Lisa Dixon (00:07):

Welcome to our podcast, Psychiatric Services from Pages to Practice. In this podcast, we highlight new research or columns published this month in the journal Psychiatric Services. I'm Lisa Dixon, editor of Psychiatric Services, and I'm here with podcast editor and my co-host Josh Berezin. Hi, Josh.

Josh Berezin (00:25):

Hi, Lisa.

Lisa Dixon (00:26):

Today, we are going to be talking about a really interesting article on measurement-based care.

Josh Berezin (00:32):

We're very fortunate to have Breanna Keepers, who is a second year psychiatrist resident at the Columbia Adult Psychiatrist Residency, along with Dr. Ish Bhalla, who is a medical director at Blue Cross Blue Shield North Carolina, here to talk with us about their paper, Measuring Measurement: A Survey of Behavioral Health Providers on Use and Barriers to Use of Measurement-Based Care. So, Breanna, Ish, welcome. Thanks so much for joining us.

Breanna Keepers (00:55):

Thanks. Excited to be here.

Ish Bhalla (00:56):

Thanks for having us.

Josh Berezin (00:50)

So, Breanna, maybe you could start us off by just letting us know a little bit how you got interested in this paper. And, I'm particularly interested as a psychiatry resident how you got interested in this line of research and questioning.

Breanna Keepers (01:12):

Yeah, definitely. So I actually got interested in this project as an MD/MBA student at UNC. I had the opportunity to do an internship at Blue Cross Blue Shield, which is where I met Ish. And, he asked me if I wanted to help create a survey to better understand what providers think about measurement-based care, to which I replied, "Measurement-based what?"

(01:41):

I had finished my third year of medical school. And, we use measures all the time. We use hemoglobin A1C to better understand how patients are doing with diabetes. When patients have hypertension, we're tracking their blood pressure and adjusting treatment. But, I had never really thought about how we use measures in the behavioral health context. So, when Ish talked with me about measurement-based care and I went to the computer and looked it up, it made a lot of sense, where using measures or patient-reported symptom rating scales to track how a patient's doing and help guide care. It really seemed like a win-win that the patient is able to assess how they're progressing. The provider or trainee is able to see, "How's my treatment working? Is the patient getting better? What are things we can continue to work on?" And, from the payer perspective, they know what they're paying for. So, I was

excited to be a part of this study and really help create the survey with Ish, and was really interested in if this is evidence-based care, why aren't providers using it?

Josh Berezin (02:47):

So, Ish you roped Brianna in and now she is a measurement... Well, we'll find out. We'll find how [inaudible 00:02:53] she is as the discussion goes on. But how did you get interested in this? And, I assume it has something to do with your role at Blue Cross.

Ish Bhalla (03:01):

Yeah, thanks Josh. My interest really came because I've always really been interested in how we can incentivize and change behavior of providers really with different incentives. So with financial incentives, with other incentives to get providers to change behavior, to do things that we want. And that's one of the main reasons I really am excited to work at Blue Cross and Blue Shield of North Carolina is because we have a really strong interest in getting behavior to change for our patients and our members to get people the right care when they need it, high quality care, high value care, so that it's affordable. And, one of the things that we've seen as we're designing value-based models in mental health is that you need an outcome. And, as Bre mentioned, it's easy to choose something like A1C because you can really put your foot down and say, the A1C went up or down and the patient got better.

(03:59):

But for mental health it's been much more subjective traditionally to look at what measurement is. And, really unfortunately, or for what it's worth, the best thing that we have at this point to my knowledge is asking patients essentially, "How are you feeling today? And how have you been feeling over the past two weeks?" And then, measuring the numbers that they say on a scale, and then seeing over time whether they got better or worse. And, like Bre said, it's interesting because I was actually trained in an environment where we had to just check off that we learned measurement-based care, but it wasn't really emphasized to a strong degree in my psychotherapy training outside of very specific types of therapy. But when you compare that to the literature, you'll see that a lot of studies really do focus on measurement-based care in clinical practice, not just for the research setting. But really, people should be using measurement-based care to decide what to do next with medications and the different types of treatment.

(05:00):

And so, that dichotomy has been really interesting to me. And then also from the quality perspective, if we're going to be paying for quality, we have to define that. And, when we started out with our value-based payment program in North Carolina, we saw that a lot of providers are just not using measurement-based care. So this study was really to figure out why that is and to what extent eventually we'll talk about hopefully today what we found and also to what extent payment really matters in changing these provider's behavior.

Josh Berezin (05:30):

For the purposes of this study, as we get into it, when we're talking about measurement, should I be thinking PHQ-9? Is that the thing that I should have in my mind that you're asking about?

Breanna Keepers (05:42):

Yes. PHQ-9, GAD-7, when Ish and I created the survey, we took some time to think about how do we define measurement-based care. And, we looked at the literature, we also did some cognitive testing

with providers. We met with providers, went through the survey, and a lot of providers had a similar reaction to my response, which was, "What is measurement-based care? What is this?" So we defined it in the survey as a systematic administration of symptom rating scales to assist the provider and patient in noting progress as well as drive clinical decision making at the level of the individual patient. And we actually used PHQ-9 as the example, think of PHQ-9 for depression.

Josh Berezin (06:27):

Got it.

Lisa Dixon (06:27):

So I have to jump in here. I want to introduce something into the conversation, not to derail the conversation, but to make sure that we think about the participant or the care recipient, the consumer perspective on the notion of measurement-based care and what we're measuring, because I can hear voices that my wonder, where is the patient's input into what matters, to what we should be measuring and what matters to them? And I think, I mean, as we will I'm sure discuss, there's certainly accountability, there's lots of good things about measurement-based care that are very important, but I want us also to be thinking about this process from the perspective of different stakeholders.

Ish Bhalla (07:21):

Yeah, I'm so glad you brought that up. And, the way that I have thought about that is that there's many measures out there. There's many different patient reported outcomes out there that we, I think, clinically try to match up with what the patient is coming in as their chief complaint. So simply put, if someone comes in with depressive symptoms, we would give them something like a PHQ-9 and if they had anxiety symptoms, we would hand them a GAD-7 to give us symptomatic feedback. And when you were talking, I was thinking about how not all patients fit into those categories neatly and what if they have two things or three things or five things going on with substance use disorders and different disease pathology that we're treating? Do we give them all the scales or do we just give them one? And that question I think has really been difficult to make sure that we're asking the patients the right questions for what matters to them.

(08:13):

And usually, at least in my clinical experience and understanding, we would start with what they are coming in with a complaint about and trying to match that. But it doesn't always happen. And I think to me, that's actually one of my barriers that I've seen in terms of making sure that we're listening to the patient and not giving them something that is going to help me and not help them. And that difference has been something that makes me question a lot about what we're measuring in measurement-based care.

Breanna Keepers (08:44):

Completely agree. And, you mentioned we need to make sure that we're listening to the patients, when we're a clinician, the patient's coming in, we need to make sure that we're taking time to listen to what's most important to the patient. I think, this leads nicely into some of our findings, where we'll get to discussing them more, but I wonder if we're taking enough time to listen to the providers too and listen to what's important to them.

Josh Berezin (09:08):

So, let's get into it a little bit. What was your study design? What were some of your key findings that you were just alluding to?

Breanna Keepers (09:16):

Ish and I worked on creating a survey and sending it out to real world providers. We really wanted to know what do providers out in the community who take insurance, what do they think about measurement-based care? So we developed a 30 question survey and sent it out to the Blue Cross Blue Shield listserv as well as to a number of professional organizations and asked them to distribute the survey and see how many responses we could get back. And we actually got 922 providers respond to the survey and fit the requirements, which was exciting to see. I think some of our main findings were that 426 of the 922 providers reported use of measurement-based care with at least half of their patients. So we can talk a little bit more about that finding.

(10:11):

But, just some of the other findings that stood out to me where that in addition to understanding self-reported use of measurement-based care, we wanted to understand what are the biggest barriers to using measurement-based care. We asked providers to look at 16 different statements and rank one strongly disagree, to five, strongly agree, and see what do they think about these different statements. The statements were used to assess four barriers, lack of knowledge and self-efficacy, data use concerns, administrative burden, and low perceived clinical utility. And, what we found was that when you ask providers, "What's the biggest barrier to measurement-based care? They said, "Data use concerns." They were concerned about how this data is going to be used to measure how they're doing clinically and are these measures going to be tied to reimbursement? But, when we looked at the barriers and how they were associated with decrease in use of measurement-based care, what we found was it was actually low perceived clinical utility that was associated with the largest decrease in use of measurement-based care.

Josh Berezin (11:31):

Just so I have this right, so people were saying that they were most concerned about data use, but when you looked at it, that concern didn't really correlate to them using less measurement-based care and what really made the difference in whether or not they were using measurement-based care was how clinically useful they thought the measurement was. Is that right?

Breanna Keepers (11:51):

Exactly.

Josh Berezin (11:52):

Okay. Was that what you were expecting when you were going into the study? Or, what were you thinking going in and what surprised you about some of the findings that you had?

Breanna Keepers (12:03):

I was surprised by a number of the findings. And I think, part of that was also my own bias coming in as a student and now progressing and learning more about what clinical care actually looks like. I think the first finding that was interesting to think about was the 46% of providers that report use of measurement-based care. And, we can look at this as glass half empty or half full, depending on the day. We could say, "Oh, wow! Half of providers are using measurement-based care. That's actually a lot

higher than what the literature expects." Right now, most studies have found that less than 20% of community providers use measurement-based care. So, 46% is pretty impressive. It's less than what [inaudible 00:12:51] at all the VA study that we looked at, less than what they found. They found that 58% of providers working at the VA use measurement-based care.

(13:00):

But, this was what we expected given the longstanding history of really the VA focusing on using measures, creating the infrastructure. I know they've had a lot of pushes towards quality and thinking about this topic. The 46%, we could say glass half full, we could also say glass half empty. This is evidence-based care and less than half of providers are using it. That was one of the findings that I found myself thinking about and talking with Ish and our team about.

Josh Berezin (13:31):

Ish, was there anything that stood out to you in, just in terms of the findings?

Ish Bhalla (13:35):

Yeah, I would say that I agree with what Bre said. In addition, the fact that the clinical utility was the main reason why people are not using measurement-based care, that was surprising to me because most journals that I've seen really tout the importance of measurement-based care for the most part. And, even evidence-based practices focus on measurement, like CBT, CPT, DBT, a lot of the different manualized cognitive therapies put emphasis on the clinical utility.

(14:11):

I was expecting providers to say more things like, they didn't trust what we would do with the data. This study came out from an insurance company that might have biased the providers to tell us what we wanted to hear, but that's not what we heard. We heard that they didn't think that it was as valuable as I would've thought that they would've said, and not because they weren't getting paid for it enough, or didn't have the time to do it, or were concerned with what we were doing with the data, or whether they were going to be judged by it. Really, the main driver was that it didn't have enough clinical utility. And that was surprising to me, Josh.

Josh Berezin (14:45):

So the clinical utility resonated with some of my experience. So, I've had a lot of people who I'm like, "Oh yeah, this PHQ-9 makes sense. It's helpful. It's helping me. It's helping them." And then, I also had a substantial cohort of people who... They came in and they were being like, "I'm in housing court and my partner just left me. I actually haven't slept more than three hours since I was 19. But now I'm feeling more down than usual." And I would give them PHQ-9 and they'd be like, "What am I doing here? What are we talking about?" And it would go up and down between this range. And, that's what I was thinking when I was thinking about clinical utility when it popped up into my head is, as you were talking about, people are complex and there's a lot going on. I was like, "Are we giving people the right measures?" This was a little bit beyond the scope of the paper, but that was what the clinical utility piece brought up in my mind.

Breanna Keepers (15:45):

And Josh, you're reminding me, one of the findings I forgot to mention, but I think really resonates with what you're saying. We found when talking with providers that a third of providers either strongly agree

or agree with the statement, "Current measures do not suit patients' needs and complexity." Which I think is what you're discussing.

Josh Berezin (16:08):

And that third number seemed to pop up a lot in your data. So it sounds like there's also a lot of heterogeneity in terms of provider attitudes towards measurement-based care, which I think presents its own challenges. Am I reading the paper right, Ish?

Ish Bhalla (16:27):

Yeah, that's right. Depending on lots of things, like the provider type, how long they've been in practice. And Lisa, to your point about, I was just looking up this statistic that a huge predictor of whether people are saying they use measurement-based care is whether they've received training and measurement-based care, which sounds obvious when you think about that, but a lot of people have not received training, and then they're not doing the care themselves. And that was important to us, because we were thinking about the implications of the study from a policy perspective and things that you can actually change, rather than things that are more static in nature. And, the fact that people, if they've not been trained, they're not doing it, means that we could address these things by issuing trainings either in a formal way with training programs through the ACGME or psychiatry residency programs and therapy training programs, et cetera. And so, that was an important look at the importance of training for us.

Lisa Dixon (17:25):

Yeah. It makes me think about another approach or building on the training idea, which would be to make some videos of patients talking about participating in measurement-based care, what it was like for them. And obviously, if you're trying to promote it, you'd probably want to get people who are positive, but just hearing from patients what it signaled to them, the role of that in their care, and get people to talk about it. And obviously, we want to teach people how to use it, and the numbers, and adding them up, and whether they're sub-scales, whatever. But I also think just hearing from individuals. And it actually makes me even think about wanting to do a qualitative, just to get that perspective anyways.

Ish Bhalla (18:16):

Yeah, I love that. And maybe that's something we can do next. And, you maybe also think about... Something I think a lot about is how providers make decisions. And, I know that some of my colleagues will say things like, "Oh, I don't want to try that medicine, because I haven't had a good experience with it." Or, "This medicine has been really good with this type of patient, so I really believe in using it for that specific individual." And, I think the same thing is true for measurement-based care, and that, I think as doctors, we try to match up what's worked in our own experience and what we hear from colleagues, what we hear from patients, and then match that up with what we read about in the literature and what it says in textbooks.

(19:03):

But at the end of the day, when we're sitting in front of a person that's suffering, we really try to use a breath of what we have to make the patient feel better. And, this is I think another important tool in our toolbox that's probably underused, it's not interventional in the sense that there's no side effects to it. You might lose some time, I suppose, but the signal I think that you give to the patient is something that I would be really interested to explore further. I think that's a really exciting idea.

Josh Berezin (19:30):

So Bre, was there anything else that stood out to you when you were looking at your findings?

Breanna Keepers (19:36):

Yeah, I think, one of the findings that stood out to me, we looked at provider and practice characteristics and how that was associated with use of measurement-based care. And we found, which is consistent with the current literature, that physicians were less likely to report use of measurement-based care. And, I think when we got the findings back from the study, this was initially shocking to me. And as I've progressed through and I'm now a second year psychiatry resident, I'm changing my perspective a little. I think, providing care is hard, and it's very different when you're in a clinical setting and trying to figure out what's important to the patient and what's clinically useful at that point in time.

Josh Berezin (20:17):

Well, I'm really fascinated by what it's like to be a... You're early on in your training and you've had this very specialized focused in measurement-based care, which I think gives you a pretty unique lens as you're moving through training, as you're watching how you're being trained, how your other colleagues, your supervisors do this sort of thing, how your other colleagues do it, and how you do it as well. So I'm just wondering if you've reflected on having that perspective, or it's hard to say that it's changed the way you've looked at things, because it seems like it's forming it as it's going along, but I don't know if you have any reflections about that process.

Breanna Keepers (21:02):

Yeah, it's something I've been thinking about over the past year or two, and I've actually talked with our program director, Melissa Arbuckle. She's a big proponent of measurement-based care and is working on integrating it into the third year outpatient experience for residents. I think, coming into residency I've been more aware of when measures are being used, how they're being used, for which patients do they seem to fit, for which patients do they seem harder to use. I think, I've developed humility too. I think, having that experience working at a payer system, or at a payer, and then coming into residency, I'm realizing when you're in, it's hard. I don't know if that makes sense. But, I think I'm still coming up with what my clinical practice will be like. And, to Lisa's earlier point, I think, the biggest thing is talking with the patient and figuring out what matters to them before we decide what we're going to measure.

Josh Berezin (22:10):

And, we've talked a little bit about some of the... Lisa's already added to your next steps. But Ish, what is the plan for this research program? What's next for you and your colleagues?

Ish Bhalla (22:26):

So, as part of the survey that Bre and I designed, we asked providers another question which we didn't report on yet. The first paper that we wrote really was focused on barriers and opportunities for using measurement-based care in the real world. Then the next obvious step that we're going to take is to share our findings on whether and how providers want to be paid for measurement-based care. So we've given them many other options about how they would like to be incentivized and what we think would actually make them do measurement-based care more, whether they want to get reimbursed for patients improving, or just doing the measurement, or if at all. And so, we've asked all these questions. And the teaser is that we have lots of surprises in the data that we've seen, depending on the provider

characteristics and whether they're of course doing measurement-based care or not really influences their thinking on whether they should be paid for it.

(23:20):

But to me, that question will be really exciting to explore, because a lot of other fields, you get paid based on your members' outcomes. We talk a lot about lawyers taking contingency fees, they'll only get paid if they win for their client, for example, they'll take a cut of the winnings. And in medicine we don't think that way because we have a more of a process oriented approach, where it's fee for service, where if you go see your doctor, you'll get billed the same amount whether they cure you or whether it doesn't work at all.

(23:50):

And actually there's an incentive for them to keep seeing you more often, because they'll get paid more if they see you more often. I don't think that's what doctors do, but that's where the financial incentive is. And to me, I'm having a lot of fun exploring how and whether behavioral health providers are ready to put our money where our mouth is, in terms of using the right evidence over time should make people better. And then, are we willing to put our livelihoods and our paycheck on that and to what extent are we, is it a small percentage? Is it a big percentage? And that's the question that we're willing to explore next.

Breanna Keepers (24:27):

As we've been talking, there's one other thing I want to add. I think, when we started this survey, it's important to remember we were at the very beginning of COVID. And, over the past two or three years, the way we deliver behavioral healthcare has transformed. I think the same could be true about measures. I'm coming off of a week of nights. And, was thinking the other day, "I should really start tracking my sleep." So, if you look at a PHQ-9, it's retrospective. It's, "Let's look over the past two weeks. Do you have trouble falling asleep? Staying asleep? Or sleeping too much?" And I turned to one of my younger co-residents and she said, "Oh yeah, I've been tracking my sleep too. I really need to get more REM sleep." And that's when I realized she has her watch and she has it all mapped out and she is looking at her different stages of sleep. And, it's really amazing how much data there is and how much we could track if we lean into technology. I think, some of my adolescent patients are really teaching me a lot about potential there.

Ish Bhalla (25:29):

And another thing I also would love to add, Josh, is about how this measurement-based care are part of our quality program is really just a small sliver of the entire way that we look at quality for mental health, at least in Blue Cross North Carolina. So, we have 12 other quality measures that are mostly process focused measures and maybe some structural measures of care, like access to care. How quickly can you get seen by a provider? Or, are you also testing medical issues in addition to the psychiatric issues that you're doing? And the one that gets the most attention is this measurement-based care outcome, because it's provocative to hold providers accountable for outcomes all over medicine, but particularly for mental health and psychiatry, for the reasons we talked about, it's the most subjective, at least on its face. I'm glad that we started out by including this as a measure and really incentivizing people to do it, and then measure it over time if they can actually move the needle on patients getting better.

(26:34):

But I just wanted to make sure that you were aware that this outcomes-based measure has really been watered down with lots of other ways that we look at quality. But when you and I think about referring a patient to a friend or if a colleague asks for a referral, we don't think about who can be seen first. Most of the time we think about, who's the right fit for this patient? Who's going to make them better over time? And that to me is really how we should be thinking about quality long-term and not just the auxiliary looks at quality that we look at, that are more easy to measure and less controversial.

Josh Berezin (27:09):

Well, thanks for both of those points. I think it just points to how big of a topic this is, right? It seems like, "Oh yeah, measurement. We measure something and then we've got an outcome." But it's a huge topic. It's very, very challenging when you look under the hood. And, I'm happy that you two are on it. And, I really like the paper. It's very clear. And, I think it's a good entree into some of these really, really thorny questions. We definitely encourage our listeners to take a deeper dive with the paper. And, I want to thank both of you for taking some time to come and talk with us and some of your work.

Breanna Keepers (27:45):

Lisa, Josh, I just want to thank you so much. It has been a true pleasure joining and being on this podcast. But, before we go, I just want to really thank our collaborators and our team, Caleb Easterly an MD/PHD played really a pivotal role in helping with the data and the statistics, Marisa Domino, Nora Dennis, and I really want to thank our collaborators at the professional organizations for really getting out this survey and helping us hear the provider's voice.

Lisa Dixon (28:14):

That's it for today. We invite you to visit our website, ps.psychiatryonline.org. To read the articles we discussed in this episode as well as other great research. We also welcome your feedback. Please email us at psjournal@psych.org. I'm Lisa Dixon.

Josh Berezin (28:31):

I'm Josh Berezin.

Lisa Dixon (28:32):

Thanks for listening. We'll talk to you next time.

Speaker 5 (28:36):

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