

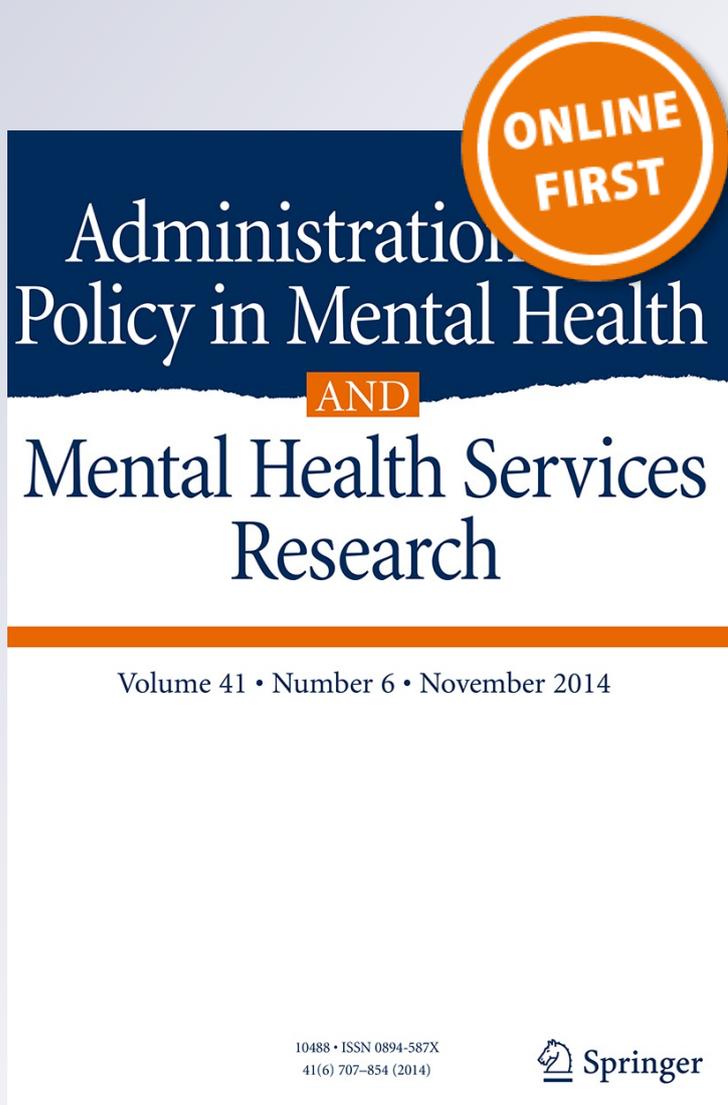
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Administration and Policy in Mental Health and Mental Health Services Research

ISSN 0894-587X

Adm Policy Ment Health
DOI 10.1007/s10488-014-0607-8



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Implementing for Sustainability: Promoting Use of a Measurement Feedback System for Innovation and Quality Improvement

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Abstract Measurement feedback systems (MFSs) are increasingly recognized as evidence-based treatments for improving mental health outcomes, in addition to being a useful administrative tool for service planning and reporting. Promising research findings have driven practice administrators and policymakers to emphasize the incorporation of outcomes monitoring into electronic health systems. To promote MFS integrity and protect against potentially negative outcomes, it is vital that adoption and implementation be guided by scientifically rigorous yet practical principles. In this point of view, the authors discuss and provide examples of three user-centered and theory-based principles: emphasizing integration with clinical values and workflow, promoting administrative leadership with the 'golden thread' of data-informed decision-making, and facilitating sustainability by encouraging innovation. In our experience, enacting these principles serves to promote sustainable implementation of MFSs in the community while also allowing innovation to

occur, which can inform improvements to guide future MFS research.

Keywords Measurement feedback system · Implementation · Innovation · Quality improvement · Sustainability

What is a Measurement Feedback System and Why Does Definition Matter?

A measurement feedback system (MFS) consists of (1) a psychometrically sound measure or measures of treatment progress and process administered frequently and systematically throughout treatment, and (2) interpreted results delivered to clinicians as timely and clinically useful feedback (Bickman 2008; Douglas Kelley and Bickman 2009). MFSs typically utilize technology for completion of measures and viewing of feedback to promote ease of use. Measures are completed by those who are central to the treatment process, such as the client (and caregivers if the client is a youth) and the clinician. MFSs have demonstrated effectiveness in improving outcomes in mental health care with adults (Amble et al. 2014; Harmon et al. 2007; Lambert et al. 2001/2005; Shimokawa et al. 2010), couples (Morten et al. 2009), youths (Bickman et al. 2011; Chorpita et al. 2008, 2011) and in general health care (Carrier et al. 2012; Goodman et al. 2013).

The burgeoning interest in outcomes monitoring from both the research and practice communities, as well as third party payors, requires attention to implementation practices that promote both intervention integrity (e.g., fidelity) and sustainable use in the context of typical care settings. We would suggest that a user-centered, theory-based, and flexibly evolving approach to MFS development and

Susan Douglas has been previously published as Susan Douglas Kelley. The three co-authors have a decade of shared experience in development and implementing measurement feedback systems as part of a research-practice partnership.

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implementation is critical (Bickman et al. 2012). This point of view¹ is based on over a decade of experience implementing a MFS called Contextualized Feedback Systems (CFS) in home-based and outpatient community mental health treatment settings for youths (Bickman et al. 2011, 2014). CFS was based on a comprehensive theoretical model of the mediating and moderating structure of feedback interventions, which synthesizes perspectives from social cognitive psychology, organizational theory, and management (Riemer and Bickman 2011; Riemer et al. 2005; Sapyta et al. 2005). The implementation of CFS emphasized a strong research-practice partnership with common goals, shared leadership and intentional flexibility to adapt and grow as challenges were encountered (Riemer et al. 2012). Here we discuss and give examples of three key principles to inform MFS adoption and implementation: (1) emphasize integration with clinical values and workflow, (2) promote administrative leadership with the 'golden thread' of data-informed decision-making, and (3) facilitate sustainability by encouraging innovation.

Integration with Clinical Values and Workflow

At its core a MFS is a tool for gathering and reporting information to support clinical decision-making (Kluger and DeNisi 1996; Sapyta et al. 2005). The MFS, in this view, simply measures client outcomes as the clinical team develops and follows the treatment plan. Regular review of feedback allows for incremental modifications to the treatment plan as needed.

Yet, the challenges in implementing a MFS are substantial. There are practical (e.g., time burden, organizational and managerial resources) and philosophical barriers (e.g., clinician perceptions and attitudes) (Boswell et al. 2013; Duncan and Murray 2012). The regular use of data from feedback in clinical decision-making may seem antithetical to the person-centered values of a typical clinician (Fitzpatrick 2012; Martin et al. 2011; Wolpert et al. 2014). Sustainable implementation requires intensive support for individual attitude and knowledge shifts (Edbrooke-Childs et al. 2014; Hall et al. 2014; Unsworth et al. 2012) and organizational culture change using complex and subtle implementation methodologies and post-implementation strategies (Mellor-Clark et al. 2014). Our implementation approach was designed to address some of these barriers by encouraging the integration of the MFS with clinical values and workflow to increase relevance in

training, reduce burden, and promote structural and leadership supports for actual use.

A core feature of our implementation and training support was the valuing of multiple forms of evidence through the integration of quantitative data with the clinician's intuition and experience (Kazdin 2008; Sexton and Douglas Kelley 2010). A key strategy to accomplish this was the incorporation of clinical language and values in our training and support materials and structure, framing the use of feedback as an interactive clinical process rather than simply a measurement and reporting process. Active learning strategies included role plays and case examples derived from actual use that highlighted the use of feedback in the therapeutic relationship and clinical conversation. For example, we found that clinicians who were top implementers (based on rates of measure completion and feedback viewing) believed that the MFS empowered clients and enhanced the client-clinician relationship through the process of engaging clients in reporting on outcomes and facilitating clinical conversation based on feedback. These anecdotal findings are consistent with the person-centered themes from qualitative studies of routine outcome monitoring (Hall et al. 2014; Martin et al. 2011; Unsworth et al. 2012; Wolpert et al. 2014).

To reduce burden related to competing demands, we worked with local agency leadership to integrate the use of MFS feedback into existing clinical workflow and support structures, such as supervision and required documentation. During the initial readiness assessment and workflow analysis stage, for example, we strategically targeted steps in workflow that increase efficiency (e.g., "What steps in the clinician workload can be eliminated or consolidated by the presence of the MFS?"). For example, in one agency the clinicians conducting home-based treatment met as a group once a week for case review and supervision. After implementing CFS, the group began projecting a session-based feedback report for one client on the wall with a brief presentation from the treating clinician. Previously, clinicians had presented from personal notes developed from a review of the written treatment plan and session documentation. The clinicians shared with the research team that this practice increased the specificity and usefulness of treatment questions and suggestions from other members of the group. As a side benefit, the clinicians also noted that they felt their cohesion as a peer supervision team had been enhanced.

Leadership support that includes explicit behavioral expectations is a vital strategy for promoting utilization of a new intervention (Fixsen et al. 2005). Policies of evaluating clinical performance by productivity (e.g., number of sessions held) might be modified, for example, to include number of feedback reports viewed and measure completion rates. Performance benchmarks should be reasonable, achievable, and based on what is known about dosage of

¹ As a point of view, we focus primarily on the experience and work of the CFS development and implementation team. It should be noted that there is a growing literature on the implementation of MFSs and routine outcomes monitoring, which is partly represented by several of the authors in this special section.

feedback that is required to produce desirable outcomes (e.g., Gresham 2014). We strongly recommend that feedback data (e.g., treatment progress) are *not* used for performance evaluation. Not only is this an example of a strategy that can negatively impact implementation by arousing anxiety in the clinical staff (Wolpert et al. 2012), it is inappropriate because we do not yet know enough about the mechanisms of action and role-relationship implications of using treatment progress or process data as performance feedback (Evans 2012; Noell and Gansle 2014).

The 'Golden Thread' of Data-Informed Decision-Making

MFSs make it possible to realize integrated, data-informed decision making at every level of a care organization (direct service, management, and executive leadership). Individual client treatment goals are linked to real-time session-by-session client data, supervision and service planning are informed by aggregate clinician or program information, and executive strategy is driven by organization-wide analysis of timely client outcomes data. This best practice concept in documentation and measurement, commonly referred to as a 'golden thread' through care, allows organizations to identify their strengths and focus on improving their weaknesses with respect to meaningful client outcomes (Lloyd 2013).

Access to timely information, consolidated so as to be relevant to a given user or organizational level, overcomes a common barrier in quality improvement initiatives; that is, limited access to easily interpreted data at the time a decision needs to be made. From a management perspective, the value of efficiently and rapidly spreading the "golden thread" of readily usable and clinically salient information that drives treatment and decision-making throughout an organization cannot be understated. For example, MFSs have been recommended as a promising tool to improve supervision effectiveness (Dorsey et al. 2013; Lambert and Hawkins 2001; Sparks et al. 2011; Worthen and Lambert 2007). A MFS is ultimately a client empowerment tool by making the client's 'voice' accessible to all aspects of clinical care including supervision. A supervisor at one of our training sites mentioned the utility of using a MFS to support clinicians for 'in the hall' supervision. As part of the typical crisis response and anxiety management that supervisors attempt when asked for urgent consultation outside of regularly scheduled supervision, viewing feedback could help place the current issue within the larger clinical picture.

Further, a MFS could be incorporated as that part of the electronic medical record that allows for tracking of client

outcomes for service planning and reporting. MFSs can work as stand alone applications in parallel with other health technology or be integrated as part of a comprehensive software solution. Reay (2013) recommends technological solutions to improve the application of data that include evidence-based practices, an electronic clinical record system, and a MFS for continuous quality improvement. The U.S. government is driving funding efforts for the mental health care community to integrate electronic health records and 'meaningful use' metrics into their administrative systems as part of the Affordable Care Act (Marriott et al. 2012). MFSs are a vital part of the current national emphasis on transforming health care by increasing the use of information technology to support clinical decision-making (DeLeon and Pachter 2010; Institute of Medicine 2001).

Facilitate Sustainability by Encouraging Innovation

Real world resources are targeted to strategies and actions that contribute to cost containment, improved productivity, and risk management. The value of a MFS in addressing the needs of an organization must be proven because service systems are inherently dynamic, while research-based interventions are typically static. Recently, there has been a shift from defining deviations from rigid implementation protocols as 'program drift' to considering them as potential innovations that may promote sustainability in local organizational and cultural contexts (Chambers et al. 2013). Likewise, the full potential of a MFS is predicated upon the capacity (and willingness) of the practice organization to be disrupted by the innovative impact of its use.

The typical continuous quality improvement cycle addresses a focal process, while a MFS represents a potentially radical and transformative use of technology that can change the treatment and management culture to improve quality. Implementation that supports innovation while driving more immediate quality improvement requires structures and interventions that are flexible but consistent, challenge static organizational practice and structure while celebrating strengths, and build culture through a combination of shared information and bi-directional communication.

An example of an inspired action that emerged from a MFS implemented in a community health system was a match between data collected as part of feedback and a pre-existing program need. The administration had identified concerns with re-engaging with families who dropped out early from treatment. Through the use of the MFS data to identify specific problems with engagement, the agency developed an initiative for a pre-treatment engagement intervention that was informed by feedback. This initiative

became an important driver in early implementation by creating strong management support for the MFS.

Such dynamic, responsive implementation requires grounding in a strong theoretical framework, and the quality of information gained will only be as sound as the soundness of the program models and outcomes measures selected (Chambers et al. 2013; Fixsen et al. 2005; Glasgow and Chambers 2012; Gresham 2014). The program theory can be used to inform the development of feedback interventions and to formulate useful implementation strategies (de Jong 2014). This balance of responsiveness and rigor allows researchers and practitioners to question at each stage where processes should be improved, eliminated, or disrupted (and which should not), thus deeply contextualizing the MFS implementation to the organization without adding undo stress or chaos. Because innovation can lead to creative, inspired action but also opens organizations to the risk of drift, organizations must be committed to ongoing implementation measurement and reporting.

Continual monitoring of MFS fidelity and use is an essential part of the feedback loop back to the MFS developers to continually assess adaptations for impact on desired outcomes. In the case of CFS, fidelity monitoring was built into the application with automated tracking of feedback viewing and measure completion (Bickman et al. 2012). Use, both in terms of adaptations and quality, can be more difficult to assess. We relied on an ongoing coaching and support framework to not only provide support to sites as needed but also to continually gather information on any implementation barriers, potential ameliorative strategies, and successful problem-solving approaches. Specific contextual factors included staff and client engagement, attitudes, leadership support, and organizational structure and resources. Notably, our discussions were data-driven by linking aggregated fidelity feedback to implementation barriers and facilitators.

Practice Implications and Future Directions

MFSs are not only evidence-supported interventions themselves—with the capacity for routine outcome and fidelity monitoring they can also support implementation of other evidence-based practices (Fixsen et al. 2005; Proctor et al. 2009; Weisz et al. 2014). There are multiple uses and users of the information produced by a MFS. As shown in the examples herein, clinicians can use feedback as an integral part of the clinical process; staff can use client-level and clinician-level data to support individual and group supervision; and agency leaders can use a MFS to support the golden thread of data-informed decision making throughout an organization. At the same time, as a data-centric technological innovation, there are several barriers

to implementation as described previously. In our experience, clients will stop regularly completing measures (if at all) if their clinicians do not support it; clinicians will stop if their supervisors and practice leaders do not support it. Without the completion of measures, there can be no feedback and thus no intervention is delivered. We believe that sustainable implementation of a MFS depends on creating ongoing value for the resulting feedback throughout all levels of an organization. Future research should explore the active ingredients and mechanisms of change of MFSs, as well as the contextual factors that contribute to innovative use to better inform strategies for responsive implementation.

Acknowledgments This paper was partially supported by the National Institute of Mental Health of the National Institutes of Health under Award Number R01MH087814. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

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