

Measurement-Based Care in Mental Health: The What Key Themes from Session 3

Looking to our own backyard, the final webinar in our three-part education series focused in on ideas and solutions for Ontario organizations to make measurement-based care (MBC) an integral part of their mental health and addictions service delivery. The June 23, 2021, virtual session engaged more than 400 people—senior administrative and clinical leaders from hospitals and community organizations, as well as direct patient care providers. That so many were willing to take the time during an ongoing pandemic shows us there is great appetite in Ontario for learning how local peers have tackled the challenges of implementing measurement-based care.

The third session built on and echoed key themes from the first two webinars in this series. In January, **David Clark** of NHS England walked us through the “why” of MBC, demonstrating the value for both patients and providers when data collection routinely informs clinical practice and patients actively participate in that process. In March, **Dr. Juveria Zaheer** of the Centre for Addiction and Mental Health (CAMH) and **Dr. Phil Klassen** of Ontario Shores Centre for Mental Health Services spoke about the “how” of MBC, sharing their extensive experience with using routinely collected data to improve both the quality and processes of care.

The two presentations in June emphasized the nuts and bolts of implementing MBC in the Ontario mental health care context, one perspective from a decades-old program and the other from a new initiative still in the pilot stage.

With several colleagues, **Dr. Leena K. Augimeri**, Director, Scientific and Program Development at the Child Development Institute (CDI) in Toronto, told the story of CDI’s SNAP program (Stop Now and Plan) and their 35-year journey with measurement-based care. SNAP serves children aged 6 to 11 years who need help with emotion-regulation, self-control, and problem-solving, teaching them and their parents how to make better choices “in the moment.” From its inception in 1985, the program has built a “scientist–practitioner” approach that marries routine evaluation and clinical practice. Nothing in SNAP’s service delivery vision could be realized without measurement: (1) make a difference in the lives of children and families, (2) apply empirically supported treatments, and (3) scrutinize our work. The story Dr. Augimeri tells is about how data leads to findings and findings lead to improved service delivery, which then allows an evidence-based, measurement-informed program to be scaled and spread and to continually innovate.

From a very different starting point, **Dr. Simone Vigod**, Chief of Psychiatry at Women’s College Hospital (WCH), and **Dhara Desai**, the hospital’s Manager of Clinical Applications, told a story of integrating MBC into existing structures and cultures. They and colleagues at Women’s are running a pilot study of electronic measurement-based care (eMBC) for perinatal depression and anxiety to address an important gap in mental health care: In pregnancy and/or postpartum, depression and anxiety are common but only about 1 in 5 or

fewer people affected receive effective treatment. The pilot is designed around what Dr. Vigod called “the MBC checklist”: a routinely administered measure (of symptom, outcome, or process); provider review of the data; patient review of the data; and collaborative re-evaluation of the treatment plan. The opportunity—and the challenge—in this case was to embed the entire “checklist” cycle into the hospital’s Epic electronic medical records (EMR) system. “Can we leverage digital technology for this tech-savvy age group [pregnant and postpartum people] and also make it easier for clinicians to use the data?” Dr. Vigod asked.

The answer seems to be yes. Before each visit, patients get an auto-reminder to log in and complete a brief questionnaire (10 minutes maximum, 4 measures, developed with patients). The results automatically appear in the patient record, available to the provider and patient to refer to at the upcoming visit, with graphs showing change over time. “Our hope is that implementing MBC will lead to more effective treatment decisions,” Dr. Vigod said, “that it will become part of the risk–benefit calculus such as in decisions about starting or changing medication or adjusting dosage when current treatment is not providing benefit.”

Several key themes emerged from the speakers’ stories and the dynamic discussion that followed:

“Just start”

Yes, SNAP invested in MBC from the outset, but you can also jump in midstream. “Start small, but don’t be afraid to think big,” Dr. Augimeri advised, and then gradually work towards more sophisticated measurement. Start measuring based on the outcome or process changes you’re targeting, she said.

“We cannot afford *not* to engage in measurement-based practice,” stressed Dr. Augimeri. For SNAP, MBC has provided an indispensable feedback mechanism in real time. For example, they were able to learn where the manualized program was most effective (low- to moderate-risk kids) and where it was less so, which has led to program changes—and better outcomes—for high-risk kids.

Get ahead of the barriers

“We did a *lot* of socialization of our model prior to starting,” Dr. Vigod said, and a number of concerns were raised. “Is my treatment being evaluated? Will patients feel they are being reduced to a number?” Getting questions aired and addressed before the measurement starts helps avoid resistance, bring people on board from the start, and ensure everyone involved understands the purpose and benefits of the data collection.

The key thing, Dr. Vigod emphasized, is to be sure the data aren’t treated like a lab value but that the information is put into the broader context of patient–provider discussions around treatment. “It’s a collaborative process that adds MBC as another data point,” she said.

Avoiding predictable process barriers is also key. The team at Women’s College Hospital knew from others’ experience with MBC that if they created an administrative burden on clinicians or patients, they would be

setting themselves up for failure. So, close and creative collaboration with the people who know the EMR inside out has been a hallmark of their pilot. “If it adds a burden, it won’t work,” Dr. Vigod said.

Equity and access: be alert to potential issues

During the Q&A, several people asked the speakers’ about equity and access concerns. “It’s a big issue. A lot of people talk about the digital divide,” acknowledged Dr. Vigod. Recognizing that not everyone has equal access to technology, it’s critical to make sure some people don’t get left behind in your desire to automate your processes. “Even if patients answer the questions over the phone, we can still input that into their EMR,” she said.

Other equity and access issues were noted: Are patient questionnaires only available in English? Are questions about race, ethnicity, income, etc. acceptable to patients, even if we feel we need to collect this information to know whether outcomes differ by group? These and similar challenges require careful consultation and attention to ensure, for example, that the data collection aligns with your organization’s equity framework and that implementation and equity goals work in tandem.

Managing risk and privacy

Given the sensitive nature of mental health and addictions care, perhaps it’s no surprise that participants also asked about how the speakers’ programs address patient risk and privacy concerns in the data collection process. And it’s no surprise that the programs grapple with these questions, too.

In both programs, if a patient’s response to a questionnaire item indicates a risk of self-harm, this is automatically flagged for the clinician. Neha Patel, with the WCH perinatal study team, noted that whenever patients answer a question that could indicate a high medical risk, they are reminded of crisis support information and a reassurance of privacy. It’s also important, she noted, to consider carefully whether a question is appropriate for an electronic questionnaire or whether it is better to prompt clinicians to ask that question during in-person or video visits, where they can immediately respond to any risk concerns that emerge. Your organization’s ethics advisors are essential partners in this process.

In case you missed it

All three webinars in this series presented rich detail and experience about implementing MBC across diverse settings. To learn more, watch the recordings and download the presentations [here](#).

What’s next?

This series may be over, but our MBC journey is far from finished. We’re spending time this summer thinking about how to build on the clear interest and enthusiasm for this work across Ontario. Stay tuned.