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Promoting Evidence-Based and Measurement-Based Care

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Imagine that major auto manufacturers have announced a quality breakthrough. Going forward, they will produce each model of car by using a standard set of parts assembled in the same order. And before selling any vehicle, they will test to be sure it can both start and stop. As auto consumers, we might not celebrate this breakthrough. Instead we might ask, “What has taken you so long?”

The learning collaborative program described by Vannoy and colleagues in this issue deserves celebration. Primary care and mental health clinics serving disadvantaged patients can successfully implement integrated care programs for mood disorders, including evidence-based care protocols and systematic outcome assessment. However, evidence-based depression care guidelines have existed for 20 years, and standard depression outcome measures have existed for 40. So consumers might ask, “What has taken you so long?”

Unfortunately, spreading evidence-based and measurement-based mental health care is not as straightforward as improving auto manufacturing. Some providers fear that evidence-based care means “cookbook medicine,” precluding personalization for individuals. In addition, organized mental health outcome measurement raises concerns about privacy of sensitive information. Neither of these concerns, however, actually argues against evidence-based or measurement-based care.

The supposed conflict between evidence-based mental health care and personalized care is rooted in misunderstanding; the two are completely compatible. If we hope to choose the best treatment for any individual, we require two things. First, we need better evidence regarding how individual characteristics (such as symptom patterns and genetic variation) predict response to specific treatments. Our evidence must extend beyond average effectiveness to consider individual differences. Second, we need accurate measurement of how individuals differ in pre-treatment characteristics and in response to specific treatments. Better evidence and better measurement are therefore essential to personalizing care. Conflict between personalized care and evidence-based care arises only if we are personalizing care to meet the needs of providers. That is, unfortunately, sometimes the case.

Privacy concerns regarding measurement-based care are also sometimes misplaced. Consumers' privacy concerns focus more on sensitive personal details than on standard outcome questionnaires. In contrast, providers' privacy concerns often reflect a wish to avoid scrutiny regarding quality or safety. Consumers' privacy deserves protection; unsafe or ineffective care has no right to privacy.

None of these comments are intended to dispute the importance of the collaborative efforts that Vannoy and colleagues describe. Instead they are intended as an apologetic answer to the question, "What has taken you so long?" We can celebrate the success of these learning collaboratives and also hope for a day when such success is no longer a newsworthy breakthrough.