MEASUREMENT-BASED CARE

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CONVERSATION STARTER

- Why do you think MBC should or should not be implemented as a standard of care?
- How might it improve or not improve the delivery of mental health services?

INTRODUCTION:
WHY MBC IS IMPORTANT TO GREAT CLINICAL CARE!

Since we are psychologists, I am going to focus on **why MBC is important to being an effective psychotherapist** but it is just as important to other mental health providers and their clinical practice

- Psychotherapy in general is a highly effective treatment (See NNT)
- As effective as psychotherapy is there is wide variation in "therapist effects"
- What does research tell us about the qualities of an effective therapist
- What gets in the way of being an effective therapist
- Why MBC is important

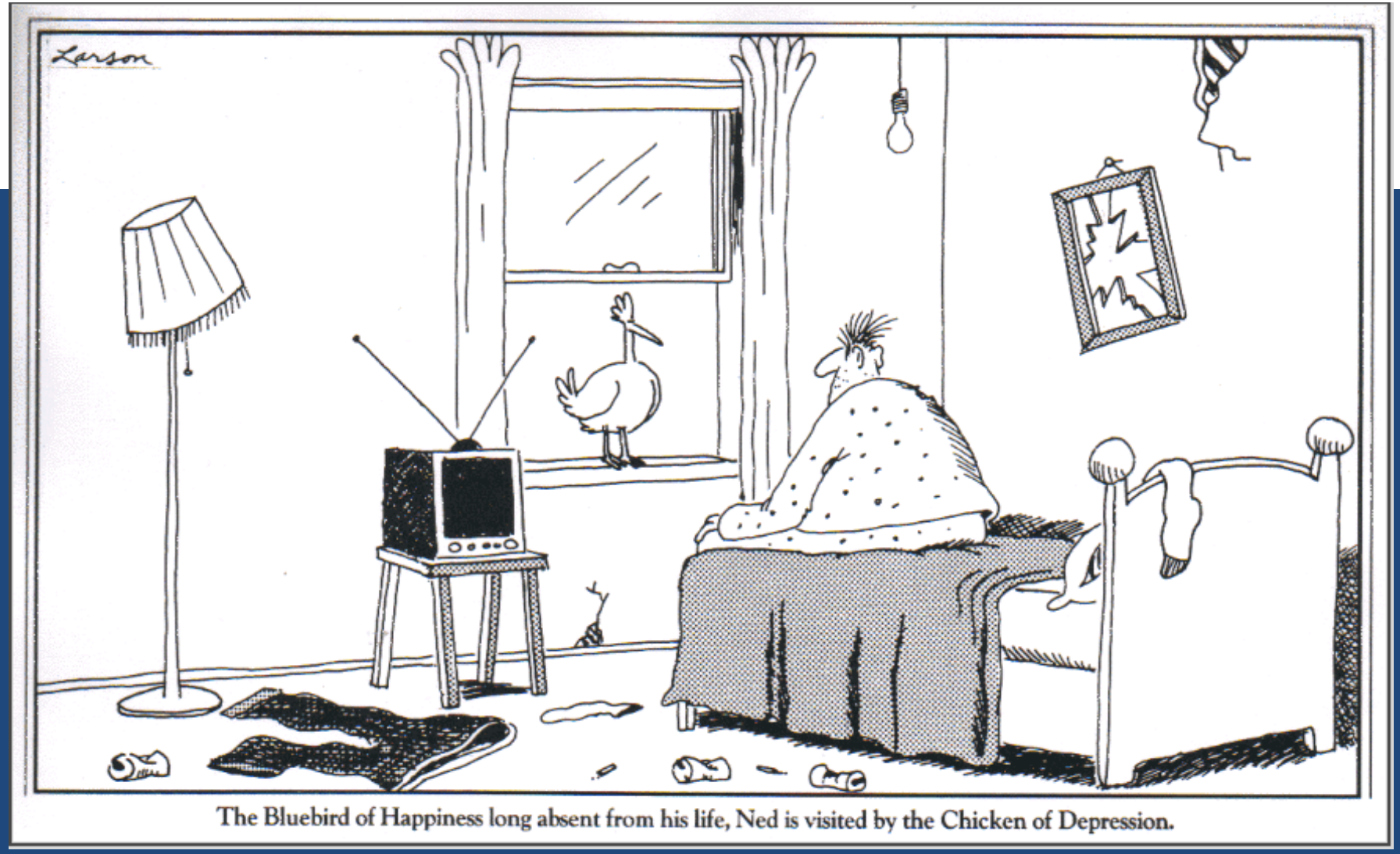
EVIDENCE BASED MEDICINE NNT

AREA	Treatment	NNT
Post menopausal osteoporosis	Bisphosphonates for Women w/ Prior Fractures	100
Cardiology	Aspirin prophylaxis*	50
Stroke Prevention	Oral anticoagulants	25
Influenza	Vaccine	12
Acute Asthma	Nebulized Ipratropium Given During an Asthma Attack	11
Smoking Cessation	Nicotine Inhaler	10
Sickle Cell Anemia	Transfusion	7
SSRI	Depression	7
Acute myeloid leukemia	Bone Marrow Transplant	5
Mental Health	**Psychotherapy**	**3**

*Aspirin to Prevent Cardiovascular Disease in Patients with Known Heart Disease or Strokes

Wampold, 2010
& TheNNT.com

The Bluebird of Happiness long absent from his life, Ned is visited by the Chicken of Depression



The Bluebird of Happiness long absent from his life, Ned is visited by the Chicken of Depression.

NED SHOULD CONSIDER PSYCHOTHERAPY.

QUALITIES OF AN EFFECTIVE THERAPIST

- A sophisticated set of interpersonal skills.
- Is influential, persuasive and convincing.
- Builds trust, understanding and belief.
- **Builds strong alliance**
- Has an acceptable/adaptive explanation of client's condition.
- Has a treatment plan and allows it to be flexible.
- **Monitors patient progress.**
- Offers hope and realistic optimism.
- Is aware of a client's characteristics in context.
- Is reflective.
- Relies on best research evidence.
- Continually improves through professional development.

Wampold, B. (2011). Psychotherapy is effective and here's why. APA Monitor, Vol 42, (9).

THERAPIST EFFECTS

- Study by Laska, et al., with 25 therapists and 192 Veterans.
- All Veterans received CPT, all therapists had successfully completed CPT training and had same CPT supervisor
- Large reductions in PTSD (*d*= 0.71)
- Approximately 12% of the variability in the PCL at the end of CPT was due to therapists.
- As therapists we owe it to our patients to constantly strive to improve our effectiveness and *that is difficult to do without objective data*

Laska KM[1], Smith TL, Wislocki AP, Minami T, Wampold BE. (2013). **Uniformity of evidence-based treatments in practice? Therapist effects in the delivery of cognitive processing therapy for PTSD.** J Couns Psychol. 2013 Jan;60(1):31-41. doi: 10.1037/a0031294.

WE THINK WE ARE BETTER THAN WE ARE*

- Like the children of Lake Wobegone, most of us think we are above average
  - Most said "I'm better than 75% of peers"; 25% said better than 90%, and no one said "I'm less than average"
- On average we think 77% of our clients improve and estimate 3.7% deteriorate
  - 58.4% said 80% of their clients improved
  - 21.2% said 90% or more of their clients improved
  - About half of us (47.7%) believe NONE of our clients deteriorate during treatment

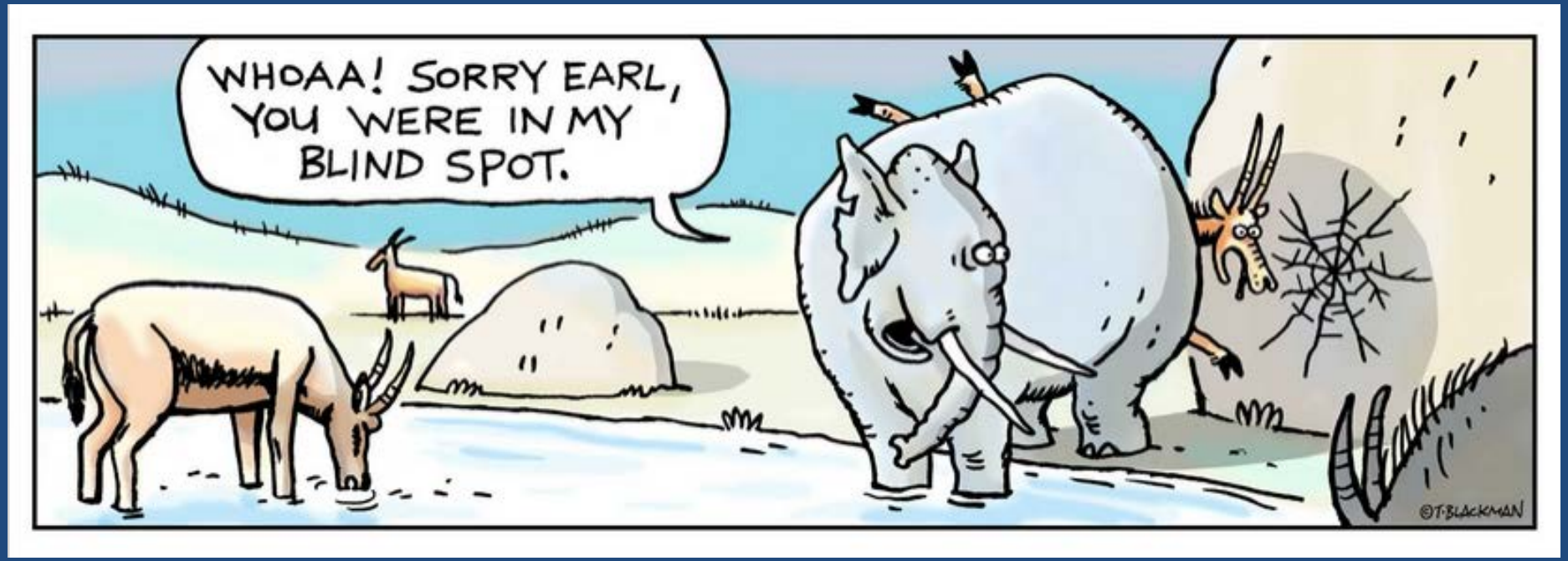
***AND WE ARE NOT THE ONLY PROFESSION THAT DOES**

Walfish S[1], McAlister B, O'Donnell P, Lambert MJ. (2012). **An investigation of self-assessment bias in mental health providers.** Psychol Rep., 110(2):639-44.

WE THINK WE ARE BETTER THAN WE ARE

- REALITY is in routine care about:
  - 35-48% of our clients improve
  - 48-57% don't change
  - and 3-8% deteriorated
- We are **NOT** good at telling when patients are deteriorating (miss about 75-100% of them) nor are we good at recognizing when patients recover early
- When rated objectively, less competent therapists over-rate their abilities more than competent therapists
- We probably need to believe this to stay positive and keep working but its important to be aware of our blind spots!

Parker ZJ[1], Waller G[2]. (2015). **Factors related to psychotherapists' self-assessment when treating anxiety and other disorders.** Behav Res Ther. 66:1-7. doi: 10.1016/j.brat.2014.12.010.


WHOAA! SORRY EARL, YOU WERE IN MY BLIND SPOT.
©T.BLACKMAN

WHY IS IS NECESSARY TO BE AWARE OF THESE BLIND SPOTS?

Without accurate objective information:

- Our biases lead us to assume we do NOT need to make changes or try alternative approaches
- Our patients may be deteriorating and we won't act to change course before they drop out
- Our patients may be showing reliable recovery and should be discharged to another level of care

RCTS OF MEASUREMENT BASED CARE

- 14 of 15 RCTs of MBC have demonstrated that it improves outcomes compared to UC
- These findings are robust and are consistent across
  - Patient groups:
    - Disorders
    - Age
  - Provider types
    - Psychotherapists
    - Psychiatrists
    - Primary Care Providers

Slide from Fortney (2105) The Evidence for Measurement-Based Care

MBC IMPROVES OUTCOMES

- Meta-analysis of 6 studies (n=300 therapists, 6,000 patients) found that those randomized to MBC had ***significantly and substantially*** better outcomes than patients randomized to UC
- Medium (Hedges' g=-.28) for all patients[1]
- Only effective for patients who deteriorated or did NOT respond to treatment intially[2]

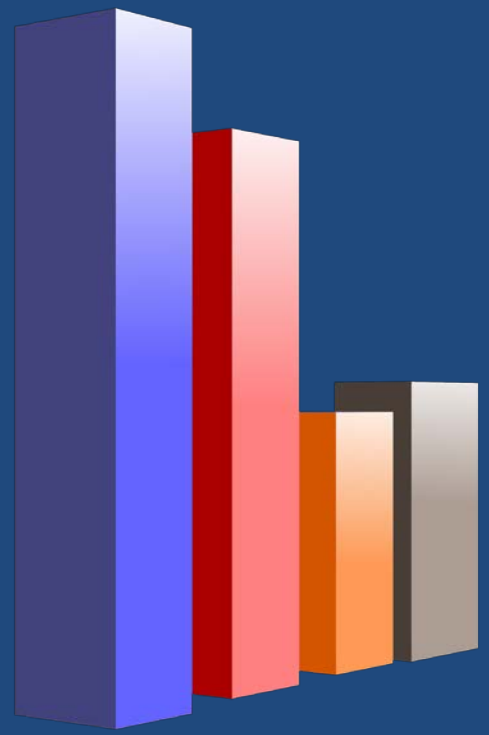
1.Lambert MJ, et. al., Clinical Psychol Sci Prac, 2003

2.Lambert MJ, Clinical Psychology & Psychotherapy, 2002

Slide from Fortney (2105) The Evidence for Measurement-Based Care

WHAT HELPS TO DEAL WITH THIS?

- Track your outcomes
  - Give your patients brief measures of target symptoms and functioning.
  - Best to have someone else collect alliance measure at Session 2 or 3
- Outcomes should be used to make these clinical decisions
  - Doing well (consider termination)
  - On track (no change to plan)
  - Moderate risk (intensify tx or alter plan)
  - High risk (alter plan and seek consultation)



Whipple, JL.; Lambert, MJ.; Vermeersch, DA.; Smart, DW.; Nielsen, SL.; Hawkins, EJ.; **Improving the effects of psychotherapy: The use of early identification of treatment and problem-solving strategies in routine practice.** Journal of Counseling Psychology, Vol 50(1), Jan, 2003 pp. 59-68.

RESULTS OF TRACKING OUTCOMES

Regardless of what therapy you are doing tracking helps:

- Identify early that therapy is not helping and a change in course is needed
- Reduces premature drop out from treatment
- Results in more patients showing clinically reliable improvement
- Allows discharge of patients showing clinically reliable improvement
- Improves clinic flow since the shorter course of treatment for some balances out the longer treatment of others

WHY DOES MBC IMPROVE OUTCOMES? PATIENT BEHAVIOR

- More knowledgeable about their disorders
  - Leading to a more informed and activated patient
  - Prepared to participate meaningfully in shared decision making
- Attune to their symptoms
  - Aware of symptom fluctuation over time
  - Cognizant of the warning signs of relapse or reoccurrence
- Recognize improvement early in the course of treatment
  - Help patients feel more optimistic and hopeful
  - Maintain better adherence to the treatment
- Validates feelings
  - Mitigates the self-blame that patients sometimes experience
- Empowers patients
  - Helps them communicate more effectively with their providers
  - Enhanced therapeutic relationship


LASSIE!
GET HELP!!

MBC INITIATIVE: FY 18 REQUIREMENTS

Reference: 12-15-17 Memo, MBC in MH Initiative, FY18 Requirements and Appendices

- Must implement MBC in Joint Commission required programs:
  - MH Residential Rehabilitation Treatment Programs
  - Any specialized outpatient Substance Use Disorder Program
- Must implement MBC in at least 1 MH program
- At least one of the 4 standardized measures must be used:
  - PCL-5, GAD-7, BAM-R (or BAM-IOP for 30 day reassessments), PHQ-9
  - Exemption from this requirement for TSES, PRRCs, and ICMHRs – use program relevant measures
  - RRTP Guidance: SUD RRTPs and PTSD RRTPs would be expected to administer the BAM-R and PCL5, respectively, given their specialty focus. Veterans with co-occurring SUD and PTSD would be expected to complete both the BAM-R and PCL5.
  - SUD Specialty Guidance: BAM-R should be implemented

MBC INITIATIVE: FY 18 REQUIREMENTS

- Implement principles of Collect, Share, and Act
- Use Mental Health Assistant or Behavioral Health Lab Software
- Sites encouraged to create a MBC Implementation Plan
- Participate in regular national surveys on progress

MBC INITIATIVE: FY 18 REQUIREMENTS FOR FREQUENCY OF MEASUREMENT FOR SUD PROGRAMS

Minimum recommended frequency for program length greater than or equal to 42 days:

- at the start of a new episode of care,
- every 30 days for the first three months of a patient's episode of care, and
- at the transition to the next phase (program) of care.

Minimum recommended frequency for program length less than 42 days

- at the start of a new episode of care,
- at least one time during their care in the program, and
- at the transition to the next phase (program) of care.
- Sharing data requirements based on re-assessment intervals
  - > 30 days or longer, share data (BAM-R or BAM-IOP) no later than 7 calendar days from collection
  - <30 days, share data (BAM-R or BAM-IOP) with patients no later than 3 calendar days from collection

MBC INITIATIVE: FY 18 REQUIREMENTS FOR FREQUENCY OF MEASUREMENT FOR RRTPS

Specific requirements for RRTPs

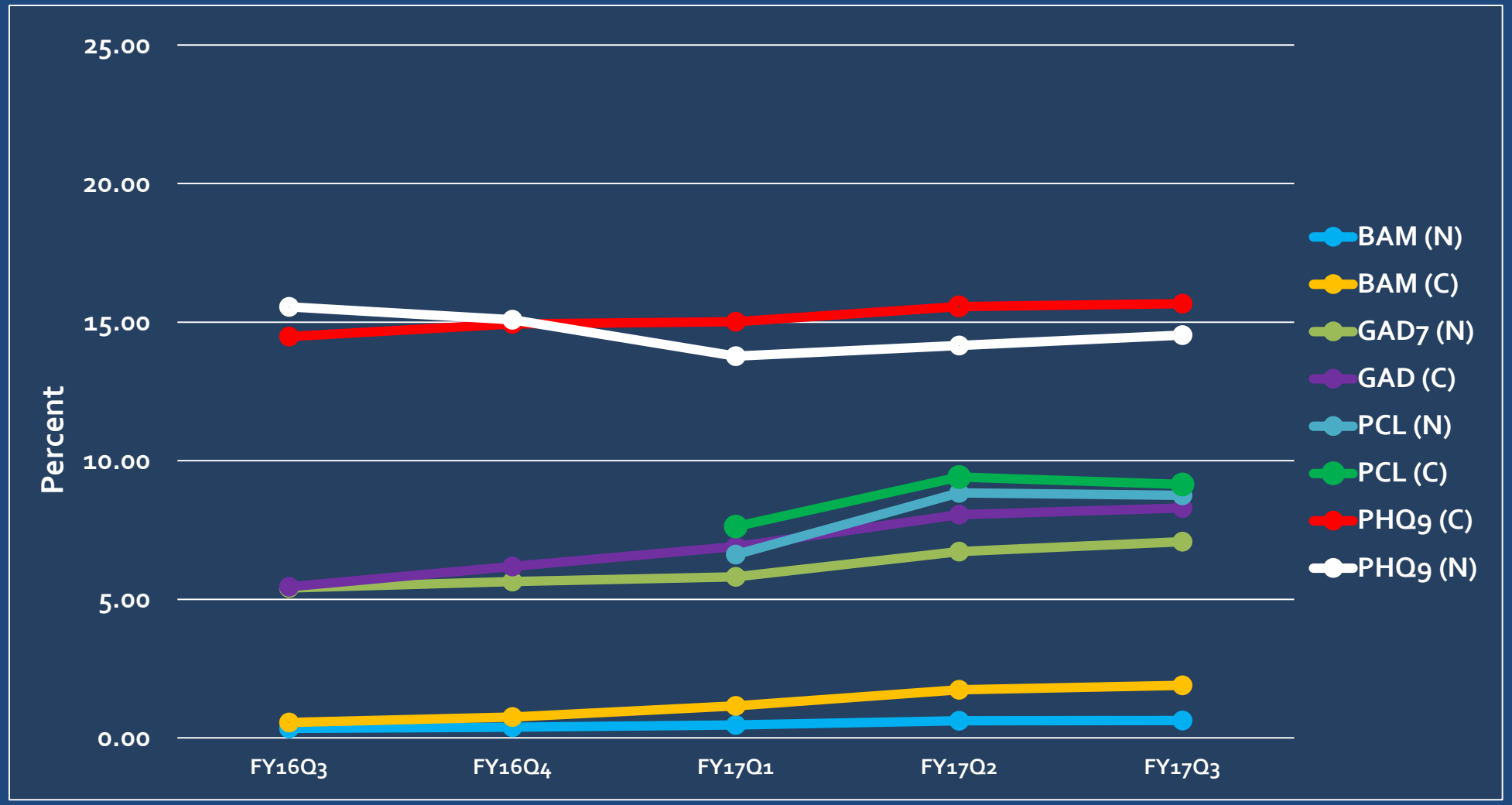
- RRTPs: At the time of admission (defined as within 7 days of admission, before or after) and prior to discharge (defined as within 7 days of discharge) and ongoing for treatment progress assessment
- RRTPS with average lengths of stay greater than 30 days, assessment instruments are administered at a minimum every 30 days.

All other programs: ***minimum*** at baseline and monthly during first 6 months of treatment

SO WHERE ARE WE NOW?

PERCENTAGE OF VETERANS WITH RECEIPT OF A SPECIFIC MEASURE WITHIN THE FIRST 6 MONTHS OF A NEW TREATMENT EPISODE BY MEASURE AND CHAMPION SITE STATUS: OUTPATIENT SERVICES ONLY

CHAMPION SITES = C (N=58) NON-CHAMPION SITES = N (N=83)



BARRIERS/CHALLENGES DISCUSSION

What are the common barriers to implementation of MBC you are facing locally?

What strategies are you using to address these?

Take 10 minutes to discuss within your small groups and we will share with the larger group.

STRONG PRACTICES DISCUSSION

- What has helped facilitate implementation at your facility?
- What has gone well for you and why?
- Are there any lessons learned that may be helpful to share with other sites?
- Take 10 minutes to share in small groups and then come back together for a discussion broadly.

MBC RESOURCE SUPPORT

- MBC SharePoint site: Tools, implementation information, resources related to the measures, links to dashboards
  - TMS training on MBC (course #31368), with CEU credits
  - Slide decks that translate the TMS training into modules for local use
  - 10 short (4-5 minute) videos on MBC
  - Behavioral Health Lab (BHL) on SharePoint and the BHL Pulse page
  - Tips for implementation planning
  - Mental Health Assistant quick guides
  - Suggestions for use of specific measures
- MBC Pulse site : Discussions on MBC for implementation
- Tracking tool : data on measure use
- Community of Practice Calls: Check the SharePoint calendar
- Consultation Support: MBCInformation@va.gov