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Measurement-informed care: Current state and recommendations

The promises of measurement-informed care (MIC) to improve the quality of behavioral health care and increase efficiency are substantial. However, MIC is currently underutilized in the behavioral health provider community.

To advance the overall effectiveness and efficiency of behavioral health service delivery, stakeholders across the behavioral health industry should work together on a cohesive measurement-informed care agenda. This agenda should look to create consensus on what should be measured and with what frequency, as well as supporting implementation of MIC among existing providers and advocating for training new clinicians in the use of MIC.

Payers have a unique role in shaping the future of the use of MIC through reimbursement mechanisms and bi-directional data sharing that leverages MIC data and claims-based data to provide a full picture of patients' overall health. With increased education and coordination across these various groups, MIC can and should become part of the standard of behavioral health care delivery.

Understanding what works best across the population and anchoring value-based arrangements on clinical outcomes leads to more effective, efficient care, increased quality and a decrease in overall cost.

Background and research

Health care continues to suffer from a quality chasm.[1] That is, the existing technologies and treatment approaches are not always applied in a consistent and efficient manner. As a result, patients can't expect the same high-quality care whenever they seek treatment.

This is even more evident in behavioral health, which includes the treatment of mental health and substance use disorders. The evidence for treatment approaches to behavioral health conditions has been growing, but not all treating providers are knowledgeable and proficient in the application of evidence-based practices and not all patients are aware of what to ask for. This results in wasted resources at a time when the demand for mental health treatment is increasing.

The Institute of Medicine (IOM) laid out a vision for quality behavioral health care.[2] Among the many components of a quality behavioral health system is the necessary infrastructure to produce scientific evidence more quickly and promote its application in patient care. In addition, the health care workforce needs to have the education, training and capacity to deliver high-quality care for mental health and substance-use conditions.

Multiple factors of the health care system need to be assessed to improve the quality of care for patients. These include the process of care, or measurement of what occurs during intervention/ treatment in relation to evidence-based practice.

Measurement-informed care is the foundation for implementing and evaluating evidence-based treatment. It is defined as the use of repeated, validated measures to track symptoms and functional outcomes in clinical settings.[3]

The process of MIC can be broken into 4 primary components[4]:

1. Routinely administered symptom, outcome or process measures before each encounter
2. Clinician review of data to guide treatment
3. Client review of data
4. Use of the data collaboratively to inform and shape treatment

It's important to highlight the difference between MIC and simply monitoring outcomes, as there's a broader evidence base for the effectiveness of MIC as an evidence-based practice than outcome monitoring alone. Outcome monitoring is the use of symptom measures at the start and end of treatment to determine the degree of change throughout the episode, while MIC involves more regular use of patient-reported outcome (PRO) monitoring to inform treatment in a systematic way.

The benefits of using MIC are well documented and include:

- Lower likelihood of patient deterioration
- Increased patient engagement and understanding of symptoms
- Decreased costs of care compared with usual care (i.e., treatment without the use of MIC)[5]
- Improved outcome and identification of patients who were not improving[6]

Despite the broad evidence base in support of the use of MIC, it's generally underutilized. Less than 20% of practitioners of all training types (psychiatrists, psychologists, master's-level) make MIC part of their standard practice.[7] A survey of 504 mental health professionals revealed that only 5.2% were using MIC at every 1–2 sessions and 45% said they'd prefer to never administer MIC.[8]

There are myriad reasons for the lack of use of MIC that vary by stakeholder group, specifically providers and clients but also at the organizational and broader system and structural levels. For providers, lack of use tends to be due to[5,6]:

- Resource constraints
- Feeling that there's not enough time
- Negative attitudes toward MIC
- Lack of adequate training in the benefits and logistics of MIC
- Concern that data will be used punitively either by organizational leaders or to impact reimbursement

Research suggests that practitioners tend to have more positive attitudes about the psychometric properties of PROs than in the practicality of administering them.[9] In other words, providers believe in MIC but have considerable barriers to implementing its use into their day-to-day work with clients. Hesitance to complete measures for patients is aligned with response burden (particularly when practitioners aren't discussing measures in session), belief that the measures aren't relevant and concerns about confidentiality.[7] Organizationally and structurally, barriers tend to be related to lack of training resources, lack of leadership support, poor incentives and minimal consensus about benefits.[10]

Research into the mediators of MIC implementation in community mental health settings provide insight into how practitioner communities can begin to integrate MIC in their clinical work.[11] Communication was found to be paramount in successfully implementing use of MIC, especially from leadership. Rather than being directive, this communication was more well-received if the messaging was compelling and provided a clear rationale for the adoption of MIC. Supportive supervision was also found to buoy the use of MIC when supervisors are willing to devote time to the clinical and logistical details of MIC with their supervisees. Lastly, providing additional consultative time for clinicians aided in their adoption of MIC by giving them opportunities to learn from one another and offer tips and support surrounding barriers. An important conclusion to be made from this study is that successfully implementing the use of MIC requires approaches tailored to an individual practice and its clinicians.

As noted above, there are significant headwinds for clients, clinicians and systems in the implementation of MIC, but there are several well-researched strategies that leaders can leverage to encourage adoption of MIC.[5]

- Use of measurement feedback systems (leveraging technology to help with the scoring and aggregation of PRO data) can help with the administrative burdens that are associated with MIC; the benefits of these systems rise exponentially when integrated into an electronic-medical record system already in use.
- Ensuring that these systems use HIPAA and HL7 compliant technologies can ease client fears about confidentiality and data breaches.
- Providing comprehensive, supportive training opportunities that include active learning components and learning communities can help clinicians improve their attitudes about MIC and add clarity about the clinical utility of measurement.
- Engaging in value-based arrangements or providing incentives can serve as motivators for ongoing use of MIC once a successful implementation has been launched.
- Finally, a standard industry-wide approach to implementing, maintaining and reimbursing for MIC will drive greater adoption, increased fidelity and improved data sharing.

Any successful MIC program must have the ability to be easily implemented and have clinical utility.[12] Clinical utility is defined as an MIC approach that assists stakeholders in fulfilling clinical goals related to care quality at the client (including caregiver), clinician, supervisor and administrator levels within a particular clinical setting. In other words, an MIC program can be successfully implemented if it is easily adopted and offers additional clinical value.

Payer opportunities and our recommended approach

Given the broad evidence base to support the use of MIC and equally broad evidence base highlighting the lack of use of MIC, there's a strong need in the behavioral health field to align across stakeholders to encourage adoption of MIC. Optum® Behavioral Health Solutions (OBHS) has an opportunity to partner with organizations and the provider community to encourage the adoption and use of MIC for treatment of members who receive psychotherapy. Optum has several areas where it can lead the industry to greater adoption of MIC, which should ultimately provide more information about treatment effectiveness and efficiency.

With a network of over 150,000 behavioral health outpatient providers across the U.S. servicing members with commercial, Medicaid and Medicare, Optum is in a unique position to influence behavioral health service delivery. While we don't mandate how clinicians provide care, we can provide guidelines and expectations for treatment and offer support to network providers. Our role is to ensure that members are receiving the highest quality of care and to enable providers with our resources to do so. We can help impact moving toward the goal of increased use of MIC by:

- Setting baseline standards and expectations
- Paying the network for use of MIC
- Sharing and providing clinically useful data
- Working across key industry stakeholders to develop a standardized approach

The following recommendations provide a roadmap for increasing MIC among the OBHS network community.

1 Set baseline standards and expectations

While it's not the role of Optum or any payer to dictate how network providers provide treatment to their members, we can provide minimal standards for how contracted clinicians are expected to deliver care with respect to providing high quality, evidence-based treatment. This can be communicated through education and training, contractual arrangements and incentives for use of MIC. There are several industry organizations addressing this topic in various forums.

- Many institutions such as the APA, VA and The Joint Commission have made declarations of the importance of use of MIC to inform and drive care but have not provided prescriptive expectations about what measures to use and with what frequency.[13,14]
- Some accrediting bodies are now requiring providers to implement outcome measurement and use their data for quality purposes.[15]
- The CMS Merit Incentive Payment System (MIPS) is focused on population health metrics but also includes the possibility of paying for ongoing measurement of symptoms and can help increase the incentive to adopt MIC.[16]
- The Kennedy Forum has published a list of recommended measures to use for MIC, as part of their assessment of the state of MIC in behavioral health.[17,18]

These various perspectives and recommendations will help drive the adoption of MIC and Optum can significantly influence these efforts.

Recommendation: Optum recommends that providers administer PROs to their clients at a regular frequency and use data to inform and guide treatment, especially when treatment is not progressing as expected. In line with recommendations by Scott and Lewis, Optum recommends that providers measure not only symptom severity, but also additional domains such as quality of life, functioning and feedback about the therapy process.[19] Optum has created a recommended list of measures informed by established research and recommendations and has cross-referenced this with the recommended measures from the Kennedy Forum. Many providers see clients with benefits from many different payers who have different treatment expectations. Multiple payer expectations around treatment and data exchange causes confusion for practitioners. Thus, Optum recommends a cross-payer position on MIC guidelines and submission processes to remove as many barriers as possible.

As a starting point, OBHS recommends the following measures be considered as part of a routine battery of measures for MIC. All of these tools are well researched and in the public domain and most are recommended by the Kennedy Forum.

- Accountable Health Communities Health-Related Social Needs Screening Tool (AHC HRSN)*
- Alcohol Use Disorders Identification Test (Audit-C Plus)
- Columbia-Suicide Severity Rating Scale (C-SSRS)*
- Drug Abuse Screening Test (DAST-10)
- Generalized Anxiety Disorder Scale-7 (GAD-7)
- Survey 20-Item Short Form (SF-20)
- Patient Health Questionnaire-9 (PHQ-9)
- Pediatric Symptom Checklist (PSC) and Pediatric Symptom Checklist-17 (PSC-17)
- PTSD Checklist for DSM-5 (PCL-5)
- The Wellness Assessment (WA)
- Veterans RAND 12 Item Health Survey (VR-12)*
- World Health Organization Quality of Life Assessment (WHOQOL-BREF)*

*Not on Kennedy Forum recommended measure list.

2 Train and pay the network for use of MIC

As has been well established, most behavioral health providers aren't using measurement-informed care routinely in their practices, nor have they received adequate training in the process and implementation of MIC. Use of MIC will likely be a change in service delivery for many providers that will cause disruption to workflows and documentation. These disruptions take time away from patient care that should be accounted for through compensation.

Recommendation: Research has made the case that for MIC to achieve its promise of improving behavioral health outcomes, there must be a path for reimbursement.[20] Optum is actively working on building out its repertoire of value-based arrangements that include both process and outcome metrics for the use of MIC. It's also working on ways to reach additional provider organizations through other creative reimbursement models. Other national payers should consider similar strategies to reinforce the message of the importance of MIC with their networks of providers. Optum and other payers should direct providers to training resources on not only the value of MIC but also successful strategies to implement its use within their organizations. In addition to value-based payment arrangements, OBHS should also continuously review the benefit of reimbursing for the CPT® code 96127, which is used to report brief behavioral or emotional assessments for reimbursement.

3 Gather and analyze data

An important aspect of MIC is the use of the data on both the individual and aggregate level to drive treatment and make organizational improvements. Having easy and timely access to MIC data is crucial to using MIC as an evidence-based practice and driver of continuous quality improvement. Data should be easily integrated into a measurement feedback system or EMR to enhance the ease with which it's used by providers and members.

Recommendation: Optum and other payers have access to rich data sets that provide information about many aspects of a member's functioning and about the impact a behavioral health organization is having on its clients. The marriage of provider MIC data with claims-based data can provide opportunities to drive the behavioral health ecosystem in a more quality-driven and efficient direction. Optum is working to allow for easier sharing of this data through our provider portal while also sharing data back with providers, giving insights into a member/provider group's total health outcomes and impact of behavioral health conditions on medical conditions and vice versa. This work should continue to be advanced with the input of multiple stakeholders.

In addition, multiple vendors offer services to providers to implement MIC within existing EMR systems and aggregate and analyze data in real time. OBHS does not support a specific vendor but does encourage providers to engage with the handful of reputable vendors in the market.

4 Partner with industry leaders, training programs and vendors

One barrier to greater adoption of MIC is the lack of a cohesive approach from payers. Providers cannot comply with diverse requirements across payers. Optum can help drive a coalition of payers to adopt one standard approach across the provider community. This needs to be led by one of the industry guild representatives, such as the American Psychological Association, the American Psychiatric Association or the Association for Behavioral Health and Wellness. Through its relationships with these organizations Optum has the opportunity to lead from behind to help create a consistent, standardized and efficient approach to MIC.

The challenges of implementing use of MIC in practice settings have been well documented. In their introduction of the Collect, Share, Act Model, Barber and Resnick highlight a lack of consensus and an absence of model clarity as key limiters to the uptake of MIC into routine care, noting that clinicians are not clear on how to do MIC and how to do it right.[21] This highlights the need for consistent guidelines for clinicians starting early in their careers.

Recommendation: A key area of opportunity for the training of MIC is in the curricula of graduate training programs, both in coursework and practicum settings to ensure that behavioral health clinicians enter the workforce prepared to evaluate the effectiveness of the treatment they are providing and are clear on best practices for using MIC in routine care. The academic setting is primed to help behavioral health practitioners overcome barriers to implementation as they can be shown by trusted mentors and supervisors paths to making use of MIC practical, and that MIC can be additive to their clinical judgment. Optum can support and encourage greater adoption and training in MIC both in the academic setting and in field practicum placements.

Vendor partners are also a potential resource to encourage adoption of MIC. Several vendors are positioned to work with payers and providers to provide the infrastructure and guidance to providers to implement MIC as well as provide the data transfer capabilities with payers. Optum has worked with one such vendor on a pilot project. The learnings from this program will be used to create an implementation playbook that will help providers and venders implement MIC in the future. Optum can help broker vendor provider relationships and encourage relationships among the multiple stakeholders.

To learn how Optum applies this guidance, contact us today:

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