Measurement-Based Care in Mental Health: The How
Key Themes from Session 2

The second webinar in a three-part education series took place on March 17, 2021. Building on our first session in January, this webinar explored lessons learned from experience in implementing measurement-based care (MBC) in mental health and addictions care in Ontario.

Series moderator **Dr. Paul Kurdyak**, Provincial Clinical Lead with the Mental Health and Addictions Centre of Excellence at Ontario Health and a leader in mental health systems research in Ontario, reminded participants that, in session 1, **David Clark** of NHS England "treated us to a tour de force" in sharing how they have used MBC to improve access to evidence-based therapies for anxiety and depression. The UK's Improving Access to Psychological Therapies (IAPT) program has achieved one of the first true "learning health systems" in the area of mental health and addictions, Dr. Kurdyak said. In a learning health system (an Institute of Medicine concept), "data collection is part of routine clinical practice, it informs quality of care, but it also informs the processes of care," he continued. "Data are collected, analyzed, and interpreted, but it doesn't stop there. They are fed back to motivate and inspire a change and quality process. It's one thing to collect data, but how do we use it to improve the care experience and the outcomes of the individuals we are treating?" This was the focus for session 2.

Our two speakers both have extensive experience implementing MBC in mental health care in this province. **Dr. Juveria Zaheer** is Clinician Scientist at the Centre for Addiction and Mental Health (CAMH) and an assistant professor in the University of Toronto Department of Psychiatry. She spoke about an implementation study of the Integrated Care Pathway (ICP), a program created at CAMH for clients with first-episode psychosis to improve equitable access to evidence-based care. MBC is a key component of this program. The study included qualitative interviews with clients, family members, and clinicians (case managers and psychiatrists) to capture their perspectives and understand why implementation rates were low for some aspects of the program. The results were informative, powerful, and sometimes surprising.

Dr. Phil Klassen, a practicing forensic psychiatrist, is Vice-President, Medical Affairs, at Ontario Shores Centre for Mental Health Services and an assistant professor of medicine and psychiatry at the University of Toronto. He presented several examples of how programs at Ontario Shores (e.g., Cognitive Processing Therapy for trauma, Stepped Care + iCBT for mood and anxiety disorders) have integrated MBC to monitor and improve access and quality. MBC is part of an organization-wide commitment at Ontario Shores to invest in technology as a tool for understanding and addressing variations in care.

Here are some key takeaways on implementing MBC from their presentations and the lively Q&A:

Challenge your own assumptions

- We may think there's a lot of resistance out there to implementing MBC, but Dr. Zaheer's qualitative research found that both clinicians and clients believe strongly in the value of MBC.
    - From providers: *"… you can notice small changes and act on them quickly."*
    - *"… the person sees how well they do on the instruments,"* helping to decrease self-stigma
    - Clients see how the routine use of scales can help them *"narrow down and recognize the way you are feeling."* MBC enables them to *"develop an average"* for themselves, to see a *"pattern across time"* and to *"compare myself to myself"* rather than against impersonal statistics (will I be part of the 90% who relapse when they stop medication, or can I be one of the people who can manage without?)

Understand the barriers you're facing

- Measurement fatigue is a reality. Clinicians say they have too many scales to complete and lack confidence the data will be used, even if they appreciate the potential for MBC to improve care.
- Some measures are more useful than others. Identify which scales or tools are most valuable for your teams. If completion is poor, find out why.

Make sure the measures you collect are useful … and used

- Don't measure what you're not going to use, and make sure what you're measuring gets back to people through sustained, routine channels (e.g., case meetings, dashboards)
- How much measurement is the right amount? Consider that question carefully and "be thoughtful about the number of clicks you require," Dr. Klassen advised. "There's an engagement and opportunity cost [to capturing data that don't get used]. It's bad for morale, and it's time not spent with patients."
- Remember that MBC is not just about capturing data about the care you deliver. It's also fundamentally a tool to empower patients. With measurement-based care, you can "make a promise to patients," Dr. Klassen said, about the process of their care, the outcomes they can expect, and the data you will engage with together every step of the way.

Build trust and collaboration

- To bring clinicians on board, rely on your thought leaders—the people known to be aligned with the best evidence and who are highly respected within your community.
- For patients, engagement and relationships are invaluable. Dr. Zaheer's study found that "feeling heard, respected, and understood" by their clinicians was, for clients and family members, the most valued part of the program. Trusting the care you receive is key.
- Can this work for diverse populations? Where the health system itself has not earned people's trust, can we earn trust for MBC? Yes, this is a challenge, the panel agreed. But without measuring, we can't know if people are receiving the standard of care. As David Clark demonstrated in session 1, MBC may be part of the solution, as it can help to reduce inequities in access and outcomes, despite social disparities.

Necessary but not sufficient: the role of IT

- Having the right hardware, software, and the people to make the IT work are obviously important foundations for measurement-based care. But they alone won't make the changes that MBC is intended to stimulate. For MBC to work, you need to build the culture, the trust, by supporting and meaningfully engaging patients, clinicians, and program managers.
- From Dr. Klassen's experience, "Your EMR is your best friend" if you can use it to "make it easier to do the right thing" (i.e., build in supports for clinical decision-making). In his work with a community of practice evaluating the implementation of Ontario Health quality standards for mental health care, a key finding was that the quality of an organization's EMR system was an important enabler. At the same time, one hospital did quite well in measuring and meeting the standards using only a paper-based system. Even if that hospital is the exception, there's a message there about what it takes to become a learning health system.

Next up: Session 3, The What — What do we need to do to overcome challenges to implementing MBC in Ontario?

Join us **April 28, 2021, 4:00 – 5:30 pm** in this three-part series. Session 3 will focus on what needs to happen to embed measurement-based care in mental health and addictions care in this province.

To register, please sign up at this link

And in case you missed it ....

Our first webinar, held on January 21, 2021, asked why Ontario should apply measurement-based care in mental health and addictions services. Watch the keynote presentation and Q&A with David Clark here