

How Can We Encourage Clinicians to Support Outcome Monitoring?

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Short Communication

Almost two decades have elapsed since Sperry's article (1997) appeared announcing an "Outcomes Revolution." Since then it is still making its way into becoming a routine part of clinical practice. Yet we need to use the measurement of treatment outcomes to determine if effective and economically responsible healthcare has been delivered. Outcome Measurement means making meaningful measures of quality, access and cost visible by using standardized measurement instruments. Outcome Monitoring means using those instruments to assess these key metrics at pre-determined points in the processes of care. Outcome Management means collecting data on individuals, populations and services to continuously improve performance.

Unfortunately, at present, Outcome Measurement and Monitoring is too seldom used in daily psychiatric practice. Clinicians, organizations, government bodies, insurers and other stakeholders throughout the world are trying resolutely to promote their use [1-3].

Is it possible to build measurement into daily psychiatric practice?

An important aspect of Outcome Monitoring is to feedback meaningful information of performance and outcomes to patients and clinicians. Two meta-analyses by [4,5] show that offering feedback of outcomes had little effect in daily practice unless: 1) both patient and clinician were offered feedback on at least two occasions, and 2) the information provided concerned progress in the treatment. These findings were confirmed by Carlier [5].

However, the approach used by Lambert is quite different. His research was carried out on psychotherapy groups in a highly organized setting; his baseline was groups that had shown no improvement, the Not on Track or NOT group. The NOT group did show significant improvement after introducing a variety of interventions, including a warning signal for client improvement (four color codes indicates the degree of progression: normal, adequate, less than adequate, no adequate progression steps should be taken changes in treatment), a clinical support tool that used a decision tree, and ongoing electronic feedback each week.

In my work (see Buwalda, PhD thesis [6], we studied the entire process of validating and implementing Outcome Measures; our setting was a psychiatric outpatient clinic for anxiety and mood disorders. We aimed to understand the three quality domains defined by [7] structure, process and outcomes. Our study consisted of two parts; the first evaluated the validity of the Outcome Monitoring measures: are these measurement instruments capable of demonstrating insight into the treatment process? The second studied the implementation of the outcome measures, where we offered feedback about the treatment results to clinicians and patients, as well as their attitudes about the use of Outcome Measurements in daily clinical practice.

We trained clinicians to interpret outcomes of treatment, though feedback to them showed little impact on results. The patients were divided into three groups: the "Care as Usual" group; a "Reflective" group (for which clinicians could complete two very short measures, the Clinical Global Impression scale [8] ;and the Global Assessment of Functioning (GAF; Endicott et al., 1976) where feedback was available if they wished; and an "Obligatory" group in which clinicians were required to discuss with the patients 1) the results of a standardized scale (the Health of the Nation Outcome Scales [9], and 2) a self-report scale (the Outcome Questionnaire [10]. Participation in the obligatory group appeared to have a negative effect on the willingness of clinicians to use the Outcome Measures. The extra monitoring plus the additional burden of working with researchers may have negatively influenced the attitude of these clinicians.

Professional autonomy is another factor thought to influence the use of Outcome Measures. This factor may determine whether a clinician is inclined to use the data and feedback generated, or not. In our experience, it is important to consider the effect of Outcomes Monitoring on professional autonomy; unless autonomy is respected the implementation of Outcome Measures can fail [11]. Lambert created an atmosphere which led to minimal intrusion in the treatment process [10,12]; perhaps his focus on failed treatment (the NOT group) helped. In our study this was impossible. [13], studied the use of Routine Outcome Monitoring in Leiden, the Netherlands, but did not evaluate clinicians having feedback voluntarily the results of treatment to their patients and their intention to change their behavior to use outcome measures in their clinical practice.

In addition to the above, there were many other internal and external factors which impacted our work, and bear noting for others:

Organizational factors, including ambiguous lines of responsibility and leadership; more top-down than bottom-up leadership; unclear treatment processes; and an excess of new regulatory and financial changes imposed by external bodies;

An environment where there is little time or support for professional input due to a constantly changing health care environment;

An environment where insurers, governmental bodies and business interests determine the financial resources available to the mental health services leading to pressures to make care cheaper and to put at financial risk those who deliver care [14].

I would like to add that the patients did not have input into the implementation of Outcome Monitoring. We believe that too would have helped, as Happell has reported [15].

Another point we observed is that establishing outcomes measurement in routine clinical practice in a non-academic setting appears to be more difficult [16].

We live in times when change is the only constant. In health care, a great deal is demanded of the clinician, often while his professional autonomy is questioned. Clinicians need to be able to focus on their work and be protected from a variety of extraneous demands. Understanding any progress, or lack of it, achieved during treatment, and adapting treatment accordingly, is in everyone's interests. Research also supports engaging the patient in treatment and outcomes monitoring; the patient should be a full partner in care for it to work [17].

A properly implemented OM can promote clinical effectiveness [18] amongst others) and lead to better use of scarce resources. When those responsible for clinical and operations management partner with those involved with clinical care and monitoring [19] quality care attends the best chance to succeed. More research will tell us how to better optimize services and patient care.

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