Models for Implementing Outcome Measures

Types of Assessment

Model	Pros	Cons	Comments
Using only one general measure for all patients	• Easiest model to understand for staff and patients • Easy implementation since no complicated tracking mechanism needed	• No diagnosis-specific data on patients (less specificity on what symptoms have improved/declined) • Lack of diagnosis-specific measures may create problems complying with DoD directives	If using this model, consider using the measure that your Service is already using in the Behavioral Health Data Portal (BHDP).
Using a general measure and several diagnosis-specific measures (for all patients)	• Relatively simple to implement, as all patients receive the same packet of measures • Clinic has multiple data points on each patient that can cover diagnosis-specific symptom levels	• Patients may push back on completing multiple measures and measures for disorders they do not have • Limits how often a site will give the measures due to risk of survey fatigue and patient complaints	This is the model that has been used in various DoD programs in the past. This standardized model allows for standardization in outcome tracking.
Using a general measure for all patients and diagnosis-specific measure for those with the related diagnosis	• Aligns with the model used by the BHDP program, making it easier to transition later • Providers will have data points relevant to their particular patients (eliminates measures not relevant to patient's case)	• Clinic needs to set up mechanism for tracking what diagnosis-specific measures are needed for each patient at each visit	This is the model used by the BHDP Program, which gives a general measure (BASIS-32) and other measures as needed based on patient's case.
Using only diagnosis-specific measures for those with the disorder (no general measure)	• Reducing the number of measures makes the process easier in regards to patient time • Requires slightly less time from providers and admin staff because the general measure is dropped	• Clinic not able to compare patient progress across diagnostic categories (no general measure) • Difficult to track, as you need a mechanism for knowing what measures patients should receive	If using this model, we suggest that the clinic focus on a small number of common disorders and choose one measure for each.
Unstructured: Providers choose the measures given to their patients	• Clinic leaders avoid having to convince providers to use a particular measure • Easy implementation since no complicated tracking mechanism is needed	• No ability to gauge clinic-level improvement in patient outcomes • No standardized data on patients means no comparison across diagnostic subgroup • No governance on what measures are used	Due to time and level of effort required for implementing more structured programs, this is the most common model in DoD.

Frequency of Assessment

Model	Pros	Cons	Comments
Assess at every visit to clinic	• Easiest model as far as tracking since every patient completes the measure(s) each visit • Easy implementation since no complicated tracking mechanism needed	• Large amount of workload for staff • May encounter resistance from some patients regarding frequency • Limits how many measures can use, since more measures take more time to complete	This is the model used by the BHDP, which assesses a very small number of measures every visit.
Assess every Xth visit or week (e.g., every 4th visit to the clinic or every 4 weeks)	• Since frequency is less often, can include more measures, allowing greater range of information about patients • Patients may like this better since spend less time filling out measures	• Tracking mechanism needed is complex, requiring a lot of admin staff time • Fewer data points on patient status make it harder to gauge treatment outcome	This is the model that has been used in various DoD programs in the past. This standardized model allows for standardization in outcome tracking.
Assess pre and post treatment only	• Very light workload as far as measure administration time and tracking (outcome measures added into intake packet) • Easy implementation since no complicated tracking mechanism needed	• Capturing post-treatment scores are large obstacle, as large portion of patients stop coming once they feel better, without clinic knowing when their last session is • Fewer data points on patient status make it harder to gauge treatment outcome and when to end therapy	This model works best within programs that have a set length of time for treatment, such as 28-day inpatient substance abuse treatment or fixed length intensive outpatient programs.
Use outcome measures only in specialty tracks within clinic (e.g., PTSD Clinic only)	• Using measures for a subset of patients makes it less labor intensive • Easy implementation since no complicated tracking mechanism needed (e.g., all PTSD program patient complete the PCL every session)	• Clinic will not have data on outcomes for most of beneficiaries • Can create resentment among staff and even patients if one set of patients is seen as more important	This model may be considered when staff lack time for other models and/or when there is an intensive focus on one type of diagnosis (e.g., high interest patients or PTSD cases).
Ad hoc: Measures are administered whenever providers have time and feel it is appropriate	• By leaving it up to the clinician, admin staff not burdened by tracking responsibilities • Greatest level of flexibility for providers	• Most providers do not feel they have time to administer measures without some support • Fewer data points on patient status make it harder to gauge treatment outcome and when to end therapy.	Due to time and level of effort required for implementing more structured programs, this is the most common model in DoD.