



Implementation of an electronic routine outcome monitoring at an inpatient unit for psychosomatic medicine

Jonas Egeter, Katharina Hüfner*, Monika Sztankay, Bernhard Holzner, Barbara Sperner-Unterweger

Medical University of Innsbruck, Department for Psychiatry, Psychotherapy and Psychosomatics, University Hospital of Psychiatry II, Austria

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ABSTRACT

Background: Patient-reported outcomes (PROs) can be part of an electronic routine outcome monitoring (eROM). eROM can improve patient involvement, treatment outcomes and simplify scientific data assessment. Available studies on eROM focus on its evaluation only and lack a detailed description of the prior implementation procedure.

Objective: The aim was to implement an eROM assessment at a division of Psychosomatic Medicine and provide a detailed description of the implementation procedure.

Methods: According to the Replicating Effective Program concept the project consisted of 4 phases: pre-condition (1), pre-implementation (2), implementation (3) and maintenance and evolution (4) mainly focusing the description of the implementation procedure and a short evaluation.

Results: We describe the actions taken during the implementation procedure and steps which were taken to overcome identified barriers. All decisions were carried out based on the Participatory Action Research process. A core set consisting of sociodemographic and clinical data and a comprehensive questionnaire battery covering symptoms, functioning parameters and psychological constructs was implemented. In total 164 patients, took part in the eROM assessment from June 2015 to December 2016.

The evaluation showed that eROM was appreciated by health-care professionals (85.2%) and patients (70.2%) alike. The majority of patients (89.4%) and health-care professionals (85.7%) experienced no delays in daily clinical routine due to eROM.

Conclusion: The detailed description of the implementation process can guide institutions planning to implement eROM into their daily clinical routine. Focusing scientific efforts on the implementation process is essential since this influences all further steps such as evaluation and acceptance.

1. Introduction

Patients' self-reports of symptoms in addition to clinician-based ratings has a long-standing tradition in psychiatry and clinical psychology. In recent years, patients' self-ratings of symptoms and subjective wellbeing as well as their perception of treatment procedures or satisfaction with care have also entered other medical specialities such as oncology or orthopaedics [1,2]. The increasing importance of patients' self-reports in various medical fields resulted in the use of the new term "patient-reported outcomes (PROs)" emphasising patient-centeredness and individual treatment decision making and facilitates treatment evaluation.

PROs are defined as measurements of „any report of the status of a patient's health condition that comes directly from the patient, without

interpretation of the patient's response by a clinician or anyone else" (FDA 2009, p. 3) [3]. By now, a large number of well-validated PRO questionnaires is available that allow the standardized assessment of important psychological and psychiatric parameters, including depression [4], anxiety [5], other psychopathological symptoms [6], or personality traits [7]. These measures are used in clinical trials evaluating psychopharmacological drugs [8–10] or psychotherapeutic or psychological interventions [11,12]. However, PROs are not only of relevance for research, but are also used in daily clinical practice for treatment monitoring and screening [13–15]. In this context PRO measures provide an efficient and standardized assessment of the patient's mental health [16,17] and its improvement [18]. In recent years, PRO measures are increasingly assessed via electronic devices (e.g. tablet PCs or mobile phones) to reduce time and staff requirements related to

* Corresponding author at: Medical University of Innsbruck, Department of Psychiatry, Psychotherapy and Psychosomatics, University Hospital of Psychiatry II, Anichstraße 35, 6020 Innsbruck, Austria.

E-mail address: katharina.huefner@i-med.ac.at (K. Hüfner).

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questionnaire administration, data entry, questionnaire scoring and writing reports [19,20]. An important characteristic of electronic PRO questionnaire assessment is the immediate availability of the results for the medical staff. Electronic routine outcome monitoring (eROM), which describes the regular assessment of treatment outcomes like PROs and clinical data (e.g. weight, pharmacological serum levels, blood pressure) for continuous observation of patients health status [21], provides data that can be of use for all HCPs and improve treatment outcomes by feedback to patients in daily clinical routine [22].

From patient's perspective, eROM can contribute to improvement of treatment outcomes. The systematic feedback about treatment progress itself could be therapeutic. In this context, feedback is considered as a cognitive-motivational technique which informs and influences the patient, and contributes to the therapeutic alliance [14]. Additionally, HCPs can benefit from information that has not been communicated in initial interviews or therapeutical settings [23,24]. In the same way, ROM can also promote shared decision making between patient and health-care professional (HCP) [25].

Some previous studies on the effects of eROM on treatment outcome demonstrated positive effects on the process of care as well as varying effects on the outcomes of individual patients with a range of mental health problems [24]. The provision of feedback on ROM results proved to have a positive impact on diagnosis and monitoring of treatment and on patient-therapist communication and the process quality of treatment [14,26]. Drawing final conclusions on the effectiveness on eROM in mental health care is hindered by the methodological heterogeneity of the available studies necessitating further research [27].

Challenges in implementing eROM programs in clinical daily routine have also been identified and include the worry that eROM might require additional time resources in an already busy clinical work flow as well as clinicians' perception of their work performance being evaluated [23]. According to Valderas et al. problems regarding PROs in daily clinical routine consist of the way clinicians receive the data, clinicians scepticism of the significance of the data and the possibility of causing unintended harm by revealing previously unrecognized psychological or physical problems [28]. Black et al. also mention the potential for misuse of ROM by e.g. rationing care [29].

The implementation of a comprehensive eROM assessment in the daily clinical routine of an inpatient unit at a clinic for psychosomatic medicine is a challenging process in which many barriers have to be overcome. To the best of our knowledge, the literature on the use of eROM in psychosomatic medicine is scarce. Moreover, most studies available so far focus mainly on the evaluation processes and do not provide a detailed description of the prior implementation procedure [17,30]. The level of implementation itself, however, was shown to influence the outcomes of the any particular intervention [31]. Due to the impact of multiple contextual factors on the success and sustainability of an implementation in clinical practice, many interventions fail to meet their full potential outside their developmental setting (e.g. academic settings) [32]. The assessment of implementation data is an essential aspect of program evaluation. Therefore, we present a detailed description of our implementation procedure including a first evaluation of its acceptance.

2. Method

2.1. Study design

In October 2014, we began to set up the basic requirements for implementing an eROM assessment with self- and expert-ratings at the inpatient unit (max. capacity of 21 patients) for psychosomatic medicine. The project was initiated by the authors to improve clinical care and provide data for research. The average length of an inpatient stay varies from 5 to 12 weeks depending on diagnoses and treatment focus. Patients are admitted via referral by general practitioners, other departments at the hospital or outpatient units (general psychiatric,

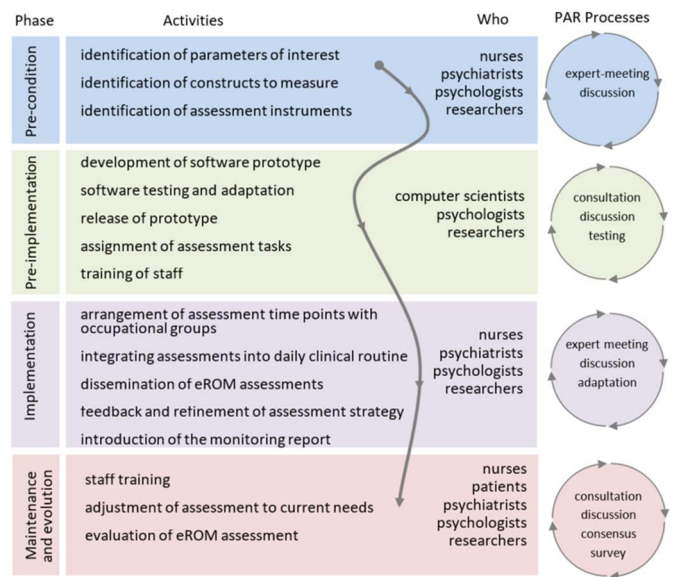


Fig. 1. Implementation procedure.

Based on the Replicating Effective Programs (REP) concept, the implementation process was split in 4 phases, indicated by 4 different colours. All activities carried out are listed in the respective phase. The column "Who" shows the people involved in the respective activities. The respective modules of the PAR Process, shown in the circles, specify the actions taken to make decisions.

psychosomatic). Before and after an inpatient stay most patients are typically in outpatient psychiatric care not associated with the hospital setting. 15.5 nurses, 4 psychiatrists, 1 psychologist, 1 occupational therapist and 1 physiotherapist are currently working at the inpatient unit.

In accordance with the Replicating Effective Programs (REP) framework, the project consisted of 4 phases: pre-condition (Phase 1), pre-implementation (Phase 2), implementation (Phase 3) and a fourth phase (maintenance and evolution) including a short evaluation (two questions) of the implementation procedure (Fig. 1) [32]. The concept of participatory action research (PAR) was used to refine and adapt the respective phases. This concept is designed as an integrative process used to empower stakeholder involved in the process to change existing or emerging systems [33]. In the first three phases, suggestions for improvement and feedback from discussions in multi-disciplinary focus groups were obtained. In the fourth phase, patient and staff surveys were conducted as proposed in the PAR concept by Baum et al. [33].

2.2. Inclusion/exclusion criteria for eROM assessment

2.2.1. Patients

All inpatients treated at the unit for psychosomatic medicine were included in the routine eROM assessment if they had sufficient German language skills, no overt cognitive impairment and did not object participation. In order to smooth the implementation process we consecutively included more and more diagnostic groups. From October 2015, all patients were included in eROM. All psychiatric diagnoses were based on expert ratings of three senior psychiatrists, in case of disagreement standardized diagnostic procedures were carried out.

2.3. eROM assessment instruments

2.3.1. Patient reported outcome instruments

We aimed at assessing a core symptom set, covering symptoms and functioning parameters that are important across various diagnostic groups. The instruments are presented in Table 1.

The questionnaire battery selected consisted of 150 items for admission and discharge assessment which takes approx. 30–40 min to

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