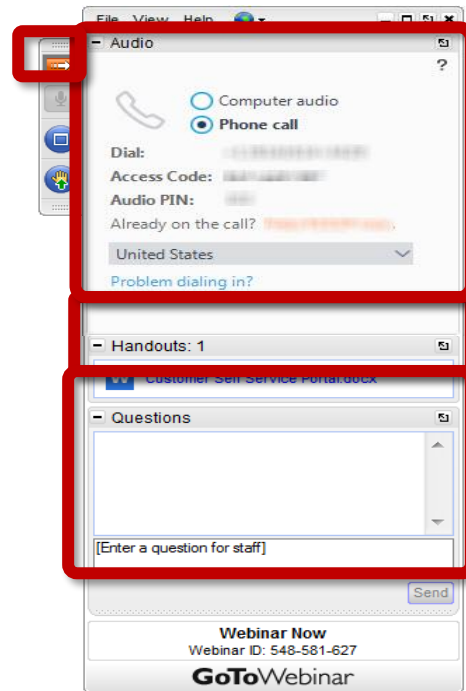


# Webinar Housekeeping: Your participation



## Your Participation

### Join audio:

- Choose “Computer audio” to use computer speakers
- Choose “Phone call” and dial in using the information provided (recommended)

### Questions/Comments:

- Submit questions and comments via the Questions panel at any time.
- Please download the slide deck from the Handout pane if you would like a copy today. They will also be emailed with the recording after the webinar.

**Note: Today's presentation is being recorded and a replay link & copy of the slides will be sent to you following the webinar. Slides are also available in the Handouts Pane.**

# Improving Outcomes with Measurement Based Care

Facilitated by:

Colette A. Bukowski, MA, LPCC-S

Associate Director of Behavioral Healthcare and Human Services

November 9, 2021

# Agenda:

- 🏆 Overview of Measurement Based Care
- 🏆 Measurement Based Care: Successes from the Field
  - 🏆 UnityPoint Health – UnityPlace
  - 🏆 Alta Mira Recovery Programs
  - 🏆 Hazelden Betty Ford
- 🏆 Questions



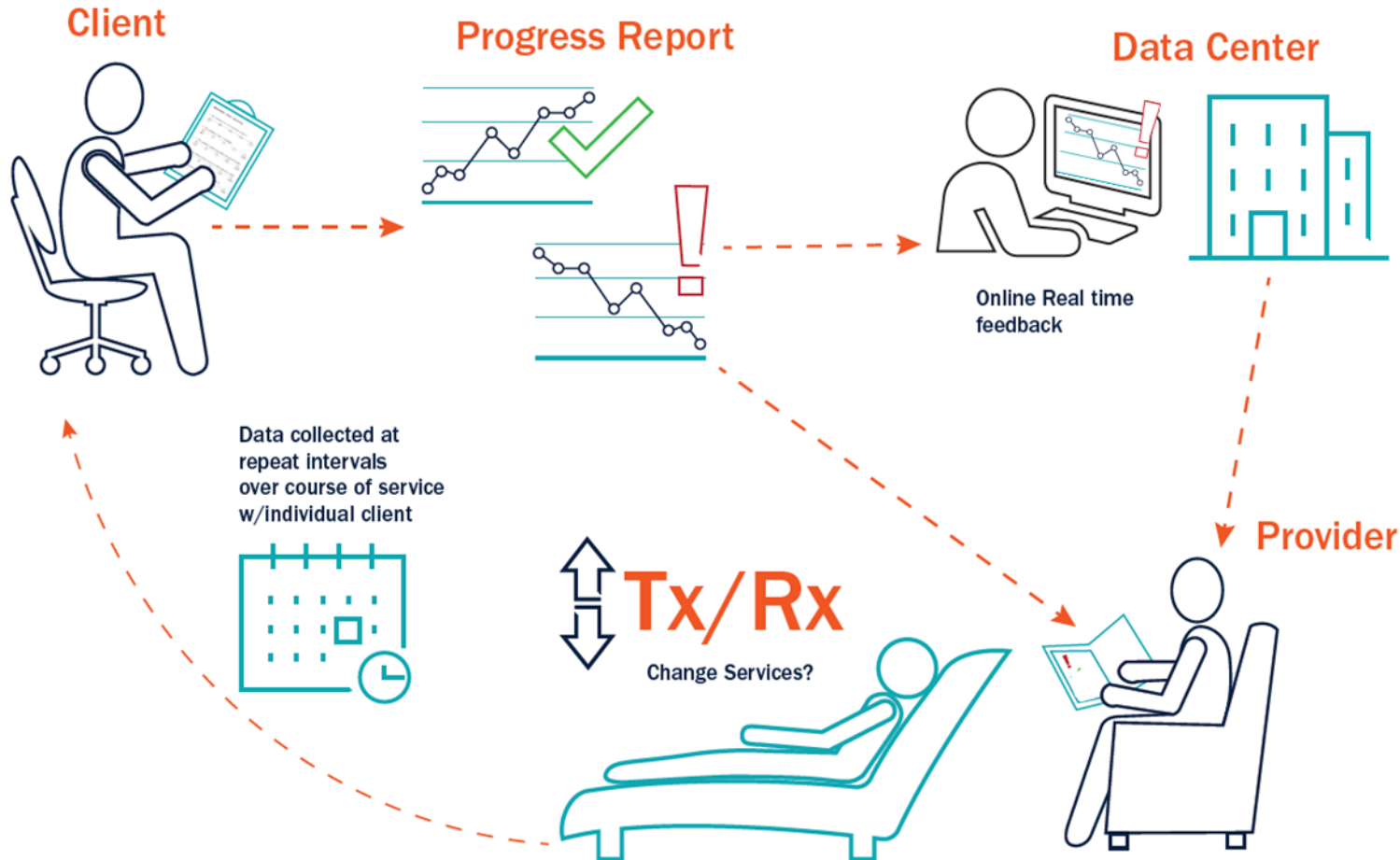
# Introduction

Scott Williams, PsyD  
Director, Department of Research

# What is Measurement-Based Care?

- Measurement-based care is an evidence-based process for improving outcomes of care, treatment or services
  - Supported by over 20 years of research
  - Findings are robust (extending across modalities, populations, and settings)
- Successful implementation
  - Benefits nearly all clients/individuals served
  - Creates a data infrastructure that can be used to support
    - quality improvement efforts
    - objective assessment of the impact of services provided

# Standard CTS.03.01.09 (a requirement for measurement-based care)



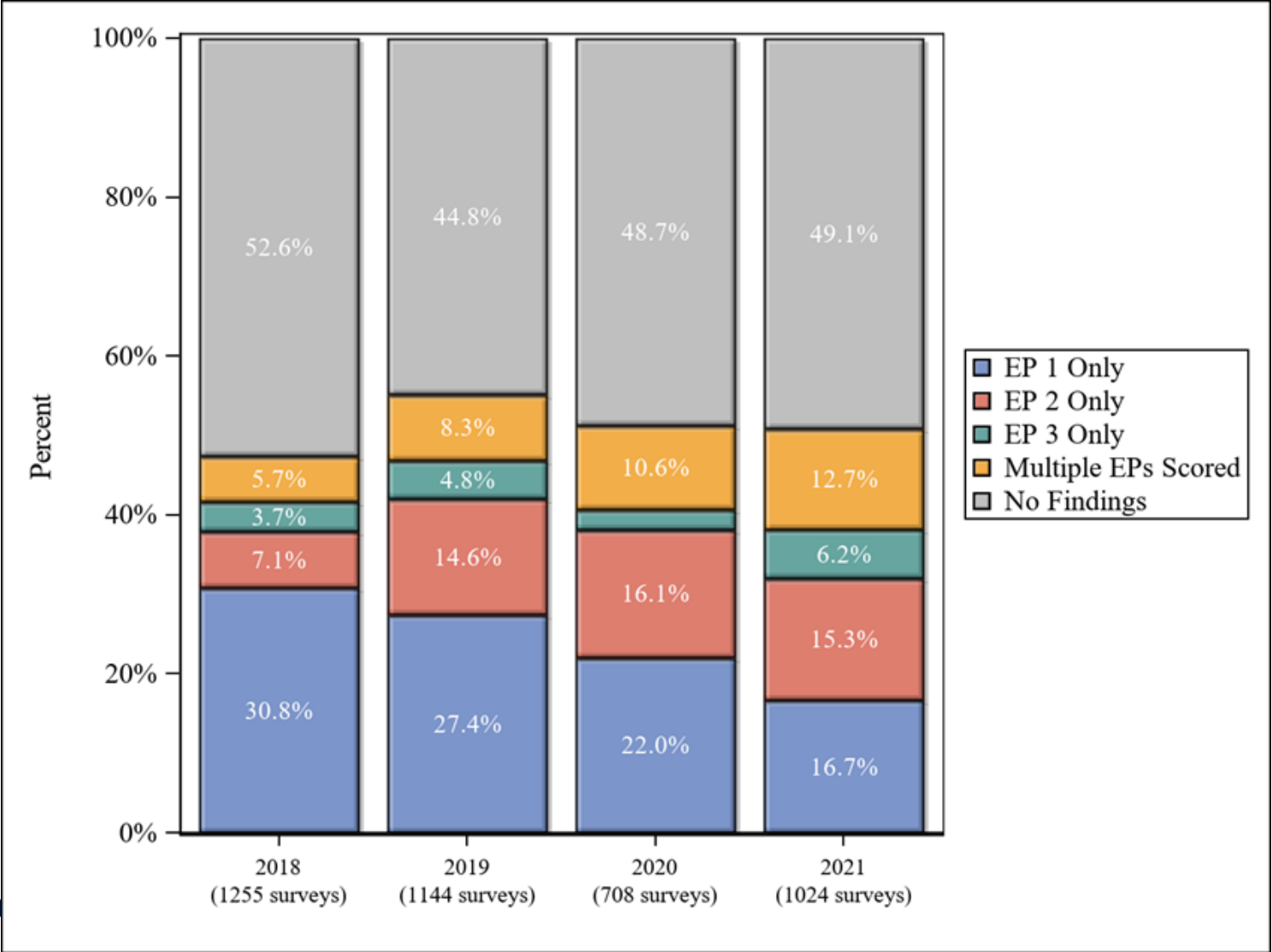
**Standard CTS.03.01.09** – The organization assesses the outcomes of care, treatment, or services provided to the individual served

- 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

# Scoring patterns around CTS.03.01.09

- This standard has now been required for over three years (over a full accreditation cycle)
- Evaluating compliance with the standard is relatively easy (i.e., EPs are highly “observable”)
- Survey findings suggest that implementation remains challenging for many accredited organizations
  - Significant practical and cultural challenges

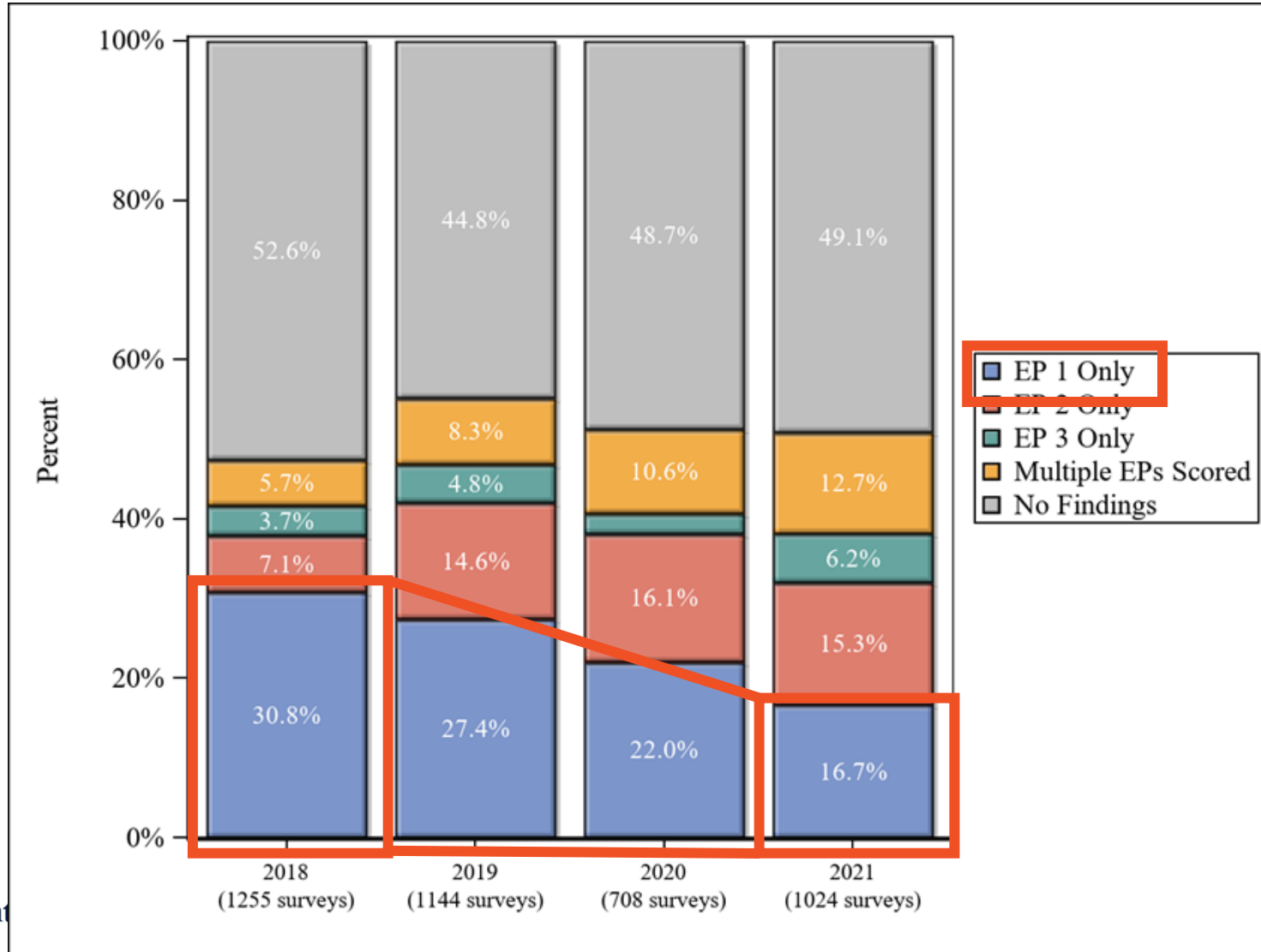
# HCOs with CTS.03.01.09 Findings



CTS.03.01.09 has been scored on approximately half of all BHC Full surveys since 2018 (when the standard was changed to encourage Measurement-Based Care)...



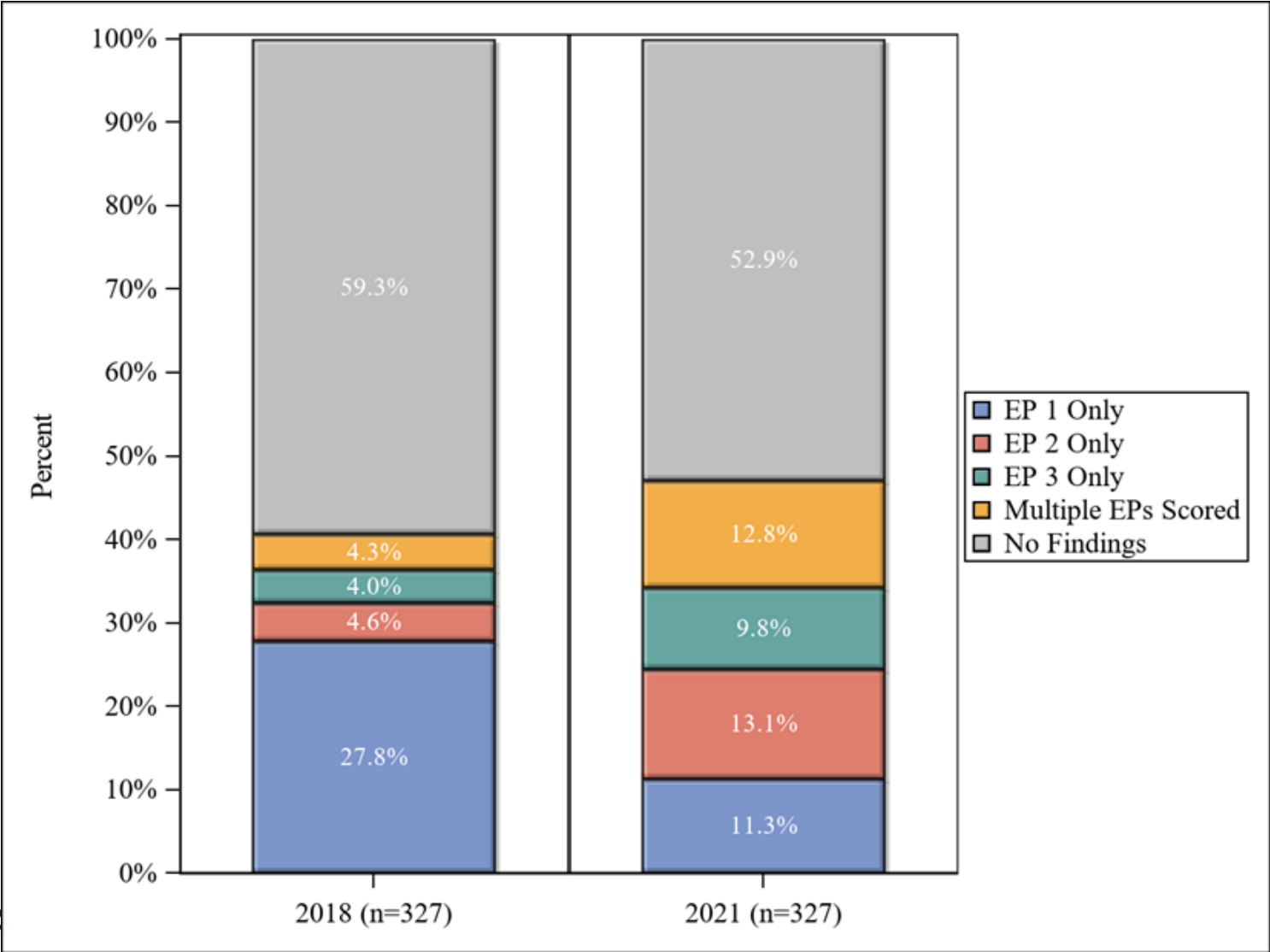
# HCOs with CTS.03.01.09 Findings



...but scoring patterns have changed significantly since 2018

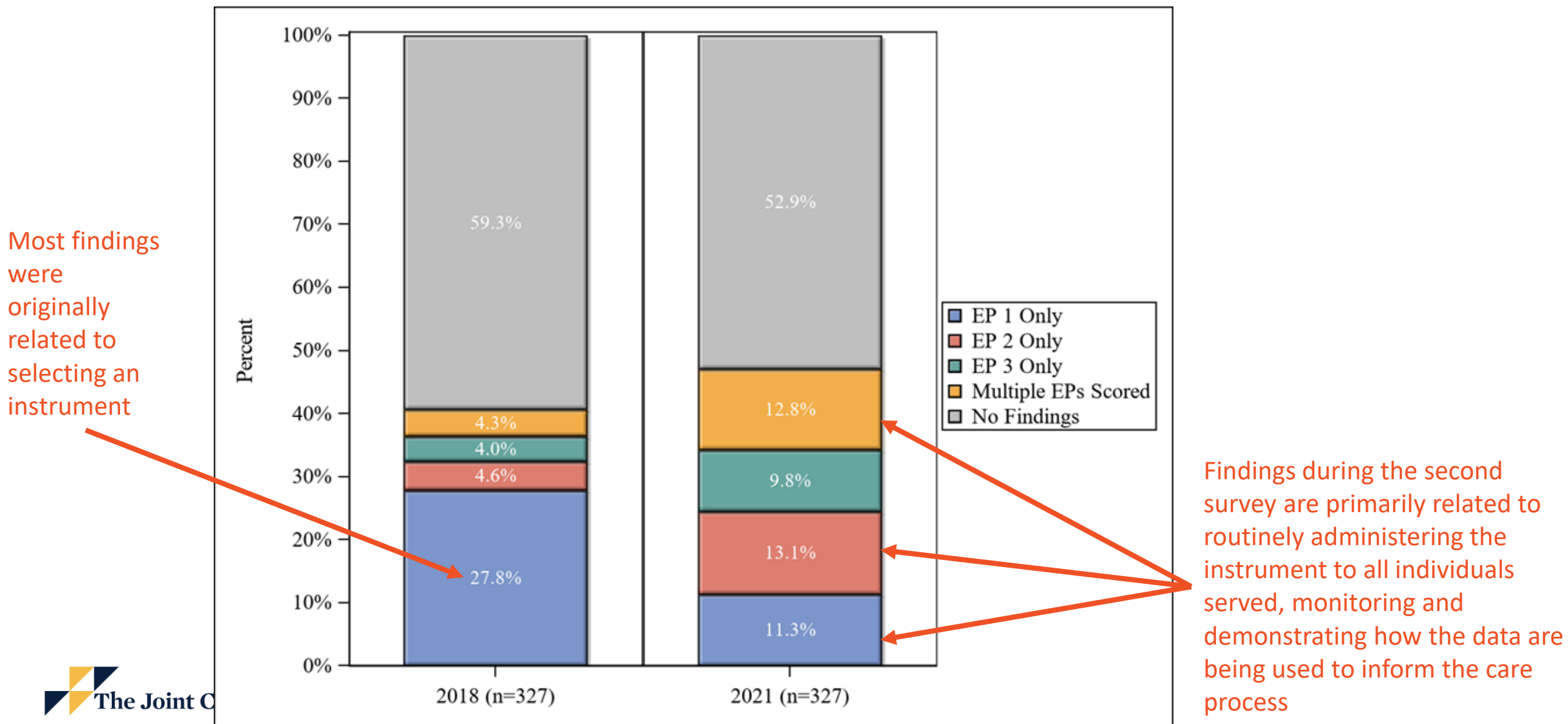
Initially, organizations were struggling to select and administer objective instruments.

# Scoring Among HCOs Completing the Survey Cycle

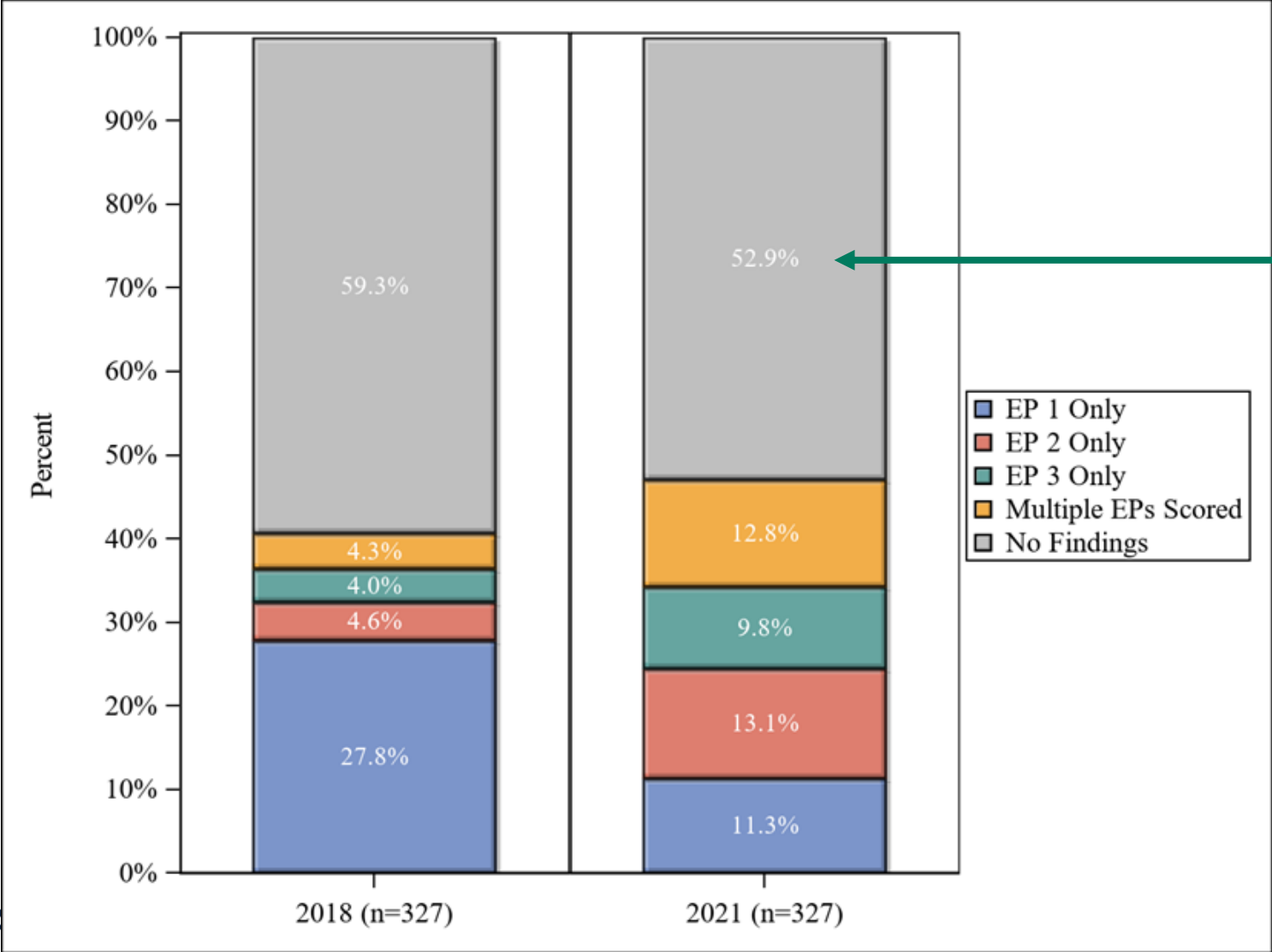


These trends can be most readily observed among organizations that are now being surveyed for the second time since the standard went into effect.

# Scoring Among HCOs Completing the Survey Cycle



# Scoring Among HCOs Completing the Survey Cycle



So, what does successful implementation of measurement-based care look like?

# Let's meet our presenters:

- 🏆 UnityPoint Health - UnityPlace, Illinois  
David Moore
- 🏆 Alta Mira Recovery Programs, California  
Ian Wolds
- 🏆 Hazeldon Betty Ford, Minnesota  
John Driscoll

# Measurement-Based Care: Using the Brief Addiction Monitor Across Settings

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Presentation for The Joint Commission

NOVEMBER 9, 2021

David Moore



UnityPoint Health  
UnityPlace



UnityPoint Health  
Human Service Center  
Tazwood Center for Wellness

**TOGETHER**  
WE ARE NOW

**UnityPoint Health - UnityPlace**

# Services

## Mental Health & Substance Use Disorders



Inpatient Mental Health



Adult Residential  
Mental Health



Community-Based  
Services | Mobile Crisis



Psychiatry



Neuropsychological  
Evaluations



Counseling



Substance Use  
Disorder



## Identifying A Tool...

**2010** – Involved in a NIAAA study that used smart phones as aids in continuing care. A-CHESS (Alcohol – Comprehensive Health Enhancement Support System). Modified BAM was pushed to participants for on-going measure throughout the study.

**2011** – Began using the BAM (modified) as a pilot outside of the study and developed our first database. Data was shared with clients across subsequent BAMs and clinical staff began treatment planning with the client based on risk and protective factor scores. Residential only.

## Expanding Use...

**2017** – Developed new database and modified the BAM to serve both Residential and Outpatient. New database has a built-in graphing function for clients to see/use the graph.

**2018** – Further implementation across the organization - managers identified salient measures to look at in the aggregate for the various populations.

**2020** – Further implementation following UnityPlace merger. Some difficulty with implementation and data tracking due to an inability to provide access to the database.

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## 5 - Risk Factors

- Physical Health
- Sleep
- Mental Health
- Cravings
- Family Concerns

## 5 - Protective Factors

- Confidence in Ability to Not Use
- Attendance at Self-help Meetings
- Religion or Spiritual Support
- Financial Support
- Family Support

\*\* Level of Satisfaction Toward Achieving Recovery Goals

\*\* Medication Assisted Treatment Question

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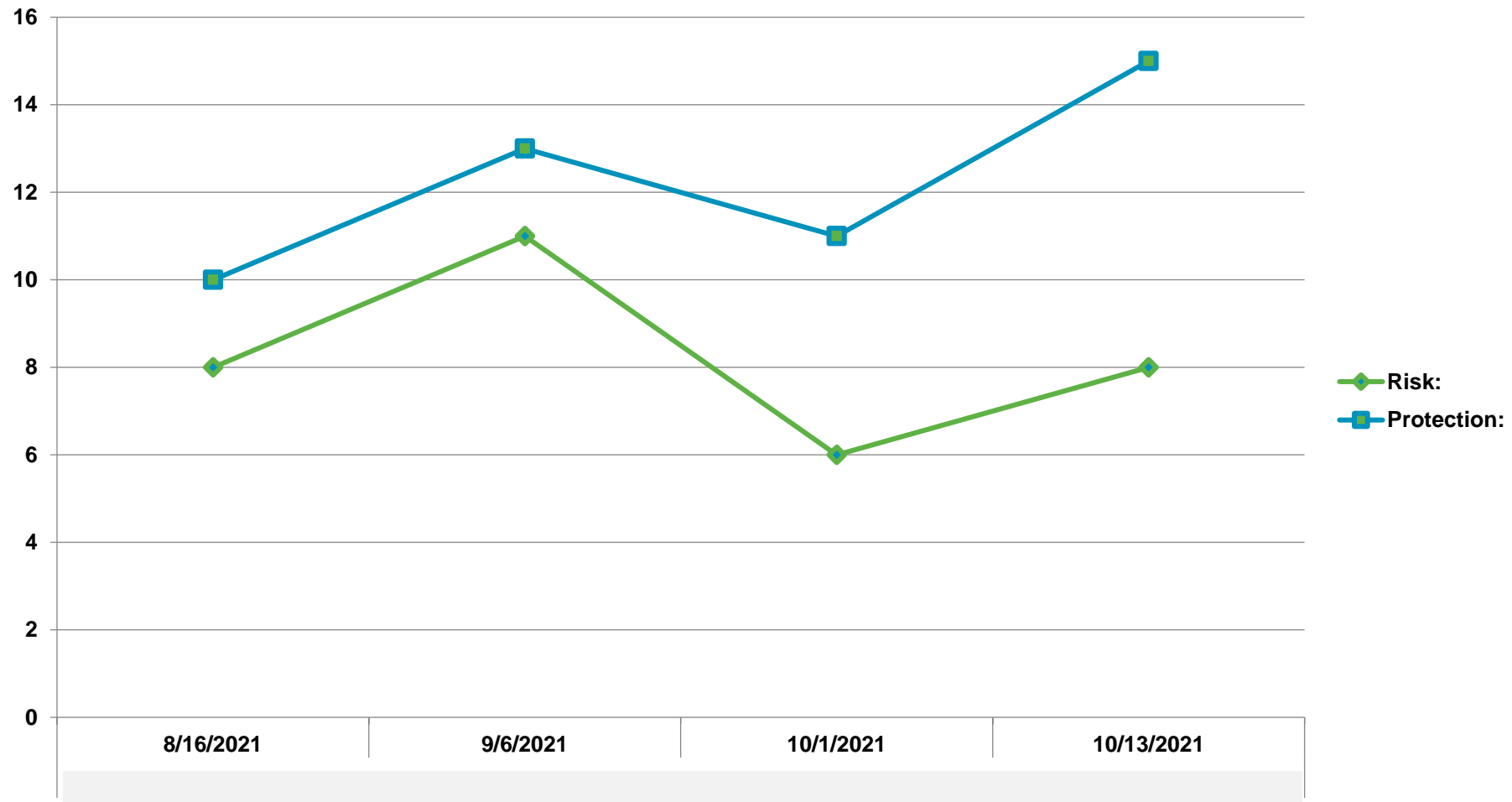
## Frequency

- Each of the programs uses the BAM-R with clients at:
  - Admission,
  - Intervals that correlate with Treatment Plan Reviews
  - Discharge (if the patient is available to complete).
- Treatment plan review cycle is different depending on the level of care - programs may be administering the BAM-R at 14 days, 30 days or 90 days.

- Patients complete the survey and turn it in to staff.
- Once scored, the staff person shares the results (across multiple surveys) and treatment plans with the patient. Specific “risk” or “protective” scores are discussed so that treatment planning objectives and interventions can be targeted towards those areas.
- *Most programs have access to the electronic database which allows the counselor to graph the results for the client.*

# Individual BAM Scores

## Four Individual Residential Surveys



# Treatment Plan Reviews

Was the BAM completed during the review cycle? ☒ Yes ☐ No

Please explain: Within this review cycle, Chris described being in good health. Chris described slight difficulty with sleep and reported experiencing considerable struggles with mood (...dep/anx.) Chris endorsed experiencing moderate struggles with cravings/urges. Chris described feeling considerably confident in his ability to abstain from use. Chris described experiencing considerable benefit to his cause through community support meetings and slight benefit to his cause through spirituality. Chris described a calm and extremely supportive familial dynamic. Chris described feeling considerably satisfied with progress he has made towards his treatment goal.

Was there a significant change? ☒ Yes ☐ No

Please explain: increased cravings/urges; increased support through community support groups.

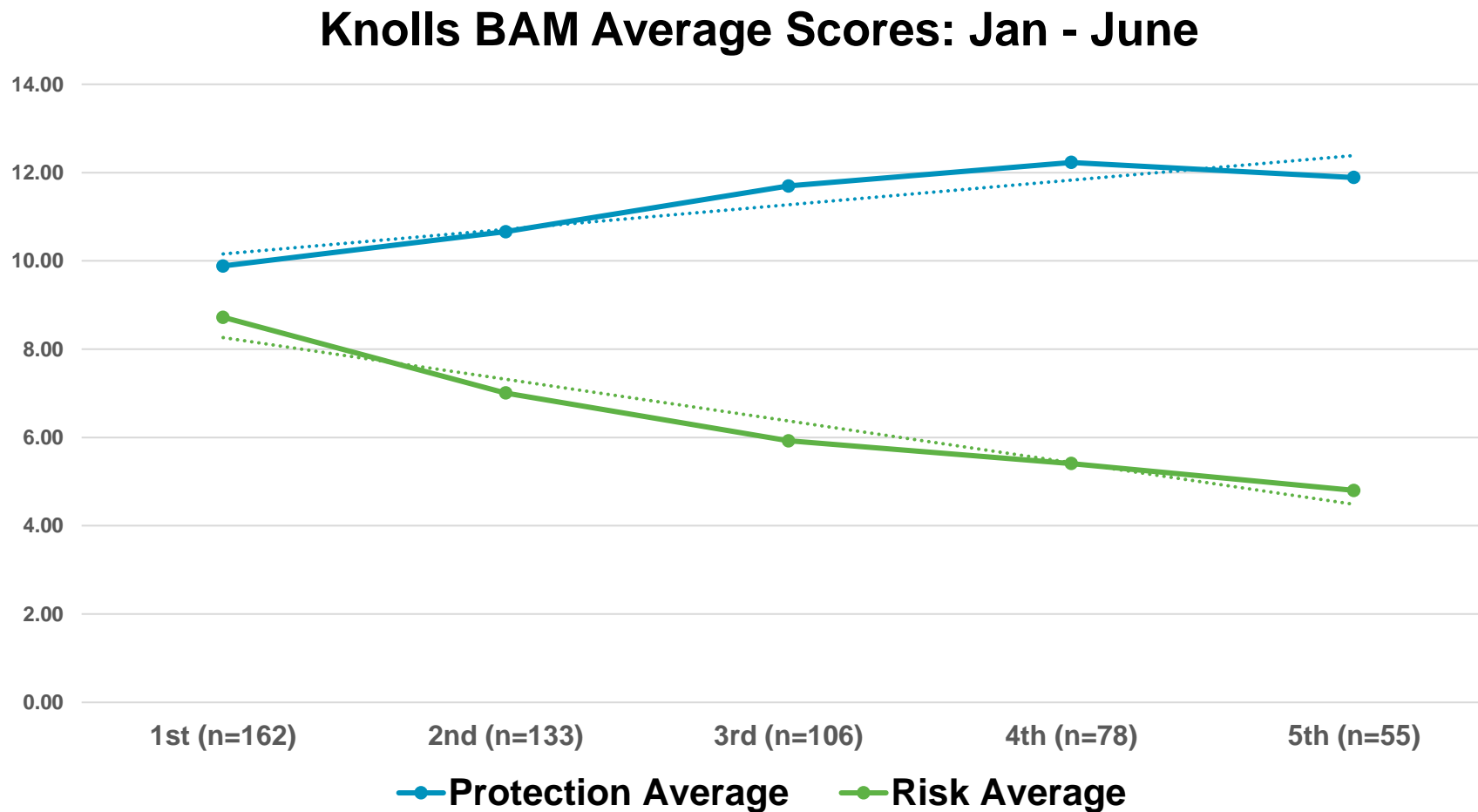
Does the Tx plan need to be modified? ☐ Yes ☒ No

Please explain: Chris will continue attending group and sessions and completing work through both.

- Program managers receive aggregate data at six-month intervals.
- Aggregate data is shared as a chart showing the average composite score for both “Risk” and “Protection” factors across subsequent surveys within the period.
- Managers have also asked to look at each of the five "risk" questions - in descending order (for each six-month period) so that they could prioritize education efforts for higher priority areas such as sleep or mood.

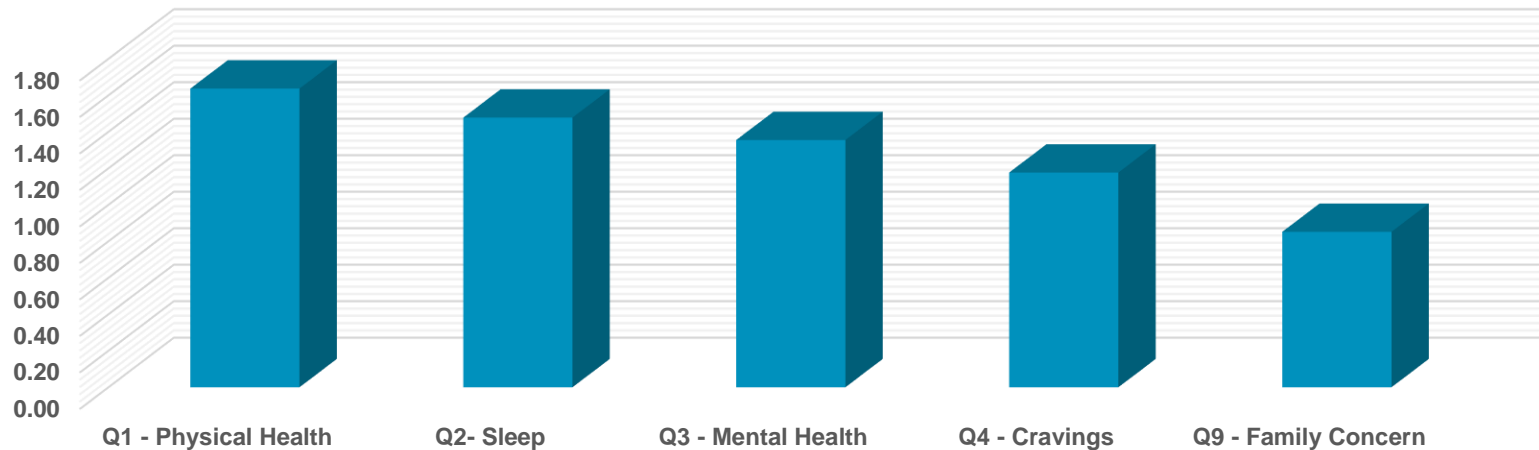


# Aggregate Risk & Protection Scores

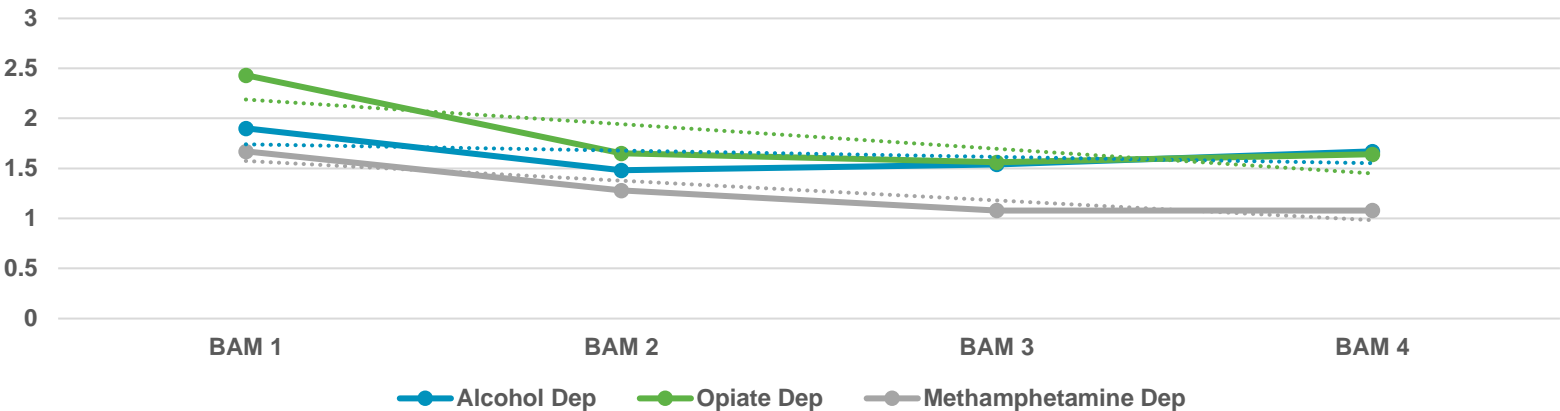


# Aggregate BAM Scores – Drilling Down on Risks

Knolls BAM (Ave) Risk Questions: Jan - June



Knolls BAM Sleep Measure (Q2): Jan-June



# Thank You

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[Unityplace.org](http://Unityplace.org)



**UnityPoint Health**  
UnityPlace

# Alta Mira Recovery Programs

## Measurement-Based Care



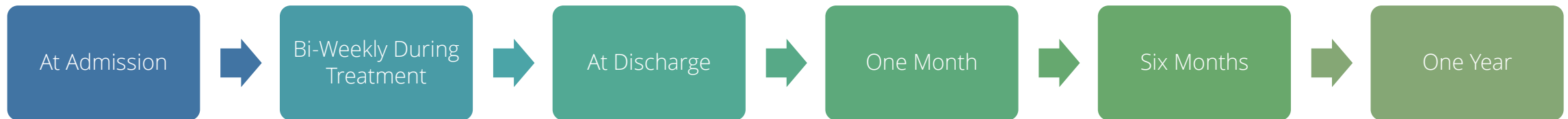
Ian Wolds



# Vista Research Group

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- HIPAA-compliant, web-based platform
- Collects data from clients about how they're feeling and summarizes it so our clinicians can use it to inform clinical care and make changes/updates to the treatment plan.
- Client issues related to treatment success can be identified and tracked
  - Co-occurring disorders (depression, anxiety, trauma, eating disorders, etc.)
  - Suicidality and self-harming behaviors
  - Cravings
  - Satisfaction with treatment
- These client issues are monitored up to one-year post-treatment



# Vista Research Group - Measurement-Based Care

- What drew our interest?
  - Independent, and therefore objective, research group.
  - Utilization of in-treatment and post-treatment surveys to measure, track, and improve outcomes.
  - Validated research methodologies and assessment tools to monitor treatment progress/efficacy.
- Progress Monitoring Surveys
  - Serve as the basis of measurement-based care
  - Conducted at intake and every 1-2 weeks thereafter throughout the course of treatment
  - Tailored to symptom areas endorsed by each client and/or selected by staff
  - Survey domains include:

*Depression - Patient Health Questionnaire (PHQ)-9*

*Anxiety – General Anxiety Disorder (GAD)-7*

*Trauma – PTSD Checklist (PCL)-6*

*Mania – Altman Self-Rating Mania Scale*

*Psychosis - PRIME Screen Revised Score*

*Suicide Risk Severity Scale*

*Eating Disorder Scales – Fasting, Intense Exercise, BMI*

*Substance Use Scales – Current Use, Frequency/Severity of Cravings*

*Quality of Family Relationships*

*Satisfaction with Treatment*

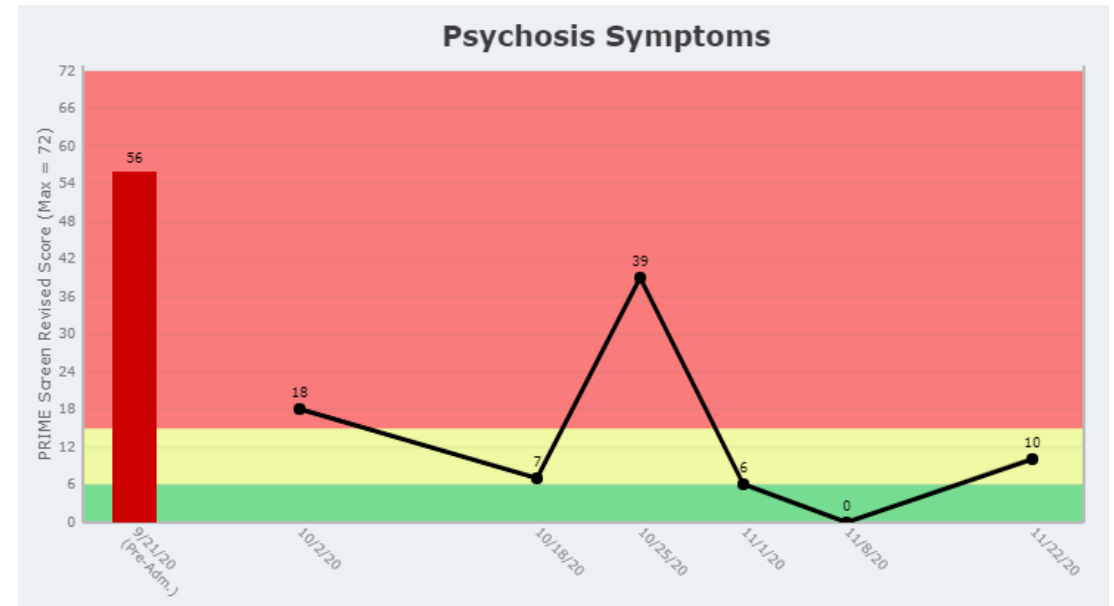
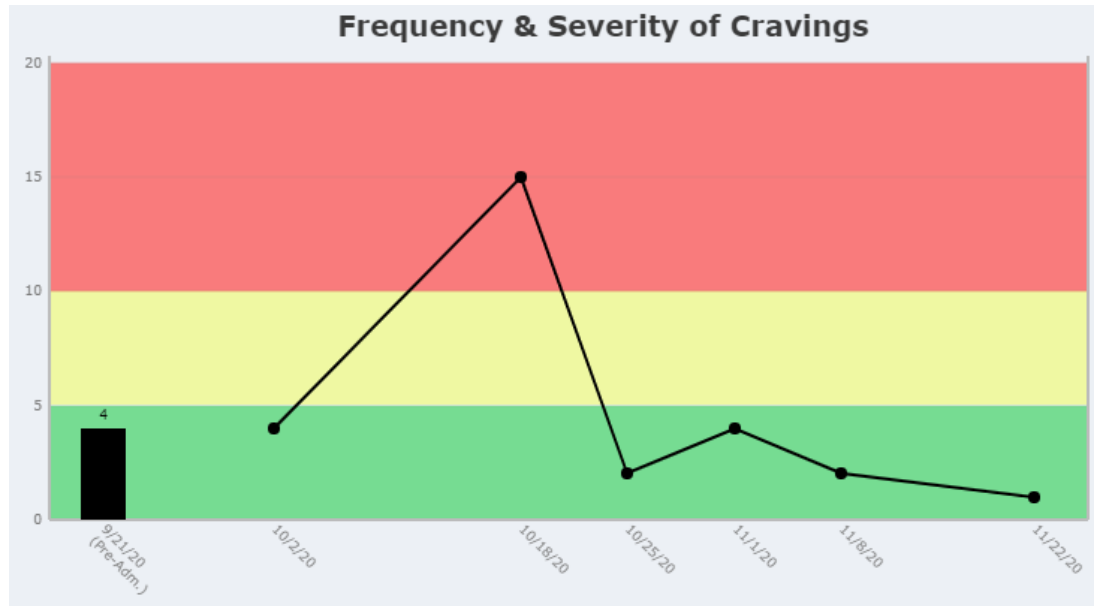
# Vista Research Group - Survey Data Utilization

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- Graphical representation of survey results allows us to:
  - Integrate survey data into weekly Treatment Team Meetings - reviewed as team, on screen
  - Track treatment response across domains
  - Determine proactive responses to persistent or increasing symptom profiles - therapeutic engagement or intervention strategies, medication management, treatment plan changes
  - Bring the client's voice via comments/self-report into treatment team discussion (Feedback-Informed Treatment)
  - Track client satisfaction closer to real-time - identify, strategize, and respond to ruptures in a manner that can demonstrate attunement and responsiveness to the client, facilitate repair, and support stronger alignment with client on treatment goals/objectives.
- Benefits experienced by our clients:
  - Highly validating to see progress over time and reflect on gains/improvements
  - Increased sense of collaboration with therapist and medical providers regarding how to address specific areas of treatment
  - Tangible demonstration of the benefits of their efforts in treatment

# Client 1

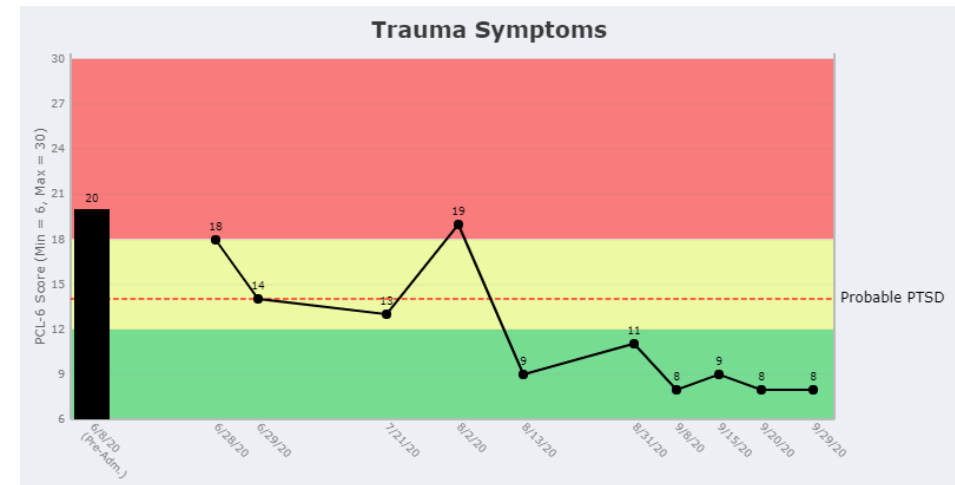
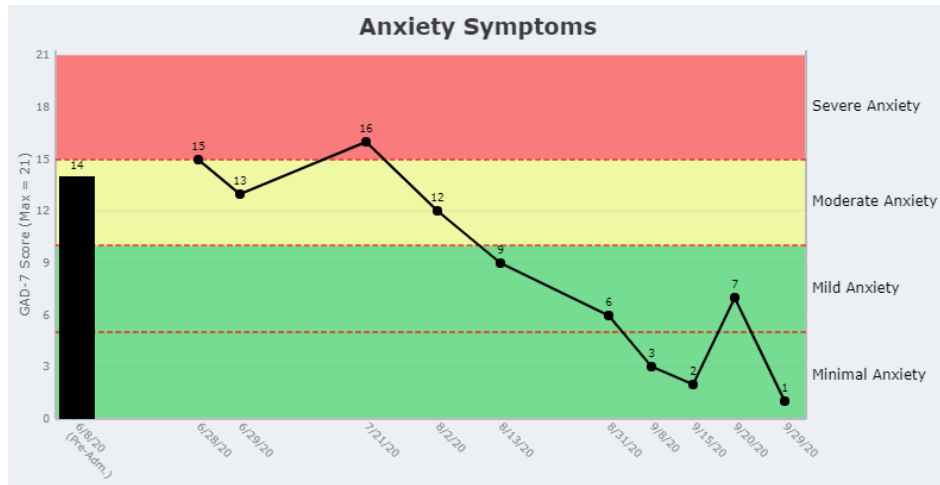
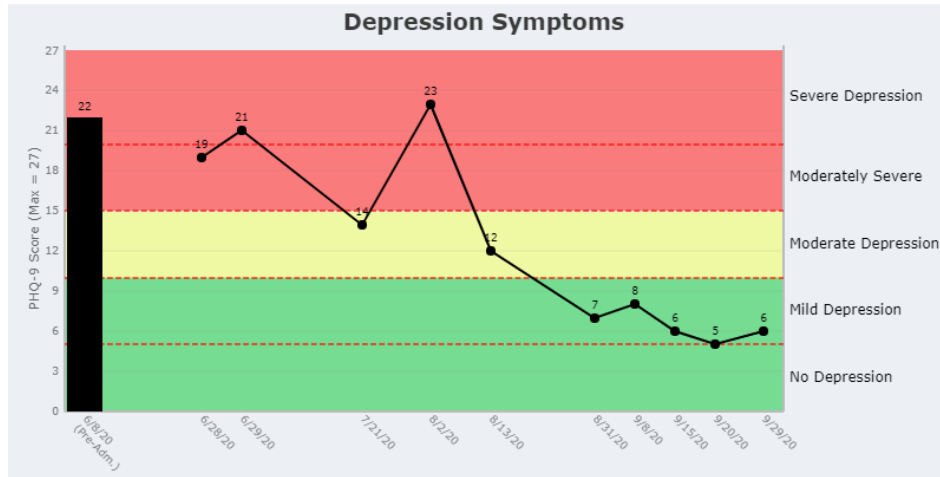
Demonstrates spikes in specific areas, allowing for targeted focus





# Client 2

Demonstrates ability to track trends and fluctuations across time that can mobilize various responses (medications, therapeutic intervention, modifications to treatment plans, etc.)



# Client 3

Demonstrates ability to respond to overall treatment satisfaction and identify/address issues that emerge regarding a person's experience of treatment.



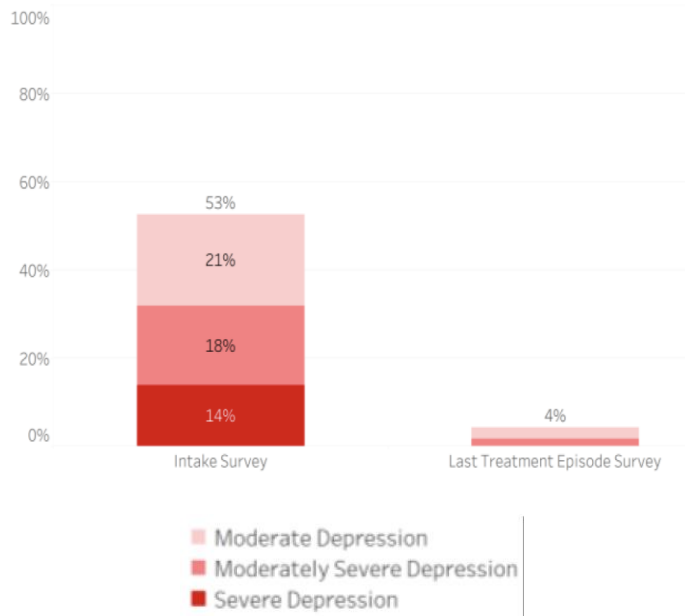
# Support for Program Development

Measurement-based improvements to support evolution of our programming, in order to benefit current and future clients.

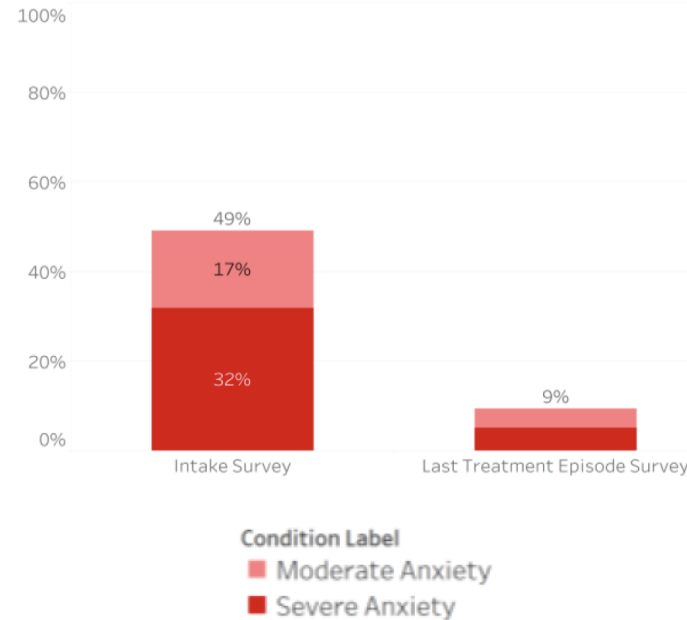
A decorative flourish consisting of a horizontal line with symmetrical, flowing scrollwork and leaf-like patterns extending downwards from the center.

# Pre- and Post-Treatment Analytics

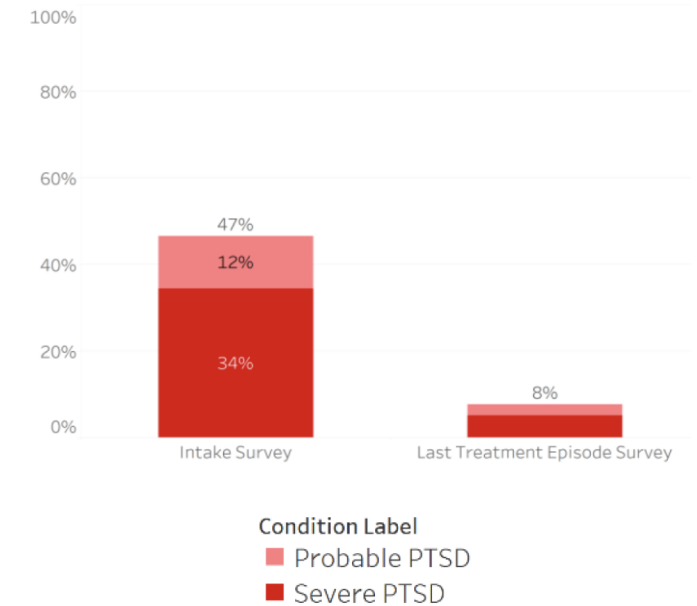
**Patient Progress On Depression Symptoms (PHQ-9)**  
(Among 116 patients in treatment between 7/1/2020 and 6/30/2021 with at least 1 progress survey response)



**Patient Progress On Anxiety Symptoms (GAD-7)**  
(Among 116 patients in treatment between 7/1/2020 and 6/30/2021 with at least 1 progress survey response)

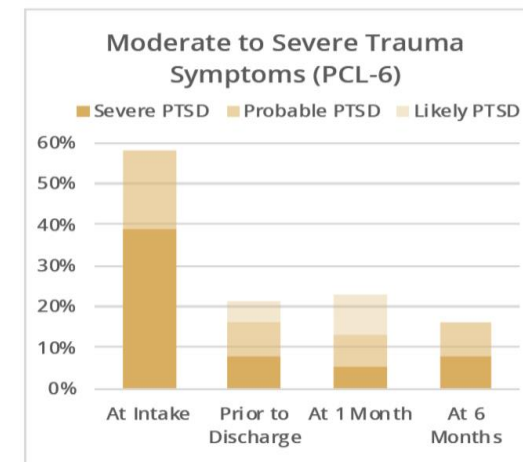
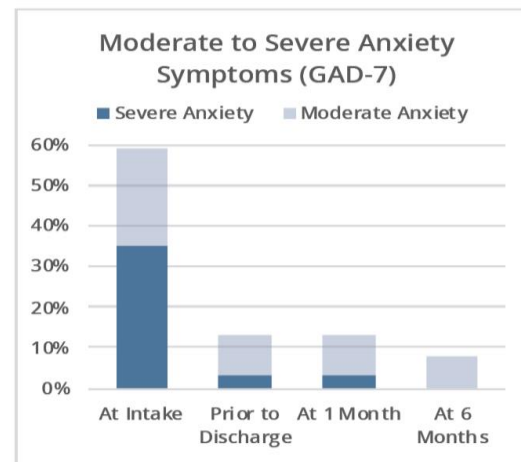
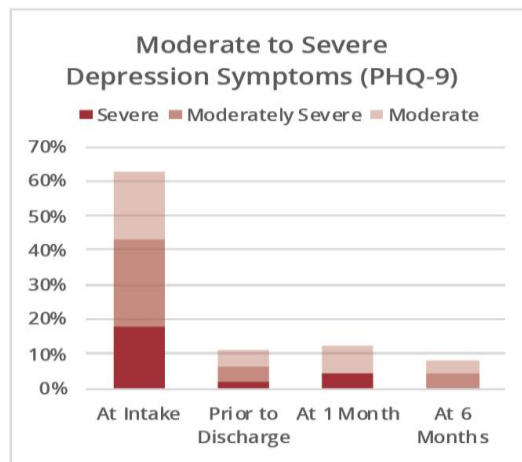
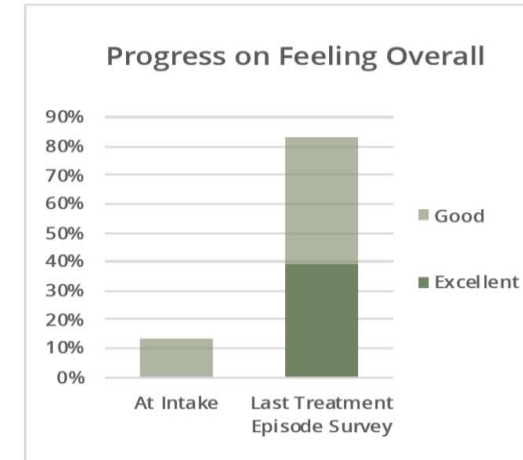
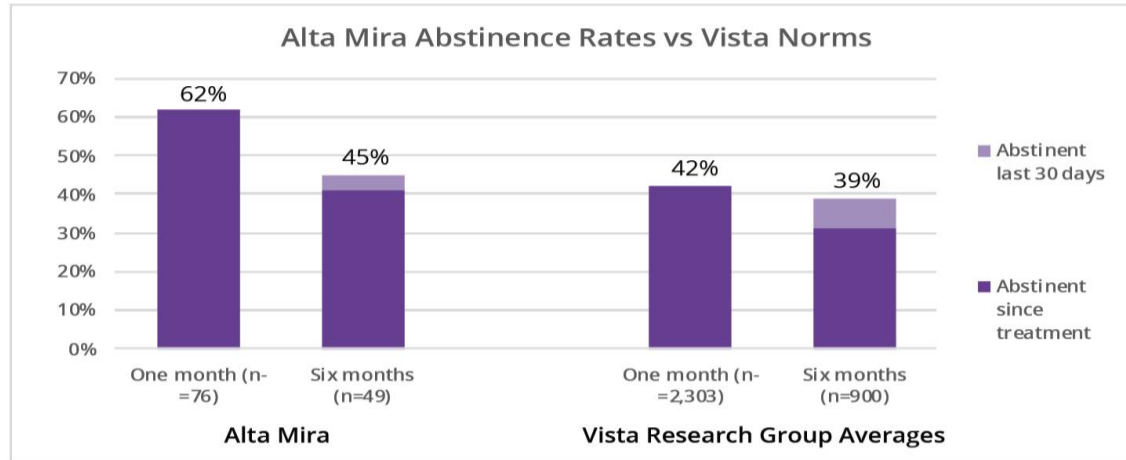


**Patient Progress On Trauma Symptoms (PCL-6)**  
(Among 116 patients in treatment between 7/1/2020 and 6/30/2021 with at least 1 progress survey response)



Source: Vista Research Group, Alta Mira Treatment Effectiveness Report July 1, 2020 – June 30, 2021

# Outcomes Data Across Intervals

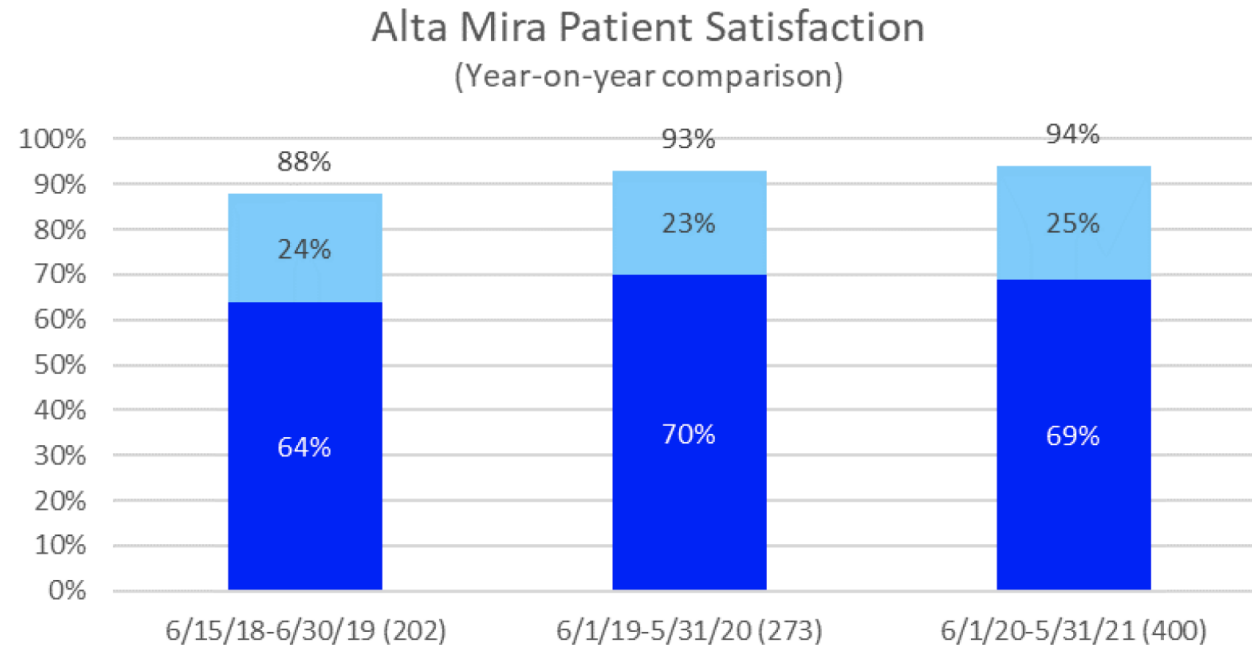


# Comparative Data and Trends over Time

This year's satisfaction rate is consistent with that of the previous year, and higher than the satisfaction rate recorded for 2018/19:

Demonstration of improvements in two targeted areas of performance:

- Survey Enrollment
- Satisfaction Rates

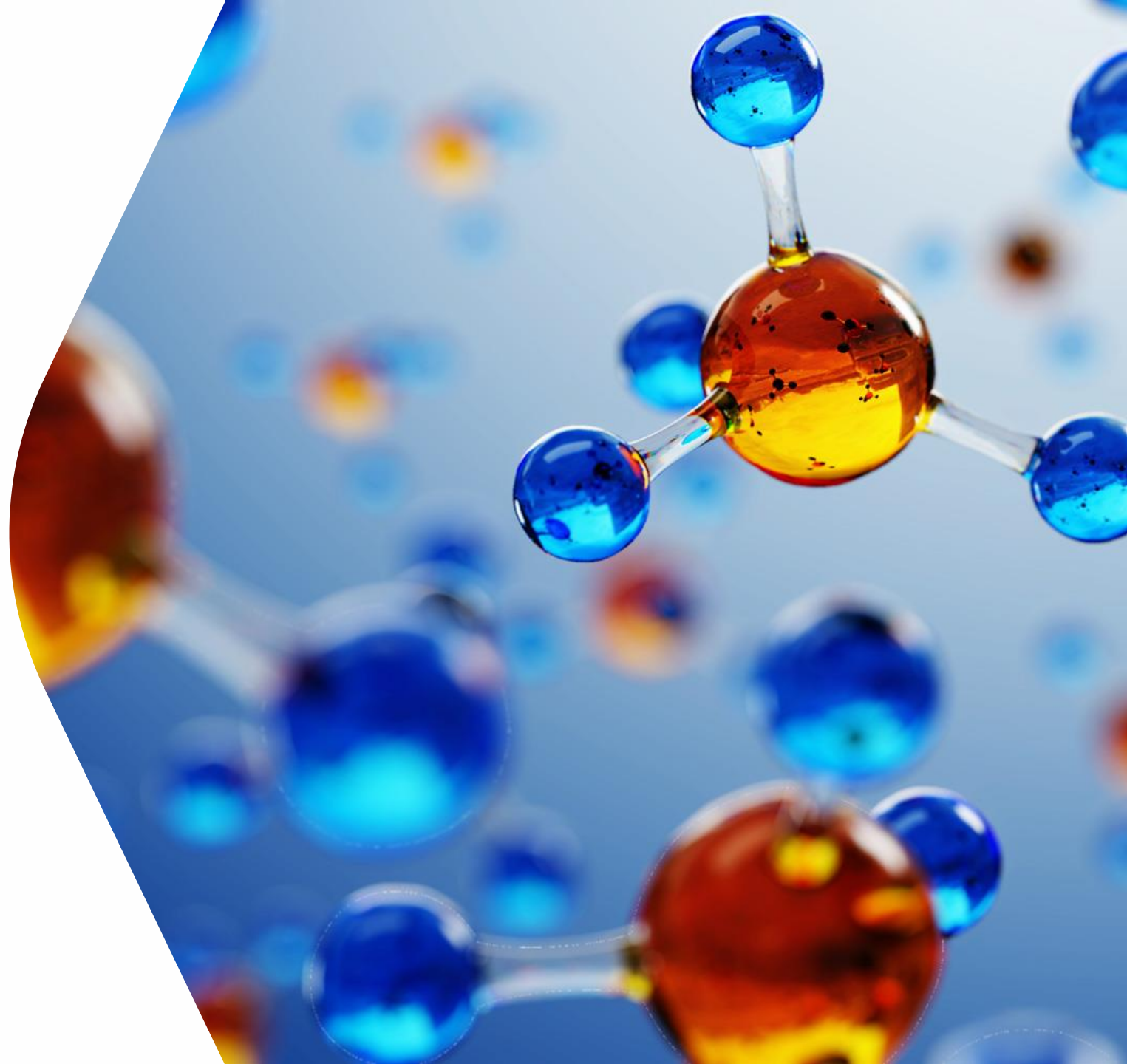


Source: Vista Research Group, Alta Mira Treatment Effectiveness Report July 1, 2020 – June 30, 2021

Measurement Based Care

John Driscoll

Sr. VP Recovery Services



# Why:

Measurement based treatment, embedded within the clinical process, ensures objective data is utilized in care decisions, ultimately improving quality and outcomes for our patients.

FIT (Feedback Informed Treatment) increases the provider's ability to personalize treatment to specific patient needs by using objective data to regularly monitor progress or regression in key clinical areas. This helps to inform:

- The need to add or change treatment interventions
- Length of stay and readiness for level of care transitions
- Ongoing recovery support recommendations



# How:

- Integrated FIT functionality within Compass/EHR supports FIT processes so clinicians have efficient, intuitive, and simplified clinical tools
- Ongoing staff training and messaging to create a culture of measurement based care within addiction treatment
- Patients easily access and complete FIT assessments in the patient portal (MyRecoveryCompass)
- Strategies to improve patient engagement in measurement based care include weekly automated reminder messages to complete FIT as a part of their care
- Yearly strategic FIT goal to measure FIT Integration across all levels of care

# FIT Assessments

- Patient Health Questionnaire (PHQ-9)
- Generalized Anxiety Disorder 7 item scale (GAD-7)
- Desire for Substances Questionnaire (DSQ)
- Commitment to Sobriety Scale (CSS-5)
- Working Alliance Inventory (WAI)



# Implementing FIT with Patients

- Patients take FIT assessments in MyRecoveryCompass; patient portal
- Register and orient patients to portal and FIT using key messages
  - Ideally registration takes place during pre-entry process
  - Admissions team registers any that are not done pre-entry
  - Patients refusing registration are referred to counselor to discuss as a clinical issue for resolution
- Once admitted, email/Message Center automated reminder is sent weekly, every Sunday

# Tracking Patient Adherence to FIT

- **Overall:** 86% of patients across all of HBFF took at least one FIT assessment in September 2021
- **Range:** 75% to 98%

Count of ASSESSMENTS_COMPLETED Col ▾				
Row Labels ▾	No	Yes	Total	%
▢ Beaverton	8	105	113	93%
Intensive Outpatient	8	105	113	
▢ Bellevue	10	48	58	83%
Intensive Outpatient	10	48	58	
▢ Betty Ford Ctr	46	323	369	
Day Treatment	6	100	106	94%
Intensive Outpatient	1	50	51	98%
Residential	39	173	212	82%
▢ Center City	109	403	512	
Day Treatment	10	87	97	90%
Residential	99	316	415	76%
▢ Chaska	1	44	45	98%

# Implementing FIT with Staff

- Trained on FIT as part of clinical model during onboarding process
- Reviewed in supervisory shadowing/record review
- Multiple reference tools available on Fusion (HBFF intranet)
- Continually enhancing functionality to EHR to streamline integration of FIT into patient care
- Monthly data collected and shared re: utilization/integration
- Strategic plan goal with annual targets tied to performance reviews for line staff, incentives for impacted leaders

## FIT

[FIT Staff Quickguide](#)

[FIT How to Assign Scorecard](#)

[Making Treatment FIT for Improved Outcomes](#)

[Updated FIT Scoring Rubric](#)

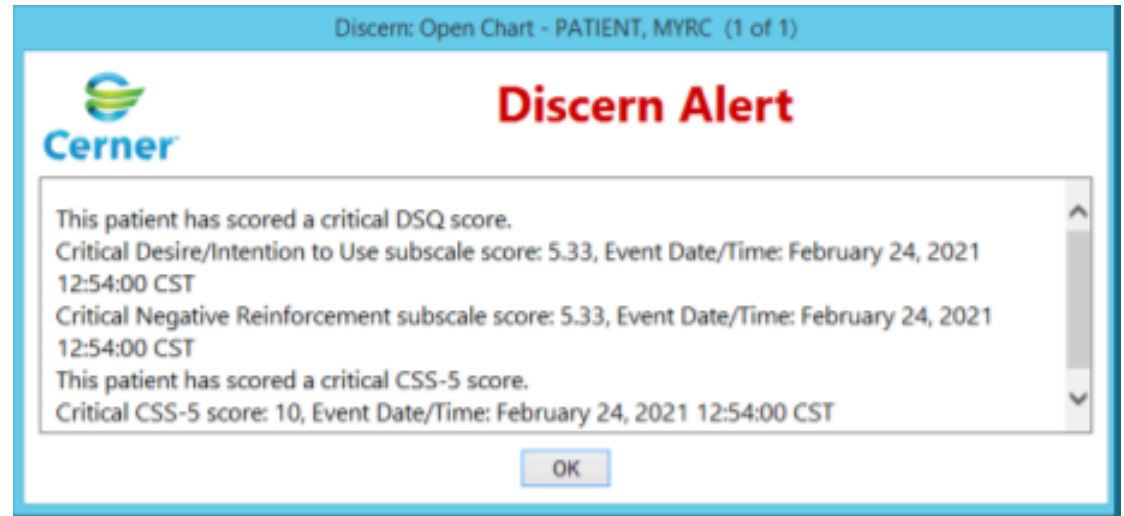
[FIT Enhancement Training](#)

[FIT Enhancement FAQs](#)

[Video: Leaders Discuss FIT vision and new enhancements](#)

# Efficient, Intuitive, Simplified Clinical Workflow

- “At a glance” dashboard view of key FIT information visible across caseload/unit
- Quicker/clearer recognition of completed assessments and “red zone” scores indicating a need for action
- Alert notifications/visuals to direct attention to high risk responses to prompt intervention
- Improved graph representation of results for observing trends/changes to be used for progress monitoring



# FIT Dashboard (home screen for all clinicians)

**FIT Dashboard**

User: **ZZTest, Counselor1** Medical Service: **Select options** Relationship Type: **Counselor**

View/Refresh Data

Show **25** entries

Search:

Headers ALL allow to sort by ascending or descending order

Patient Name	FIN	Admitted Date	Unit	Alerts	Last Assessment	CS55	DSQ	GAD7	PHQ9	WAI	Communicate	Graphs	History
<a href="#">ZZTEST_DEJAH</a>	100152761	03/31/2020	CC Cronin	24	<a href="#">02/04/2021</a>	20	3	10	14	25		<a href="#">Launch Graphs</a>	<a href="#">History</a>
<a href="#">ZZTEST_DEJAH</a>	100153329	03/20/2020	CK OP EvnWGr2	24	<a href="#">02/04/2021</a>	20	3	10	14	25		<a href="#">Launch Graphs</a>	<a href="#">History</a>
<a href="#">ZZTEST_DEJAH</a>	100152709	08/23/2019	CC Cork	22	<a href="#">02/04/2021</a>	30		12	14	28		<a href="#">Launch Graphs</a>	<a href="#">History</a>
<a href="#">ZZTEST_DEJAH</a>	100153885	09/03/2020	CK IOP EvnMGr3	22	<a href="#">02/04/2021</a>	30		12	14	28	<a href="#">Send</a>	<a href="#">Launch Graphs</a>	<a href="#">History</a>
<a href="#">ZZTEST_BRYAN</a>	100152872	10/07/2020	CC Assessment	17	<a href="#">02/11/2021</a>	14	3.67	11	11	12	<a href="#">Send</a>	<a href="#">Launch Graphs</a>	<a href="#">History</a>
<a href="#">ZZTEST_BRYAN</a>	100152706	08/19/2019	CC Cronin	17	<a href="#">02/11/2021</a>	14	3.67	11	11	12	<a href="#">Send</a>	<a href="#">Launch Graphs</a>	<a href="#">History</a>
<a href="#">ZZTEST_BRYAN</a>	100153088	02/04/2020	CC Cronin	17	<a href="#">02/11/2021</a>	14				12	<a href="#">Send</a>	<a href="#">Launch Graphs</a>	<a href="#">History</a>
<a href="#">ZZTEST_LADEMA</a>	100153330	03/20/2020	SP OP MorWmGr1	16	<a href="#">01/26/2021</a>	8				9	<a href="#">Send</a>	<a href="#">Launch Graphs</a>	<a href="#">History</a>
<a href="#">ZZPORTAL_H</a>	100153477	04/24/2020	CC Cork	15	<a href="#">02/01/2021</a>	6				5	<a href="#">Send</a>	<a href="#">Launch Graphs</a>	<a href="#">History</a>
<a href="#">ZZTEST_IMEDXA</a>	100154473	12/29/2020	CC Med Serv	13	<a href="#">02/12/2021</a>	30				7	<a href="#">Send</a>	<a href="#">Launch Graphs</a>	<a href="#">History</a>
<a href="#">ZZPORTAL_F</a>	100152842	11/08/2019	CK IOP EvnMGr2	10	<a href="#">01/15/2021</a>	7	1.67	2	2	6	<a href="#">Send</a>	<a href="#">Launch Graphs</a>	<a href="#">History</a>

Click to open patient chart

Open and review answers on most recent FIT Assessment

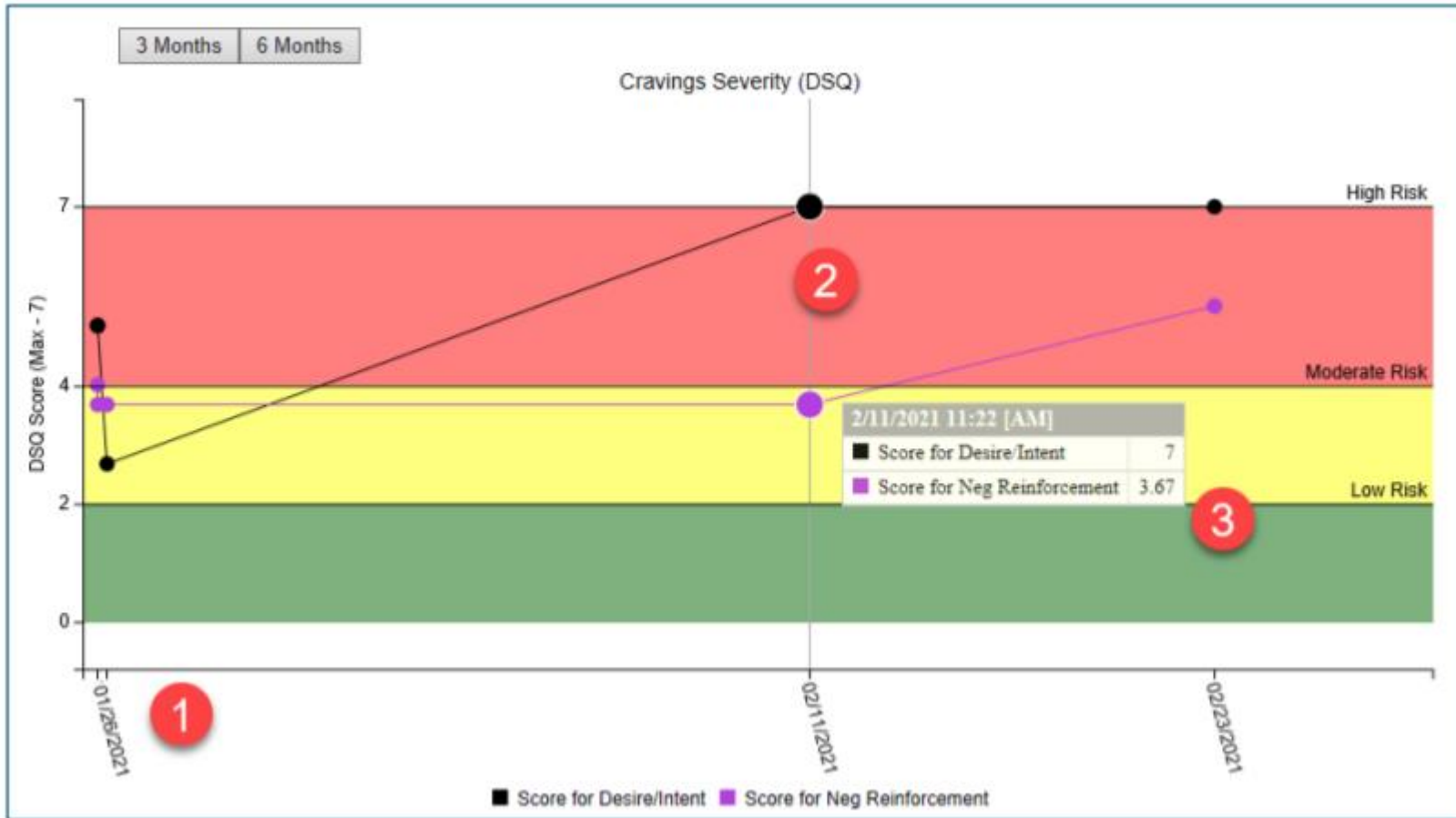
Columns display scoring ranges in color Mild, Moderate and Severe Refer to FIT Rubric for next steps

Communicate with patient using Message Center

View 3 and 6 month FIT scoring trends

Direct link to Patients Results Review tab

# FIT Graphs: Progress Over Time



1. This recognizes the first date of assessment within the 3 or 6 month view.
2. Denotes subsets of scoring. In this case there are two different subsets in the DSQ.
3. Hover over the individual axis point to view the overall date and time of the FIT Assessment.



# Scoring Rubric: Making meaning, Taking action...

Assessment Tool Name	What is the tool assessing?	Score Interpretation	Clinical Action Steps/Suggested IPOCS
Patient Health Questionnaire 9 Item (PHQ 9)	Depression severity	0 – 9 = None or mild	None
		10 – 14 = Moderate	<b>Action Step:</b> Monitor symptoms, add/change interventions if not resolving
		15 – 27 = Severe	<b>Action Step:</b> Consult with/Refer to internal/external Mental Health for individual therapy; Consult with/Refer to internal/external psychiatry for evaluation; Update treatment team <b>Note:</b> If severe impairment or poor response, consider referral to MH-specific facility <b>IPOC:</b> Improve ability to manage symptoms of mood disorders <b>Dim3</b> ; Maintain stability with mental health symptoms <b>Dim3</b>
Generalized Anxiety Disorder Scale 7 Item (GAD-7)	Anxiety severity	0 – 9 = None or mild	None
		10 – 14 = Moderate	<b>Action Step:</b> Monitor symptoms, add/change interventions if not resolving
		15 – 21 = Severe	<b>Action Step:</b> Consult with/Refer to internal/external Mental Health for individual therapy; Consult with/Refer to internal/external psychiatry for evaluation; Update treatment team <b>IPOC:</b> Improve ability to manage symptoms of anxiety <b>Dim3</b> ; Maintain stability with mental health symptoms <b>Dim3</b>
Desire for Substances Questionnaire (DSQ)	Cravings severity	<b>Subscale 1: Desire/Intention to Use</b>	
		0 – 2 = Low risk	None
		3 – 4 = Moderate risk	<b>Action Step:</b> Monitor symptoms, add/change interventions if not resolving
		5 – 7 = High risk	<b>Action Step:</b> Consult with/Refer to internal/external medical provider for MAT; Assess for atypical discharge risk; Update treatment team <b>IPOC:</b> Incorporate medication assisted treatment into recovery plan <b>Dim1</b> ; Reduce cravings for substances and manage symptoms of withdrawal <b>Dim1</b>
		<b>Subscale 2: Negative Reinforcement</b>	
		0 – 2 = Low risk	None
		3 – 4 = Moderate risk	<b>Action Step:</b> Monitor symptoms, add/change interventions if not resolving
		5 – 7 = High risk	<b>Action Step:</b> Consult with/Refer to internal/external health and wellness activities; Update treatment team <b>IPOC:</b> Increase use of coping skills for craving <b>Dim5</b>

# Goal: Integration into Patient Care

- Monthly Data
- % of patients TAKING the FIT assessments
- % of INTEGRATION into the patient care
  - Target is at least 75% in 2021
  - Target will increase in 2022

Site	July		August		September	
	FIT Integration	Percentage of Assessments Complete	FIT Integration	Percentage of Assessments Complete	FIT Integration	Percentage of Assessments Complete
Beaverton	67%	79%	59%	84%	70%	93%
Bellevue	55%	93%	50%	84%	58%	83%
BFC Day Tx	90%	98%	79%	96%	71%	94%
BFC IOP	67%	100%	90%	100%	80%	98%
BFC Res	86%	86%	84%	80%	78%	82%
Center City Day Tx	65%	89%	50%	93%	74%	90%
Center City Res	69%	80%	59%	75%	49%	76%
Chaska	77%	97%	67%	97%	67%	98%
Chicago	39%	83%	50%	78%	53%	84%
Maple Grove	68%	96%	67%	95%	79%	96%
Naples IOP	71%	82%	27%	87%	36%	95%
Naples Residential/Day TX	59%	92%	64%	90%	54%	89%
Newberg Day Tx	23%	87%	42%	92%	33%	91%
Newberg Res	42%	72%	20%	77%	60%	81%
New York	28%	81%	56%	70%	37%	75%
Plymouth Day TX			70%	94%	58%	87%
Plymouth IOP	4%	86%	8%	73%	27%	95%
Plymouth Res	48%	82%	76%	75%	58%	77%
San Diego	62%	83%	40%	83%	40%	80%
St. Paul Day Tx	44%	91%	48%	92%	61%	96%
St. Paul IOP	63%	96%	48%	94%	55%	96%
W. LA	20%	79%	25%	80%	57%	77%

# Determining “Integration”

- Getting to “yes”:
- FIT assessment taken
- Results reviewed and documented
- Action taken for concerning results

Betty Ford Day IOP- FIT Data Review					
	Was a FIT assessment completed within the seven days prior to the randomly selected date?	Were the FIT assessment results reviewed within 7 days of completion (14 days for those that do not require weekly IPS), as identified in the IPS (with two weeks of FIT results summarized for those that do not require weekly IPS)?	Was there documentation of score results (green/normal, yellow/concerning, or red/critical) and identified clinical action steps if required for red zone score (with two weeks of FIT results summarized for those that do not require weekly IPS)?	FIT Integration	FIT Review dates 9/7-9/14
100266787	yes	yes	yes	yes	Overall Site Score 80.00%
100266831	yes	yes	yes	yes	
100260589	yes	yes	yes	yes	
100265165	yes	yes	yes	yes	
100262129	yes	yes	yes	yes	
100263883	yes	yes	yes	yes	
100266473	yes	yes	yes	yes	
100264695	yes	yes	yes	yes	
100268341	yes	no	no	no	
100265994	no	no	no	no	
					FIT completed 9/7 and 9/13, no IPS completed after 9/3
					FIT not completed during the month of September

# Highlights

- Dashboard has helped streamline entire process
- Clinicians that have integrated FIT into care model seeing benefits such as catching clinical issues to intervene sooner, potentially preventing atypical discharge, poor outcome
- Helps clinicians explain progress and/or areas of focus for patient to work on, through objective data that the patient provided
- Patients like seeing progress on the graphs
- Utilization with managed care, objective, measurable data helps with additional days authorized for care

# Challenges

- Inconsistent integration across locations
- Shifting clinicians to using FIT as part of clinical practice vs a “bolt on” or “box to check”
- Ensuring documentation of FIT integration occurs in a timely way AND in a standardized location
- Patients not able to access mobile phones at several residential locations (changing soon!) makes taking assessments more difficult
- Some patients do not have email addresses (required for registration)
- Working on ways to aggregate the data to help with informing programmatic changes (coming soon!)

# QUESTIONS





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# Thank you for joining us!

