Measurement Based Care: From Clinician Adoption toward Organization Accreditation

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Oregon Health & Science University School of Nursing

DNP Quality Improvement Project

Chair: Tara O'Connor, DNP, APRN, PMHNP-BC

March 17th, 2023

Abstract

BACKGROUND & LOCAL PROBLEM: Research demonstrates measurement-based care (MBC) in psychiatry improves patient outcomes and quality of life, as well as provides data for continual quality improvement efforts. This project aimed to explore organizational rates of MBC implementation and adoption at a large outpatient psychiatric organization and work towards accreditation through The Joint Commission.

METHODS & INTERVENTION: Through short cycles of Plan-Do-Study-Act (PDSA) from the Model for Improvement, guided by literature review and stakeholder knowledge, rates for MBC adoption, organizational culture and provider base knowledge and opinions were explored along with organizational readiness for accreditation through The Joint Commission.

RESULTS: 85% of providers participated in the initial survey and 54% participated in the final survey. All providers were in attendance of the presentation or provided access to a recording. Minimum MBC adoption rate was identified at 60% with 100% of providers using at least 1 MBC screening tool each month. No barriers were identified to MBC adoption; however, the final survey demonstrated that providers were using tools in initial assessment but not using tools to guide treatment decisions consistently. Interventions also demonstrated a mixed culture among providers around accreditation.

CONCLUSIONS: This quality improvement project highlights the benefits of MBC adoption and how adoption promotes behavioral health organizational accreditation through The Joint Commission. Many opportunities for improvement were found: policy around MBC use in treatment, transparent leadership culture promoting explicit evidence-based benefits of MBC in treatment and accreditation benefits, and streamlined reporting to accommodate reporting needs in accreditation processes.

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Introduction

Problem Description/Background

A reliable, quantitative and objective form of measurement of psychiatric symptoms and symptom improvement has been elusive. Beginning in the 19th century, initial attempts to measure mental health conditions were crude and discriminatory (Aboraya et al., 2018). In the past several decades, researchers have developed and demonstrated the validity of many instruments or tools to fill this need which are now referred to collectively as Measurement-Based Care (MBC) (Aboraya et al., 2018; Xiao et al., 2021).

Despite the demonstrated effectiveness of MBC in research settings, few organizations and independent clinicians manage to fully implement this level of structured treatment (Aboraya et al., 2018; Connors et al., 2021; Krishna et al., 2020; Martin-Cook et al., 2021; Wray et al., 2018). Only 20% of clinicians report they use a MBC structured method of treatment in their practice (Connors et al., 2021; Lewis, 2019), and a meager 5% use MBC according to the empirically based fidelity (Lewis, 2019). Even with the growing number of research studies exploring MBC in psychopharmacological and psychotherapy treatment, there is a paucity of research into why mental health organizations or independent clinicians do not use these methods more consistently and how to support clinicians to overcome the barriers (Aboraya et al., 2018; Connors et al., 2021; Krishna et al., 2020; Lewis et al., 2019; Martin-Cook et al., 2021; Meza et al., 2021). Addressing barriers is important because, if an organization can successfully implement and adopt MBC within their practice, the benefits can greatly improve patient care and provide a launch pad for quality improvement throughout the organization.

Available Knowledge

MBC tools often take the form of patient-reported rating scales, structured interview techniques, and outcome reviews (Aboraya et al., 2018; Lewis et al., 2019) and work in tangent with symptom specific treatment algorithms that focus treatment goals toward full remission of symptoms

(Krishna et al., 2020; Xiao et al., 2021). More specifically, MBC tools objectively report on the safety and efficacy of offered treatments, as well as the level of improved functioning and quality of life for individuals throughout treatment (Aboraya et al., 2018; Krishna et al., 2020; Xiao et al., 2021). Benefits of MBC include increased detection of symptom changes (improvement or deterioration), improved communication and therapeutic alliance between provider and patient, improved interprofessional communication and collaboration, and greater outcomes and quality of life for patients (Aboraya et al., 2018; Connors et al., 2021; Krishna et al., 2020; Lewis et al., 2019; Martin-Cook et al., 2021; Xiao et al., 2021). Despite the evidence for MBC, important barriers exist to MBC adoption and implementation.

The barriers for MBC implementation range from time consumption to poor consensus on which to use of the numerous tools available (Aboraya et al., 2018). Most notably, barriers include vague mechanisms of action to explain how they improve treatment, lack of demonstrated efficacy in complex clinical pictures and mixed treatment modalities, and increased workload commitments for providers and patients (Connors et al., 2021; Lewis et al., 2019; Martin-Cook et al., 2021). There are decades of research examining various MBC tools for treatment, and yet scarce research reviewing ways to support clinical implementation for providers using the tools.

When implementing MBC, organizational leadership must be clear on how the data will be used and build trust that it will not be considered for punitive correction or incentivized to promote competition, but as a shared vision to improve care for patients and organization growth and improvement (Connors et al., 2021; Lewis et al., 2019; Martin-Cook et al., 2021). Despite concerns around implementing MBC, there is growing support in industry guidelines for MBC to measure the efficacy and value of treatment and to collect data for quality improvement projects (Connors et al., 2021; Martin-Cook et al., 2021; Oslin et al., 2019). With valid and quantified rating scales, areas for quality improvement can be specifically targeted and efforts toward improvement can be monitored and supported. Accreditation is the culmination and recognition of an organization's dedication to

quality patient-centered care and continued improvement, and MBC is a key component of the accreditation process.

Using an external organization of peers within the field to review the care provided by mental health professionals can provide the team valuable information to improve the systems, policies and procedures that are impacting patient care and experience (Aimola et al., 2018). Accreditation review can provide an organization with a comparison of the care they provide to patients with that of the industry standard, through the assessment of the physical safety of the environment, selected chart reviews and staff interviews to explore treatment provided, documentation practices, policy and procedures set for staff and organizational culture (Aimola et al., 2018). While accreditation is not shown to lead to improved patient outcomes in some inpatient hospital settings (Aimola et al., 2018), the industry standards outlined exemplify evidence-based practice and promote streamlined efficiency improving the care experience and staff satisfaction (Bernardes et al., 2020; Lam et al., 2018; TJC, 2021; Viswanathan & Salmon, 2000). Of the accrediting bodies within the US, TJC is the sole option for oversight to the behavioral health field (Viswanathan & Salmon, 2000). TJC works to provide a collaborative relationship with and among the organizations they review to incorporate strategic quality planning and improvement (Bernardes et al., 2020; TJC, 2021; Viswanathan & Salmon, 2000). The accreditation process provides space for organizations to equip teams toward a shared vision of evidence-based best practice and accountability to maintain those standards.

Rationale

The Institute for Healthcare Improvement (IHI) developed the Model for Improvement (MFI) around the scientific method of continual change through short cycles of Plan-Do-Study-Act (PDSA) to promote innovation within a wide variety of health organizations (Moen, 2009). This system is simple and well-known amongst healthcare professionals; and, allowed timely identification of quality improvement area(s), rapid change and then analysis of the change specifically suited for the short

timeline of this quality improvement project. Additionally, the MFI provided common language throughout the organization and promoted collaboration between organizational staff and research team.

Specific Aims

The specific aim was to evaluate rates of MBC adoption in a large out-patient psychiatric organization (OPO) using reports generated within the Electronic Health Record and voluntary surveys completed by psychiatric providers exploring potential barriers to complete MBC adoption. Additionally, based on MBC adoption rates meeting the standards, accreditation through The Joint Commission (TJC) was explored, contact initiated, and preliminary steps were taken to begin the accreditation process.

Methods

Context

The OPO operates 3 offices within the Pacific Northwest. Collectively, the organization sees over 1200 patients monthly and is growing significantly with new patient admissions reaching over 100 each month. Patients are of varying ages across the lifespan and have a wide variety of mental health conditions, none excluded, and all forms of pay are accepted (Medicare, Medicaid, private insurance and private pay). Clinical providers include 15 nurse practitioners, 2 psychologists, and 7 mental health therapists. The OPO employs 19 scribes to assist providers with documentation, funnel direct patient-provider communication, as well as support MBC tool completion through direct patient interviews during appointments when needed.

Intervention

A preliminary report was generated to assess the current state of MBC adoption within the organization through an online measurement feedback system (OMFS), IntakeQ, where most patients

complete MBC tools prior to their appointments. Supplementary reports were also run through the electronic health record (EHR), Office Ally, to cross reference as some MBC tools are completed during sessions and integrated into the EHR directly.

An initial survey was used to explore general knowledge of MBC and organizational accreditation among psychiatric providers. This survey was developed with Organizational Leadership and planned to cause the least amount of time burden and concern to providers as the organization was currently in a phase of structural change. The survey (see Appendix F) was available to providers for two weeks via an anonymous online survey platform, Qualtrics.

Based on answers and feedback from the initial survey and review of the literature, an overview of behavioral health accreditation, how MBC adoption impacts the accreditation process, and a brief cost-benefit analysis was presented to providers during a monthly psychiatric department meeting. See Appendix H or the full PowerPoint presentation. The research team initiated contact with TJC, having an Executive Assistant assigned to the OPO, and began preliminary reviews of current policies through Organizational Leadership in relation to accreditation standards.

Study of the Intervention

The results from the first two PDSA cycles and initial survey were presented to psychiatric providers in attendance of the monthly department meeting and recorded for those not in attendance. The presentation discussed the benefits of accreditation, what the providers should expect in the accreditation process, and an explanation of where the OPO was within this process. The providers were given time to ask questions regarding accreditation specific to the OPO and any questions were answered by Organizational Leadership. A final project discussion was held during another department meeting and a second survey (see Appendix I) was sent to psychiatric providers to inquire how the presentation improved understanding of accreditation, as well as explore specific usage of MBC within

each provider's practice and the culture of change among the team. The second survey was also created with Organizational Leadership after reviewing results from the initial survey and discussion during the presentation, as well as further exploration of accreditation.

Measures and Analysis

The primary outcome measure was the rate of MBC adoption calculated from reports from Office Ally and IntakeQ. Outcome measures from the initial and post-presentation surveys offered further evaluation of the process and provided Organizational Leadership with ways to refine policy and procedures, and improve team buy-in as the OPO moves forward with accreditation. Both survey results were analyzed through Qualtrics. At the conclusion of this project, communication between the OPO and TJC was opened and the preliminary accreditation process initiated.

Ethical Considerations

This project was submitted to the OHSU Institutional Review Board for approval prior to initiation. This project was submitted to the OHSU Institutional Review Board and was found to be not human research. All information was gathered from the organizational secure Electronic Health Record, Office Ally, and Online Measurement Feedback System, Intake Q, and used existing report generators that were available. All data reports related to the project were accessed only on clinical site and were not shared or stored on independent storage devices. All provider information was kept confidential, and de-identified when necessary, to protect from retaliation and to promote safe engagement in the project process. In the context of the accreditation process, no organizational information was shared with TJC as accreditation readiness was only superficially explored. All interventions, organizational correspondence, and data analysis method were reviewed and approved by the Director of Psychiatry and Faculty Lead prior to dissemination.

Results

PDSA Cycle Results

Overall, the project completed four PDSA cycles (see Appendix K). In the initial cycle, the research team identified stakeholder priorities and reviewed MBC adoption rates for the OPO. In the second cycle, organizational change provided the opportunity to review project goals with new leadership stakeholders, share the first provider survey, and initiate contact with TJC for the accreditation process. The third cycle allowed for further exploration of reporting abilities, and to present during the psychiatry department meeting. The fourth and final cycle included a project wrap up discussion at another department meeting, review of outcomes with stakeholders and providing future steps for the OPO.

The initial survey was completed by nearly all psychiatric providers at the time of survey (11 of 13, or approx. 85%). All OPO providers reported they are familiar with MBC and use rating tools regularly in their practice; however, the survey highlighted that providers needed additional information regarding the connections between MBC adoption and accreditation, details on the accreditation process, and how accreditation will benefit the OPO and individual providers (See Appendix G for full survey results).

The second or wrap-up survey repeated the question regarding provider understanding of accreditation with the inclusion of more specific MBC questions requested by Organizational Leadership. This survey was answered by 8 of the 15 providers at the time of the survey (approximately 54%). Results (See Appendix J for full survey results).

In early stakeholder discussions and information gathering, it was identified that MBC adoption may be sufficient for accreditation through TJC, therefore the steps to accreditation were explored in addition to identifying organizational MBC adoption. Information was gathered from TJC website as well as initiating contact for further information to explore OPO readiness. Given the organization has been

successful in adopting MBC into practice, TJC was contacted to initiate the next phase of the project. An Executive Assistant (EA) was assigned to the OPO, and communication was shared with the research team through the Director of Psychiatry.

The reporting capability of the current EHR and organizational procedures complicated the ability to identify definitively the rate of MBC adoption; however, the OPO has at minimum a 60% usage rate of measurement-based screening tools. Data from the last six months show that all (100%) providers complete at least one MBC tool each month, with the majority utilizing two or more screeners. The most common screening tools used are the Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder scale (GAD-7), and the Adverse Childhood Events (ACEs); however, other common screening tools are the Vanderbilt Assessment Scales, ADHD Self-Reporting Scale (ASRS), Mood Disorder Questionnaire (MDQ), PTSD Checklist (PCL-5), Yale-Brown Obsessive Compulsive Scale (YBOCS), Columbia-Suicide Severity Rating Scale (CSSRS), and the Abnormal Involuntary Movement Scale (AIMS).

This project identified additional areas for improvement that will support accreditation. The OPO lacks an explicit policy to guide providers around MBC that could define expectations around the use of specific screening tools or standards for how tools could be used in treatment, nor are on-boarding procedures outlined for new providers and staff to convey the importance of MBC culture and practice at the OPO. The OPO will also need to explore more specific reporting abilities through the EHR to demonstrate their MBC adoption rates for accreditation and reaccreditation.

Discussion

Summary

This project identified that MBC adoption is possible within an OPO, and robust MBC adoption can lay foundational work for accreditation through TJC. While no barriers to MBC adoption were found, many barriers to effective reporting were uncovered. Also, provider perception and buy-in to

accreditation will need to be explored further for a successful transition to a structured treatment setting created by accreditation standards. Current literature highlights the role between inclusive and transformational leadership styles and transparency in successful organizational change (Aimola et al., 2018; Bernardes et al., 2020; Lam et al., 2018; Senge, 2006; Viswanathan & Salmon, 2000), and these forms of leadership would support the change needed in the OPO. The initial survey showed neutral to positive responses to the use of MBC tools in treatment and reporting shows that providers use an MBC screening tool at least once in a month; however, the final survey highlights minimal use of MBC according to fidelity. The initial survey showed a lack of knowledge of accreditation and the link between MBC and accreditation, which was improved by the presentation as evidenced by the improved knowledge and mixed buy-in from providers to the pursuit of accreditation within the OPO shown in the final survey. Mixed buy-in may be attributed to new providers joining the OPO mid-project, as well as the need for further transparency between leadership and providers to clarify specific expectations.

This project showed the use of the MFI Plan-Do-Study-Act model for change and how quick succession of cycles can provide significant organizational information in a short time. Overall, this project provided the OPO with next steps for the accreditation process: the need for policy around MBC use in treatment, leadership culture promoting explicit evidence-based benefits of MBC in treatment and accreditation benefits, transparent discussion with providers and staff to improve buy-in and streamline reporting abilities to accommodate upcoming reporting needs for the accreditation and reaccreditation processes.

Interpretation

Completion rates of the surveys were significant (85% and 54% respectively) and could be attributed to direct leadership involvement and support of the project. Reporting difficulties took a

considerable amount of time and poor communication with entities outside the OPO (tech support with the EHR and the assigned EA with the TJC) impeded progress for much of the project. There were several organizational staffing and structure changes occurring at the same time of this project, also contributing to fluctuating schedules, communication difficulties and leadership reluctance to push for immediate change. The MFI Plan-Do-Study-Act model for change provided a flexible structure to implement change within the OPO as well as initiate contact with outside agencies (EHR support and TJC) for continued change at the completion of this project.

Limitations

This project is limited in generalizability by the single organization. Also, patients and patient data were not included which deterred the ability to review patient understanding and preference on organizational accreditation when selecting a psychiatric or psychological provider. Suggestions for future quality improvement would include additional review of the organizational benefits to accreditation within behavioral health settings, as well as further review of barriers to MBC adoption with reasons and means to overcome these barriers. By persuing accreditation, larger behavioral health organizations could help set a standard of care within the field for continued improvement of evidenced-based care.

Conclusions

This project highlights the benefits of MBC adoption and how adoption promotes behavioral health organizational accreditation through The Joint Commission. It also touches on how accreditation can improve patient care through continued quality improvement with external oversight. MBC can provide objective measures that offer an additional piece to the treatment picture and does not negate or minimize the importance of therapeutic rapport and clinical judgment in the treatment of mental and behavioral health. The need for further research is certain, especially looking at complex clinical

application and the mechanisms of action in MBC tools (Aboraya et al., 2018; Connors et al., 2021; Lewis et al., 2019; Martin-Cook et al., 2021; Meza et al., 2021). It is hoped that organizations that have successfully implemented MBC, such as the one explored in this improvement project, could provide insights for the field regarding their implementation strategies as well as steps towards and the benefits of accreditation.

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Appendix A

Proposed Project Timeline

EHR Report Formulation, Review Accreditation Checklist, Potential Survey Preparation, Engagement with Stakeholders, Accreditation Point-Person Assigned - June-August 2022

Review Report, Address Checklist Concerns, Survey Release – Sept 2022

Survey Collection – late Sept 2022

Data Analysis & Review of literature: Oct 2022

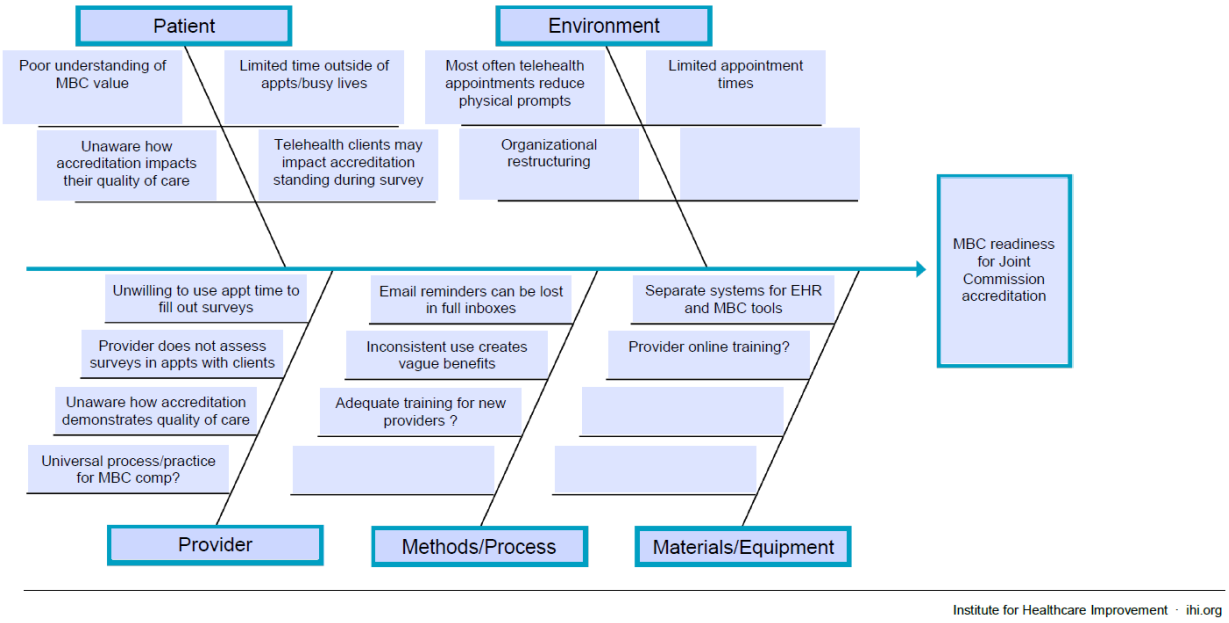
Writing Intervention Proposal, Potentially Submit Accreditation Application: Nov 2022

Proposal Presentation: Dec 2022

Writing DNP Project: Jan & Feb 2023

Appendix B

Cause and Effects



Appendix C

Letter of Support from Implementation Site

Letter of Support from Clinical Agency

Date: 07/19/2022

Dear Lynae Edmonds

This letter confirms that I, Bethany Jensen allow Lynae Edmonds (OHSU Doctor of Nursing Practice Student) access to complete her DNP Final Project at our clinical site. The project will take place from approximately May 23, 2022 to April 2023.

This letter summarizes the core elements of the project proposal, already reviewed by the DNP Project Preceptor and clinical liaison (if applicable):

- **Project Site(s)**: *Physical access: NeuStart Psychiatry, 550 NW Franklin Ave, Bend, OR. Virtual meetings, as needed.*
- **Project Plan: Use the following guidance to describe your project in a brief paragraph.**
    - Identified Clinical Problem: *As we have discussed, the organization has adopted MBC and would like to move towards the accreditation process through JACHO. A potential question to be answered with this project is: How does Measurement-Based Care (MBC) adoption support organizational Behavioral Health Care accreditation through the Joint Commission (TJC)?*
    - Rationale: *The project will use The Readiness Checklist (already reviewed) from TJC to further assess readiness. Initially I will use the Consolidated Framework for Implementation Research (CFIR) to explore five main domains of the project: characteristics of the organization and individuals involved, the inner and outer settings, and the implementation process. If barriers to MBC implementation are discovered, I will use the Expert Recommendations for Implementing Change (ERIC) as a source for intervention strategies to overcome barriers. Overall, I will use the Model for Improvement (MFI) developed by the Institute for Healthcare Improvement to support rapid change within health care systems. These frameworks will provide evidence-based scaffolding to structure each step of the project process.*
    - Specific Aims: *This project aims to identify the rates of MBC used in each clinic location, any barriers limiting implementation, and work to overcome these barriers. Also, we will initiate the accreditation process through JCAHO.*
    - Methods/Interventions/Measures: *Throughout the project, data will be collected using reports within the electronic health record to track rates of MBC, voluntary staff surveys to identify barriers, video conference meetings to problem solve barriers and promote accreditation buy-in and organizational transparency.*

- Data Management: *Reports exploring the use of MBC tools (rating scales, etc) will be produced and reviewed. All patient data will be reviewed within the electronic health record, and not stored elsewhere. All provider and organizational information will be de-identified. Organizational information used to apply for accreditation will be reviewed and submitted by assigned organizational staff member and used only for the purpose of accreditation.*
- Site(s) Support: *During the project process I will be seeking regular feedback and participation from all clinic stakeholders, including Dr. Helen Caldwell, Dr. Bethany Jensen, and Hailey Groh, as well as all providers impacted by accreditation. Feedback will be always welcomed; however, specific feedback will be sought at 4–6-week intervals throughout the duration of the project.*
- Other: *None noted.*

During the project implementation and evaluation, Lynae Edmonds will provide regular updates and communicate any necessary changes to the DNP Project Preceptor.

Our organization looks forward to working with this student to complete their DNP project. If we have any concerns related to this project, we will contact Lynae Edmonds and Dr. Tara O'Connor (student's DNP Project Chairperson).

Regards,

_____

Signature Date Signed

DNP Project Preceptor: Dr. Bethany Jensen, Psychiatric Doctor. bjensen@neustartpsychiatry.com

NeuStart Psychiatry. Bend, Oregon

Appendix D

Institutional Review Board Determination Letter

NOT HUMAN RESEARCH

August 24, 2022

Dear Investigator:

On 8/24/2022, the IRB reviewed the following submission:

Title of Study:	Quality Improvement: Measurement-based care in Mental Health
Investigator:	Tara O'Connor
IRB ID:	STUDY00024743
Funding:	None

The IRB determined that the proposed activity is not research involving human subjects. IRB review and approval is not required.

Certain changes to the research plan may affect this determination. Contact the IRB Office if your project changes and you have questions regarding the need for IRB oversight.

If this project involves the collection, use, or disclosure of Protected Health Information (PHI), you must comply with all applicable requirements under HIPAA. See the HIPAA and Research website and the Information Privacy and Security website for more information.

Sincerely,

The OHSU IRB Office

Appendix E

The Joint Commission Accreditation Readiness Checklist

Behavioral Health Care

Is My Organization Ready to Apply?

Achieve Behavioral Health Accreditation For Your Organization **Take this quick quiz and find out!**

If you answer **"YES"** to at least 20 questions, your behavioral health organization has leading business practices in place that address some of our key foundational accreditation requirements. You are prepared to move onto the next step in the process – submitting a completed application.

GENERAL ELIGIBILITY REQUIREMENTS	YES	NO

Has your organization served at least three individuals, with at least two currently active? For foster care agencies, do you have at least three foster homes, with at least two providing care for at least one foster child or adult?

Are you in compliance with all your federal, state, or local laws and regulations?

Does your organization meet the applicable fire code?

LEADERSHIP	YES	NO

Do the mission, vision, and goals of your organization support safety and quality of care, treatment or services?

Do ethical principles guide the organization's business practices?

Can your organization demonstrate that it continually assesses and improves the quality of its care, treatment, and/or services?

Does leadership manage safety and security risks in the organization?
Are your organization's information management processes able to meet your internal and external information needs?

Do you have a written policy to address privacy, confidentiality, and security of information about your staff and your patients?
Does your organization have a written emergency management plan?

HUMAN RESOURCES MANAGEMENT	YES	NO

Do you have a written policy in place to confirm that a person's qualifications and competencies fit with their assignment and their job responsibilities? Does it include such items as:

Current licensure, certification, or registration required
Education, training, and experience
A criminal background check
Health screening and immunization requirements
Proof of identity
A job description including minimum qualifications and competencies required

Does your organization provide thorough orientations for your staff?

Is the competency of your staff to perform their job duties assessed, demonstrated, and maintained on an ongoing basis?

Do you facilitate ongoing educational opportunities to maintain and improve the clinical competency of your staff?

PERFORMANCE MANAGEMENT & IMPROVEMENT	YES	NO

Does your organization have an organized, comprehensive plan for performance improvement based on collecting and analyzing data?

Do you use input from the individuals you serve in your performance improvement process?

CARE, TREATMENT OR SERVICES	YES	NO

Does your organization evaluate, assess, and/or screen individuals served?

Is this data used to create a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served?

If providing foster care, does your agency use screening and assessment data to determine needed services and placement to match a competent foster or respite home to an individual?

Do you identify individuals who may have experienced trauma, abuse, neglect, or exploitation?

Are your plans for care, treatment and/or services based on the tenets of trauma informed care, recovery and resiliency?

Does the plan for care, treatment, and services address the family's involvement?

Does your organization use a standardized tool to assess the outcomes of care, treatment, and services provided to the individual served?

Are the rights of the individual served respected in a manner that supports their dignity? Does this include cultural and personal values, beliefs, and preferences?

Appendix F

Provider Survey 1

Please share your understanding of Measurement-Based Care (MBC) tools, such as the PHQ-9 and GAD-7

	Disagree	Neutral
I have a strong understanding of MBC tools	○	○
I use MBC tools regularly in practice	○	○
I feel these tools help my practice	○	○

Please share your understanding of Accreditation through The Joint Commission

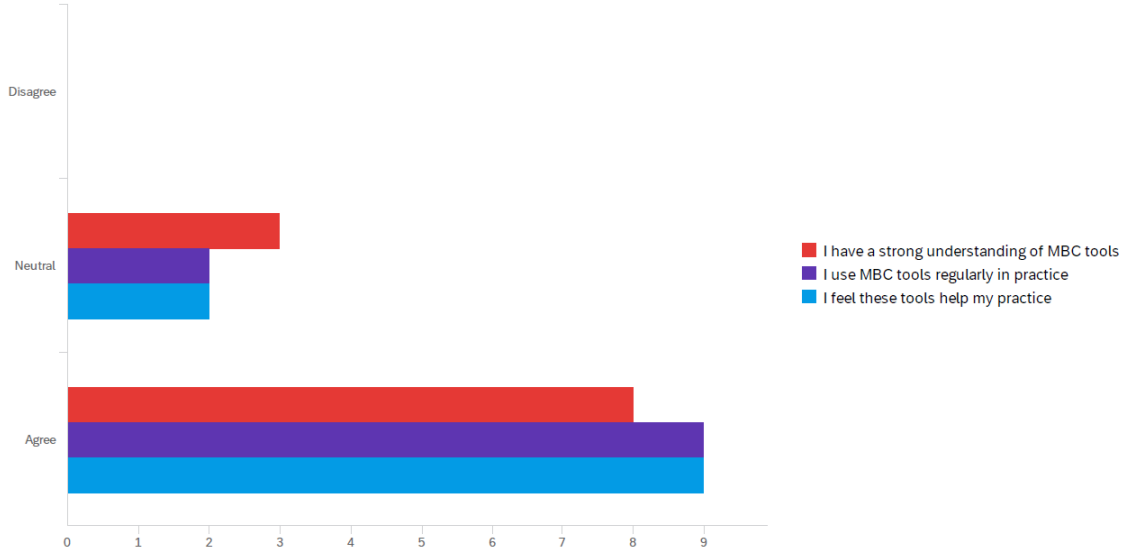
	Disagree	Neutral
I understand why accreditation is beneficial to the OPO and my practice	○	○
I understand how accreditation is beneficial to our patients	○	○
I would like the OPO to explore accreditation	○	○

What information would you like regarding MBC tools and the connection between MBC adoption and accreditation through the Joint Commission?

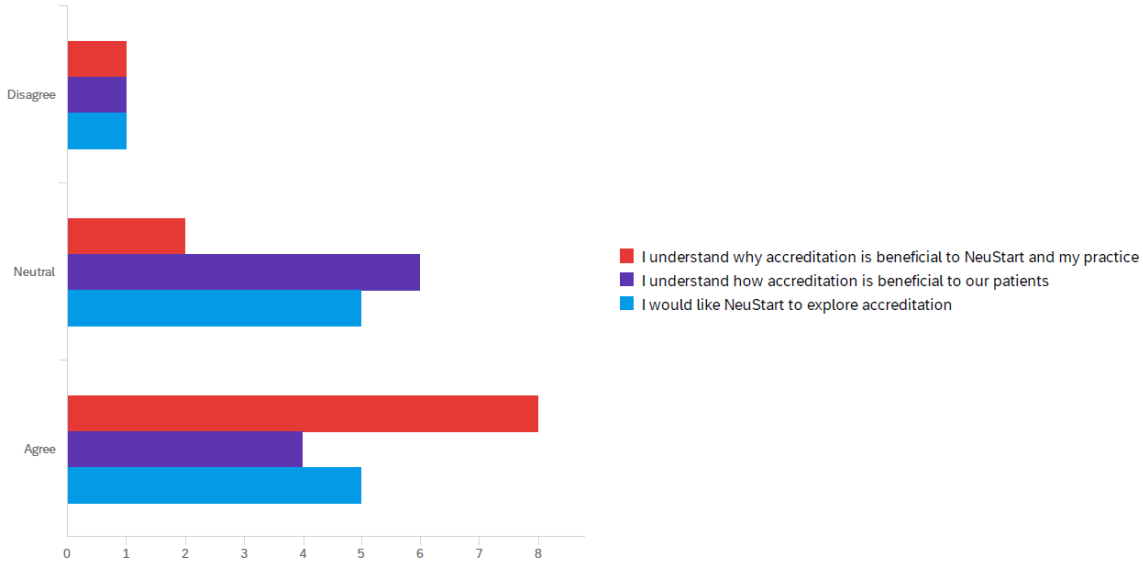
Appendix G

Provider Survey 1 Results

Q1 - Please share your understanding of Measurement-Based Care (MBC) tools, such as the PHQ-9 and GAD-7



Q2 - Please share your understanding of Accreditation through The Joint Commission

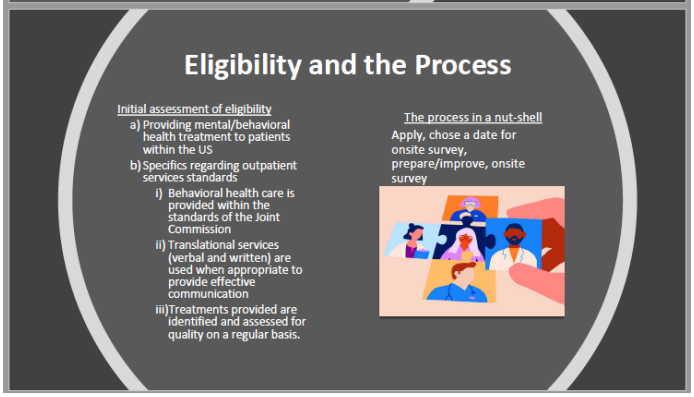


Q3 - What information would you like regarding MBC tools and the connection between MBC adoption and accreditation through the Joint Commission?

What information would you like regarding MBC tools and the connection betw...
What are the benefits of being accredited by the Joint Commission
I wasn't' aware of a connection between JCO and MBC, so would like to understand more about that.
Does the Joint Commission have a list of the accepted/accredited MBC tools?
I have a very poor understanding of how Joint Commission works, the rationale for Joint Commission, and regulations they ensure are in place. I understand they are more of a systems/organization that works with hospitals and the like, so I'm unsure how Joint Commission is beneficial to NeuStart at this level in the clinic.

Appendix H

Provider Presentation PowerPoint



Accreditation Process

1

Apply for accreditation

- Online process with individual Joint Commission Account Executive assigned to support progress and success
- Extranet site created to follow progress and open communication
- Pay deposit and submit form

2

Choose a month for on-site survey

- Can be up to 12 months from the date you apply

3

Prepare and improve

- Based on preliminary assessments, identify areas to improve across the organization and make necessary changes

4

Day of survey

- Clinically trained Joint Commission evaluators come to the site(s) to assess compliance with standards or offer further education for areas to improve
- Preliminary accreditation report will be provided at the end of the day

What to expect after

Celebration!

Share the accomplishment with the community and payors

References

- The Joint Commission Behavioral Health Care and Human Services Accreditation retrieved on August 8th, 2022 from https://www.jointcommission.org/accreditation-and-certification/health-care-settings/behavioral-health-care/

Appendix I

Provider Survey 2

How do you use measurement-based care (MBC) tools (such as the PHQ9, GAD7, ASRS or YBOC) in your practice and/or to guide treatment?

Do you use SMART Goals in your treatment plans? (S: Specific, M: Measurable, A: Achievable, R: Realistic, T: Time bound)

- ○ No
- ○ Yes

Do you incorporate MBC into SMART goals within your treatment plans?

- ○ No
- ○ Yes

Why is MBC important to your practice?

Please share your understanding of Accreditation through The Joint Commission (TJC)

	Disagree	Neutral	Agree
I understand why accreditation is beneficial to the organization and my practice	○	○	○
I understand how accreditation is beneficial to our patients	○	○	○
I would like the organization to explore accreditation	○	○	○

I am willing to adapt my current practice within the organization to meet TJC accreditation standards.

- ○ Disagree
- ○ Neutral
- ○ Agree

Please share additional questions for the leadership team or other information you would like to know.

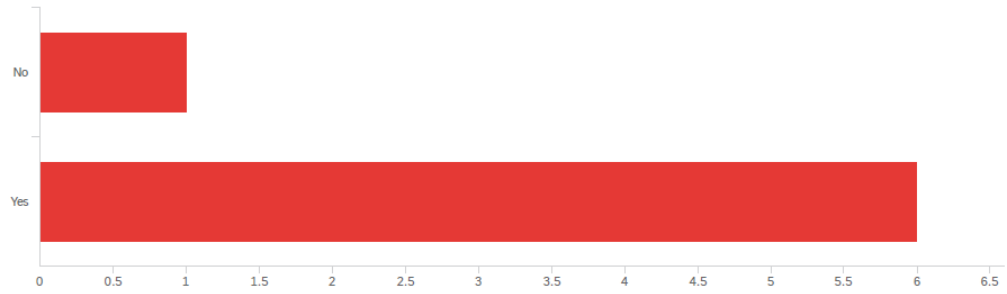
Appendix J

Provider Survey 2 Results

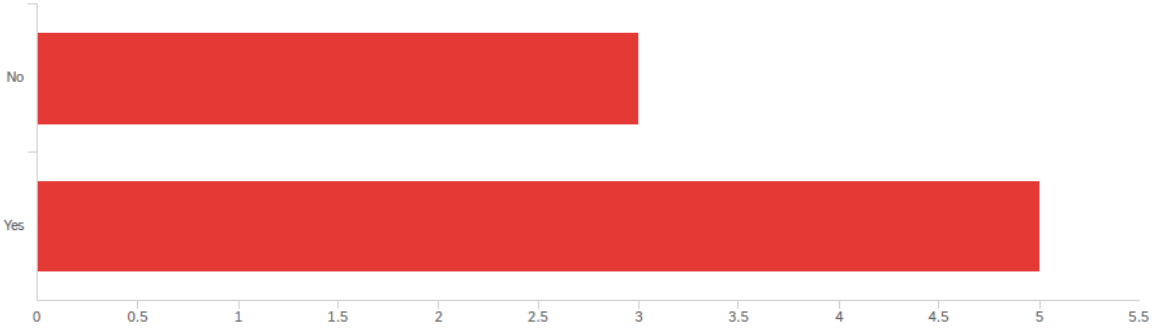
Q1 - How do you use measurement-based care (MBC) tools (such as the PHQ9, GAD7, ASRS or YBOC) in your practice and/or to guide treatment?

How do you use measurement-based care (MBC) tools (such as the PHQ9, GAD7,...
To help guide initial diagnosis and then to track / eval progress throughout treatment.
I use the PHQ-9 and GAD-7 every appointment as this is a procedure within our agency. I utilize other diagnostic specific screening tools as clinically indicated. The tools are helpful in making collaborative decisions with my patients to empower them to have quantitative data when making medication or non-pharmacological decisions for their case. Specifically for TMS, folks with a certain PHQ/GAD scores qualify for insurance coverage. Quantitative data can illuminate the qualitative in session and unveil issues/concerns/symptoms that may not arise in a psychiatric interview alone
I use PHQ-9 and GAD-7 prior to each appointment. I utilize the information/scores to ask about specific symptoms.
I use these regularly as collateral data of patient symptoms/status, sometimes I use them for specific inquiry into symptoms when reviewing during an appointment. We also use them heavily in relation to our TMS program for insurance purposes (PA's) and monitoring patient progress and outcomes.
To track treatment progress, and to supplement the interview to narrow down dx.
daily with each patient session
To have an objective measurement tool
To qualify patients for TMS services

Q7 - Do you use SMART Goals in your treatment plans? (S: Specific, M: Measurable, A: Achievable, R: Realistic, T: Time bound)



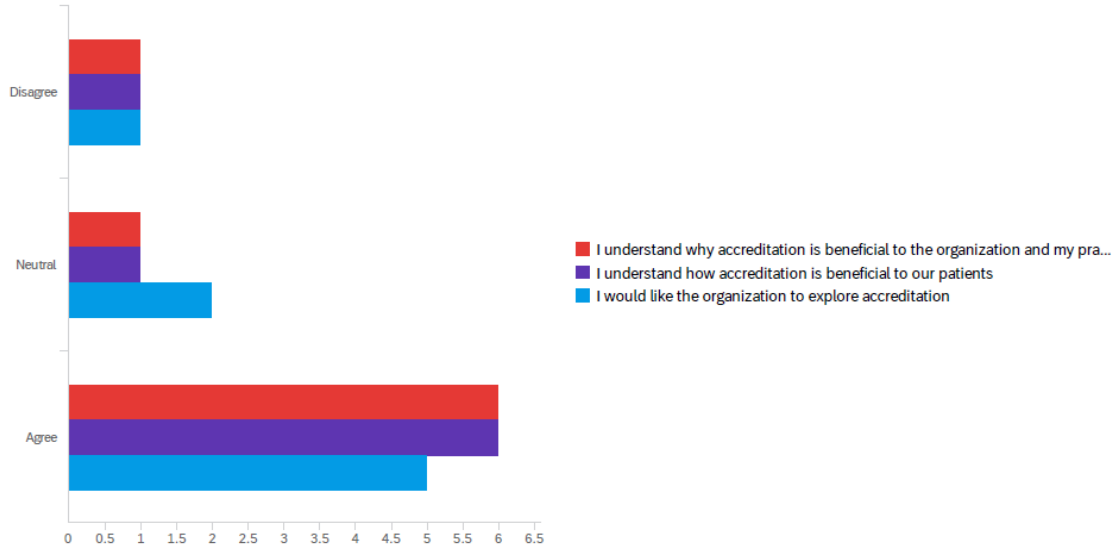
Q2 - Do you incorporate MBC into SMART goals within your treatment plans?



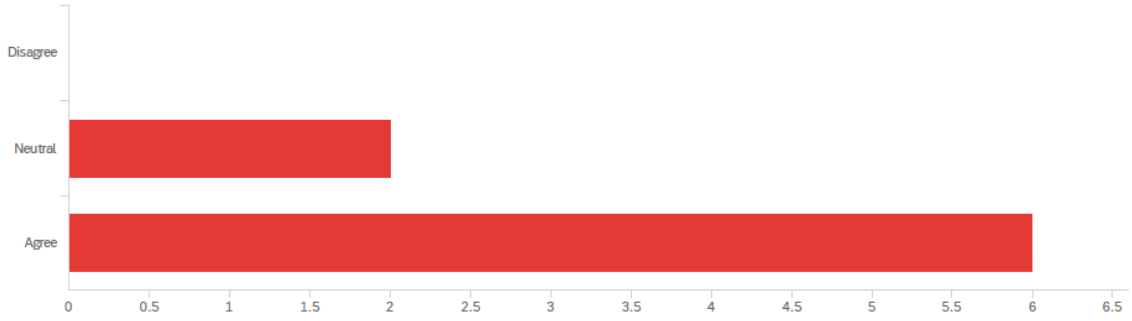
Q3 - Why is MBC important to your practice?

Why is MBC important to your practice?
Helps track progress and insurers require those for PA approvals of TMS or other higher level services.
It is in line with evidence-based practice and provides scientific data for treatment planning, safety planning, etc.
Although I don't base any care decisions on results of PHQ/GAD, it can be a helpful cue for questions. The scores can help to provide an objective measure of improvement/decline.
largely for the reasons noted in question 1; they help identify if patient is getting better or worse (especially if they are not particularly skilled at communicating their distress/symptoms/have poor insight). Also important for supporting additional treatment steps when insurance requires for PA's.
It helps track pt progress more objectively.
It helps to show the patient their journey to mental wellness, and helps me to understand the overall picture of their struggles.
They provide objective measurements over time for patient status
They are recommended by Practice Guidelines

Q4 - Please share your understanding of Accreditation through The Joint Commission (TJC)



Q5 - I am willing to adapt my current practice within the organization to meet TJC accreditation standards.



Q6 - Please share additional questions for the leadership team or other information you would like to know.

Please share additional questions for the leadership team or other informat...
Would we need to have a quality department? How do we keep track and report our findings for improvement?
Can we get in trouble if we do not use measurement based care within our own practice?

Appendix K

Plan-Do-Study-Act Cycles

June 2022: Stakeholder meetings to discuss project and OPO needs and preferences.

Cycle 1 Jun-Aug 2022

P: Identify areas for improvement within the organization based on MBC implementation or adoption.

D: Explore and report the current adoption rate for MBC according to IntakeQ

S: Reports are not efficient nor accurate. Communication barriers due to structural and leadership changes delayed results.

A: Cross reference IntakeQ reports with EHR to gather approximate adoption rate.

Cycle 2 Sept-Oct 2022

P: Meet with new Director to introduce project.

D: Identify accreditation steps and share with stakeholders.

S: Review MBC adoption rates, explore potential questions from providers and ways to overcome resistance to change

A: Contact TJC for accreditation process. Share survey with OPO providers to gather information and potential barriers to adoption and accreditation.

Cycle 3 Oct-Dec 2022

P: Work with Director to identify improved reporting potentials

D: Director provided billing reports that show when MBC codes were used by providers

S: Cross reference billing reports with EHR and IntakeQ reports

A: Request additional reporting abilities through the EHR. Request meeting with TJC Executive Assistant appointed to OPO. Present survey results at Dept Meeting.

Cycle 4 Jan 2023

P: Project wrap up. Identify additional needs of OPO for accreditation

D: Review presentation, share post survey with providers. Continue to reach out to EA to garner information regarding accreditation

S: Communication and scheduling barriers impeded progress with TJC. Providers need additional information from leadership regarding accreditation planning and impact. Specific policy needed to outline organizational culture and expectations regarding MBC tools in treatment

A: Continue with accreditation process