

Complying with Standard CTS.03.01.09 Behavioral Health Care Accreditation Program

On January 1, 2018, The Joint Commission modified Standard CTS.03.01.09 to require that outcomes of care, treatment, or services be monitored using a standardized instrument. Organizations use feedback derived through these standardized instruments to inform goals and objectives, monitor individual progress, and inform decisions related to individual plans for care, treatment, or services. Aggregate data from the tools may also be used for organizational performance improvement efforts and to evaluate outcomes of care, treatment, or services provided to the population(s) served.

Commonly referred to as “measurement-based care” or “routine outcome measurement,” using objective data to track the impact of care, treatment, or services has become a high-profile issue in the behavioral health care field. The Joint Commission believes that successful implementation of this standard will help accredited organizations simultaneously improve the quality of the care, treatment, or services they provide, and put them in a position to meet the growing demand from stakeholders to demonstrate the value of their services. Nearly twenty years of behavioral health care research has demonstrated the value of measurement-based care as a mechanism for improving the outcomes of care, treatment, or services.^{1,2,3,4,5} The findings are robust and extend across modalities, populations, and settings^{1,2} (for example, within populations such as individual psychotherapy,^{4,5} therapy with couples/families^{6,7} and groups,⁸ substance use treatment,⁴ eating disorder programs,⁹ pharmacological treatment,¹⁰ services for children and adolescents,^{11,12} and in settings as diverse as outdoor/wilderness facilities¹³ to large public behavioral health care settings¹⁴).

By introducing standardized data into the care, treatment or service process, measurement-based care provides the organization and individual practitioners with an objective source of information that enhances their ability to determine whether what they’re doing is having a positive and significant impact on the individual served.¹⁵ This practice, therefore, has been shown to be particularly beneficial as a means to prevent the failure of care, treatment, or services.^{1,2,16} There is also some tentative support for measurement-based care providing a direct benefit to the individual served as a means to quantify whether he or she is making progress over the course of care, treatment, or services.² When both the organization and the individual objectively see what is happening, it can inform shared decisions about whether to stay the course or make corrections. This leads to better outcomes, which in turn leads to higher quality care, treatment, or services. In short, the use of standardized outcome measures can help organizations to answer the question, how do we know that what we’re doing is working?

STANDARD CTS.03.01.09

**THE ORGANIZATION ASSESSES
THE OUTCOMES OF CARE,
TREATMENT, OR SERVICES
PROVIDED TO THE INDIVIDUAL
SERVED.**

**EP 1 – THE ORGANIZATION USES A
STANDARDIZED TOOL OR INSTRUMENT TO
MONITOR THE INDIVIDUAL’S PROGRESS IN
ACHIEVING HIS OR HER CARE, TREATMENT, OR
SERVICE GOALS.**

**EP 2 – THE ORGANIZATION GATHERS AND
ANALYZES THE DATA GENERATED THROUGH
STANDARDIZED MONITORING, AND THE
RESULTS ARE USED TO INFORM THE GOALS AND
OBJECTIVES OF THE INDIVIDUAL’S PLAN FOR
CARE, TREATMENT, OR SERVICES AS NEEDED.**

**EP 3 – THE ORGANIZATION EVALUATES THE
OUTCOMES OF CARE, TREATMENT, OR SERVICES
PROVIDED TO THE POPULATION(S) IT SERVES BY
AGGREGATING AND ANALYZING THE DATA
GATHERED THROUGH THE STANDARDIZED
MONITORING EFFORT.**

Choosing an Instrument

The choice of an instrument(s) belongs to the accredited organization; however, any instrument used must meet the criteria listed below for routine outcome measures:

- Well-established psychometric properties (i.e., reliability and validity)
 - Instruments that are appropriate will have been tested for their reliability (consistency as a measure) and validity (measuring what they are intending to measure). Results of this testing will likely be published, and organizations are encouraged to inquire about the instrument's psychometric properties as they weigh their options.
- Documented sensitivity to change (i.e., the ability to detect true/meaningful changes over time)
 - Instruments that include a “reliable change index” or similar construct can be used to distinguish normal or expected variation from changes that are statistically significant or meaningful. As one seeks to determine the impact of care, treatment, or services, it is critical to distinguish between changes that represent true improvement or deterioration versus typical variation that might be expected on a daily basis.
- Use as a repeated measure (i.e., can reliably detect change from administration to administration)
 - Instruments that can be used as routine outcome measures will be administered repeatedly. The *frequency of use* is an important consideration for organizations based upon the types and typical lengths of services they provide. The organization should select a tool or instrument that can be administered frequently enough to ensure that the care, treatment, or services the individual is receiving can be adjusted (when and if necessary).
- Established norms (i.e., the instrument can distinguish between populations that need or do not need services)
 - Depending upon the nature of the setting and population served, an individual's score on an instrument should provide an indication of his or her current state relative to a norm or benchmark (e.g., clinical/non-clinical, healthy/non-healthy functioning, typical/non-typical, etc.).

Organizational leaders must identify an instrument that meets their unique needs, budget, and technical requirements. Instruments should meet the needs of both staff and individuals served. It is also possible that the organization may already be using a tool/instrument that meets the requirements of the standard. It may be helpful to begin a search for an instrument by reviewing some already assembled lists of instruments and tools that are well suited for use as routine outcome measures. The Joint Commission maintains a list of measurement-based care tools at: <https://manual.jointcommission.org/BHCInstruments/WebHome>. Additional measurement-based care instrument lists can be found at:

- The Journal, Integrating Science and Practice provides a 45-page issue that summarizes 10 well-established and frequently used instruments (or suites of instruments).
<https://www.slideshare.net/scottdmiller/integrating-science-and-practice-mller-bargmann>
- The Kennedy Forum provides a list of dozens of instruments that are appropriate tools for measurement-based care categorized by type, setting, and other factors.
http://thekennedyforum-dot-org.s3.amazonaws.com/documents/MBC_supplement.pdf

As organizations consider options for instruments, it is important to draw a distinction between an *instrument/tool* and a *measurement system*. An instrument (or tool) is essentially a validated and standardized data collection form. In many cases, these forms can be administered with paper and pencil and scored manually. There are a number of

high-quality instruments available at no cost to the organization (some instruments are in the public domain, and some are proprietary and require a licensing agreement but are otherwise free to use).

In contrast, a “measurement system” generally refers to a vendor and/or a process for administering, scoring, and aggregating data that has been collected using a specific instrument. A measurement system vendor may utilize one or more instruments (or sometimes a related suite of instruments) and may offer options that include administering an instrument using tablets or smart phone apps, automated scoring, aggregation, and reporting. Many systems can even provide real-time feedback directly to practitioners. The costs vary widely by vendor and that must be considered by organizational leaders as they balance both cost and feasibility (i.e., staff time and effort spent administering, scoring, aggregating, and reporting data).

Using the Data

While selecting an instrument is an important (and easily verifiable) step towards implementing measurement-based care throughout an organization, this act alone is insufficient to comply with the standard. The standard requires that organizations use data from the instrument to track the progress of individuals served in order to inform care, treatment, or services. For many organizations and individual practitioners, this will require a major cultural shift in how they think about data and assess client progress. Organizations should be prepared, therefore, to address the implementation challenges that will inevitably arise. If staff are told they must use an instrument in order to fulfill a Joint Commission requirement, it is unlikely that implementation will be highly successful. Successfully implementing any change takes time and effort, and leadership needs to be committed to making the change.³ Specifically, leadership needs to clearly embrace the use of outcome measures and emphasize the advantages of using objective data throughout the care process for clients, staff, and the organization.

Assistance for identifying and overcoming challenges associated with making organizational change can be found at The Joint Commission’s Center for Transforming Healthcare under the *Education and Training* tab. (http://www.centerfortransforminghealthcare.org/high_reliability_health_care_training_programs.aspx). Also, see the Additional Resources section at the end of this article for helpful information.

Organizations should be prepared to work with clinical staff to address common implementation barriers. Boswell et al. (2013) recommend carefully considering and preparing to address both practical and philosophical challenges.³ Practical challenges include financial barriers, time constraints, meeting different needs for different stakeholders, and turnover at both the leadership and staff level. While philosophical challenges can be more difficult to address, they are just as important for successful implementation. They include: Addressing questions about the “value” of outcome assessment, directly addressing fears and mistrust (e.g., How will the data be used?), and ensuring that privacy and ethics concerns are acknowledged and satisfied. Boswell et al. suggest that organization leaders work closely with staff and clinicians to develop an implementation strategy that addresses barriers and challenges across three key dimensions: Adding incentives to encourage adoption, simplifying data collection and minimizing disruption, creating flexibility and implementation options (e.g., initially sacrificing some standardization in exchange for increased buy-in and adoption). Implementation efforts that encourage transparency between leaders and staff and take a non-hierarchical implementation approach (i.e., a “normative-educational” implementation approach), are more likely to be successful.

The specific processes that organizations adopt to incorporating data into the care process can vary tremendously. Based upon the size and technological sophistication of the organization, leaders and staff may decide to track individuals’ progress using the old-fashioned paper-and-pencil user interface—hand scoring the instrument and plotting each individual’s progress on a paper graph. At the other end of the spectrum, organizations may elect to work with a measurement system vendor, which may provide electronic administration and scoring of instruments,

as well as real-time feedback displays and statistical benchmarking. Either way, as long as providers are looking at the data and using it to inform care, the organization would be complying with the standard.

Ultimately, accredited organizations are expected to support a care, treatment or service process that uses objective data to *inform* care, treatment, or services. Such data can be used to objectively demonstrate progress towards goals and objectives. When data indicate that an individual is responding well to care, treatment, or services, this information can often be used to document progress towards an individual's treatment goals and objectives. In contrast, when data reveal that an individual is not responding to care, treatment, or services, the information can be used to document changes in care or services. In such cases, organizations should document the lack of progress/goal attainment, how it was discussed with the individual, and how it may be used to make changes in the goals and objectives related to care, treatment, or services.

Quality Improvement

In addition to using routine outcome measure data to directly inform care for the individual served, the standard requires that organizations aggregate their data to inform quality improvement efforts across the organization. Working with a measurement system vendor can be a very helpful and efficient mechanism to accomplish this, but there is no requirement that an organization work with a vendor. For some organizations, entering data into a spreadsheet and tracking aggregate performance on a graph might be part of an effective quality improvement approach. The goal of the standard—consistent with the general quality improvement mission of The Joint Commission—is to use the data being collected to explore opportunities to provide higher quality care, treatment, or services. In the aggregate, the data from these instruments can be used to identify specific programs, service areas, units, or practitioners that could benefit from additional resources or education (or to identify exceptional performers who can mentor others or take on the most difficult cases).^{17 18,19,20} Organizations may also choose to use aggregate data to demonstrate the value that the organization is providing to the individuals and populations it serves.

Additional Implementation Resources

Boswell JF, et al. 2013. Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. This article reviews the benefits, obstacles, and challenges that can hinder (and have hindered) implementation of routine outcome monitoring in clinical practice. Recommendations for future routine outcome assessment efforts are also provided.³

Brown GS, et al. 2001. Pushing the quality envelope: A new outcomes management system. This article is based in the authors' experience in designing and implementing outcomes management systems for large managed care organizations. Topics addressed include design of instruments, use of cost-effective technology, development of computerized decision-support tools, and methods for case-mix adjustment.²¹

De Jong K. 2016. Challenges in the Implementation of Measurement Feedback Systems. This article discusses three challenging themes in the process of measurement feedback systems implementation: design and planning, organizational context, and sustainability and unintended consequence.²²

Hannan C, et al. 2005. A Lab Test and Algorithms for Identifying Clients at Risk for Treatment Failure. This article presents data that demonstrate that clinicians rarely accurately predict who will not benefit from psychotherapy. Practitioners are encouraged to consider formal methods of identifying the deteriorating client.¹⁵

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