevention
Challenges

• Get it done. Now.

• No implementation model
  – What measure?
  – How often?
  – Local differences
  – VHA MH is more than psychotherapy
How to create an initiative?
- Implementation science principles
- Organizational theory
- Common sense
Areas of uncertainty and lack of clear evidence base led to the initiative as learning organization and national laboratory.
Phase 1: creating a learning infrastructure and implementation process to facilitate a national laboratory using double-looped learning
Single-Loop Learning
most common learning style, problem solving

Governing Variables
Goals, values, beliefs, conceptual frameworks
Why we do what we do

Action Strategies and Techniques
What we do

Results and Consequences
What we obtain

Double-Loop Learning
more than problem solving, this learning style reevaluates and reframes goals, values, etc.
Hallmarks of a Learning Organization

- Unifying set of core vision and values
- Networked intelligence
- Reproducible structures
Unifying set of core vision and values

- **Goal:** Collect, Share, Act
- **Quality improvement culture**
- **Veteran-Centered Care**
Networked Intelligence

- Accessible information systems
- Allow for different points of view
- Champion Sites are full participants
• Some commonalities
• Innovation can be replicated
Commonalities

• Four core measures
  – PCL-5 (PTSD)  -- PHQ-9 (depression/distress)
  – GAD-7 (anxiety) -- BAM-R (SUD)

• Minimum 2 administrations in 6 months

• Recommend new episodes of care

• Enter into MHA VistA files
  – shared language of measurement
  – travels with the Veteran throughout care
  – allows the initiative to create tracking tools
Who is the VA’s MBC Initiative?

MBC Forum

Jennifer Burden, Dave Carroll, Brady Cole, Elliot Fielstein, Richard Goldberg, Pete Hauser, Rani Hoff, Ira Katz, Angela Keen, JoAnn Kirchner, Harold Kudler, Katy Lysell, John McCarthy, Pearl McGee-Vincent, Marsden McGuire, Matt Moore, Bruce Nelson, Dave Oslin, Stacey Pollack, Sandy Resnick, Joe Ruzek, Paula Schnurr, Wendy Tenhula, Jodie Trafton, Kendra Weaver, Shannon Wiltsey-Stirman, Alex Young
June 2016: Phase 1 Planning Meeting

July 2016: RFP Released

August 2016: RFP Due

October 2016: Phase 1 Kick-Off
Fifty-nine Champion Sites, representing 18 VISNS, 174 programs

- Outpt SUD, 34
- Outpt PTSD, 33
- GMH, 20
- PCMHI, 22
- BHIP, 22
- RRTP, 32
- Other, 22
Commonalities: Tools

- Pulse - Agents of Change!
- Monthly Champion Site Check-In Calls
- Special events – data tools, BHL trainings
- Coaching
- Education/Training
Coaching Workgroup

• Implementation Planning Worksheet
• Individualized implementation coaching
• Community of Practice calls

JoAnn Kirchner, Sandy Resnick, Jennifer Burden, Kathy Dollar, Dom DePhilippis, Jason Goodson, Eric Hermes, Pearl McGee-Vincent, Courtney Worley
Coaching Workgroup

Monthly CoP calls by setting, facilitated by coaches:

- SUD - Dominick DePhilippis
- PCMHI – Kathy Dollar
- GMH/BHIP – Pearl McGee-Vincent, Courtney Worley
- RRTP – Jennifer Burden
- PTSD – Pearl McGee-Vincent, Jason Goodson
- Inpatient/Other – Sandy Resnick

- 72 individual coaching calls
- 40 uploaded Implementation plans
- 25 CoP calls held

JoAnn Kirchner, Sandy Resnick, Jennifer Burden, Kathy Dollar, Dom DePhilippis, Jason Goodson, Eric Hermes, Pearl McGee-Vincent, Courtney Worley
Education Workgroup

- TMS training for CEU credits
- Monthly panel discussions
  - How do we feel about MBC? Challenges and Concerns from the Clinician Perspective
  - Service Connection Concerns
  - MBC Across Diverse Settings
  - PTSD Clinical Teams and MBC
  - MBC in Groups

Joe Ruzek, Dom DePhilippis, Natacha Jacques, Jennee Evans, Lisa Kearney, Jennifer Burden, Katy Lysell, Sandy Resnick
Communications work group

• A wide variety of stakeholders
  – Veterans
  – Providers
  – Federal leadership
  Senior leadership
  Mental health leadership
  Public

• What is needed is very different for each
  – Slide decks, newsletters, fact sheets, press releases, announcements/posters, feedback to sites, FAQ documents

Nancy Bernardy, Brady Cole, Stacy Gavin, Rani Hoff, Harold Kudler, Stacey Pollack, Rebecca Sripada, Shannon Wiltsy-Stirman, Laura Wray
Learning how to learn--evaluation work group

- Baseline needs assessment
- Provider survey
- Analysis of implementation plans
- End of Phase I assessment

Rani Hoff, John Mignogna, Tiffany Mulligan, Dave Oslin, Paula Schnurr, Laura Wray, Craig Rosen, Elliot Fielstein, Richard Goldberg, Sandy Resnick, Alex Young
Measurement Based Care

- Informs treatment for an individual Veteran
- Repeated mid-treatment measurement helps to track a Veteran’s progress

Program Evaluation

- Informs treatment for a program (groups of Veterans)
- Baseline and discharge measurement is often sufficient to inform programmatic changes

Use of standardized, valid, brief measures
Baseline needs assessment

• Purpose: determine where clinics were starting from, some implementation plans, and main concerns and/or barriers to implementation

• 158 clinics returned assessments

• Combination quantitative, qualitative items
# Measures proposed

<table>
<thead>
<tr>
<th>Measure</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ9</td>
<td>113</td>
<td>71.1</td>
</tr>
<tr>
<td>PCL-5</td>
<td>96</td>
<td>60.42</td>
</tr>
<tr>
<td>GAD-7</td>
<td>81</td>
<td>50.9</td>
</tr>
<tr>
<td>BAM</td>
<td>80</td>
<td>50.3</td>
</tr>
<tr>
<td>WHODAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VR-12</td>
<td></td>
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<tr>
<td>QOLI</td>
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<td></td>
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<tr>
<td>WHOQOL</td>
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</table>
### Proposed method of data capture

<table>
<thead>
<tr>
<th>Method</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper and pencil—clerk entry</td>
<td>30.8</td>
</tr>
<tr>
<td>Paper and pencil—provider entry</td>
<td>63.5</td>
</tr>
<tr>
<td>Direct patient entry with secure desktop</td>
<td>25.2</td>
</tr>
<tr>
<td>Behavioral Health Lab</td>
<td>55.3</td>
</tr>
<tr>
<td>E-Screening</td>
<td>8.8</td>
</tr>
</tbody>
</table>

45.9% of Champion Sites reported that MBC would be a completely new process
## Confidence

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Mean (std)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient PTSD</td>
<td>7.4 (1.3)</td>
</tr>
<tr>
<td>Outpatient SUD</td>
<td>7.0 (1.2)</td>
</tr>
<tr>
<td>RRTP</td>
<td>7.0 (1.6)</td>
</tr>
<tr>
<td>PCMHI</td>
<td>6.9 (1.2)</td>
</tr>
<tr>
<td>GMH</td>
<td>6.6 (1.5)</td>
</tr>
<tr>
<td>Inpatient mental health</td>
<td>6.5 (0.6)</td>
</tr>
<tr>
<td>BHIP</td>
<td>6.3 (1.5)</td>
</tr>
<tr>
<td>PRRC/vocational</td>
<td>3.5 (2.1)</td>
</tr>
</tbody>
</table>

82.3% requested coaching
Challenges and concerns

- Integration into current processes
- Sustainability

- Provider buy-in
- Veteran buy-in

- Increased burden
- Effect on session time

- Software challenges
- Hardware challenges

Measurement Based Care (MBC) Initiative
Provider Survey

• Purpose: to assess providers’ attitudes about MBC and their current practices

• Web based survey distributed to front line providers at Champion Sites

• 297 responses
## Attitudes are moderately positive

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean (std)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVERALL</td>
<td>7.4 (1.5)</td>
</tr>
<tr>
<td>CLINICAL TIME—&lt;20 HOURS</td>
<td>7.7 (0.16)</td>
</tr>
<tr>
<td>CLINICAL TIME—20-32 HOURS</td>
<td>7.4 (0.12)</td>
</tr>
<tr>
<td>CLINICAL TIME—32+ HOURS</td>
<td>6.8 (0.21)</td>
</tr>
<tr>
<td>PROVIDER TYPE—PSYCHOLOGIST</td>
<td>7.7 (0.12)</td>
</tr>
<tr>
<td>PROVIDER TYPE—PSYCHIATRIST</td>
<td>6.7 (0.24)</td>
</tr>
<tr>
<td>PROVIDER TYPE—NURSE</td>
<td>7.4 (0.27)</td>
</tr>
<tr>
<td>PROVIDER TYPE—OTHER</td>
<td>7.2 (0.17)</td>
</tr>
</tbody>
</table>
MBC isn’t new for some

• About 60% of respondents reported behavior consistent with the provision of MBC
  – Use measures at multiple time points
  – Talk with Veterans about measure results
  – Use measures in shared decision making

• Most likely to be
  – In clinic 20-32 hours
  – Psychologists
  – PTSD clinics
Tracking report

- As MBC is disseminated the administrative data will reflect the use of measures

- Tracking mechanisms are helpful for providing feedback to facilities and monitoring the initiative

- A dashboard was developed for participating clinics to monitor the number of measures used, the number of providers administering measures, and the number of Veterans receiving measures

Elliot Fielstein, Rani Hoff, Jennifer Jedele, John McCarthy, Sandy Resnick
## Baseline—Q3FY16

<table>
<thead>
<tr>
<th>Metric</th>
<th>Champion Sites</th>
<th>Non-Champion Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veterans new to mental health care</td>
<td>87,232</td>
<td>113,508</td>
</tr>
<tr>
<td>Encounters per Veteran</td>
<td>6.56</td>
<td>6.69</td>
</tr>
<tr>
<td>% with any measures</td>
<td>15.57</td>
<td>14.53</td>
</tr>
<tr>
<td># measures per Veteran</td>
<td>0.13</td>
<td>0.10</td>
</tr>
<tr>
<td>% with any PHQ-9</td>
<td>14.69</td>
<td>13.72</td>
</tr>
<tr>
<td># PHQ-9 per Veteran</td>
<td>0.27</td>
<td>0.25</td>
</tr>
<tr>
<td>% with BAM in SUD clinics</td>
<td>9.89</td>
<td>4.56</td>
</tr>
<tr>
<td># BAM per Veteran</td>
<td>0.19</td>
<td>0.13</td>
</tr>
<tr>
<td>% with any GAD-7</td>
<td>6.41</td>
<td>5.55</td>
</tr>
<tr>
<td># GAD-7 per Veteran</td>
<td>0.18</td>
<td>0.16</td>
</tr>
<tr>
<td>% with any PCL-5 in PTSD clinics</td>
<td>4.97</td>
<td>2.39</td>
</tr>
<tr>
<td># PCL-5 per Veteran</td>
<td>0.07</td>
<td>0.11</td>
</tr>
</tbody>
</table>
Phase I assessment

• Purpose: to assess how sites are progressing on their MBC implementation and collect feedback on challenges, enabling factors, and success stories

• Web based survey for Champion Site leads

• 5 quantitative questions, 10 qualitative
<table>
<thead>
<tr>
<th>Stage of implementation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decided not to implement MBC your clinic</td>
<td>0</td>
</tr>
<tr>
<td>Not yet started to implement and have not started implementation plan, or done minimal planning</td>
<td>0</td>
</tr>
<tr>
<td>Not yet started to implement, actively working on implementation plan</td>
<td>12</td>
</tr>
<tr>
<td>Not yet started to implement, finalized implementation plan and getting ready to start</td>
<td>3</td>
</tr>
<tr>
<td>Not yet started to implement, delaying implementation to wait for resources, IT, etc.</td>
<td>5</td>
</tr>
<tr>
<td>Early stages of implementation (e.g., activities in preparation for starting MBC, limited pilots, problem solving, etc.)</td>
<td>28</td>
</tr>
<tr>
<td>Full implementation of MBC is underway (all providers and/or target Veterans are involved)</td>
<td>43</td>
</tr>
</tbody>
</table>
Specific milestones

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>How is your program progressing in being able to administer MBC measures to individual Veterans?</td>
<td>6.8</td>
</tr>
<tr>
<td>How is your program progressing in entering MBC measures into the medical record?</td>
<td>6.8</td>
</tr>
<tr>
<td>How is your program progressing in being able to view MBC data from medical records to use with individual Veterans?</td>
<td>5.7</td>
</tr>
<tr>
<td>How is your program progressing with using repeated MBC data points to make clinical decisions with individual Veterans?</td>
<td>5.2</td>
</tr>
</tbody>
</table>

On a scale from 1 to 10, where 1 is “no progress, insurmountable challenges/barriers” 10 is “progressing well, no challenges/barriers”
Success stories

• Team has been impressed with how meaningful the graphs have been to Veterans. Particularly when they see their progress, displayed on a graph, they have some positive emotional reaction (e.g., tearful, smiling, etc.) We commonly hear things like, 'I want to frame this,' or 'I knew this was working.' This helps with staff morale, as well.
• Just recently had a Veteran in care management whose PHQ-9 and GAD-7 scores have not really been improving much if at all on his medication regimen...We collaboratively decided that it was time to change something up, so we coordinated with the PACT provider to do an increase in the antidepressant. We are now in the process of determining if the new higher dose will be effective or not. This situation seems to highlight exactly what MBC is all about: working with the Veteran and the treatment team to collaborate in the best possible care!
• Just this morning I cosigned the final therapy note of a Veteran who was being seen by our social work intern for CPT... [the intern’s] last day at the VA was this week and she....said it was incredibly powerful for her to be able [to] see change in Veterans so quickly and she felt so effective in delivering the treatment as she observed the reduction in scores.
No success story?

Too many sites said they didn’t have one, that it was too early

Implementation is hard