Revised Outcome Measures Standard
Behavioral Health Care Accreditation Program

Measurement-Based Care

The Joint Commission has developed new requirements related to Standard CTS.03.01.09. While this standard has always required organizations to assess outcomes of care, treatment, or services, organizations will now be required to accomplish this through the use of a standardized tool or instrument. Feedback derived through these standardized instruments may be used 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.

Frequently 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 these standards enhancements will help accredited customers meet the growing demand to demonstrate the value of their services and increase the quality of the care, treatment, or services they provide. Several initiatives recently occurring in the field support this project. Among these is an Issue Brief released by the Kennedy Forum (www.thekennedyforum.org) entitled, "*Fixing Behavioral Health Care in America: A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services*." The Brief stated:

> "All primary care and behavioral health providers treating mental health and substance use disorders should implement a system of measurement-based care whereby validated symptom rating scales are completed by patients and reviewed by clinicians during encounters. Measurement-based care will help providers determine whether the treatment is working and facilitate treatment adjustments, consultations, or referrals for higher intensity services when patients are not improving as expected."

Nearly twenty years of behavioral health care research has demonstrated the value of measurement-based care as a tool for improving the outcomes of care, treatment, or services.[1,2,3] The findings are robust and extend across modalities, populations, and settings[4] (for example, within populations such as individual psychotherapy,[1,3] therapy with couples/families[5,6] and groups,[7] substance use treatment,[2] eating disorder programs,[8] services for children and adolescents,[9,10] and in settings as diverse as outdoor/wilderness facilities[11] to large public behavioral health care settings[12]). Measurement-based care allows the organization and individual practitioners to determine whether what they're doing is having a positive and significant impact on the individual served, and it is especially beneficial as a means to prevent the failure of care, treatment, or services.[13,14] It also helps the individual served to evaluate, in some quantifiable way, whether he or she is making progress over the course of care, treatment, or services. 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?

Choosing an Instrument

While organizations should choose an instrument that meets the basic criteria listed below, it is very important to note that the choice of instruments belongs to the accredited organization. At the most basic level, however, instruments that are used as routine outcome measures must have the following characteristics:

- 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.).

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, such as the following:

- 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://www3.ordrepsy.qc.ca/pdf/2012_11_Integrating_SandP_10_Tools_for_Progress_Monitoring_in_Psychotherapy.pdf)
- 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)

While The Joint Commission may assemble a list of standardized tools and instruments that are currently available and appropriate for meeting this standard, we recommend using the materials listed above as an excellent starting point. Ultimately, any list (assembled by The Joint Commission or any other entity) will never be an exclusive or exhaustive list, as new instruments are continually being developed. Accredited organizations must select an instrument (or instruments) that is appropriate for their setting(s) and population(s) served. It will be up to organizational leaders to identify an instrument that meets their unique needs, budget, and technical requirements and is a tool that both staff and individuals served can use. It is also possible that the organization may already be using a tool/instrument that meets the requirements of the standard.

Among the many things to consider when selecting an instrument, *cost* is likely an important factor. Fortunately, the costs can be as different as the tools themselves. 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). As cost is considered, it is important to distinguish between an *instrument or tool* and a *measurement system*. An instrument (or tool) is essentially a standardized data collection form. In many cases, the forms can be administered with paper and pencil and scored manually. In contrast, the term "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 the process may include administering an instrument using tablets or smart phone apps, automated scoring, aggregation, and reporting. Many can even provide real-time feedback directly to practitioners. These advances obviously come with a cost (which can also vary widely by vendor), and that must be considered by organizational leaders as they balance both cost and *feasibility* (i.e., time and effort spent administering, scoring, aggregating, and reporting data).

Implementation

Once the tool or instrument has been selected and implemented, *change management* should become the organization's focus. If staff are simply told they have to use the instrument to fulfill a Joint Commission requirement, chances are implementation will not be highly successful. Leadership needs to embrace the use of outcome measures and convey to staff why it is important and how it can be helpful to both staff and individuals served. Successfully implementing a change takes time and effort, and leadership needs to be committed to making the change.

Assistance for identifying and overcoming the 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.

Using the Data

The revised standard requires that organizations use the data from the instrument to track the progress of individuals served and to inform care, treatment, or services. How that is done is also up to each organization. An organization might decide to track individuals' progress with its own

"home grown" approach. This could be as simple as using the old fashioned paper-and-pencil user interface, hand scoring the instrument, and plotting each individual's progress on a paper graph. 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. Organizations may also elect to work with a measurement system vendor. As previously mentioned, these types of measurement systems can be quite helpful, but they also come with costs. Benefits may include reduced staff time (i.e., less time spent scoring and aggregating data), real-time feedback systems, clinical decision support tools, integration with electronic health records, and/or efficiencies in organization-level data aggregation.

Ultimately, data are expected to be used to *inform care, treatment, or services*. Such data can be used to objectively demonstrate progress towards goals and objectives. If data show that the individual is responding well to care, treatment, or services, then the organization will probably choose to continue what it has been doing. On the other hand, if the data show that the individual is not responding to care, treatment, or services, the organization should consider taking another approach. In such cases, the lack of progress/goal attainment should be discussed with the individual, and it may be linked to changes in the goals and objectives related to care, treatment, or services.

In addition to using routine outcome measure data as it relates to 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). 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 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.[1]
Miller S et al. 2014. The Secrets of Supershrinks: Pathways to Clinical Excellence. This article discusses the premise that to reach the top, attentiveness to feedback is crucial. [15]
Miller SD et al. 2005. Making Treatment Count: Client-Directed, Outcome-Informed Clinical Work with Problem Drinkers. This article presents a client-directed, outcome-informed approach and documents how this way of thinking about, and working with, problem drinkers facilitates better client engagement and improves treatment outcomes. [16]
Brown GS, Burlingame GM, Lambert MJ, 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. [17]

Chow DL et al. 2015. The Role of Deliberate Practice in the Development of Highly Effective Psychotherapists. Consistent with the literature on expertise and expert performance, the amount of time spent targeted at improving therapeutic skills was a significant predictor of client outcomes. Caveats and implications for clinical practice, continuing professional development, and training are discussed.[18]

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. The implementation of MFSs is complex, but is an important step in improving outcomes in routine care for children and young persons. [19]

Hannan C, Lambert MJ, Harmon 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.[20]

Brown GS, Jones ER. 2005. Implementation of a feedback system in a managed care environment: What are patients teaching us? This article summarizes lessons about patient treatment response from a large-scale outcomes management project.[21]

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