

A Different Way to Mind the Gap: Mandated Versus Voluntary Collection of Measures

Preprint

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To the Editor:

Measurement-based care (MBC) has been called the bridge for the gap between outcomes achieved in randomized clinical trials and routine clinical care.¹ Trials of MBC have improved outcomes, helped identify patients with residual symptoms, prompted clinicians to know when to intensify treatment, created more informed patients, and improved the patient-provider relationship.¹ But these previous studies were grant-funded projects which were implemented on project deadlines with research staff committed to the success of the project. In a recent letter to the editor in the *Journal*, Liu *et al.* reported on their efforts to implement a digital measurement feedback system in a pediatric clinic.² This Letter to the Editor, to my knowledge, was the first report about how a clinic implements MBC without grant funding on a project deadline, which is likely to be more generalizable to community practice. The purpose of this report is to add our clinic experience.

In 2012, I founded Child Counseling Associates, LLC (Metairie, LA) as a private practice child and adolescent psychiatry outpatient clinic. The clinic is staffed by three- to four-clinicians at a time and has included nine different clinicians over a five-year span. Collection of three standardized measures (posttraumatic stress disorder with 40 items, depression with 20 items, and anxiety with 41 items) at two time points was the clinic policy from the beginning. In 2015, a fourth measure for functional impairment (14 items) was added. The first collection of

measures is during intake in the waiting room before patients meet with clinicians. The second collection of measures is three months later. No auxiliary staff is used to collect measures.

For children six years and younger, only caregivers complete measures. For children seven years and older, both children and caregivers complete measures. For seven- to 10-year-old children, clinicians used their judgments if children are competent to complete self-administered questionnaires or if clinicians needed to read the questionnaires. Initially, all measures were collected on paper. In 2018, an electronic option was added to complete the questionnaires on an iPad.

Figure 1 shows the progress of implementation over five years for a total of 839 patients. By the third quarter of operation, we achieved a baseline assessment completion rate of 97% and then remained over 90% for all but four quarters. This contrasts with the completion rates reported by Liu et al. that hovered around 50% in the first year, 60% in the second year, 75% in the third and fourth years, and 80% in the fifth year.

Repeated-measures completion rates reached 88% by the third quarter of operation and has never dipped below 75% since then. This contrasts with the completion rates reported by Liu et al that hovered around 15% for the first two years, 30% in the third and fourth years, and 40% in the fifth year.

Our success in collecting measures is likely explained by clinician cooperation. Liu et al. noticed lackluster clinician cooperation so they added reminders during daily huddles and group incentives. As in all other known reports of MBC implementation, their success relied on voluntary implementation. In contrast, clinicians at my clinic are contractually-obligated to collect measures as part of their duties and responsibilities of employment.

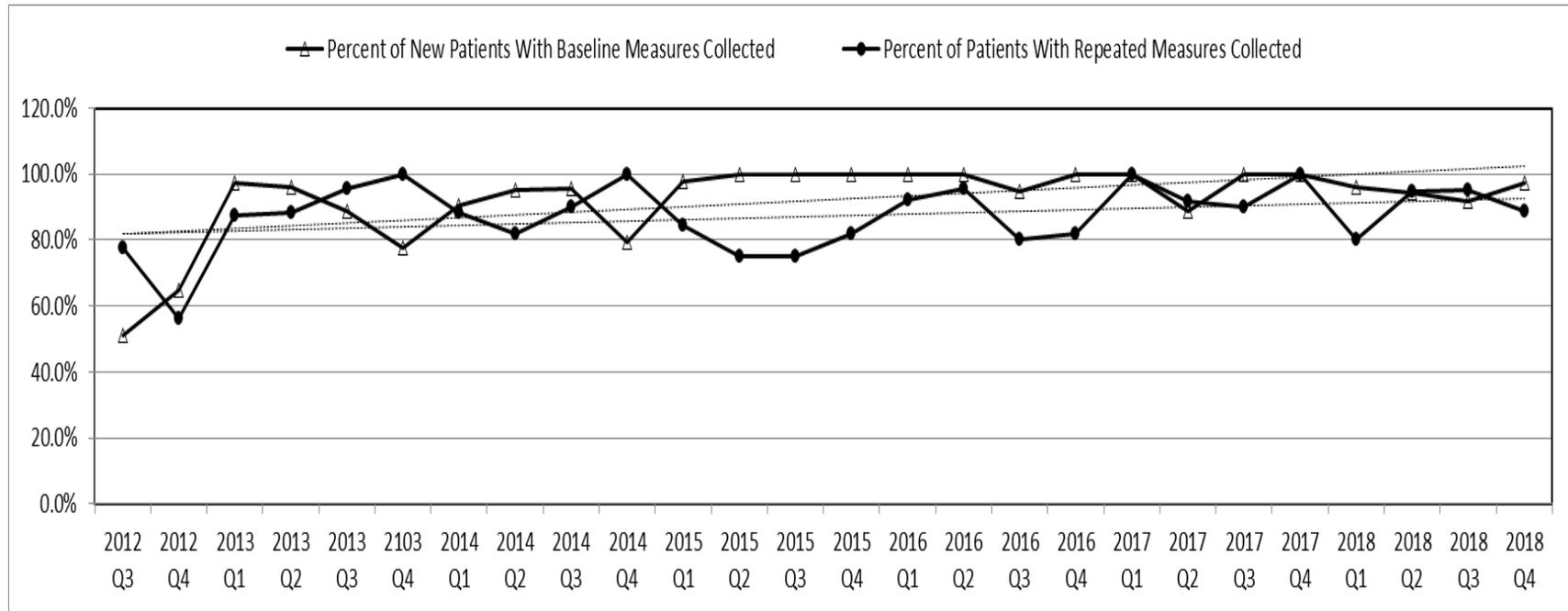
There were several other potential differences that may have influenced completion rates between the two clinics. Liu et al. involved a larger clinic with 64 clinicians. Their system was digital, and required a separate login from their electronic medical record. They did not report what measures were used, the length of measures, when repeat measures were collected, who completed the measures (parents or children), or the number of patients.

Prior studies have discussed ways to improve voluntary cooperation with champions, incentives, smartphone apps,³ memory aids, and daily team huddles.² These voluntary methods appear to have limited reach; Mellor-Clark and colleagues found that collection of outcome data levels out around 40-50% even with different procedures.⁴ Also, 80% of psychotherapist businesses are solo practices,⁵ where incentives and group reminders would not be applicable.

The promise of MBC relies on the collection of data before the data can be used. These findings suggest that voluntary implementation of data collection can penetrate only so far. New models of mandated implementation - whether this is mandated by clinic owners, insurance companies, or government agencies – appears to warrant further consideration.

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Figure 1. Progress Over Five Years of Collection of Baseline and Repeat Measures



Note: Dashed lines show the linear trend for each set of data.

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