Best Practices in Implementing and Utilizing Patient-Level Outcome Measures

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Disclaimer

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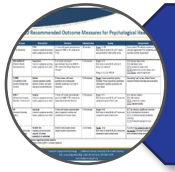
Clinic Optimization Toolkit

Modules

- Clinic Gap Analysis
- Patient Management
- EBP Utilization
- Group Therapy Expansion
- Technician Support
- **Metrics**
- Evaluation

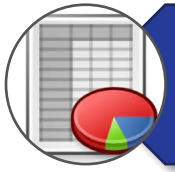
Types of Resources

Training Decks



Factsheets & Handouts

Forms & Templates



Spreadsheets & Supporting Documents

Standard Operating Procedures

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Learning Objectives

- Determine the benefits of using Outcome Measures (OMs)

- Analyze challenges of implementing OMs at a clinic level

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Why Measure Outcomes?

- Ensure Patients are Improving
- Requirements from Agencies
- Performance Improvement in Clinics
- Sustainment of your Program
- Sharing Best Practices/Replication

Aboraya et al., 2018; Aldea et al., 2021; Defense Health Agency, 2018; Dollar et al., 2020; Hong et al., 2021; Institute of Medicine, 2006; Lewis et al., 2019; The Joint Commission, 2017; The Kennedy Forum, 2015

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Models for Outcome Measures

Models of Implementation Vary by Site

Type of Measure

Frequency and Consistency

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Difficulty with Clinic-Wide Use

Providers Overwhelmed with Patient Care

Many Measures to Choose

Clinics or Providers are not Evaluated on Outcomes

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Assessment Domains

General Symptom
BASIS-24
Specific Symptom Screeners
PTSD (PCL-5); Anxiety (GAD-7)
Other Domains:
Quality of life Disability Therapeutic or Working Alliance Satisfaction with Care

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Recommended Measures by VA/DOD

Domain/Use	Measure
PTSD	**PCL-5** (PTSD Checklist)
Depression	**PHQ-8/PHQ-9** (Patient Health Questionnaire)
Anxiety	**GAD-7** (Generalized Anxiety Disorder 7-item Scale)
Insomnia	**ISI** (Insomnia Severity Index)
Alcohol Use	**AUDIT-C** (Alcohol Use Disorders Identification Test-Consumption)
Trans-diagnostic symptoms	**Basis-24** (Behavior and Symptom Identification Scale - 24)
Suicide Risk	**C-SSRS** (Columbia Suicide Severity Rating Scale)

Deputy Assistant Secretary of Defense, 2013

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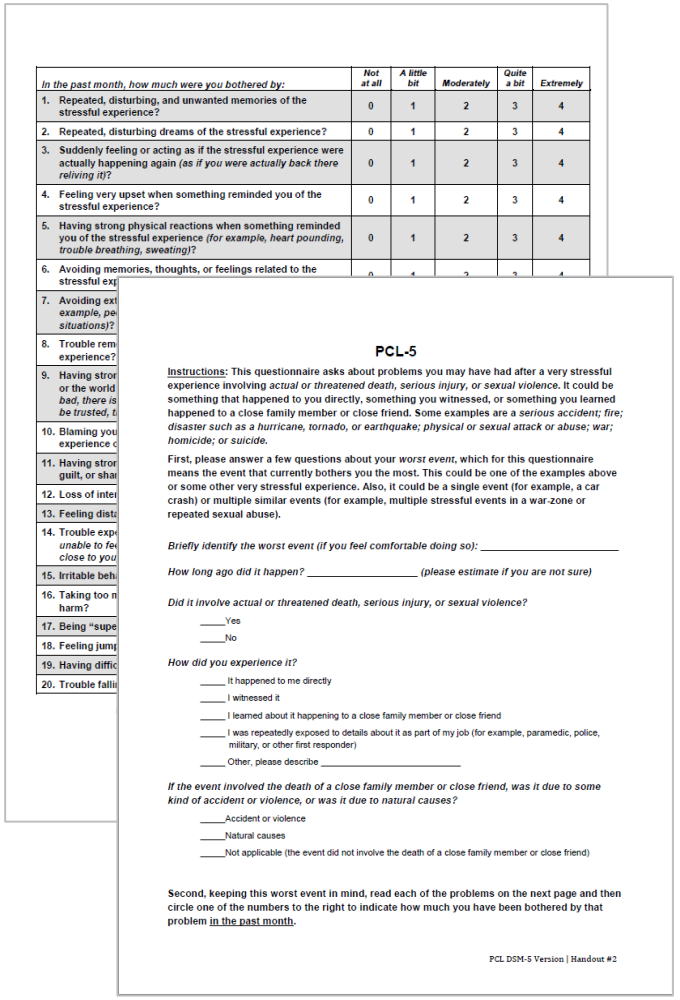
PCL-5 (PTSD)

- 20-item questionnaire
- 10 minutes to complete
- Scoring:
  - Range: 0-80
  - Each item is rated (0-4)
- Interpretation:
  - Scores above 33 warrant further screening and assessment



In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful exp					
7. Avoiding ext *example, pe situations)*?					
8. Trouble rem experience?					
9. Having stror or the world *bad, there is be trusted, t*					
10. Blaming you experience					
11. Having stror guilt, or shar					
12. Loss of inter					
13. Feeling dist					
14. Trouble exp *unable to fe close to you*					
15. Irritable beh					
16. Taking too n harm?					
17. Being "supe					
18. Feeling jump					
19. Having diffic					
20. Trouble falli					

PCL-5

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving *actual or threatened death, serious injury, or sexual violence*. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a *serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.*

First, please answer a few questions about your *worst event*, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

Briefly identify the worst event (if you feel comfortable doing so): _____

How long ago did it happen? _____ *(please estimate if you are not sure)*

Did it involve actual or threatened death, serious injury, or sexual violence?

____Yes
____No

How did you experience it?

____ It happened to me directly
____ I witnessed it
____ I learned about it happening to a close family member or close friend
____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)
____ Other, please describe _____

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

____Accident or violence
____Natural causes
____Not applicable (the event did not involve the death of a close family member or close friend)

Second, keeping this worst event in mind, read each of the problems on the next page and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

PCL DSM-5 Version | Handout #2

Weathers et al., 2013

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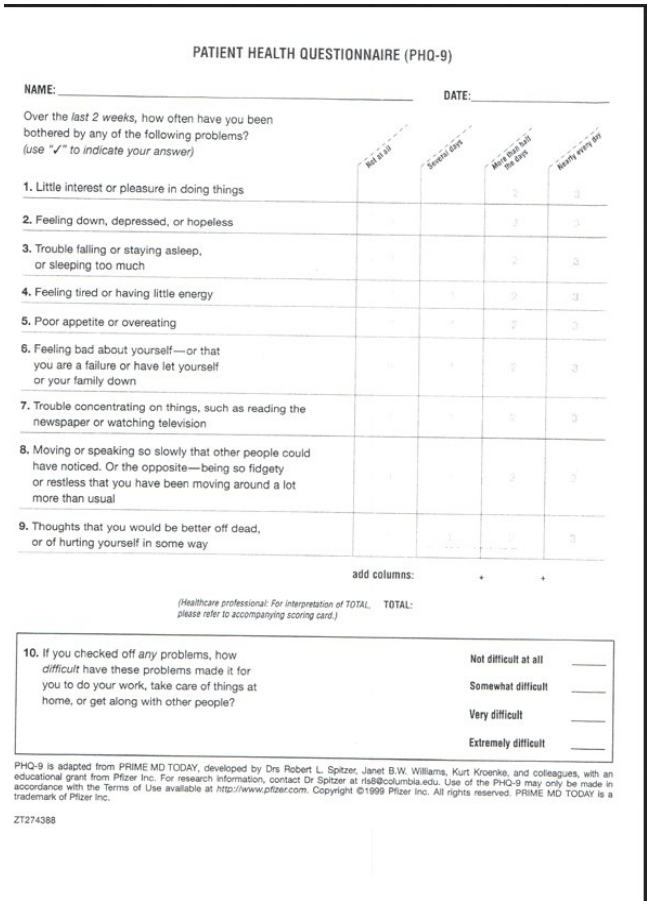
PHQ-8/PHQ-9 (Depression)

- 8 or 9-item questionnaire
- 5-10 minutes to complete
- Scoring:
  - Range: 0-24 or 0-27
  - Each item is rated (0-3)
- Interpretation:
  - Mild: 5-9
  - Moderate: 10-14
  - Moderately Severe: 15-19
  - Severe: 20-27



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) TOTAL: _____

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all ____
- Somewhat difficult ____
- Very difficult ____
- Extremely difficult ____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at *http://www.pfizer.com*. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

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Kroenke et al., 2001

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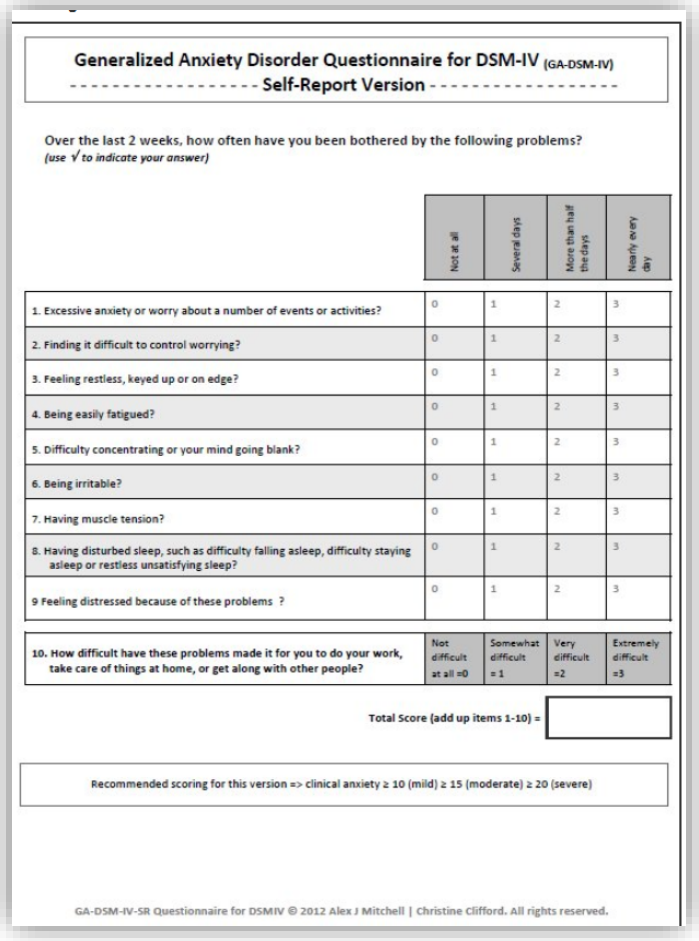
GAD-7

- 7-item questionnaire
- 5-7 minutes to complete
- Scoring:
  - Range: 0-21
  - Each item is rated (0-3)
- Interpretation:
  - Mild: 5-9
  - Moderate: 10-14
  - Severe: 15-21



Generalized Anxiety Disorder Questionnaire for DSM-IV (GA-DSM-IV)
Self-Report Version

Over the last 2 weeks, how often have you been bothered by the following problems?
(use √ to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Excessive anxiety or worry about a number of events or activities?	0	1	2	3
2. Finding it difficult to control worrying?	0	1	2	3
3. Feeling restless, keyed up or on edge?	0	1	2	3
4. Being easily fatigued?	0	1	2	3
5. Difficulty concentrating or your mind going blank?	0	1	2	3
6. Being irritable?	0	1	2	3
7. Having muscle tension?	0	1	2	3
8. Having disturbed sleep, such as difficulty falling asleep, difficulty staying asleep or restless unsatisfying sleep?	0	1	2	3
9 Feeling distressed because of these problems ?	0	1	2	3

10. How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all =0	Somewhat difficult = 1	Very difficult =2	Extremely difficult =3

Total Score (add up items 1-10) =

Recommended scoring for this version => clinical anxiety ≥ 10 (mild) ≥ 15 (moderate) ≥ 20 (severe)

Spitzer et al,. 2006

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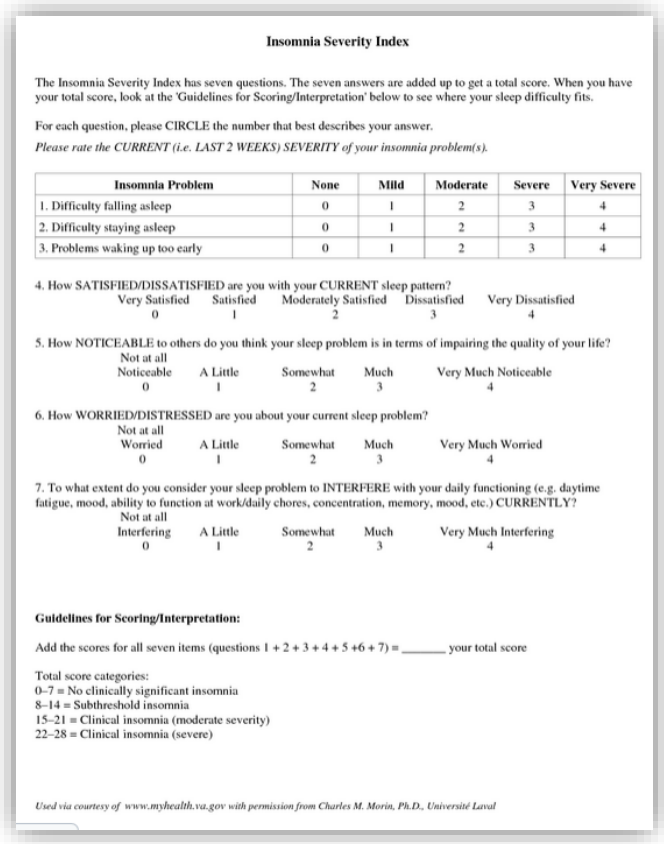
ISI

- 7-item questionnaire
- 5-7 minutes to complete
- Scoring:
  - Range: 0-28
  - Each item is rated (0-4)
- Interpretation:
  - Subthreshold:8-14
  - Moderate Insomnia: 15-21
  - Severe Insomnia: 22-28



Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = _____ your total score

Total score categories:
0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

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Bastien et al., 2001

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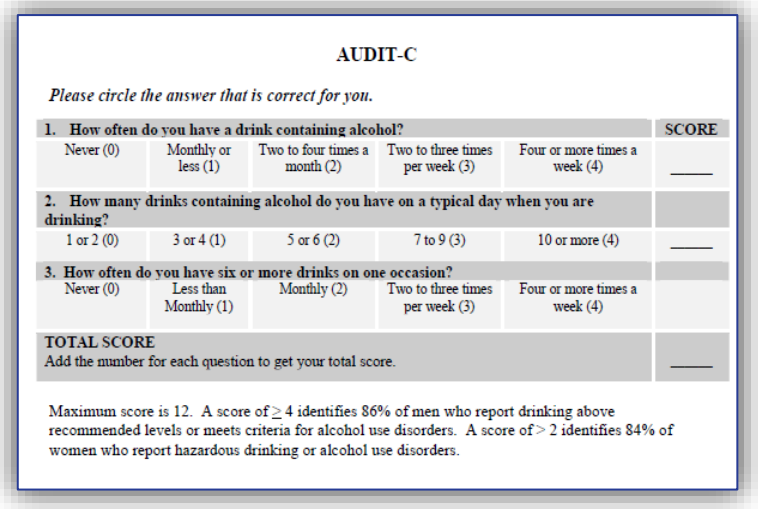
AUDIT-C

- 3-item screen for alcohol consumption
- 3-5 minutes to complete
- Scoring:
  - Range: 0-12
  - Each item is rated 0-4
- Interpretation:
  - Low Risk: 0-2 (Women), 0-3 (Men)
  - Mod Risk: 3-5 (Women), 4-5 (Men)
  - High Risk: 6-7
  - Severe Risk: 8-12



AUDIT-C

Please circle the answer that is correct for you.

1. How often do you have a drink containing alcohol?					**SCORE**
Never (0)	Monthly or less (1)	Two to four times a month (2)	Two to three times per week (3)	Four or more times a week (4)	____
2. How many drinks containing alcohol do you have on a typical day when you are drinking?					
1 or 2 (0)	3 or 4 (1)	5 or 6 (2)	7 to 9 (3)	10 or more (4)	____
3. How often do you have six or more drinks on one occasion?					
Never (0)	Less than Monthly (1)	Monthly (2)	Two to three times per week (3)	Four or more times a week (4)	
TOTAL SCORE Add the number for each question to get your total score.					____

Maximum score is 12. A score of $\geq$ 4 identifies 86% of men who report drinking above recommended levels or meets criteria for alcohol use disorders. A score of $>$ 2 identifies 84% of women who report hazardous drinking or alcohol use disorders.

Bush et al., 1998

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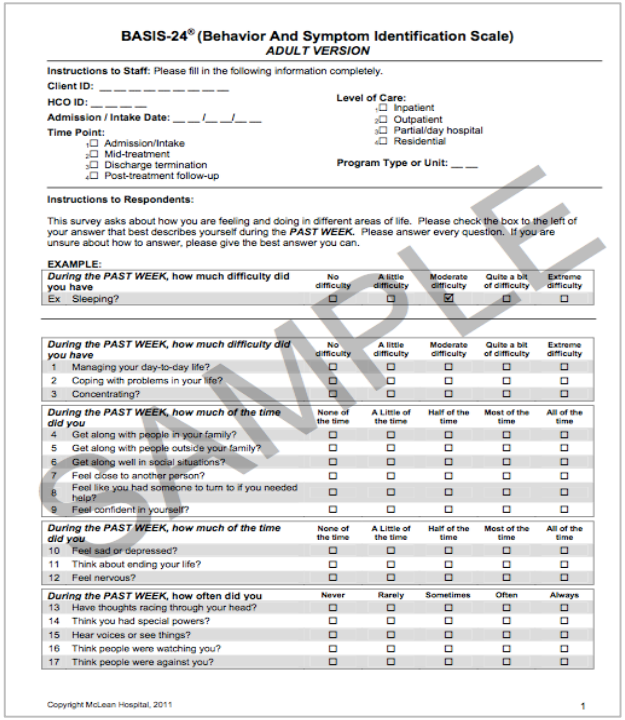
BASIS-24

- 24-item questionnaire
- 5-15 minutes to complete
- Scoring:
  - Range: 0-96
  - Each item is rated (0-4)
  - Reversed rating values for items 4-9
- Interpretation: There are no cutoff scores for classification



BASIS-24® (Behavior And Symptom Identification Scale)
ADULT VERSION

Instructions to Staff: Please fill in the following information completely.

Client ID: _ _ _ _ _ _ _ _ _ _

HCO ID: _ _ _ _ _

Admission / Intake Date: _ _ /_ _ _/_ _

Time Point:
1☐ Admission/Intake
2☐ Mid-treatment
3☐ Discharge termination
4☐ Post-treatment follow-up

Level of Care:
1☐ Inpatient
2☐ Outpatient
3☐ Partial/day hospital
4☐ Residential

Program Type or Unit: _ _

Instructions to Respondents:

This survey asks about how you are feeling and doing in different areas of life. Please check the box to the left of your answer that best describes yourself during the ***PAST WEEK.*** Please answer every question. If you are unsure about how to answer, please give the best answer you can.

EXAMPLE:

***During the PAST WEEK,* how much difficulty did you have**	**No difficulty**	**A little difficulty**	**Moderate difficulty**	**Quite a bit of difficulty**	**Extreme difficulty**
Ex Sleeping?	☐	☐	☑	☐	☐

During the PAST WEEK, how much difficulty did you have	**No difficulty**	**A little difficulty**	**Moderate difficulty**	**Quite a bit of difficulty**	**Extreme difficulty**
1 Managing your day-to-day life?	☐	☐	☐	☐	☐
2 Coping with problems in your life?	☐	☐	☐	☐	☐
3 Concentrating?	☐	☐	☐	☐	☐

During the PAST WEEK, how much of the time did you	**None of the time**	**A Little of the time**	**Half of the time**	**Most of the time**	**All of the time**
4 Get along with people in your family?	☐	☐	☐	☐	☐
5 Get along with people outside your family?	☐	☐	☐	☐	☐
6 Get along well in social situations?	☐	☐	☐	☐	☐
7 Feel close to another person?	☐	☐	☐	☐	☐
8 Feel like you had someone to turn to if you needed help?	☐	☐	☐	☐	☐
9 Feel confident in yourself?	☐	☐	☐	☐	☐

During the PAST WEEK, how much of the time did you	**None of the time**	**A Little of the time**	**Half of the time**	**Most of the time**	**All of the time**
10 Feel sad or depressed?	☐	☐	☐	☐	☐
11 Think about ending your life?	☐	☐	☐	☐	☐
12 Feel nervous?	☐	☐	☐	☐	☐

***During the PAST WEEK,* how often did you**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
13 Have thoughts racing through your head?	☐	☐	☐	☐	☐
14 Think you had special powers?	☐	☐	☐	☐	☐
15 Hear voices or see things?	☐	☐	☐	☐	☐
16 Think people were watching you?	☐	☐	☐	☐	☐
17 Think people were against you?	☐	☐	☐	☐	☐

Eisen et al., 2006

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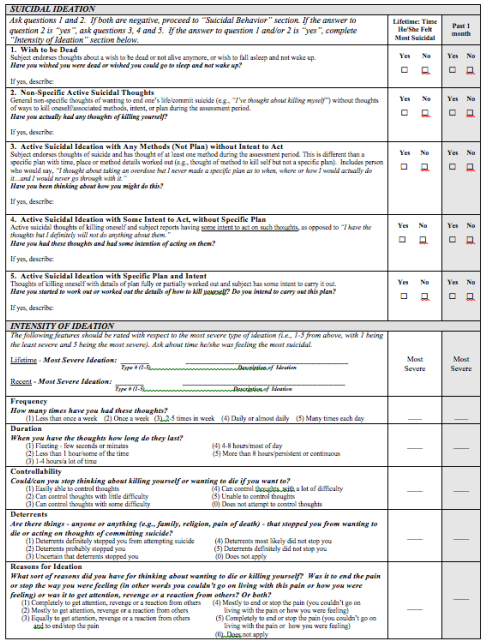
C-SSRS

- Four distinct versions of the scale
- 5-15 minutes to complete
- Scoring:
  - Measures 4 constructs
  - Binary responses (yes/no) indicating presence or absence of the behavior
- Interpretation: There are no cutoff scores for classification



SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

Lifetime: Time He/She Felt Most Suicidal | Past 1 month

1. Wish to be Dead
Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.
Have you wished you were dead or wished you could go to sleep and not wake up?
Yes ☐ No ☐ | Yes ☐ No ☐
If yes, describe:

2. Non-Specific Active Suicidal Thoughts
General non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.
Have you actually had any thoughts of killing yourself?
Yes ☐ No ☐ | Yes ☐ No ☐
If yes, describe:

3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act
Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."*
Have you been thinking about how you might do this?
Yes ☐ No ☐ | Yes ☐ No ☐
If yes, describe:

4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan
Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."*
Have you had these thoughts and had some intention of acting on them?
Yes ☐ No ☐ | Yes ☐ No ☐
If yes, describe:

5. Active Suicidal Ideation with Specific Plan and Intent
Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.
Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
Yes ☐ No ☐ | Yes ☐ No ☐
If yes, describe:

INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.

Most Severe | Most Severe

Lifetime - ***Most Severe Ideation:*** Type # (1-5)_____ Description of Ideation
Recent - ***Most Severe Ideation:*** Type # (1-5)_____ Description of Ideation

Frequency
How many times have you had these thoughts?
(1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day

Duration
When you have the thoughts how long do they last?
(1) Fleeting - few seconds or minutes
(2) Less than 1 hour/some of the time
(3) 1-4 hours/a lot of time
(4) 4-8 hours/most of day
(5) More than 8 hours/persistent or continuous

Controllability
Could/can you stop thinking about killing yourself or wanting to die if you want to?
(1) Easily able to control thoughts
(2) Can control thoughts with little difficulty
(3) Can control thoughts with some difficulty
(4) Can control thoughts with a lot of difficulty
(5) Unable to control thoughts
(0) Does not attempt to control thoughts

Deterrents
Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?
(1) Deterrents definitely stopped you from attempting suicide
(2) Deterrents probably stopped you
(3) Uncertain that deterrents stopped you
(4) Deterrents most likely did not stop you
(5) Deterrents definitely did not stop you
(0) Does not apply

Reasons for Ideation
What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?
(1) Completely to get attention, revenge or a reaction from others
(2) Mostly to get attention, revenge or a reaction from others
(3) Equally to get attention, revenge or a reaction from others and to end/stop the pain
(4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling)
(5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling)
(6) Does not apply

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Posner et al., 2011

Key Implementation Decisions

- Approach to Utilization
- Measures to Use
- Target Frequency
- Number of Measures

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Decisions about Utilization

One General Measure

General Measure plus Diagnosis Specific Measures

All Patients

Based on Patient Diagnosis

Only Diagnosis Specific Measures

Provider Choice

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Selecting Measures

Choose Measures for Each Domain	
General Measure	Diagnosis Specific

Factors to Consider	
VA/DoD Recommended	Time to Administer
Psychometrically Sound	Cost and Ease of Scoring

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Frequency for Administering

Available in Each Intake Packet

Frequency of Each Measure

Choose Measures for Each Domain

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How Many at Each Interval

Limit the Number if Measuring at Every Visit

Use More with Larger Intervals

Hybrid Approach

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Additional Considerations

Length of Treatment/Program

Fixed or Interval

Availability of Support Staff

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Liability Considerations

Be Aware of Copyright Laws

Be Mindful of Suicide Risk Assessments

Precautions and Procedures for any Endorsements

Review by Provider

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Implementation Challenges

Disruption to System &
Degree of Hardship

Concrete Stops to
Minimize Effects

Build Patient and Provider Buy-in

Aboraya et al., 2018; Lewis et al., 2019

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Improving Outcome Measure Use

Clinic Policy in Place

Few Providers are Using the Results

Patient Complaints

Provider Complaints

Enhancing Patient Buy-In

Select Measures & Frequency

Decide How to Handle Patients

Obtain Provider Buy-in

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Enhancing Patient Buy-In

Outcome Assessments are Routine

Motivate Patients to Complete Measures

Develop Standard Message

Educate Patients about the Benefits

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Enhancing Provider Buy-In

Select Measures and Frequency

Acknowledge Challenges and Present Solutions

Obtain Leadership Buy-in

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Enhancing Provider Buy-In

Minimize Provider Effort

Perform a “Dry Run”

Reassure Providers about Admin Staff Abilities

Address Worries about How Data will be Used

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Data Collection

Collecting Data on Outcomes is Difficult

Planning is a Critical Component in Implementation

Involves Various Levels of Personnel

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Execution of Data Collection

Using Admin/Clinical Staff

Training Staff on Administration & Scoring

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Execution of Data Collection

Dry Run Data Collection Processes

Test Run with Providers who Have Buy-in

Designate Roles with Oversight

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Storing and Handling Data

Maintain Outcomes Data in a Spreadsheet

Decide What is Recorded

Automate Placing Information Into Charts

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Storing and Handling Data

Security/Access of Hard Copy Measures

PHI Protections & Guidelines

How Long to Keep the Measures?

Destroy the Hard Copies after Scores are Recorded?

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Storing and Handling Data

- Electronic Tracking/Storage
- Password Protected
- Limited Number of People with Access
- Designated Staff Enter Data

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Use of Patient Data

Treatment Planning for Individual Patients

Process Improvement/ Program Evaluation

Data Limitations

Microsoft office prior to mid-2015

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Measures & Treatment Planning

Evidence-based Decisions

How to Use Data

Benchmarks/Goals

Promptly Introduce to Patients in Treatment

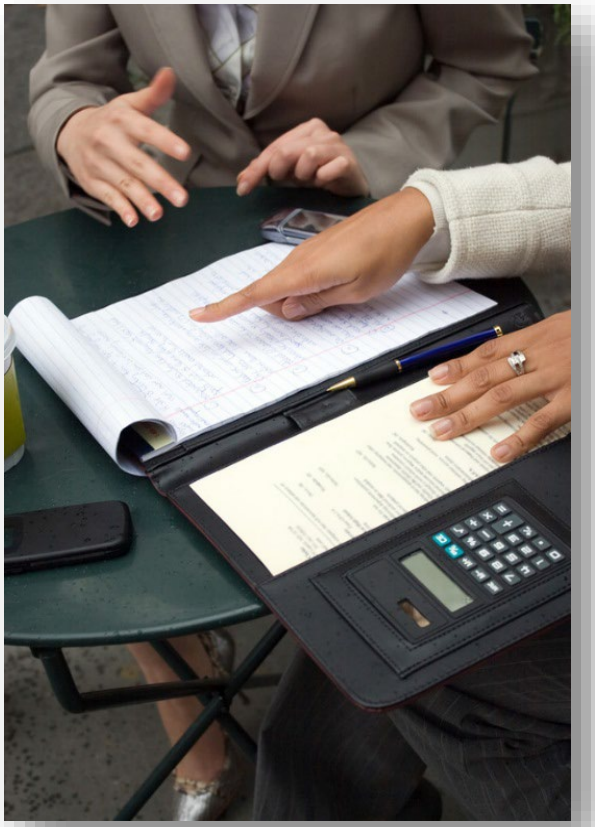

Image: Microsoft office prior to mid-2015

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When Patients Don't Get Better

- Re-evaluate Diagnosis
- Assess Level of Engagement
- Change in Type of Care

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Aggregated data

Answer Questions about Clinic Services

Process Improvement

Program Evaluation

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Data Limitations

Cannot Solely Determine Care Levels

No Research or Publications

Can Inform Local Clinic Brochures and Leadership

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Toolkit Resources: Metrics I

- *Training Deck*
- *Forms*
- *Data Tracking Tools*
- *SOP/OI*

Toolkit Resources: Metrics I

- *Training Deck*
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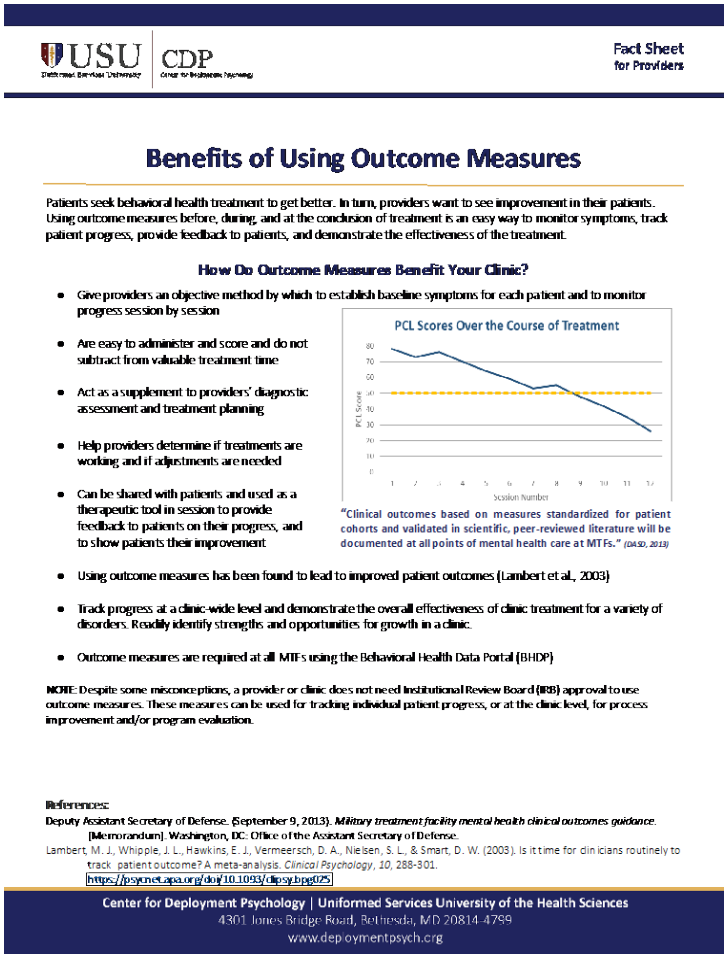

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Fact Sheet for Providers

Benefits of Using Outcome Measures

Patients seek behavioral health treatment to get better. In turn, providers want to see improvement in their patients. Using outcome measures before, during, and at the conclusion of treatment is an easy way to monitor symptoms, track patient progress, provide feedback to patients, and demonstrate the effectiveness of the treatment.

How Do Outcome Measures Benefit Your Clinic?

- Give providers an objective method by which to establish baseline symptoms for each patient and to monitor progress session by session
- Are easy to administer and score and do not subtract from valuable treatment time
- Act as a supplement to providers' diagnostic assessment and treatment planning
- Help providers determine if treatments are working and if adjustments are needed
- Can be shared with patients and used as a therapeutic tool in session to provide feedback to patients on their progress, and to show patients their improvement

"Clinical outcomes based on measures standardized for patient cohorts and validated in scientific, peer-reviewed literature will be documented at all points of mental health care at MTFs." *(DASD, 2013)*

- Using outcome measures has been found to lead to improved patient outcomes (Lambert et al., 2003)
- Track progress at a clinic-wide level and demonstrate the overall effectiveness of clinic treatment for a variety of disorders. Readily identify strengths and opportunities for growth in a clinic.
- Outcome measures are required at all MTFs using the Behavioral Health Data Portal (BHDP)

NOTE: Despite some misconceptions, a provider or clinic does not need Institutional Review Board (IRB) approval to use outcome measures. These measures can be used for tracking individual patient progress, or at the clinic level, for process improvement and/or program evaluation.

References:

Deputy Assistant Secretary of Defense. (September 9, 2013). *Military treatment facility mental health clinical outcomes guidance.* [Memorandum]. Washington, DC: Office of the Assistant Secretary of Defense.

Lambert, M. J., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielsen, S. L., & Smart, D. W. (2003). Is it time for clinicians routinely to track patient outcome? A meta-analysis. *Clinical Psychology, 10,* 288-301. https://psycnet.apa.org/doi/10.1093/clipsy.bpg025

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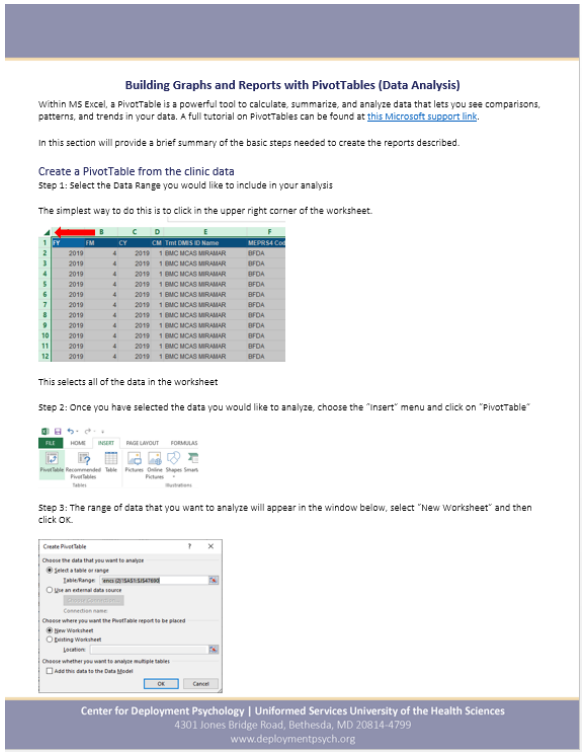
Toolkit Resources: Metrics I

- *Training Deck*
- *Forms*
- ***Data Tracking Tools***
- *SOP/OI*



Building Graphs and Reports with PivotTables (Data Analysis)

Within MS Excel, a PivotTable is a powerful tool to calculate, summarize, and analyze data that lets you see comparisons, patterns, and trends in your data. A full tutorial on PivotTables can be found at this Microsoft support link.

In this section will provide a brief summary of the basic steps needed to create the reports described.

Create a PivotTable from the clinic data

Step 1: Select the Data Range you would like to include in your analysis

The simplest way to do this is to click in the upper right corner of the worksheet.

This selects all of the data in the worksheet

Step 2: Once you have selected the data you would like to analyze, choose the "Insert" menu and click on "PivotTable"

Step 3: The range of data that you want to analyze will appear in the window below, select "New Worksheet" and then click OK.

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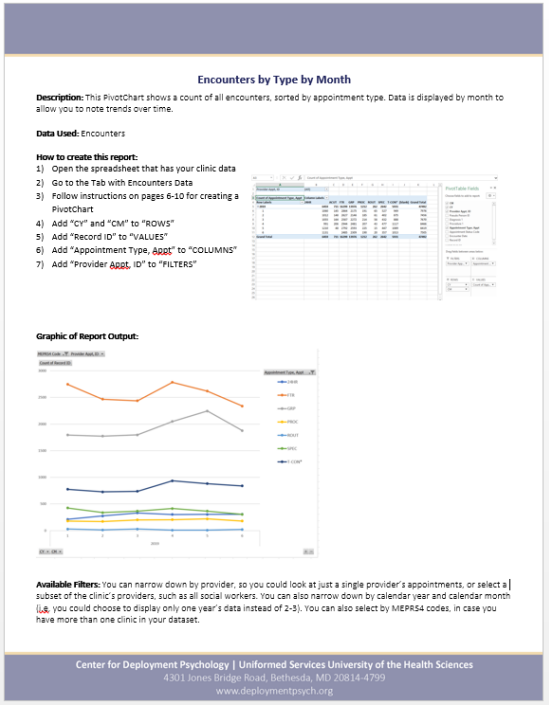

Encounters by Type by Month

Description: This PivotChart shows a count of all encounters, sorted by appointment type. Data is displayed by month to allow you to note trends over time.

Data Used: Encounters

How to create this report:

1) Open the spreadsheet that has your clinic data
2) Go to the Tab with Encounters Data
3) Follow instructions on pages 6-10 for creating a PivotChart
4) Add "CY" and "CM" to "ROWS"
5) Add "Record ID" to "VALUES"
6) Add "Appointment Type, Appt" to "COLUMNS"
7) Add "Provider Appt. ID" to "FILTERS"

Graphic of Report Output:

Available Filters: You can narrow down by provider, so you could look at just a single provider's appointments, or select a subset of the clinic's providers, such as all social workers. You can also narrow down by calendar year and calendar month (i.e. you could choose to display only one year's data instead of 2-3). You can also select by MEPRS4 codes, in case you have more than one clinic in your dataset.

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Toolkit Resources: Metrics I

- Training Deck
- Forms
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- **SOP/OI**

NOTE TO USER- This template is intended to give your clinic a head start on developing its own SOP/OI for this topic. The template can quickly be adapted to fit your clinic's needs, dropping content you do not need and adding anything you feel is relevant. Note that there are several highlighted areas, which should be addressed as you customize this template for your clinic.

Subject: Standard Operating Procedure (SOP)/Operating Instructions (OI) for Patient-Level Outcome Measures at the [Behavioral Health Clinic] at [Medical Center]

Purpose: To identify procedures in the collection, storing, and safeguarding of patient-level outcome measures in an outpatient behavioral health treatment clinic, in support of providing Evidence-Based Psychotherapy (EBP).

References:

- Memorandum for Assistant Secretary of the Army; Assistant Secretary of the Navy; Assistant Secretary of the Air Force, regarding Military Treatment Facility Mental Health Clinical Outcomes Guidance dated September 09, 2013, from Jonathon Woodson, M.D., Assistant Secretary of Defense for Health Affairs (Enclosure 1).
- BHDP Operations Manual and User Guide & Patient Kiosk Instruction Sheet
- Add any clinic SOPs/OIs that are referenced in this document

1. Objectives.
   - 1.1. To include the use of patient-level outcome measures in providing EBPs.
   - 1.2. Standardize clinic procedures related to patient-level outcome measures.
   - 1.3. Provide patient-level outcome measures to monitor symptoms, track patient progress, provide feedback to patients, and demonstrate effectiveness of EBP treatment.

2. Responsibilities.
   - 2.1. [Clinic Manager] has overall responsibility for the provision of services and their method of delivery within the clinic.
     - 2.1.1. [Clinic Manager] will determine the list of measures, frequency of administration, and method to implement patient-level outcome measures in the clinic.
     - 2.1.2. [Clinic Manager] will assign responsibility to Behavioral Health Technicians (BHTs) to address procedures for implementing plans of patient-level outcome measures in EBP groups.
   - 2.2. [Providers] will implement the procedures below for their individual and group EBP treatment sessions. Providers are responsible for ensuring their patients understand the necessity for routine assessment of clinical outcomes and should support the clinic's overall policy on patient-level outcome measures.

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Summary

- Determine the benefits of using Outcome Measures (OMs)

- Analyze challenges of implementing OMs at a clinic level

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Clinic Optimization Toolkit

https://deploymentpsych.org/clinicoptimizationtoolkit

Modules

- Clinic Gap Analysis
- Patient Management
- EBP Utilization
- Group Therapy Expansion
- Technician Support
- Metrics
- Evaluation

Types of Resources

- Training Decks
- Factsheets & Handouts
- Forms & Templates
- Spreadsheets & Supporting Documents
- Standard Operating Procedures

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Center for Deployment Psychology

Department of Medical & Clinical Psychology
Uniformed Services University of the Health Sciences
4301 Jones Bridge Road
Bethesda, MD 20814-4799

Contact Us

Email: cdp-ggg@usuhs.edu
Website: deploymentpsych.org
Facebook: http://www.facebook.com/DeploymentPsych
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