COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

RESOURCE GUIDE: IMPLEMENTATION OF MEASUREMENT-BASED CARE IN INTEGRATED CARE

CFHA Measurement-Based Care Workgroup

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Resource 1:

Orientation to the Measurement-Based Care Process and Implementation Considerations for "Collect, Share, Act" in Integrated Care

The Collaborative Family Healthcare Association (CFHA) has recognized the utility and potential for Measurement-Based Care (MBC) as a core feature of high-quality integrated healthcare[1]. The purpose of the resources in this document is to help catalyze the implementation of MBC in integrated healthcare and improve understanding that MBC supports optimal clinical practice, demonstrates the value of integrated care teams, and improves outcomes. It is based on the understanding of MBC as a dynamic, evidence-based clinical process that enhances outcomes, promotes equity, and strengthens team-based care at the levels of the patient, clinician/provider, practice/population, and system[2] [3].

This document provides an orientation to the MBC process (collect, share, and act phases) and outlines initial implementation considerations for the integrated care context. This work was supported by CFHA membership and spearheaded by the Measurement-Based Care workgroup.

MBC as Clinical Process: Collect, Share, Act

Along with a number of existing terms in the literature that described the MBC process, recently Barber and Resnick (2022) offered their framework for understanding this clinical process which they called "Collect, Share, Act" [4]. As a helpful way of remembering, our workgroup and this document will use these terms to describe the MBC process in a wide range of health care environments, including its compatibility with integrated healthcare. In addition, MBC can be conceptualized as a transtheoretical and transdiagnostic framework for evaluating patient progress in treating behavioral health-related conditions (i.e., all biopsychosocially-influenced conditions) [5]. MBC enhances the effectiveness of evidence-based interventions often utilized in integrated care (i.e., ACT, CBT, motivational interviewing, etc.) through its three-phase process and active ingredients (see visuals 1 and 2) and is not a substitute nor a dilution of their clinical effectiveness[6]. All stakeholders should be familiar with the three phases of MBC and embrace the process, not just the data collection, in order to improve outcomes. Just as models of service delivery (i.e., PCBH, COCM, etc.) are readily adapted for each clinical setting or system, the MBC process can be implemented within large integrated healthcare systems as well as small clinics or practices.

During implementation of MBC, the selection of patient-reported outcome measures (PROMs) often represents both an opportunity and barrier for integrated care teams. Integrated care teams should place sufficient attention into measurement selection, paying close attention to their patient population (e.g. primary care vs. specialty healthcare clinics, such as pain management,

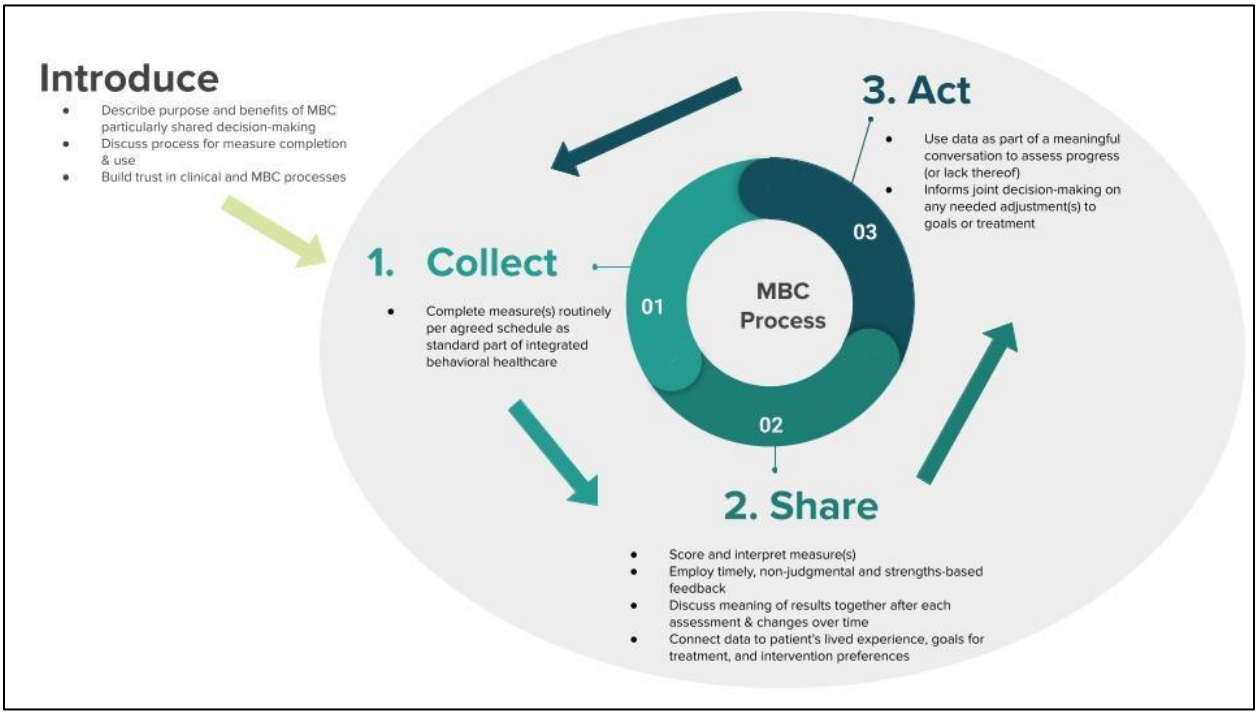
diabetes, etc.); their goals for MBC implementation, and the important considerations offered in this guide [7] [8]. While appropriate PROM selection catalyzes the sharing of patient-reported data with the clinical team and health system and is an essential component of MBC, there is a tendency for clinicians, leadership, and administrators to experience choosing a measure as a daunting task that stops them from moving forward with implementation. Integrated care teams should pursue appropriate measure selection while being mindful of the perfection trap. In sum, PROMs should facilitate an MBC clinical process, not just data collection, that enhances communication, shared decision-making, improvements in therapeutic alliance, and more timely and effective treatments [9].

As such, the MBC workgroup encourages teams to utilize widely available resources created by this and other groups related to measure selection (see resources 2-4) **and proceed with equal emphasis on the entire MBC clinical process (i.e., collect, share, act) to facilitate successful implementation within integrated care settings**.

The sections below offer visual depictions and technical guidance in implementing the three phases of the MBC process.

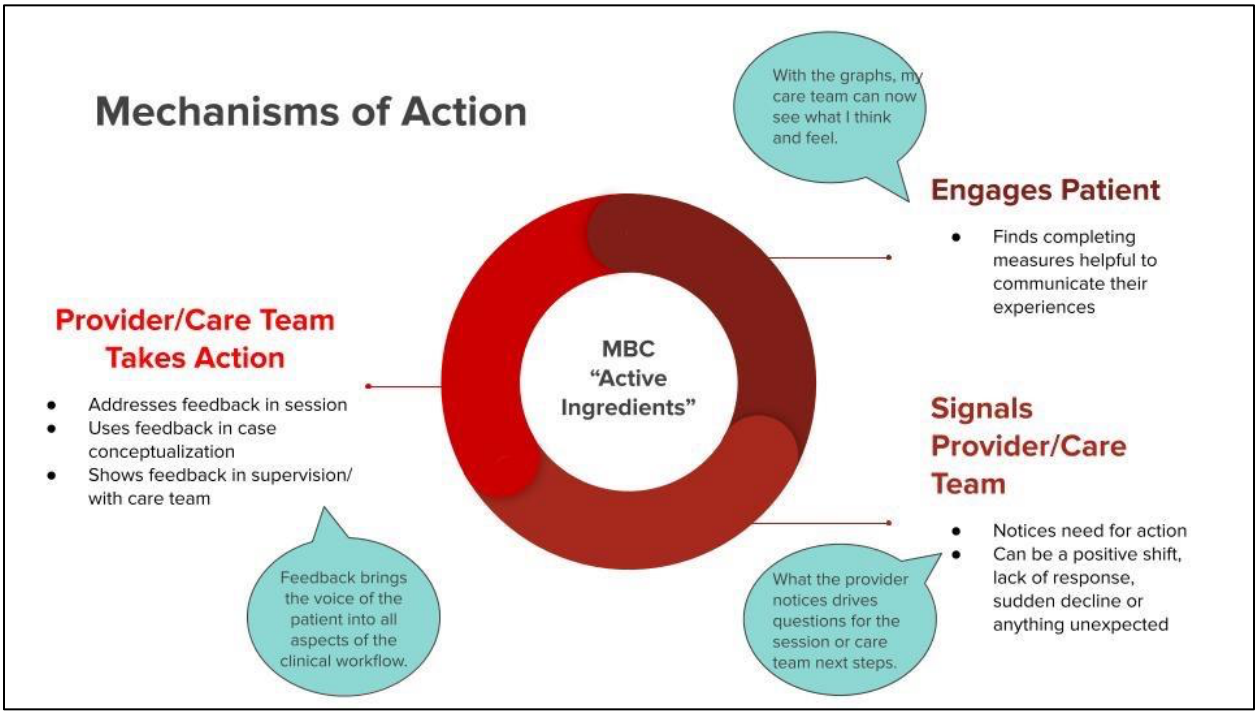
The clinical process of MBC entails the three phases of Collect, Share, and Act as depicted in visual 1 [10]:

Visual 1: Collect, Share, Act



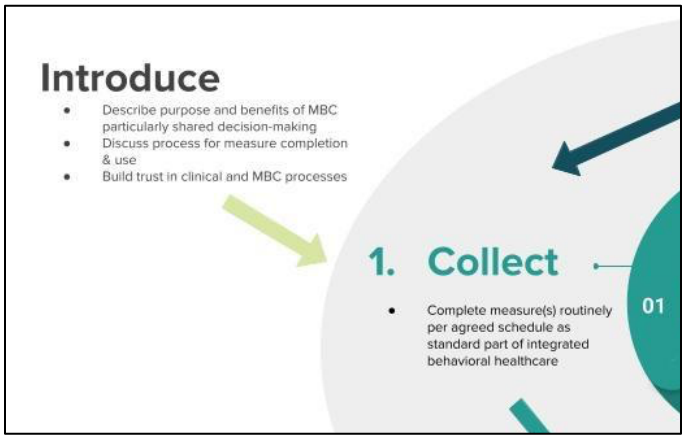
The mechanisms of action in the MBC clinical process consist of several active ingredients as depicted in visual 2[11]. The implementation of MBC should activate all of these ingredients in order to achieve high fidelity.

Visual 2: MBC Mechanisms of Action



Implementation of MBC Process (Collect, Share, Act) in Integrated Care

Collect Phase: ensures that a process of repeated data gathering through routine and frequent administration of patient-reported outcome measures (PROMs).

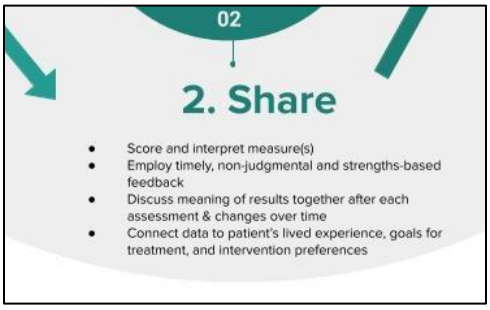


a. Collect phase implementation tips:
    a. Assess resources and your role in MBC implementation in your organization.
        i. Determine readiness and support resources (i.e., financial, technology-based, training, etc.) among administrative and clinical teams as well as the target population based on setting (i.e., primary care, specialty, etc.).
    b. Identify and invest in tools for completion of PROMs. Partner with your EHR or external companies to integrate with your EHR to support automation and asynchronous completion of PROMs.
        i. Select a measure that assesses the symptom(s), function(s), or outcome(s) that reflect the target(s) of care for a given patient population (e.g., symptom or function-based, anxiety symptoms, impact of pain on day-to-day functioning, alcohol use).
        ii. For a primary care patient population, consider advocating for a PROMS measure that provides broad applicability (symptom or function based) to this patient population and their numerous and presenting complaints. For specialty clinics or specific clinical pathways, measures can be more specific and focused.
        iii. Measures should be reliable, valid, and feasible (e.g. brief with a low patient/provider burden on administration, scoring, and interpreting with patient in < 5 mins.)
        iv. Be aware of the terms and conditions for use of a given measure (e.g., permissions, license for use).
        v. Ensure the measure is scored using the recommended scoring instructions as soon as possible after administration.
    c. Develop patient-facing materials and clinician-provided introductions to MBC explaining the following:
        i. The patient will complete questionnaires consistently that will assess symptoms and/or functioning over the episode of care.
        ii. Questionnaires will be brief and take less than 5 minutes to complete.
        iii. Instructions on how the patient will complete the measure (electronically-do they need to sign up for a portal, in-person, before the appt., at the appt., etc.)
        iv. Research has supported that measurement improves outcomes.
        v. Note: staff and providers should be trained in introducing the PROMs and MBC. Personalization of the introduction should be fostered in order for it to be authentic to the provider and situation. Example introduction:
            1. *“Measurement-Based Care is a tool our team at _ [insert name of clinic]__ uses regularly throughout care to help us track changes in your symptoms and functioning and help us all stay on the same page on the goals and progress we’re making in care. Completing*

the assessments will only take a few minutes on your own and is similar to other processes in the clinic, like tracking your blood pressure. Then, at the beginning of our appointments, you and I will take time to quickly look at your scores similar to reviewing lab results with your PCP. It really is a simple and quick way to help us all understand where you're improving, where you're not, and ensure we address the things that matter most to you throughout your care."

d. Identify and address barriers to data collection in real time. Seek to activate the patient's voice in all aspects of the clinical workflow.
e. Apply a standard of data collection and review similar to collection of other health data (i.e., vitals, routine labs, etc.) with accountable measures through quality review processes.
    i. Ensure data collection is not a single occurrence, instead administer and score the measure(s) on a regular basis
        1. Develop a practice guideline for MBC that includes an agreed upon frequency for administration of PROMs depending on your patient population, the type of treatment provided, and how quickly you expect change to happen.
    ii. Seek to automate the collection and scoring of PROMs as often as possible to reduce staff and provider burden.

Share: ensures that review of the data occurs with the patient and provider/ integrated care team



a. Share phase implementation tips:
    a. Determine who on the integrated care team will receive the PROMs data (i.e., does it go to the ordering provider, PCP, designated BH provider, or another team member).
    b. Develop processes to ensure providers are acknowledging the receipt of PROMs with the patient during the encounter, documenting them appropriately, and

demonstrating how they are using the PROMs over time in their interventions or changes in treatment plan.

c. Utilize tools in the EHR or MBC platform to show trends in data over time for review by the care team, provider, and patient.
d. Train providers on how to report data and discuss measures with the patient/family, and ensure your patient understands the results. It is important to discuss:
    i. Trends over time
    ii. Normative cutoff ranges
    iii. Patient or family's perspective on the data and/or trends

Act: ensures shared-decision making and collaborative adjustment of the treatment plan is informed by patient-reported data [12] [13]

a. Act phase implementation tips:
    a. Train providers and care teams to review the data trajectory individually and as a care team, i.e. how is treatment going? Have things improved, declined, or stayed the same? Have barriers been identified and addressed?
    b. Educate providers, teams, and patients on how to understand when treatment adjustments may be needed, at the earliest possible indication, and how patient-reported data assists with treatment planning and episode-of-care decisions.
    c. Providers/care teams work collaboratively with patients to:
        i. Brainstorm next steps for treatment and identify barriers and opportunities, and
        ii. Decide on a plan of action and follow-up plan.
            1. Note: This may include "failing successfully" by identifying that identified treatment is not working, and a change in approach/provider may be necessary to help the patient reach their goals.
    d. Ensure actions and follow-up plans are clearly documented for the care team and patient to reference in future visits.

b. Repeat the "Collect, Share, Act" MBC process. Work towards all members of the care team embracing the MBC process as the standard of care for monitoring behavioral health outcomes.

Next Steps

Championing all three phases of the MBC clinical process is crucial to MBC's success in integrated healthcare. Where the pace is fast, presenting problems are complex and varied, and volume is high, MBC implementation presents unique challenges to providers and care teams that can be addressed proactively and in real time. Carefully considering these challenges during and throughout implementation leads to continuous improvement of the MBC process and thus clinical outcomes. Leveraging automation and health informatics/technology platforms in ways similar to well-established procedures for physical symptoms monitoring (e.g., vital signs, bloodwork laboratory findings, and other physical test data) may help integrated healthcare teams implement MBC sustainably.

In addition to investing in clinical tools to support the MBC process at the patient-level, implementation strategies should include investments in training, technical assistance, and quality improvement processes that facilitate practice change at the clinician-level, practice-level, and systems-level. We encourage all levels to become familiar with the MBC clinical process as outlined in this document and accompanying appendices and embed MBC within policies, procedures, workflows, and guidelines.

We hope to inspire confidence in all integrated healthcare teams that they CAN implement MBC and experience the benefits of transforming their practices and systems. In addition to the orientation and implementation strategies for MBC described in this document, we offer the following resources to support the work of MBC in integrated healthcare:

- Considerations for Selecting Behavioral Health Measures for MBC in Integrated Care
- Patient Monitoring Programs and Practice Management Systems
- Implementation Strategies for Automation of MBC into Integrated Care
- No Frills MBC for Integrated Care Clinicians: Start Today, Minimal/No Budget Needed
- MBC Definition, Key Components, History, and Empirical Foundation

Resource 2:

Considerations for Selecting Behavioral Health Measures for MBC in Integrated Care

The CFHA MBC Workgroup recommends including a consideration of the following issues in the selection of a measure or multiple measures that enable the MBC process:

- Strong psychometric properties including content validity and sensitivity to change
- Low respondent/patient burden (i.e., < 5 minutes)
- Low burden on provider scoring and administration
- Broadly available at low or not cost (i.e., public domain)
- Validation in multiple languages
- There be an evidence-based normative database with validated cut-offs scores to inform shared decision-making processes
- Measures whose efficiency can be enhanced by technology that administers, scores, and interprets them for the team (e.g. web-based tablets/phones; easily incorporated into existing EMRs/EHRs, etc.)

Please reference CFHA's website page "Top 40 Outcome Measures For Integrated Care" via the link below for the following tools to support MBC in Integrated Care:

- Master Measurement Repository Document: *Repository Data Based On PAPERS Framework*
- AI chatbot to interact with the repository data

Link: https://www.cfha.net/resources/top-40-outcome-measures-for-integrated-care/

Resource 3: Patient Monitoring Programs and Practice Management Systems

For health systems or practices sufficiently resourced with funding, leadership, and health information technology support, there are several existing and emerging patient monitoring systems that facilitate MBC that are detailed in table 3. Electronic health records, patient portals, and practice management programs may offer similar capabilities; however, their limitations must be considered for implementation at the practice and population level.

Potential limitations to functionality of systems for consideration:

- Stand-alone versus EHR-integrated systems.
- Ease and accessibility of data to integrated care (i.e., is there a flow sheet? Who accesses the information to share with the team and patients?).
- Reflect principles and priorities of integrated care (i.e., family-focused, across the lifespan).
- Ensure the system streamlines and enables the MBC process (Collect, Share, and Act) and not just a large repository of measures that focus on Collect-only.
- Refer to the section proceeding this one for additional considerations for automation of measures in Integrated Care.

Patient Monitoring Programs (PMPs) and Practice Management Systems (PMS)	
Name	**Website**
Blueprint	https://www.blueprint.ai/
Mirah	https://www.mirah.com/
Greenspace	https://greenspacehealth.com/en-us/
Better Outcomes Now	https://betteroutcomesnow.com/
Neuroflow	https://www.neuroflow.com/
BH-Works	https://mdlogix.com/ -Child and Adolescent focus

Disclaimer and notes of caution:

- CFHA does not endorse any program or system over the other. The list above is for informational purposes only.
- Due diligence is crucial. MBC and the use of technology represent a continuously evolving aspect of the field. As such, we recommend organizations educate themselves on the best practices of MBC before committing to a technology platform.
- Identify and engage key stakeholders in the PMP/PMS selection process, which may include members of behavioral health and primary care leadership, operations, health informatics/technology, quality and compliance, and full-time clinical providers.
- This list was generated in the Fall of 2025 and may not reflect current availability.

Resource 4: Implementation Strategies for Automation of MBC into Integrated Care

Automation of PROMs is considered a best practice. Should you have the organizational resources to automate parts of the MBC process, see the suggested 5 strategies below to support your MBC implementation in Integrated Care.

5 Strategies for Automating Implementation of MBC into Integrated Care	
1: **Outcome measure selection for the EHR**	EHRs have limited patient-reported outcome measures (PROMs) available to integrated care teams. Practices can: (1) use available PROMs, (2) request to add PROMs, (3) utilize tracking systems (i.e., spreadsheet registries, health technology platforms) external to the EHR, and/or (4) contract with practice management software (see Resource 3).
2: **Administration of measures**	Integrated Care systems have options for how PROMs are administered to patients. Options include: (1) in the office, (2) patient portal, and/or (3) an external website. If administering in the office, it is critical to determine by whom and how the data will be entered into the EHR and shared with the care team and patient. Additionally, determine EHR capabilities for ordering PROMs and/or automatic PROMs administration at the frequency determined by the program.

	When automating, also decide the timeframe that the PROM is released to the patient prior to the appointment/planned follow-up in order to gather feedback appropriate to the treatment plan.
3: **Patient experience/interface**	Preview the patient's view of the PROMs and determine if the interface makes it feasible to complete the PROM and whether it is valid in your patient population. Questions to consider: 1. Is the PROM on the portal app compatible with completion from a smartphone and tablet? 2. Is the font large enough and is the PROM available in the patient's preferred language? 3. Is there an introduction to the PROM and its role in their care? 4. Is the PROM explained in a way that helps a patient understand how the data is used? It is important that the patient's experience of the PROM allows them to actually complete it. Consider using a patient advisory group or other focus groups.
4: **Location of data in chart**	Determine where the data will appear in the chart for the care team. It should appear similar to other lab data, with graphs showing results over time. Optimize the data/lab panels and administration by creating alerts for abnormal results, determining who is notified, and including results interpretation as relevant.
5: **Patient access to results**	Understand if and how patients will see the results of their PROMs via patient portal and/or after visit summaries.

	Determine how providers/care teams can share results in a way that emphasizes the clinical process and engages the patient. For example, can a graph be printed to show progress over time and instill hope?

Resource 5: No Frills MBC for Integrated Care Clinicians: Start Today, Minimal/No Budget Needed

3 Key Strategies

1. Simplify: *Lean into the process and keep it simple to align with primary care workflows*.

- Lean into the full MBC "Collect, Share, and Act" process
- Align with Primary Care workflows, such as screening protocols, clinic huddles, and orienting patients to collection of data (labs and patient-reported outcome measures) to inform care.
- Select MBC measures that are already part of the clinic's screening process AND are validated for both screening and symptom monitoring.
- It's okay to select measures that you probably already are using:
    - Pediatric Symptom Checklist-17 (PSC-17)
    - GAD-7
    - PHQ-9

2. Enhance: *Build on what you already have in your system*.

- Identify and partner with ways your clinic is already collecting data from patients.
- Enhance systems already in place for the "collect" phase that minimize burden on the patient, care team, and system.
- Consider using tips from Resource 4 on automation.

3. Empower: *Yourself, your team(s), and system(s) to focus on making progress and not perfection with MBC implementation. Ask yourself, what is the best next step?*

- Complete initial training on MBC for all core team members.
- Add MBC as a topic to your regular meetings.
- Add MBC as a competency for your providers and staff.
- Encourage continued learning and foster champions to improve buy in.
- Support clinical teams to make the process as easy as possible.
- Highlight how MBC is a transtheoretical intervention that enhances your clinical work.

- Enable opportunities for routine data analysis and include review on who's not benefiting.
- Start with a pilot (PDSA model).
- Provide feedback at the clinician-, panel-, and system-level to clinicians and care teams on PROMs to promote learning, patient engagement, and team-based care (i.e., a process similar to PCPs reviewing diabetes outcomes such as A1Cs across their panel).
- Embrace the MBC process as a learning system/team and learn from your implementation mistakes.

Implementation Examples

Below are some ways that MBC can be implemented in Integrated Care (a lot of which you are probably partially doing or already doing!)

Patient Example:

Patient A attends their annual well visit and as part of visit triage, the MA administers the PHQ-9 and enters the results in the EHR. The results are visible to the PCP in the visit note and the PCP notes the total score is 15. The PCP discusses the results with the patient, informing the patient "There is a Behavioral Health Consultant on my care team who can meet with you today and help me help you". The PCP facilitates a WHO to the BHC for focused assessment, intervention and care planning.

- Collect: MA ensures measure completion and that results are visible for the care team in the EHR.
- Share: PCP reviewed results and shared recommendations with the patient and team.
- Act: the PCP did a warm hand off to the BHC. The BHC did a focused assessment, clinical intervention, and collaboratively worked with the patient on identifying 1-2 next steps (plan) that reflect the patient's values and stage of change.
- Repeat:
    - Care as usual (the patient has a Single session with BHC and PHQ-9 is repeated per clinic policies- annually, 2x year)
    - Episode of care with the BHC- continue use of PROMs (collect) and MBC process (share and act) throughout the episode of care to inform care planning.

System Example:

Collect:

1. Health Center A has already started the process of MBC because it is using screening tools that can also be used for symptom monitoring!
2. The screening protocol ensures that patients are completing the PHQ-9 at least annually on a tablet at registration.
3. The results of the PHQ-9 are already integrated into the EHR.
4. PHQ-9 score over 10 or + answer on question 9, routinely triggers a warm hand off to the BHC.
5. Health Center A leverages the PHQ-9 as its MBC collect phase, because the PHQ-9 can be used transdiagnostically to measure general distress [14].

Share:

1. The EHR automatically scores the PHQ-9.
2. The results are automatically pulled into flowsheet, screening summary, data/lab panels in the EHR and are visible on the patient portal.
3. The PCP/ BHC know where to easily see the results at the start of the visit
4. They can also review previous scores for a quick view of progress over time.
5. As part of the visit, the PCP and/ or BHC discuss PHQ-9 results with the patient, including changes over time if there are prior results.
6. The health care system also shares data back to the care team with a daily huddle report that notes the most recent PHQ-9 date and score for scheduled patients. This allows the care team to assess which patients could benefit from a warm hand off to the BHC.

Act:

1. The BHC and/or PCP provide clinical intervention.
2. The care plan's next steps reflect the shared decision making that happens at the visit, reflecting the patient's values, priorities, and stage of change
3. The MBC process repeats as follow up appointments are scheduled at the clinic. The PHQ-9 is automatically part of the patient's check-in process to ensure repeated measurement to monitor progress.
4. The care team continues to facilitate the "Share" and "Act" processes until the measure reflects improvement.
5. Automatic screening at registration then resumes on the care as usual basis.
6. The clinic can also run a monthly report of patients with + PHQ-9s who did not attend follow up appointments.

7. Care Management/ CHWs proactively outreach patients, re-administer measures, and reengage the patient with care who needs it.
8. Health Center is enabled to reassess population level needs and related BHC staffing based on that.
9. Health Centers can also use the aggregate data to negotiate value-based care.

Resource 6: MBC Glossary of Terms and Notes on MBC History

Glossary:

Purpose: This glossary is designed to assist integrated care teams with applying common terms in literature and resources to MBC implementation.

Reliability: Demonstrated through a study that your measure is consistent with what it's measuring.

Validity: Study shows that your measure truly measures the construct you claim it measures (e.g. depression, anxiety, distress, etc.).

Sensitivity to Change: The ability of a measure to detect change.

Feasibility: Brief, practical ease of use for frontline clinicians. Any measure that takes more than approximately 5 mins.to administer, score, and have an interpretive collaborative discussion in real time will likely be shunned by clinicians. In the real world of delivering services, finding the right measure means striking a balance between the competing demands of reliability, validity, and feasibility.

Standardization: Measure has reliability, validity, and an established clinical cut-off score for distinguishing clinical vs. non-clinical populations. All BH accreditation bodies call for the use of "standardized measure" to inform treatment decisions. Most popular BH public domain measures used in integrated primary care are standardized. However, standardization does not mean "evidence based."

Randomized Clinical Trial (RCT): The sophisticated research methodology necessary to demonstrate improved outcomes for an MBC measure/outcome system. This is typically a randomized MBC measure condition vs. a "treatment as usual" (TAU) comparison.

Evidence-based: Any given approach or outcome system has demonstrated improved outcomes in at least two randomized clinical trials (RCTs) published in peer-review journals.

- Note: A fair amount of MBC systems/companies advertise "improved outcomes" on their websites or that their approach is "evidence-based" under the general rubric of MBC. However, on closer inspection they themselves nor their systems have done the hard work of conducting an RCT to demonstrate their own improved outcomes. In short, many available MBC systems that advertise their evidence-based status may be standing on the accomplishments of others. Marketing, unpublished reports, and bold claims on websites

are one thing. Published studies in top-tiered journals are significantly different. Take time to understand the difference between what is claimed (marketing hype) and what is empirically proven (research backed).

Normative Data: A measure's norms help give meaning to a changed score through primarily two metrics -- reliable change and clinically significant change indices. Clinically significant change means that there has been reliable change, and the patient has passed into the "non-clinical" range of scores. Some of the more popular BH measures have normative data (e.g. PHQ-9, GAD-7).

Expected Treatment Response (ETR): The process for developing an ETR for a tool is different from developing normative metrics. It requires lots of repetitive data (e.g. 100,000 + administrations) to develop ETR algorithms. ETRs are a higher level of sophistication regarding understanding change beyond reliable change and clinically significant change indices. Very few, if any, public domain measures have a significant database, algorithms or ETR trajectories that help a clinician understand how their patient typically responds to therapy, and importantly, alert the clinician when patients are not benefiting as expected.

MBC Definition, Key Components, History, and Empirical Foundation:

Measurement-based care (MBC) is the evidence-based practice of systematic and routine assessment using feedback from patient-reported outcome measures (PROMs) throughout the course of treatment to monitor and tailor behavioral health care to improve outcomes[15]. MBC can be conceptualized as a transtheoretical and transdiagnostic clinical process consisting of four components: (1) routine and frequent administration of validated outcome measures; (2) practitioner review of the data; (3) patient review of the data; (4) shared decision making and collaborative re-evaluation of the treatment plan, informed by the data[16 17].

The term measurement-based care (MBC) originated in psychiatry, was coined by Trivedi in 2006, and was defined as "the routine measurement of symptoms and side effects at each treatment visit and the use of a treatment manual describing when and how to modify medication doses based on these measures[18]. Ten years earlier for psychotherapeutic treatment, the pioneering "patient-focused research" of Michael Lambert introduced his broad-based Outcome Questionnaire (OQ-45)[19]. His work was followed by Barry Duncan's research of his two companion ultra-brief measures called Partners for Change Outcome Management System (PCOMS). With PCOMS, Duncan essentially promoted a clinical MBC process called "Client-Directed Outcome Informed Therapy'" which privileges the client's role in the change process (via their resources, perceptions, experience and ideas) and uses systematic client feedback through shared decision making about all aspects of treatment [20 21]. Related to the conceptualization of the MBC clinical process and preceding the development of his PROM system, Duncan, Solovey, and Rusk (1992) empirically challenged the mental health field's emphasis on diagnoses, differential treatment effectiveness,

and clinician competency and advocated for a shift in focus to client-directed outcomes using systematic client feedback[22]. Furthermore, Duncan's MBC's measures (PCOMS) are anchored by "common factor research" which demonstrated that client factors and relationship factors account for the majority of the outcome variance[23].

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