Core Competencies, Chapter 9

Measurement Based Care 1: **Using Standardized Measures to Screen and Track Patients for Mental Health, Physical Health, and Substance Use conditions**

Contributor: Jaesu Han, Marc Avery, Stavey Devenney, editors

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Definition and Why the Use of Standardized Clinical Measures is Important to Integrated Complex Care

Standardized measures are the ratings scales, physical examination measures, or laboratory tests that correlate well to important clinical outcomes for a health condition. An example is the HgA1c blood test for diabetes (The HgA1c measures the average blood glucose that has been present over the previous 2-3 months). Standardized measures allow clinicians to more objectively diagnosis a health condition and track the response of an intervention, which makes it easier to assess effectiveness.

The use of standardized measures, like blood pressure, are familiar concepts to patients and providers in "medical" clinics. However, use of standardized measures for assessment and tracking individual clinical outcomes are relatively new to most behavioral health providers. Special attention thus must be paid by behavioral health clinicians to these new forms of measuring success.

Example

A patient/client with depressive symptoms fills out a patient health questionnaire-9 with a score of 18 and diagnosed with major depression. After discussion of options with the primary care provider, the patient/client agrees to a trial of an antidepressant. After six weeks, the patient subjectively feels "a little better" but the repeat patient health questionnaire-9 score is 17 (not a significant improvement). Given the lack of significant improvement, the primary care provider and patient/client agree to add weekly psychotherapy as part of the treatment plan.

Narrative Description

The use of standardized measures for physical health conditions is routine in primary care. The physical health conditions followed as part of BHICCI are hypertension, type 2 diabetes mellitus and hyperlipidemia. These conditions are important risk factors for cardiovascular disease and have well established standardized measures associated with them. For hypertension, we measure blood pressure with a sphygmomanometer in the office or home setting. For diabetes, we obtain a fasting glucose or HgA1c blood test. For hyperlipidemia, we obtain a lipid panel blood test. National clinical practice guidelines have been developed by recognized professional organizations for these conditions and provide guidance on parameters for diagnosis, severity and management. As part of BHICCI, more specific clinical practice guidelines have been developed in line with key aspects of these national guidelines but also incorporating formularies specific to Inland Empire Health Plan.

For mental health and substance use conditions, clinicians have historically used unstructured interactions to determine subjective judgments about the severity of a health condition. This is partially due to the lack of physical measurements or laboratory tests that correlate well to the severity of specific mental health or substance use disorders. The recent decades, validated patient/client administered rating scales, such as the PATIENT HEALTH QUESTIONNAIRE-9 for depression, have been developed and validated for use to assess severity and track intervention effectiveness. However, availability of validated tracking tools is limited for a number of other conditions and populations, such as substance use and psychotic disorders.

Available Resources

1. Downloadable Patient Health Questionnaire and General Anxiety Disorder rating scales: http://www.phqscreeners.com/select-screener
2. From the MacArthur Foundation Three-Component Model (3CM), this form is a very practical summary for summary the patient health questionnaire-9 and assessing the response to treatment using the patient health questionnaire-9: https://www11.anthem.com/ca/provider/f0/s0/t0/pw_e192673.pdf?refer
3. Advancing Integrated Mental Health Solutions Center Collaborative Care Model for treatment major depression: https://aims.uw.edu/resource-library/measurement-based-treatment-target

National Guidelines

1. 4. American Diabetes Association Diabetes Care (2016): http://care.diabetesjournals.org/content/suppl/2015/12/21/39.Supplement_1.DC2/2016-Standards-of-Care.pdf
2. 5. Eighth Joint National Committee Hypertension Guidelines (2014): http://www.measureuppressuredown.com/HCProf/Find/BPs/JNC8/specialCommunication.pdf
3. American College of Cardiology/American Heart Association Cholesterol Guidelines (2013): http://circ.ahajournals.org/content/circulationaha/early/2013/11/11/01.cir.0000437738.63853.7a.full.pdf
4. American Psychiatric Association treatment guidelines for Major Depressive Disorder (quick reference 2010): http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd-guide.pdf

BHICCI Plan for Learning / Teaching / Coaching

- Agency primary care providers, care managers, clinical staff READS the materials presented in Core Competency 9 - Using Standardized Measures to Screen and Track Patients for Mental Health, Physical Health, and Substance Use Conditions (Using Standardized Measures), and discuss with the practice coach.
- PARTICIPATE OR VIEW THE Web-training or In-Person Presentation: Training on Using Standardized Measures.

How will Competence in this area be Measured

Following completion/verification of the above learning/teaching/coaching plan, each clinician will have the opportunity to practice his/her new skills under supervision. Following this, the supervisor will rate the clinician's competency in each of the following by:

1. Case discussion of 3 or more complex care patients, or
2. Chart review of 5 or more patients

COMPETENCY AREA	EVIDENCED BY:	SUPERVISOR'S RATING*
Utilizes standard outcomes measures when availed in care planning and condition tracking activities.	• Demonstrates knowledge of different standard measures for specific health conditions. • Demonstrate ability to review patient/client record to determine appropriate outcome measure or standard measure to use. • Documents appropriately in patient/client chart outcome measure or standard measure orders and/or results.	1 2 3 4 5
Work with the care to monitor appropriate intervals of measurement for each standardized measure.	Utilizes standardized measures at appropriate intervals. • Discusses outcome measure results with patient/client for purpose of promoting health literacy and self-management. • Incorporates follow up measure results into care planning process, when appropriate.	1 2 3 4 5
Uses clinical treatment guidelines to assist in setting and reaching appropriate treatment goals.	• Demonstrates familiarity with IEHP chronic condition care guidelines. • Incorporates care guideline benchmarks and treatment targets into care plans when clinically appropriate.	1 2 3 4 5

*1= Excellent results with no need for prompting or support.
3 = good results and/or required some prompting or support.
5 = required much support and/or was unable to complete necessary skills.