Institute for Healthcare Improvement

Advancing Measure-Informed Care in Mental Health

Innovation Report

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Authors

Mara Laderman, MSPH, Senior Director, Institute for Healthcare Improvement

Benjamin F. Miller, PsyD, IHI Faculty and Adjunct Faculty, Stanford University School of Medicine

Bhargavi Sampath, MPH, Director, Institute for Healthcare Improvement

Alex Anderson, Research Associate, Institute for Healthcare Improvement

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Institute for Healthcare Improvement

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Executive Summary

Interest in embedding measurement into mental health care is increasing, giving rise to practices closely related to measurement-based care. Measurement-based care involves systematic and routine assessment of the patient's symptoms throughout the course of mental health treatment.

Measure-informed care, another avenue for practices to integrate measurement, focuses less on protocols and more on using the best available evidence like leveraging standardized measures to track symptomatology and treatment progress. Measure-informed care is promising in its ability to address some of the patient- and clinician-driven barriers to implementing measurement-based care.

An IHI innovation project conducted between October 2023 and March 2024 aimed to understand how practices can improve the adoption of measurement-based and measure-informed strategies in mental health care, within their infrastructure and workforce constraints. While this work began with a focus on health care clinics more broadly, after research and stakeholder interviews, it was narrowed to focus on community mental health centers.

This report:

- Provides an overview of measurement-based care and measure-informed care in mental health;
- Describes measurement-based care evidence and uptake in mental health care; and
- Summarizes barriers and opportunities for implementing measure-informed care in mental health.

Background

In the absence of routine measurement, health care clinicians face challenges in detecting symptom deterioration of patients with mental health conditions.[1,2] Mounting evidence suggests that the systematic use of standardized patient-reported outcome measures (PROMs) to inform treatment addresses this critical gap in mental health care.[3] This approach, commonly known as measurement-based care (MBC), is an evidence-based practice that involves systematic and routine assessment of the patient's symptoms throughout the course of mental health treatment. Mirroring the traditional medical practice of using reliable and valid measures to inform treatment for biological conditions, MBC aims to promote patient-centered and value-based care.[4]

Interest in embedding measurement into mental health care has increased over the past several years, giving rise to practices closely related to measurement-based care, including routine outcome monitoring (ROM), feedback-informed treatment, and practice-based evidence.[5] Although not necessarily synonymous with MBC, these terms are sometimes used interchangeably with the concept.

Measurement-Based Care

To advance an operational definition of measurement-based care, Lewis and colleagues proposed four key components of the practice:[6]

- A routinely administered symptom, outcome, or process measure, ideally before each clinical encounter;
- Practitioner review of measure data;
- Patient review of measure data; and
- Collaborative re-evaluation of the treatment plan informed by measure data.

Lewis and colleagues further underscore the importance of a dialogue between the clinician and the patient about the measure data during the clinical encounter.[7] This serves to promote a common understanding of the data, discuss emerging patterns over time, and make shared decisions about the course of treatment.

One aspect of MBC that distinguishes it from other measurement-related practices is that collected data are specifically used to make dynamic changes during treatment at the individual level. It is important to emphasize that just simply establishing and tracking data for an outcome measure isn't itself practicing MBC; MBC is the process of using the measures to engage patients, ask if the measure reflects their experiences, and to help clinicians guide treatment.

Barber and Resnick subsequently advanced the Collect, Share, Act framework — a unifying, clinical model to support the implementation of MBC.[8] This framework, originally developed and implemented in the US Veterans Health Administration (VHA) mental health programs, breaks down MBC into a clear three-step process:[9,10]

1. Routinely collect patient-generated data throughout the course of treatment;
2. Share timely feedback with the patient about these data and observed or predicted trends over time to engage patients in their treatment; and
3. Act on these data in the context of the clinician's clinical judgment and the patient's experiences (i.e., shared decision-making).

Measure-Informed Care

Measure-informed care (MIC) is another avenue for practices to integrate measurement with a bit more flexibility in how they use these tools. MIC is less focused on protocols and more on using the best available evidence like leveraging standardized measures to track symptomatology and treatment progress. MIC allows for more flexibility in incorporating what matters to patients in addition to standardized, mostly quantitative, approaches to assessing symptomatology.

Measure-informed care is promising in its ability to address some of the patient and clinician-driven barriers to MBC implementation (described in more detail below) by building on the clinician-patient therapeutic relationship and engaging patients in conversations about progress toward goals that are meaningful to them. Measure-informed care may be more palatable to clinicians and patients and potentially more effective overall, as long as the same re-evaluation of progress occurs at regular intervals as with MBC. As a cornerstone of patient-centered care, MIC offers a transformative framework for enhancing clinical practice, improving patient outcomes, and advancing the quality and accountability of mental health services.

Research Aim and Methods

The aim of this IHI innovation project conducted between October 2023 and March 2024 was to understand how practices can improve the adoption of measurement-based and measure-informed strategies in mental health care, within their infrastructure and workforce constraints. While this work began with a focus on health care clinics more broadly, after research and stakeholder interviews, it was narrowed to focus on community mental health centers.

The innovation project included the following research activities:

- **Literature Review:** A literature review sought to answer the following research questions:
  - What are barriers to measurement-based care broadly in mental health care?
  - What are facilitators/enabling factors?
  - What is currently happening in community mental health centers, particularly Certified Community Behavioral Health Clinics (CCBHCs), around measurement-based strategies?
  - Who is doing this well? What can we learn from them?

  - What are financial incentives for providing specific types of care and what is the impact?
  - How do workforce challenges impact organizations and clinicians' ability to provide measurement-based care and what are potential mitigating strategies?

- **Expert Interviews:** Interviews with 18 experts in the field (see Table 1) captured insights on gaps, challenges, and opportunities in measurement-based and measure-informed mental health care.

Table 1. Expert interviews

Name	Organization
Alex Briscoe	California Children's Trust
Jonathan Brown	Mathematica Policy Research
Andrew Carlo	Meadows Mental Health Policy Institute and Northwestern University
Deborah Cohen	OHSU
Lauren Conaboy and Brad Nunn	Centerstone
Anne Herron	Substance Abuse and Mental Health Services Administration (SAMHSA)
Lindsay Hunt	Formerly with Meadows Mental Health Policy Institute
Tom Insel	Formerly with National Institute of Mental Health
Alexia Jaouich	Stepped Care Solutions
Ruben Martinez	Brown University
Keris Myrick	Person with lived experience
Joe Parks, Henry Chung, and Tiffany Francis	National Council on Mental Wellbeing
Sandy Resnick	Veterans Administration
Michael Schoenbaum	National Institute of Mental Health
Sarah Scholle	Leavitt Partners
Simon Weisz	Greenspace Health
C. Vaile Wright	American Psychological Association
Tom Zaubler	Neuroflow

Evidence to Support Measurement-Based Care

Over the last two decades, measurement-based care has amassed a robust evidence base, supporting its use in mental health practice. Several randomized controlled trials, systematic reviews, and meta-analyses have examined its effects relative to treatment as usual, demonstrating a clear benefit for patients, clinicians, and health care organizations.[11,12]

Patient Perspective

- A significant body of evidence shows that measurement-based care in mental health care accelerates symptom improvement, increases patient engagement and retention in care, and enhances patient satisfaction.[13,14,15,16]
- One study analyzing 51 randomized controlled trials on the effects of MBC found that virtually every trial with frequent, timely feedback of patient-reported symptoms during medication management and psychotherapy significantly improved patient outcomes.[17]
- A multilevel meta-analysis that examined the impact of MBC on 21,699 patients found a statistically significant effect on symptom reduction across all case types and a reduction in dropout rates.[18]
- Regardless of the patient population and type of treatment, integration of MBC into routine mental health care is associated with reduced symptom severity and increased rates of treatment response.[19,20]
- MBC has also been shown to enhance and deepen patient engagement and collaboration in the treatment process. By routinely asking patients to reflect on and report their symptoms before each clinical encounter, MBC encourages patients' active involvement in the treatment process.[21]
- Patients engaged in MBC report better understanding of their condition, more ease in quantifying and communicating their experience, and being more attuned to changes in symptoms and signs of deterioration.[22,23,24]
- Through the routine monitoring of progress, MBC also helps patients recognize early improvements in their symptoms, stay committed to their treatment goals, and adhere to the care plan.[25,26]

Clinician Perspective

- Through the routine practice of data review with patients and shared decision-making, MBC is instrumental to clinicians in identifying symptom deterioration and proactively adjusting treatment, as needed.[27,28]
- The use of symptom rating scales prompts clinicians to overcome clinical inertia and alter the course of treatment when patients are not responding to care.[29,30]

- In a study examining MBC in psychiatric care for depression, clinicians reported that routine feedback on patients' symptoms helped inform treatment decisions in 93 percent of clinical encounters and led to a treatment change in 40 percent of visits.[31,32] MBC has proven to be a vital tool in supporting (not replacing) clinical judgment to accurately diagnose and provide personalized treatment and effective plans.
- In addition to enhancing the therapeutic relationship between clinician and patient, MBC promotes collaboration and coordination among clinicians, enriching patient outcomes.[33,34,35] In the team-based collaborative care model, for instance, the care manager gathers self-reported data on the severity of a patient's symptoms and shares the information with the treating primary care clinician and psychiatrist.[36,37]

Organizational Perspective

- Beyond enhancing individual patient mental health care, MBC can be used to inform and improve care at the institutional level. Routine monitoring of patient progress enables clinicians to identify the most effective interventions and discontinue treatments that are not producing the desired results.[38] This, in turn, can lead to more efficient use of resources and better allocation of time and effort toward interventions that are most likely to benefit individuals with mental health disorders.
- The widespread use of measurement-based care presents new opportunities for health care organizations to easily analyze and improve the delivery of mental health care. Aggregated data from MBC offers objective measures to identify systemic gaps in care quality that can inform quality improvement efforts. One study analyzed public data on patient-reported symptoms of depression and anxiety to identify predictors of variation in patient outcomes, finding that patient outcomes were associated with systemic factors such as wait times between referral and start of treatment, the number of sessions, and consistency of attendance.[39]

Measurement-Based Care Evidence and Uptake

Despite the overwhelming empirical evidence of its positive impact, measurement-based care remains significantly underused in mental health practice.

- One study reports that less than 20 percent of clinicians engage in MBC, with as little as 5 percent using it for each patient visit.[40]
- Only 39 percent of psychologists surveyed indicated that they use some type of outcome assessment to measure patient progress in therapy. In 2004, the percentage was 37 percent.[41,42]
- In the United States, the Department of Veterans Affairs (VA) has emerged as a leader in adopting MBC practices in mental health care. In 2016, the VA launched a national

initiative to establish measurement-based care as the standard of care across all VA behavioral health programs.[43]

- A study that surveyed 230 clinicians across 47 VA medical centers to analyze clinician attitudes and self-reported use of MBC found a relatively high acceptance of MBC and positive experiences with the practice among VA clinicians.[44] However, there was a significant disparity across disciplines, with psychiatrists reporting the use of MBC less often than other mental health practitioners, especially psychologists, who reported the highest scores on attitudes toward and adoption of MBC.[45] This may reflect efforts by the American Psychological Association (APA) to support its members in using MBC as part of routine patient care.

Recognizing the need to support and incentivize the widespread adoption of measurement-based care in clinical practice, professional, regulatory, and accreditation bodies have instituted policies that promote MBC uptake.

- In recent years, the APA and the Substance Abuse and Mental Health Services Administration (SAMHSA) have both recommended use of MBC and advanced resources to support its implementation.[46,47]
- The Centers for Medicare & Medicaid Services (CMS) and two commercial payers announced value-based payment programs in 2015 that reward the implementation of standardized measurement.[48]
- The Joint Commission revised its Behavioral Health Care Accreditation Program in 2018 to require services accredited under its behavioral health standards to use MBC.[49]

Summary of Findings

Themes emerging from the literature review and expert interviews were distilled into a set of key barriers to and drivers of implementation of measurement-based care and measure-informed care in mental health care.

This section of the report describes the findings from the innovation project, which uncovered some of the key challenges and opportunities to effective implementation of MBC or MIC. Many challenges are likely exacerbated in community mental health centers, with their reliance on Medicaid funding, more limited technology infrastructure, and larger patient populations with complex needs.

While MBC has a more robust evidence base, MIC is a newer, innovative practice with potential to address some of the key barriers to effective implementation of MIC. For the remainder of the report, we will make a distinction between measurement-based care (MBC) when describing the evidence base, and measure-informed care (MIC) when discussing our recommendations for the way forward.

Barriers to Implementation

In the research, measurement-based care is framed as a simple and easy process (e.g., the Collect, Share, Act framework). In practice, however, MBC includes complex behavior change for both organizations and clinicians. Each step in the MBC implementation process has multiple components, and the intersection of all steps with an organization's available technology, capability, and capacity makes implementation challenging on many levels.

As measurement-based care increasingly becomes an expectation for many stakeholders, mental health clinicians and health care organizations face mounting pressure to integrate MBC into clinical practice. Studies attribute slow uptake of MBC in mental health care to persistent barriers at the patient, clinician, organizational, and systemic levels.[50,51]

- **Patient:** Commonly identified challenges to MBC uptake among patients include perceived response burden and patient symptoms or disability that impairs reporting progress.[52,53]
- **Clinician:** Barriers among clinicians include negative attitudes toward MBC, lack of knowledge and self-efficacy to adopt the practice, administrative burden (e.g., time, tools, costs) associated with MBC implementation, and concerns about how the data will be used beyond informing patient care.[54,55,56,57,58]
- **Organizational:** Limited resources for clinician training, technological support, and time needed to administer surveys present significant barriers to MBC implementation.[59,60,61]
- **Systemic:** Beyond the investment in resources, widespread adoption of MBC in mental health treatment requires a culture shift toward outcome-based care and alignment of financial incentives from third-party payers.[62,63]

Although the critical barriers to measurement-based care implementation in mental health care are well known, few strategies have been identified to address these challenges. However, researchers consistently point to implementation science as a methodology that offers guidance on evidence-based, practice-informed solutions to mitigate identified challenges.[64,65,66] These strategies include leveraging local champions, training leadership, forming learning collaboratives, using measurement feedback systems, and generating incentives.[67,68,69,70]

Opportunities and Recommendations

Synthesis of the published literature and expert interviews revealed five primary drivers to advance the implementation of measure-informed care in mental health.

Key Drivers for Measure-Informed Care Implementation

- Make measurement-based care the standard of care at the organization.
- Select measures that matter to clinicians and patients.
- Implement technology and workflows that make MBC as easy as possible.
- Work with payers to determine appropriate financial models and incentives.
- Establish leadership behaviors that facilitate implementation.

The opportunities for implementing measure-informed care described below include the following:

- Address system-related barriers to MIC implementation;
- Recommendations for patients;
- Recommendations for clinicians;
- Recommendations for practices and organizations; and
- Recommendations for philanthropic organizations and grant makers.

Appendix A describes more specific change ideas within each of these areas and Appendix B details potential process and outcome measures to track progress.

Address System-Related Barriers to MIC Implementation

Changing practice takes time, resources, and intention. Importantly, implementing MIC also entails changing the culture around mental health and mental health outcomes. Holding mental health clinicians accountable for delivering care that advances measurable outcomes and ensuring that all patients get consistent care that is aligned with the evidence is as powerful as it is challenging. That said, there are several factors that increase the likelihood of MBC being more firmly adopted by mental health clinicians and organizations.

Select Appropriate Measures

Mental health practices are often overwhelmed and overburdened with the number of measures for which they are responsible. Adding more measures into their processes is not likely to lead to successful adoption of measurement-based care.

- **Develop a balanced set of measures:** Practices need to find a balance between common measures tracked at a system level and measures that both clinicians and patients find useful to support care delivery and outcomes.

Incorporate MIC into Clinical Workflows

Consistent adoption of measurement-based care practices will be challenging if they do not clearly fit into existing clinical workflows.

- **Integrate MIC into workflows:** Develop a clear workflow pathway for measurement-based care in each mental health practice.
- **Clarify team member roles in the MIC process:** Every care team member, including peer support staff and community health workers, needs to understand their role in collecting data for MIC — from assessment and front-end intake to routine follow up.
- **Develop follow-up processes:** Mental health practices must also develop mechanisms and identify designated staff to follow up with individuals in the community who most need repeated measurements.

Realign Incentives

MBC implementation faces several challenges rooted in both structural and attitudinal factors.

- **Establish clinician incentives and training:** One prominent barrier is the shortage of incentives and clinician training to effectively utilize MBC in their practice; without these, clinicians may lack the motivation and skills necessary to incorporate measurement tools into routine care.
- **Address MIC time requirements during patient visits:** Additionally, the traditional model of health care delivery often prioritizes efficiency over thoroughness, leading to concerns that implementing MBC will cut into the limited time clinicians have with each patient during a visit. Integrating MBC into the previsit process can optimize time management and improve patient outcomes by enabling clinicians to review measurement data prior to the visit.
- **Identify electronic health record changes to support MIC:** Changes to the electronic health record (EHR) are also needed to facilitate and encourage better use of MIC. EHR changes can establish the conditions for practices to more consistently engage in MBC, provide incentive for clinicians to collect MIC data, and engage leadership support by demonstrating financial incentive for MIC as a routine part of care. There are existing third-party platforms that integrate with some EHR systems to support organizations and clinicians in using MIC.

Recommendations for Patients

One notable challenge is that some patients may perceive MIC as time-consuming and intrusive during their appointments.

- **Engage and communicate with patients:** Addressing this resistance requires effective patient engagement and communication to convey the importance of MIC in enhancing their overall care experience.

- **Establish MIC education for patients:** From the waiting room to the exam room, increasing patient education about MIC needs to be a consistent part of care.
- **Address patient data privacy and confidentiality concerns:** Additionally, concerns about confidentiality may further deter patients from fully participating in MIC, highlighting the need for practices to develop robust privacy measures and transparent communication regarding MIC data usage and protection.

Recommendations for Clinicians

Clinician attitudes toward the suitability of measurement tools for their patient populations also pose a significant challenge to adopting MIC. Clinician concerns such as those described below present significant barriers to effective MBC implementation.

- **Address perceived mismatches between the measures and the unique needs of patients:** A prevailing culture of longitudinal treatment in mental health care, which emphasizes long-term relationships and clinical judgment over standardized measures, may contribute to reluctance to implement MIC. Some clinicians express concern that relying too heavily on measurement data may depersonalize patient care, detracting from the therapeutic alliance, and this needs to be thoughtfully addressed.
- **Demonstrate how MIC practices may be used with complex patient cases:** Clinicians may feel overwhelmed by the diverse needs of their patients, making it challenging to select and interpret appropriate measurement tools accurately. High turnover rates among clinicians further exacerbate these challenges, as frequent staff changes can disrupt continuity of care and impede the establishment of MBC protocols.
- **Provide assurance that MIC data will not be misused to evaluate clinician performance and potentially penalize clinicians:** Apprehension that MIC data will be used for clinician accountability rather than as a tool for improving patient care may discourage clinicians from fully embracing MIC practices.

Addressing these multifaceted barriers to MIC implementation requires comprehensive strategies that encompass both structural changes within health care systems and targeted interventions to shift clinician attitudes and practices toward measurement-based approaches.

Recommendations for Practices and Organizations

Organizational barriers to MIC implementation include low retention rates in care, leading to high treatment dropout rates on both the patient and clinic sides. Patients leaving treatment prematurely, coupled with clinic policies that discontinue follow up after a certain period of inactivity, contribute to challenges in maintaining contact and monitoring patient progress over time.

- **Articulate the ways in which MIC advances care priorities:** As part of fostering a supportive environment for implementing MIC within organizations, leaders need to

clarify how adoption of MIC advances the priorities of the practice and the health system.

- **Establish psychological safety for clinicians:** It is essential for clinicians to voice concerns and ask critical questions about MIC, coupled with leadership engagement in facilitating MIC learning and understanding.
- **Engage leadership support:** Ensuring an accurate baseline understanding of MBC, its resource requirements, and potential benefits is vital for garnering leadership support.

Financial Considerations

The pressure on clinicians to see a high volume of patients conflicts with the additional time needed for MIC implementation during and outside of patient visits. Utilizing technology to support collecting and tracking MIC data is essential, with various approaches available, including workflows developed in-house, modifications to existing EHR systems, and third-party service clinicians.

However, limited financial resources pose significant challenges, particularly for clinics operating at a loss with minimal overhead resources allocated to data collection initiatives. Community mental health centers face additional hurdles since changes to IT infrastructure and EHR systems often require substantial financial investments and can be logistically stressful for organizations. Disparities in funding between public and private sources further impact the feasibility of MBC implementation, with the absence of reimbursement or incentives for clinicians compounding financial constraints. Addressing these financial barriers is critical to ensuring equitable access to MIC across health care settings.

Equity Considerations

It is critical to consider how to address the potential for MIC implementation to create or exacerbate existing inequities in care. One key issue is language in MIC assessment tools and measures. Language translation of measures, including different dialects of the same language (e.g., Spanish), is essential to ensure reliable data collection. Both patients and clinicians who are fluent in the language must review translated measures to ensure consistency and accuracy.

Another important equity consideration is the appropriateness of assessment tools in historically marginalized populations. The majority of validated tools used in mental health care (e.g., PHQ-9) were developed and normalized for a largely white, male population and thus may be of limited generalizability to other populations.

Recommendations for Philanthropic Organizations

Philanthropic leaders can play a pivotal role in advancing MIC by providing crucial support and resources to address the multifaceted barriers to its implementation.

- **Allocate funding for initiatives to increase awareness and education about the importance of MIC among mental health clinicians and organizations:** This includes

sponsoring training programs, workshops, and conferences focused on MIC best practices, as well as supporting the development of educational materials and resources tailored to diverse health care settings.

- **Leverage philanthropic organizations' neutral convening power to solve key MIC implementation issues:** Collaborating with health care and professional associations to develop and disseminate guidelines and toolkits for effectively implementing MIC is a great place to start. By working their networks and expertise, philanthropic organizations can facilitate knowledge sharing and capacity building within the mental health community, empowering clinicians and organizations to adopt evidence-based measurement tools and practices.
- **Advocate for policy change:** In addition to financial support, leaders of philanthropic organizations can advocate for policy changes and incentives that promote the integration of MIC into routine clinical care. This may involve lobbying policymakers to allocate resources for MBC implementation, incentivizing clinicians to adopt MIC practices, and incorporating MBC metrics into quality improvement initiatives and reimbursement models.
- **Invest in MIC integration into workflows and EHR systems:** Philanthropy can use its resources to encourage people to collaborate and partner to develop innovative solutions for MIC data collection, analysis, and utilization. This includes investing in the development of user-friendly EHR systems and data analytics platforms that support seamless integration of MIC into clinical workflows and decision-making processes.

Conclusion

Although there is a significant body of evidence supporting measurement-based care in mental health, implementation has been stalled due to myriad barriers related to clinician culture, insufficient organizational systems and technology, patient hesitancy, and a lack of financial and other incentives. Measure-informed care can help clinicians and organizations better meet the surging demand for mental health services by supporting patients who have sufficiently improved to be discharged from regular, weekly therapy appointments. Demonstrating impact can help with future contract negotiations with payers as value-based contracts require quality metric reporting for enhanced payments.

However, MIC represents a paradigm shift for many practices, which is both its promise and its peril. On one hand, the adoption of MIC has the potential to revolutionize mental health care delivery by introducing evidence-based decision-making and promoting personalized treatment approaches. By systematically collecting and analyzing patient-reported outcome measures, clinicians can gain deeper insights into individual symptom trajectories, treatment responses, and therapeutic needs. This data-driven approach enables clinicians to identify early warning signs of relapse, adjust treatment plans accordingly, and optimize outcomes for their patients.

On the other hand, MIC integration into routine clinical practice poses significant challenges, including logistical barriers, resistance to change, and concerns about the feasibility and sustainability of implementation. Many clinicians may lack the necessary training, resources, and infrastructure to effectively implement MIC protocols in their daily workflow. Moreover, the additional time and effort required to administer, score, and interpret outcome measures may strain already limited resources and exacerbate clinician burnout. Additionally, there may be skepticism or reluctance among some clinicians to embrace a more standardized approach to mental health care, fearing it may undermine their clinical judgment or autonomy.

Despite these challenges, the potential benefits of MIC far outweigh its inherent complexities. By fostering a culture of accountability, transparency, and continuous improvement, MIC empowers clinicians to deliver more effective, patient-centered care and achieve better outcomes for individuals with mental health conditions.

Successful implementation of MIC, however, requires comprehensive clinician training, organizational support, and ongoing quality assurance efforts to ensure its integration into routine practice and maximize its impact on patient care. Ultimately, MBC represents a transformative opportunity to bridge the gap between research and practice, elevate the standard of care in mental health, and improve the lives of countless individuals worldwide.

Appendix A: Sample Change Ideas for Implementing Measure-Informed Care

- **Make measure-informed care (MIC) the standard of care.**
  - Develop consistent messaging around MIC for patients and all staff.
  - Provide training for clinicians that includes CEUs and other incentives.
  - Establish decision-making support, guidance/guidelines, and/or algorithms to support clinicians with what to do with different assessment results.
- **Select measures that matter to clinicians and patients.**
  - Create a balance between common system-level measures (likely quantitative) and measures individuals find useful to assess their own progress toward goals (likely qualitative).
- **Implement technology and workflows that make MIC as easy as possible.**
  - Complete measurement-based care (MBC) screening tools ahead of visits.
  - Determine how to collect data — phone, email, people responsible for registering patients and maintaining patient records.
  - Integrate the MIC process into existing workflows — assessment practices, front-end intake, routine follow-up.
  - Implement technology to support MIC — templating notes, reminders, multimodal ways to complete.
  - Establish mechanisms and designate people (e.g., peers, community health workers) to follow up with individuals in the community to get repeated measurements.
  - Assess existing EHR capacity and determine in-house capacity to integrate MIC vs. contract out to a third-party platform.
- **Work with payers to determine appropriate financial models and incentives.**
  - Health plans/managed care organizations can provide infrastructure for clinics to access different systems, implement MIC themselves, or sometimes do outreach and follow up.
  - For Certified Community Behavioral Health Clinics, funding is flexible and can be used to upgrade their EHR, hire peer support staff to engage patients after they've left services, support data collection, or support outreach and initial engagement in services.
  - Use MIC to market the mental health clinic to payers (and patients), demonstrating the impact of MIC practices on outcomes of interest.
  - Improve financially feasible ways for clinics to share and receive information (e.g., simple things like notifications when a patient shows up in an ED or when they're discharged from the hospital).

- **Establish leadership behaviors to facilitate MIC implementation.**
    - Clinician leaders attend MIC trainings, ask questions, and model MIC in their practice and share their knowledge and experience with other staff.
    - Leadership is engaged and demonstrates commitment to MIC as a form of routine outcome measurement, not only to inform individual patient trajectories and clinicians but also to support more programmatic changes (e.g., What are we not doing enough of? What do we need more of?).

Appendix B: Sample Process and Outcome Measures for Measure-Informed Care

Process Measures

- Percentage of measure-informed care (MIC) assessments completed on time
- Percentage of MIC assessments discussed with patients
- Percentage of patient treatment plans updated as a result of MIC data, when indicated

Outcome Measures

- Percentage of patients with reduced symptoms
- Percentage of patients reporting progress toward goals
- Patient dropout rate

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