Behavioral Health Screening, Assessment, and Outcomes Tools: State and National Research Findings

Purpose

On October 1st, 2016, publicly funded organizations in Michigan serving individuals with a serious mental illness will be required to use the LOCUS as a level of care determination tool. To prepare for the implications of this change, and in order to better understand the current landscape related to the use of standardized and validated screening, assessment, and outcomes tools in public behavioral health systems, TBD Solutions LLC gathered information from Pre-Paid Inpatient Health Plans and Community Mental Health Services Programs (CMHSPs) in Michigan, from all 50 states, and from national experts on measurement-based care.

Scope

TBD Solutions queried all 46 CMHSPs in Michigan and all 50 states regarding the screening, assessment, and outcomes tools used in public behavioral health services. CMHSPs and states were asked about standardized tools used in screening or level of care determination for individuals with the following conditions: serious mental illness (SMI), substance use disorder (SUD), intellectual development disorder (IDD), children with serious emotional disturbance (SED), and children with Autism spectrum disorders (ASD). As of August 2016, all CMHSPs in Michigan, and all states in the US were contacted; all 46 CMHSPs responded to the questions, and all 50 states responded with information about their screening/assessment tools practices.

Practitioners and researchers with expertise in measurement-based care tools were interviewed, most of whom were involved in the Kennedy Forum Focus Group on measurement-based care.[1]

[1] Efforts from the Kennedy Forum Focus Group resulted in a report entitled *Fixing Behavioral Health Care in America: A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services*, published in 2015. A supplement to this report was released in 2016 that identified a set of rating scales for core outcome measures.

Method

In Michigan, clinical directors and access center supervisors at each CMHSP and PIHP were asked about the screening, assessment, and outcomes tools used at the point of access to care or level of care determination.

Behavioral health department directors were contacted in each state and given the same inquiry based on the screening, assessment, and outcomes tools reported by the Michigan CMHSPs, and were also questioned about any additional tools mandated or commonly in use in those states. In addition, respondents were asked follow-up questions about any changes that have been made recently in the use of standardized tools, reasons for the changes, whether state-wide data is collected from the identified tools, whether that data is shared publicly, and any other uses for the data collected.

Six researchers and practitioners from the Kennedy Forum Focus Group were interviewed to better understand the challenges of measurement-based care implementation and sustainability, as well as the keys to successful measurement based care.

Context

It must be noted that Michigan, along with many other states, remains strongly rooted and committed to the values and principles of person-centered planning. At the same time, Michigan's Behavioral Health and Developmental Disabilities Administration now requires the use of some standardized tools across all of its service populations for programs providing specialty behavioral health services.

Standardized tools for individuals served by public behavioral health systems are typically used for four main purposes:

- *Level of Care*: to assist in determining a level of care, set of services or supports, or programs that an individual may be eligible for. These tools are typically used for initial eligibility determinations, to assist in

establishing medical necessity, and as a guideline for the type of care or supports an individual requires.

- *Functional Assessment*: to assess the functional ability in key life domains and/or assist in determining the specific support needs of an individual. These tools are typically used to help formulate treatment goals and/or determine need for specific services and/or supports. These tools may also assist in differentiating diagnoses and/or clarifying eligibility based on functional status.
- *Outcomes*: to determine the effectiveness or impact of services/support or treatment- at an individual or population level
- *Symptom Severity/Risk*: to assess the severity of symptoms or impairment due to a behavioral health condition or the level of risk an individual presents to themselves or others.

Standardized tools may be effectively used at a variety of levels within an organization or system:

- At the individual level, to screen for various conditions, as a factor in medical necessity and eligibility determination, understanding service and support needs, and informing treatment planning
- At the program level, to design services that meet the needs of people seeking services; for program evaluation and outcomes management, and for utilization management
- At the population/plan/state level, to understand the needs, conditions, and severity of illness of persons in services; for planning and evaluation

Findings related to tools currently in use

Detailed results from the statewide and national inquiries can be found in the accompanying matrix.

Based on feedback from respondents, there does not appear to be a unanimous standardized tool for any behavioral health subpopulation. Based on state reports on the types of tools required/ approved, there is also no

clear pattern of the types of tools used from state to state (i.e. level of care, functional assessment, outcomes, or symptom severity/risk).

The table below shows the most frequently utilized tools*, organized by typical function:

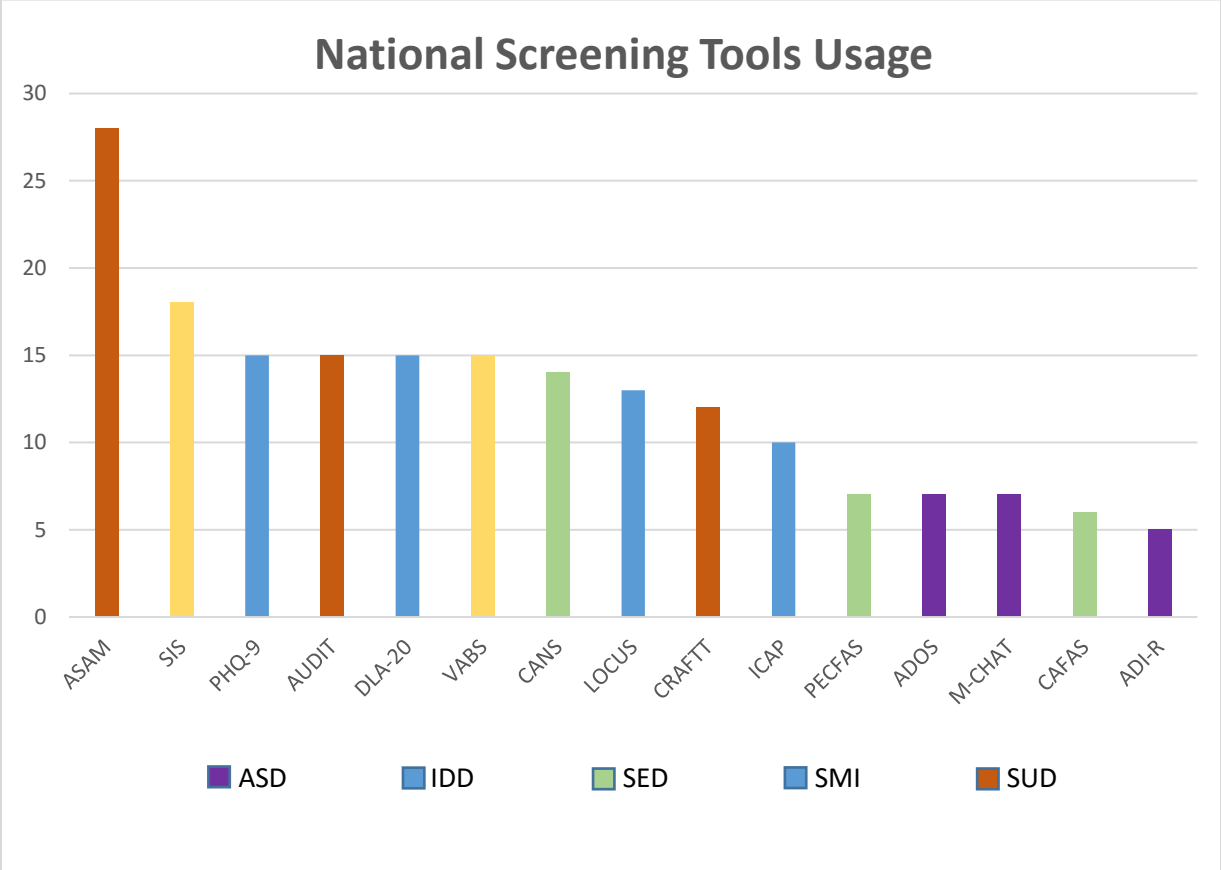
		Level of Care	Functional Assessment	Outcomes	Symptom Severity/Risk
SMI	LOCUS	X			X
	DLA		X	X	
	PHQ-9				X
	ANSA	X	X	X	X
SED	CAFAS	X	X	X	
	CANS	X	X	X	X
	PECFAS	X		X	
	DECA		X		
SUD	ASAM	X			
	CRAFTT				X
	CAGE-AID				X
	AUDIT				X
	UNCOPE				X
	GAIN-SS	X			X
	CIWA				X
IDD	SIS	X	X		
	ICAP	X	X		
	WAISS		X		
	SIB-R		X		
	ABAS-II		X		
	Vineland		X		
ASD	ADOS		X		
	M-CHAT		X		
	SCQ		X		X
	DAS		X		
	ADI-R		X		X

**Frequent utilization = 10 or more CMHSPs or 8 or more states report utilizing a tool*

The most frequently used tools for each subpopulation are listed below:

Population	SMI	SUD	IDD	SED	ASD
Screening Tool	PHQ-9	ASAM	SIS	CANS	M-CHAT
# of States	15	27	18	14	7

The tools used by the most number of states are listed below:



Some states, including Minnesota, Ohio, New Mexico, and South Dakota, do not require specific screening tools but require certain screening elements that providers can meet by utilizing the tool of their choice. Wisconsin, Idaho, and Colorado require the use of validated tools but do not endorse any specific tools. Other states like Nevada and Delaware have worked with the creators of validated tools to construct adapted versions that meet the needs of their state.[2]

[2] Nevada uses an adapted version of the CANS, called the Nevada CANS, and Delaware uses their own authorized version of the ASAM, called the ASAM-DE.

Some states cite lack of administrative capacity for sufficient monitoring as a reason for not using or discontinuing the use of a tool. In 2014, the CAFAS was removed from use in New Mexico, as it was difficult to monitor the use of the tool. Hawaii reports that the use of proprietary tools are cost-prohibitive.

States like Michigan and Wyoming authorize a robust array of screening and assessment tools across all subpopulations, while other states endorse a number of tools for a specific subpopulation.

The required use of a screening, assessment, or outcomes tool can come from one of three sources: the state, the managed care organization(s) (MCO), or the providers. It is difficult to assess the frequency of use of screening tools at the provider level if their use and reporting is not mandated by the state or an MCO.

CMHSPs and states receiving grant money for implementing an evidence-based practice or a promising integrated care initiative reported using additional screening, assessment, and outcomes tools when requiring a valid pre- and post-test measure.

Screening/ Assessment Tool	Number of CMHSPs Reporting Use of Tool*
CAFAS	45
SIS	44
PECFAS	43
ADOS	43
ASAM[3]	42
M-CHAT	42
DECA	41
ADI-R	38
VABS	36
DAS	13
**Out of 46 CMHSPs total*	

In Michigan, ten screening/assessment tools are currently required, with an 11th tool (LOCUS) to be added in October 2016. Some CMHSPs and states referenced the use of standardized tools for trauma screenings, such as the NorthShore UCLA, PCL-C, CPSS, and TSCYC. Other states reported using home-grown or locally-developed tools.

[3] ASAM is a set of criteria, not a formalized tool.

Findings on How Information from Tools is Used

Of the states and CMHSPs that participated in the survey of screening and assessment tools used, very few responded that they are using the data from the use of the standardized tools to influence any decision making, such as determining the effectiveness of treatment interventions, evaluating opportunities to improve care, incentivizing performance or outcomes, or using data to inform new program development. Many states also reported creating their own homegrown assessment tools. While these tools may meet their specific needs, they are also not being used to collect data with transparency to drive decision-making or improve clinical care.

Interviews with leaders in the research and practice of measurement-based care validated many of the experiences reported by state leaders. Providers and payers are inundated with reporting requirements, but most reporting is focused on compliance through process and structure measures with inadequate emphasis on quality or value through outcomes measures. The bevy of screening, assessment, and outcomes tools to choose from only further complicates the process. Through this research, states reported using a combined 106 screening and assessment tools for individuals with SMI, SED, addictions, IDD, ASD, and trauma. While all tools serve at least one function (Level of Care Determination, Functional Assessment, Outcomes Measure, or Symptom/Severity/Risk), few serve multiple functions (CAFAS and ANSA/CANS are a few examples), often leaving providers to use a number of tools to meet their clinical needs.

During the interviews about standardized tools, CMHSPs and states did not mention the use of tools for program development, strategy, needs assessment, or actuarial analysis. Virtually none of the states reporting the use of standardized tools stated that the collected data was used for anything besides eligibility determination. This supports the notion that the use of data in behavioral health services is rare compared to its primary care counterparts.

Considerations

Many states not currently endorsing any screening or assessment tools have acknowledged the merits of using tools. Several states, including Florida, Maryland, Montana, and Oklahoma, are considering the use of additional tools in the future with no clear timeline. Michigan will be requiring the LOCUS beginning 10/1/16, which will be the only standardized tool endorsed by the state for individuals with Serious Mental Illness (SMI). While this tool serves one common function of standardized tools (level of care determination), it does not necessarily provide useful information to inform person-centered planning, functional assessment or outcomes measurement.

It is unclear how data collected from the required screening, assessment, and outcomes tools is being used currently at the state or plan levels, but there are many opportunities for this data to drive treatment decisions and assure clients are receiving the appropriate levels of care. Based on survey results and interviews, there appears to be a lack of clear understanding or consistent guidance on how various standardized tools can most effectively be used across programs in Michigan or nationally.

Only one of the ten tools required for use by the state of Michigan is a self-report measure (ADI-R). All other tools are clinician-completed tools. The importance of client-reported measurement tools cannot be understated, as mentioned in the Kennedy Forum paper. Self-report measures empower individuals to take care of their mental health and actively contribute to treatment decisions. Symptom rating scales reinforce the importance of the provider to understand the client's experience and assure treatment efficacy. The primary health care and pharmaceutical industries rely heavily on these measures, and behavioral health organizations would stand to benefit from integrating them into their practices.

Recommendations

While screening and assessment tools are used by various providers across the country, there is no broad consensus of the use of tools for any

population or condition. However, this does not mean that the adoption of standardized tools would not be helpful; in fact, any service or system dedicated to treatment fidelity uses an outcomes measure, as is seen with most grants and pilot projects.

Despite the lack of consistency or national consensus on which tools should be used, there is certainly a growing trend and research to support measurement based care and its potential to improve the quality and effectiveness of behavioral health services. This trend is expected to grow as more payers move to performance-based or outcomes-based payment models, holding providers to a higher level of accountability in treatment[4]. Governing and accreditation bodies like CMS and The Joint Commission are moving towards the use of measurement-based care systems, which will increase provider urgency for the use of screening tools and outcomes measures.

There are four keys to getting buy-in from providers to use a screening, assessment, or outcomes tool:

1. *Pay providers to use the tool.* Many "good ideas" in health care are also supported with financial incentives to assure their adherence. Payers can create a CPT code for completing an assessment or outcomes measure.
2. *Ensure the tool can be completed quickly enough to avoid patient burnout*. Self-report measures are a gold mine of information in the behavioral health field; assuring client engagement through reasonable requests for information is an important step to gathering this information.
3. *Create an efficient workflow for the tool*. For outcomes measures, administer the tool online prior to an appointment through a PC, tablet, or with the client's own smartphone, so that the results can be available to the providers to use and discuss.

[4] Boswell, Kraus, Miller, and Lambert. "Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions." *Psychotherapy Research,* 2013. p.11

4. *Integrate data from the tools into the electronic health record and as a routine part of clinical practice*. When care teams have objective self-report data to support clinical observations, providers can effectively partner with clients to achieve the ultimate goal of reducing symptoms and improving individuals' quality of life. Research has consistently shown that providing feedback to therapists regarding patient outcomes significantly increased treatment progress and maximized effectiveness, yielding improved patient care and reallocation of therapists' time to cases in need of special attention[5].

Conclusion

There are appears to be no standard protocol for the selection, application, or use of data from screening and assessment tools nationally. Michigan stands as one of the few states to have a diverse set of required screening tools, although Michigan's lack of clear documented uses of the data collected is in line with most other states. Additional exploration should be considered to identify state or plan level practices for how such standardized data could be leveraged to achieve the aim of improved care and outcomes for individuals served.

[5] http://www.scottdmiller.com/wp-content/uploads/2014/06/Implementing-routine-outcome-monitoring-in-clinical-practice-Benefits-challenges-and-solutions-Psychotherapy-Research_Boswell-Kraus-Mi.pdf

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Southwest Michigan Behavioral Health is the public behavioral health plan for people with mental illness, developmental disability, and substance use disorders in Barry, Branch, Berrien, Cass, Kalamazoo, Calhoun, St. Joseph, and Van Buren counties in Michigan.

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