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IMPROVING QUALITY IN PSYCHOTHERAPY

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Quality improvement in psychotherapy is a timely endeavor. The often maligned managed care movement may have the effect of stimulating higher quality outpatient care. Quality Improvement and quality assurance should be contrasted: Quality assurance is argued to be counterproductive and inefficient, quality improvement is relevant and useful. Quality improvement may stimulate better compliance with treatment protocols. Academic clinical psychology has produced treatment protocols and indicators of good psychotherapy but these are widely ignored by the practicing psychotherapist as unwieldy and impractical. Continuous Quality Improvement is a behavioral data-driven technology that can be applied to mental health services. The present article gives an example of non-adversarial data-driven process and outcome improvements. A shift of paradigm toward feedback loops in psychotherapy, collecting data of therapeutic change and patient satisfaction at each session, guides therapy. Data collected cannot only help guide the individual sessions and can be collected to establish a dose-effect relationship for a particular therapist, or for a clinic or group. Such information has been used to eliminate outpatient managed care.

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The challenge posed by managed care may yet turn to our advantage as psychotherapists. As the market for managed care has matured, the initial focus on saving money is declining in importance and the issue of quality is paramount (Eckert, 1994). In any mature market, if prices are roughly the same for the service, quality is the key variable to determine purchase preferences. If managed care providers are to maintain or increase market share, they must demonstrate quality.

In the vociferous debate on the pros and cons of outpatient managed care it's clear that managing inpatient care can yield important savings. This is because inpatient care has been responsible for the increase in mental health costs (cf., Bak & Weiner, 1993; Bak, Weiner, & Jackson, 1992*a*,*b*). However, one important fact has been overlooked: it appears there is no savings to be had from outpatient management (Johnson, 1995).

Outpatient Care and Illusory Savings

There are several reasons for the inability of managed care organizations (MCOs) to save money through managing outpatient (OP) care. First, outpatient mental health services account for only 3-4% of the total health care bill and this percentage has remained stable for the last fifteen years (Ackly, 1993). This suggests there is minimal savings to be had, even if waste were present.

Second, the expense of reviewing OP MH certainly exceeds any savings, and it seems likely those savings would only come at the cost of denying needed services. Outpatient care reviews cost as much as inpatient reviews, but the costs of the service itself is much lower. This means the cost-benefit ratio for outpatient review is much higher and financially less justifiable.

Third, outpatient care is largely self-policing. Patients tend to remain in therapy an average of

six sessions, and only through draconian efforts can that average be lowered through concurrent management. So such outpatient management must be sold to customers not as a money-saving measure (as MCOs originally intended) but as a quality assurance tool (Johnson, 1995). The customer is sold on OP reviews based on the need to assure high quality of service.

MCOs and Quality

Is MCO OP review a contributor to high quality care? Many MCOs try to measure OP quality through primary source verification of degrees, licenses, malpractice insurance, and so on. Such data only speak to a clinician's compliance with basic minimums for practice and do not address the issue of quality of service. It is unreasonable for managed care organization to try to measure therapeutic quality, since such efforts are too far removed from the therapeutic hour to assess quality. Inevitably certification of "quality" will tend toward irrelevant aspects such as whether the therapist has noted the name of a primary care physician or whether the progress notes are signed. The MCO pursuit of quality must necessarily focus on what can be controlled at that level of review, for example, primary verification of credentials and chart reviews. A potential approach to quality for the MCO would be to contact patients about their reactions to the therapy they have received, but even that implies a judgmental process instead of collaborative. Furthermore, such measurement must necessarily be retrospective and thus too far removed from the event to improve practitioner quality of service.

MCOs are not doing quality improvement, therefore, but Quality Assurance (QA), a process imposed on the profession from without and usually seen by the unwilling participants as busy work not related to actual care (Chowanec, 1994). The danger of just measuring quality is that it misses the essential element of *improvement*. In other words, one can measure something called "quality" in a vacuum, which means the MCO becomes a judgmental entity. This relationship is based on an avoidance of pain model (the therapist wanting to avoid being singled out at defective or inferior) would inevitably promote evasion and game-playing with the MCO.

In fact, one can argue that quality assurance makes quality improvement impossible. Since QA tends to emphasize minimum acceptable standards of care, it forces the practitioner to "toe the mark" and thus stifles innovation which might result in more efficient and effective treatment. QA emphasizes uniformity, Continuous Quality Improvement (CQI) emphasizes development, reducing costs while improving outcome. It is inevitable that QA will tend to emphasize some standards of care which evolving practice makes irrelevant. A classic example is the requirement in public mental health centers that cases be "closed." While closing an Inpatient case makes sense (there being a definite date on which the patient leaves the hospital), closing an Outpatient case makes no sense at all, since outpatient cases are better conceived of as ongoing relationships than as discrete events. By requiring closing summaries, the "quality assurance" model actually promotes less efficient use of therapist time. Some therapist have been known to encourage a patient to come in every three months, just to avoid case closing work! To reiterate, QA encourages game playing and evasion.

QA Versus CQI

A Continuous Quality Improvement (Scherkenbach, 1988; Walton, 1986) model, in contrast with traditional QA, empowers therapists. In CQI, the aim is to improve quality, not exclude and blame. One can measure quality in a way that promotes growth and improvement on the part of the clinician (Shaha & Fonnesbeck, 1993, 1994), but to do that, the quality improvement must originate with and benefit the clinician, not an MCO. True CQI, Berwick (1989) suggests, is about growing better apples rather than weeding out bad apples. Practitioner groups and mental health organizations have an interest in cooperative efforts to improve overall outcome data; MCOs have an interest in reducing the number of practitioners to whom they refer. Quality is not improved by ejecting practitioners but by giving them tools and techniques for improving their outcomes. Only by continuous measurement of process and outcome can quality be achieved.

Continuous Quality Improvement and Total Quality Management arise from a general theory for quality in any organized endeavor. Deming (1986) and Juran (1989) have helped organize quality improvement in Japanese and American industry, with the well-known results. While the basis for Deming's work was statistical process control, measurement of the process and outcomes of the manufacturing process, the importance of *customer satisfaction* became central. In

other words, there is a convergence between doing well according to the engineers and according to the customer. In psychotherapy, following treatment models and protocols (e.g., Barlow, 1993; Klerman, Weissman, Rounsaville, & Chevron, 1984) accurately and skillfully is analogous to production quality; therapeutic alliance (e.g., Burns & Nolen-Hoeksema, 1992) is analogous to customer satisfaction.

There has been some discussion in the literature about the need for quality improvement in mental health services. Hoyt (1995) gives suggestions and examples of seeking quality within the HMO staff model, and Eckert (1994) suggests that through quality improvement psychotherapy can reduce costs and enhance outcome. Chowanec (1994, 1996) specifically addresses the CQI model and discusses the application of CQI to a state mental hospital. However, a systematic approach to CQI in outpatient mental health has not been presented.

Improving Quality in Psychotherapy

The time is optimal for psychotherapists to create and develop means for personal and organizational quality improvement. Such efforts would have personal and professional advantages:

ONE: At a personal level, therapists can take professional pride in improving skills. To achieve this, therapists must have useful and easily administered and scored instruments which have clinical utility. Such instruments must focus on two aspects: clinical outcome and therapy relationship, since the later correlates most strongly with the eventual outcome (Hill, 1989). It is possible that a revised compensation system could financially reward groups of therapists with high quality, or in other words, both low dose-response ratios (the number of sessions needed to achieve a stable remission of symptoms) and good customer satisfaction. Such teamwork can and should be recognized and rewarded. Thus the therapist with excellent skills has the personal satisfaction of knowing his/her contribution to the group is valued.

TWO: At a group professional level, practice groups which can demonstrate good quality and customer satisfaction will be able to directly bid for contracts which circumvent managed care through carve-outs, capitated care, and other innovative reimbursement plans. Practice groups that collect Average Length of Treatment (ALOT, meaning the total number of hours a patient was seen in treatment, not the length of time by the calendar) and outcome data are in an excellent position to obtain referrals on a case rate or capitated basis. Because of quality improvement data, large groups of insured lives might be covered on a "case-rate" basis. This means the therapists at that agency will not longer be managed by the MCO. Instead, based on the past performance (in terms of length of treatment and outcome), referrals will be made and the therapist will manage the case with the current data collection procedures.

The term "case rate" means the MCO agrees to pay for each patient based on the average cost of treating that diagnostic category on an outpatient basis. For example, major depressive disorder is the most common diagnosis, and a treatment course of 12-16 sessions is common in resolving the complaints. Resolution might be defined as, among other criteria, the patient scaling the depression as <9 on the Beck Depression Inventory across several weeks (Frank, Prien, Jarrett, Keller, Kupfer, Lavori, Rush, & Weissman, 1991). Major depression can be treated briefly and effectively (Johnson & Miller, 1994), and if a group can achieve the criteria for resolution (such as >50% of treated patients with stable Beck ratings >9) in less than 12 sessions in at least half of the patients, the ALOT case rate results in a mutually advantageous outcome. The MCO is satisfied because outcome data demonstrate the patient is being treated effectively, that is, until there is a resolution of the depression symptoms; the clinician is satisfied because there is no need for narrative reports to case managers.

THREE: Finally, at a profession-wide level, developing quality improvement models allows professional psychology to undo the disastrous mistakes of the past of opposing managed care (psychology's opposition to managed care only marginalized the profession and certainly did not contribute to any resolution of the problems with managed care). Continuous Quality Improvement will promote effective treatment options based on results of treatment. After all, if there is a significant difference in quality of services, those which are somewhat more expensive but measurably better in quality will always find a market, just as quality in automobiles has been a selling point. Desires by clients for quality insures there is always a significant market segment for expensive, high quality transportation.

Total Quality Management and Continuous Quality Improvement

TQM and CQI are generally conceived of as a single process, with TQM being achieved by continually improving quality. The process for maximizing improvement consists of 11 steps which proceed in four conceptual stages (see Table 1).

The TQM model requires the organization develop a *mission statement* which defines the purpose of the organization. The mission statement should capture in as few words as possible the organization's purpose. The Brief Therapy Center's (BTC) purpose is "The Brief Therapy Center offers the most effective and efficient psychological services possible." We are accountable to those who hire our services and offer timely and relevant reports on our work.

The *vision statement* delineates (a) the values of the organization, (b) the customers and stakeholders, those who have a stake in the organizational mission. The BTC values statement is: "We treat all stakeholders in every situation with respect and strive to create positive outcomes for all stakeholders in every intervention." The stakeholders include not only all those who contract for our services and those who offer those services, but also those who are affected by our services. They include the BTC therapists, clients asking for help in resolving problems with relationships, family conflict, interpersonal conflicts; with symptoms of emotional or physical disease appropriate for psychotherapy interventions; or problems with productivity social fit; organizations including insurance companies and MCOs; business organizations that contract for EAP services, executive coaching, critical incident debriefing and crisis intervention, outplacement coaching and counseling.

TABLE 1. Components of Continuous Quality Improvement

A. The Reason for Existence (two interdependent and circular processes)
   1. Define Customers and Stakeholders: The Vision Statement.
   2. Draft the Mission Statement and Define Organizationval Values.
B. The Voices of the Customer and the Process
   3. Identify Customers' Needs and Expectations.
   4. Prioritize Customers' Needs and Expectations.
   5. Select of Create Assessment Methods.
C. Process Improvement
   6. Analyze the Current Process.
   7. Revising or Redesigning the Process.
      What can be changed?
      What can be eliminated?
      What must be added?
   8. Implement and Test the New Process.
   9. Assess the Effectiveness of the New Process.
D. Continuously Learn and Improve
   10. Refine the New Process.
   11. Continuously improve.

In the circular process of defining the vision and mission of the organization, we discovered a vital customer whose needs were being ignored, namely the Managed Care Organization. As a result of the mission statement and vision statement, the first author realized that global reports of outcome to MCOs were insufficient. There are two reasons why the pre-test/post-test model is inadequate.

First, as Chowanec (1994, p. 791) stated, "(In CQI) (w)ork procedures are monitored so that they can be corrected before defects in products occur. Feedback mechanisms are build into work procedures to collect that information needed to understand and then to improve the procedures." This article reports on a first attempt by BTC to measure and report on outcomes via continuous monitoring of processes. The first author, as director of the center, was the test subject for the CQI efforts. Since then, other therapists at the center are collecting their own data.

Second, the therapist does not know what specific interventions are promoting particular outcomes. Thus, with pre-post measures, therapists were unable to report to MCOs just what they were doing to solve certain problems and how those efforts were received. The first author proposed more detailed feedback to certain MCOs that refer patients to the BTC. Generally this was met with reactions from MCOs ranging from confusion to enthusiasm. United Behavioral Systems' Regional Vice President Tim Phillippe (personal communication, March 26, 1996) reported that they are actively seeking high quality providers to be Key Providers. This would mean that providers whose quality can be counted on would be exempt from the managed care process, saving therapist's and MCO time and efforts. However, the way by which a provider's quality can be assured has not been well established. The present article proposes the therapist can provide reliable

and valid data to establish that quality and create a mutually beneficial relationship with the managed care organization.

Continuous Quality Improvement

The goal of providing continuous measures of improvement to our target customers was adopted by the BTC. Specific levels of improvement, targeted to the complaints of the patient, should also be measured regularly, and after every session if possible. CQI implies an ongoing improvement effort. That meant we had to have a measurement system.

Measurement of outcome must be valid, reliable, and feasible. Feasibility implies measurement that is simple and inexpensive. Academic measures tend to be expert-judgement driven, and given the current reimbursement patterns in therapy, it is unlikely at best that agencies will use them. For example, using the Hamilton Rating Scale for Depression (HRSD) is difficult since it should be administered by a therapist via a structured interview. There are two main reasons that this is unworkable.

First, since we are working within the requirement to be efficient (using not one session more than is necessary), to use up a session on assessment has a poor cost-benefit ratio, for the MCO (having to pay for an extra session), the therapist (spending a session in assessment that has no therapeutic value) and the patient (having to sit through the measurement process, gaining neither understanding nor useful skills). Instead, self-report devices such as the Beck Depression Inventory might track improvement effectively and efficiently.

Second, for the assessment to be objective, a therapist other than the treating therapist should administer the Hamilton. Obtaining an independent rater is not a reasonable requirement for an agency in which fees for service support the CQI efforts. Instead the agency must use a combination of self-report process measures and outcome measures. The process measures the patient's satisfaction with the therapy session, and the outcome measures symptom relief and improvement in functioning. Achieving ideal levels of validity and reliability cannot outweigh feasibility for a technology to be practical and helpful.

Schlosser (1995) has pointed out that quality improvement requires several elements. First, information must be focused on the functioning of the patient in easily administered, easily scored, and interpreted instruments. Second, the information should be in units of single sessions and patient responses to sessions and even to interventions. Pragmatically, it seems likely the single session is the most convenient unit of measurement. Such an assessment must be brief yet relevant to client concerns. Both client satisfaction and clinical improvement can be measured via objective rating methods.

Brickey and Enright (1995) reported on an outcome measure which assessed current functioning of clients seen only one time. The outcome was measured simply by asking the clients to rate their functioning on a 1-9 scale, with 1 = much worse, 5 = same, and 9 = much better. The clients rated their functioning on eight areas: Problem Status, Outlook, Social Functioning, Thinking/problem solving, anxiety/depression level, health, support from friends, family and others, and Sense of control over your life. It is not clear which of those categories contribute the most to the outcome satisfaction, and which might be repetitious, but such an easy measurement approach certainly has useful aspects. It is simple, easily understood, and easy to collect.

Many simple survey and questionnaire instruments exist to assess a variety of complaints, from the familiar (Beck Depression Inventory) to the less known but useful (cf., Fischer & Corcoran, 1994*a*,*b*). Seligman (1995) demonstrates how brief symptom-oriented questionnaires help a client who is reading a self-help book. Questionnaires help a reader distinguish between a simple problem and a more severe one, such as a depressive state which may respond to self-help versus a serious depression which requires a professional assessment and intervention.

Selection of the OQ-45

Perhaps the ideal method of measurement would be to administer specific instruments for specific complaints. For example, patients complaining of anxiety and panic would respond to a panic rating scale after each session, patients with a depression diagnosis would respond to a depression inventory. For this project such an ideal system was judged too complicated, requiring difficult data transformation to obtain dose-response curves (i.e., learning how quickly patients generally respond to treatment at BTC).

In the present investigation, a simple outcome device developed by Lambert, Lunnen, Umphress, Hansen, and Burlingame (1994) was used to assess individual outcome and response curves in a brief therapy oriented private practice. This instrument is the OQ-45, a 45-item Likert-scale checklist.[1] The OQ-45 samples three domains: Symptom Distress (the degree to which the patient feels bothered by symptoms of depression, anxiety, cognitive problems, and the like); Interpersonal Relations (the degree of dissatisfaction the patient has with relationships); and Social Role (the degree to which the patient feels unable to perform or function at work or school). The instrument also contains Critical Items pertaining to dangerousness to self or others and substance abuse. The author tracked thirty-eight consecutive adult admissions to his outpatient practice (a youth and adolescent version is under development but was not available at that time), administering the OQ-45 to each patient at each visit. Since the instrument takes only five minutes to administer and three to score, the requirement for patients to fill it out and the results to be entered in charts was modest. A "cutoff" score indicates the top of a normal range of scores. A patient falling below the cutoff is significantly more likely to be like a normal reference group than like a clinical group. The usefulness of the cutting score is as a rule of thumb indicating reasonable (not ideal) adjustment. Scores below the cutting score, if stable, suggest (at the BTC) a break from therapy, or less frequent sessions, be pursued. Other therapists may not agree with this practice guideline, and may believe it is necessary to keep patients in treatment to consolidate gains.

Patient satisfaction ratings were sometimes collected, using the Session Rating form (Johnson, 1995). We were influenced by Burns and Nolen-Hoeksema (1992) in including a satisfaction measure in addition to an outcome measure. This 10-item form asks the patient to rate the therapy relationship, the degree of agreement between therapist and patient on goals and tasks of therapy, the depth and smoothness of the session, and global ratings of helpfulness and how hopeful the patient felt at the end of the session.

The treatment guidelines followed in the present investigation have been described previously (Johnson & Miller, 1994) as Solution-Focused Brief Therapy. A thought-stopping technique was used with Case 1 that is borrowed from Psychology of Mind (Carlson, 1994).

Clinical Improvement Tracked with the OQ-45

The results collected were utilized in two ways: First, each patient's progress was tracked from session to session, and was sometimes discussed with the patient. For example, the following two profiles were helpful in improving the patient's course of treatment:

Case Example 1: A.C.

A.C. is a 36-year-old female complaining of difficulty in concentrating, lapses of memory, emotional swings, and low self-esteem. She gave a history of being sexually abused by a stepfather from ages 13 to 16, at which time she moved out and the abuse ceased. She was seeking help in stabilizing her moods, helping her be more productive at work, and coping with her history of abuse.

The therapist emphasized "active coping." The patient was encouraged to discuss times when she coped unusually well with the symptoms, or times when the symptoms were less intrusive. Several themes were isolated (e.g., staying busy, focusing on helping other people, not thinking about the abuse). Her homework assignment was to do more coping activities, including those she already did plus mastery and pleasure activities she negotiated with the therapist. She was taught a variation of thought-stopping to deal with the intrusive images. She reported the thought stopping technique was gentle, satisfying, and easy to use.[2]

On the third visit she was functioning well. She asked if the therapist could help her remember more about what had happened to her during the sexual abuse. He recommended against it, but she insisted, and he presented a hypnotic strategy for recovering memories.

On the fourth visit she was much worse, and the session was spend analyzing the pros and cons of active coping treatment versus recovery of memory treatment. She decided to continue the active coping, again made some progress, but on the sixth session again requested talk about the abuse history. Again the therapist recommended against it but complied. On the seventh session her symptoms had returned, and together the therapist and the patient examined the results of thinking about the abuse versus increasing her coping skills. She returned to the active coping, and on the eighth visit she had returned to a good mood and reported she was very productive and happy at work and at home. Unfortunately the therapist failed to obtain an OQ-45 at the last visit. The patient took a break from therapy with the understanding that she would call if more help was needed. Telephone follow up indicated

[1] The OQ-45 is available from American Professional Credentialling, 10421 Stevenson Road, Box 346, Stevenson, MD 21153-0346. A child/adolescent version is in development.

[2] A description of this technique is available from the first author.

she has had no more complaints, that she and her husband are very happy and compatible, that she is happy at work, and has not sought any other therapy since the last contact with the BTC.

Her OQ-45 Symptom Distress scores illustrate how tracking objective measures of her functioning helped to inform and guide the treatment (see Figure 1). It is worth noting that her Social Role scores illustrated the fact that she was able to work well throughout the treatment, and that she did not let her symptoms reduce her functioning (see Figure 2). That fact influenced the therapist to discourage exploration of that past. It was thought that if the patient could respond to solution-focused interventions, there was nothing to be gained from a discussion of the problems, and this apparently turned out to be the case. It is recognized that in other cases, discussion of the past is necessary.

Case Example 2: P.R.

P.R., a 44-year-old male, changed his initial focus from exploring the past to a focus on the present and future. He wanted to understand the origins of what he called "self-defeating behavior." The therapist suggested that while exploring the past might be helpful, to explore the future would be even more helpful, and oriented the patient toward solutions and outcomes instead of problems and origins of those problems (Johnson & Miller, 1994). P.R. cooperated, although with some trepidation, thinking perhaps he was missing something vital by not exploring the past.

P.R. presented with complaints of underachievement and dyssynchrony, wishing he had been able to achieve more than he was achieving. As an assistant restaurant manager, he felt he was under utilized and had not pursued opportunities. He asked for help in exploring his past to determine why he was unable to make decisions, to enjoy relationships, felt guilty, and was unable to complete tasks and projects. He had been married three times, and the last divorce precipitated his calling the therapist.

Following protocols for Solution-Focused Brief Therapy (Johnson & Miller, 1994), the patient began to increase behaviors that seemed to correlate with exceptions, and "as if" homework designed to bring about the enactment of the "miracle question." As soon as the OQ-45 indicated his Symptom Distress scores were at and below the cutoff (after the third meeting), sessions were spaced every three to four weeks. As can be seen, his adjustment in the normal range of functioning was stable and persistent over several months.

Both Interpersonal Relations and Social Distress scores declined (showing improved functioning in personal relationships and at work). He reported setting better limits with people who had been taking advantage of him, and that he felt more productive and efficient at work. The Symptom Distress and Social Distress scores are shown in figures 3 and 4. He made useful and realistic vocational plans and began to work on them. He resolved a long-standing conflict with the restaurant manager which resulted in a reduction of stress for both of them. He reported he was happy and satisfied with his life, and thought that psychotherapy had been somewhat helpful in creating positive changes in his life.

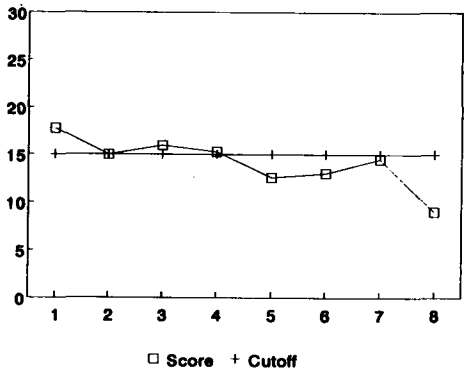

Figure 1. Symptom Distress: A.C.

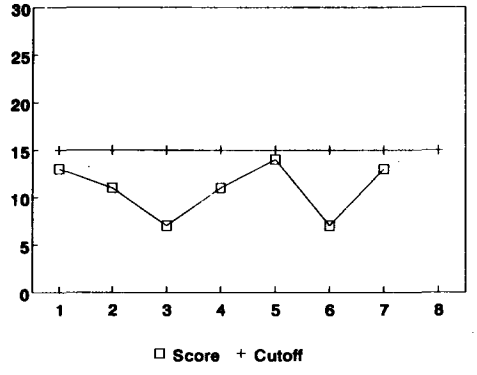

Figure 2. Social Role: A.C.

Profiling the Therapist's Dose-Response Curve

The results also yielded a *dose-response curve* for a single therapist. Thirty-eight patients began this project, and the data are shown in Figures 5 through 8. These data are preliminary but do sug-

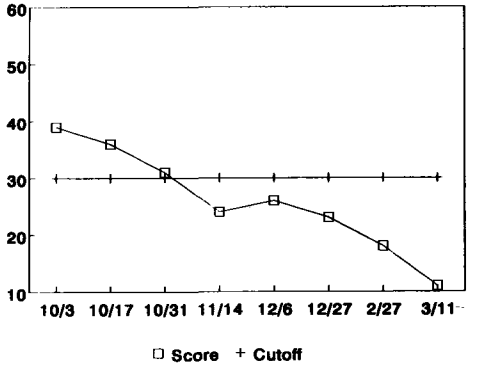

Figure 3. Symptom Distress: P.R.

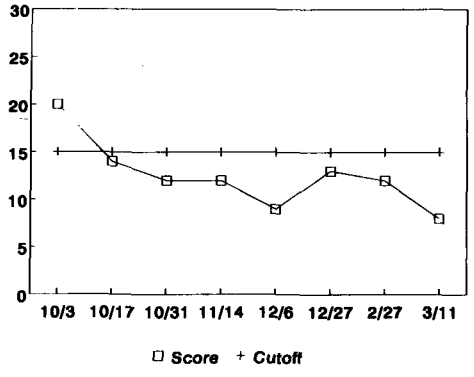

Figure 4. Social Role: P.R.

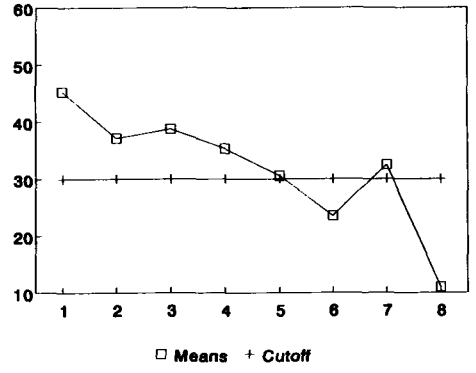

Figure 5. Dose Response Curve: Symptom Distress

gest that by the sixth session, patient or client complaints are well on the way to resolution.[3] Please note that the data are not perfect. Three patients continued in therapy but due to failure on the therapist's part did not take the OQ-45. Nevertheless, the ALOT is less than six sessions for a mixed group of patients and diagnoses. Tracking outcomes for each session helped focus the therapist's attention and efforts. Incorporating Session Rating data (Johnson, 1995) was also helpful, since the Session Rating form focused on the therapy relationship, giving complimentary information when compared with the OQ-45.

Client Satisfaction

Case Example 3: J.S.

J.S. is a 15-year-old male referred for shoplifting and refusal to attend school. He has a history school problems, learning problems, attention complaints, and of positive response to stimulant medication. He refuses to take the medication, protesting it makes him feel different. Following the Customer Status evaluation (Johnson, 1995), the therapist viewed his relationship with Mr. S. as a "complainant" relationship, in that he did acknowledge he had problems but did not agree to work hard to solve them. This is analogous to Prochaska's Contemplation category (Prochaska, DiClemente, & Norcross, 1992). The distinction between Contemplation and Complainant is in the attribution of responsibility: The complainant tends to see the problem as outside of the self.

Treatment emphasized family therapy and changing family contingencies to support positive behavior. J.S. rated the sessions on the Session Rating form as "3" or "4" on all items except "Helpfulness" and "Hopefulness." On those items, the patient rated the session at "2" on a 0-4 scale. In asking him about those items, he replied he wasn't sure how therapy was supposed to help, and didn't know what he was supposed to hope for. On the other hand, his mother, who was viewed as a "customer" rated the sessions as "4" on the same items, suggesting she knew very well what to hope for and found her son was making good progress toward the goals. To her the sessions were helpful. Nevertheless, in subsequent sessions, more attention was paid to the identified patient and his hopes. This improved his cooperation with the family sessions and he did become active in therapeutic homework. Using the Session Rating form helped the therapist maintain a good relationship with the family members, focusing on what would be of most use to each of them. Mr. S. seemed to benefit mostly from positive reframing of his complaints while mother benefitted from goal-directed structural change of the family contingencies (Alexander & Parsons, 1982). It can be argued that such information is informally available to the therapist anyway, and indeed this is true, but the Session Rating form serves to point the therapist's attention to maintaining good relationships, a vital component to therapy.

Discussion

There is no representation made that the foregoing is excellent research. Its purpose was strictly to allow the first author to track with objective data the results of his therapy efforts with a broad range of patients. Originally there was no intention of publishing the results, and only because of the kind invitation by the guest editor of this issue were the results written up. Good results with some challenging patients may have been obtained because the therapist and the patient's efforts were more focused, perhaps partly due to the accountability encouraged by the objective scales of outcome and satisfaction.

Certainly there can be no suggestion made that this report proves that obtaining outcome and satisfaction data after each session improves therapy. It does seem that there has been an improvement

[3] The seventh session with A.C. raised the mean of that session; without her data the mean would be considerably below the cutting scores.

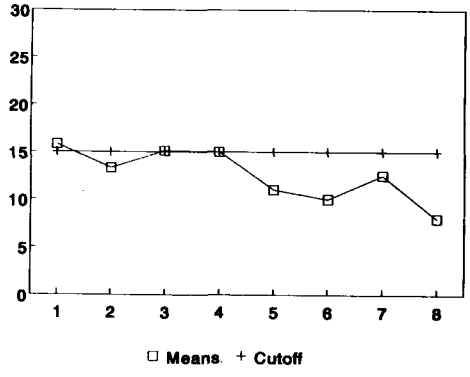

Figure 6. Dose Response Curve: Social Role

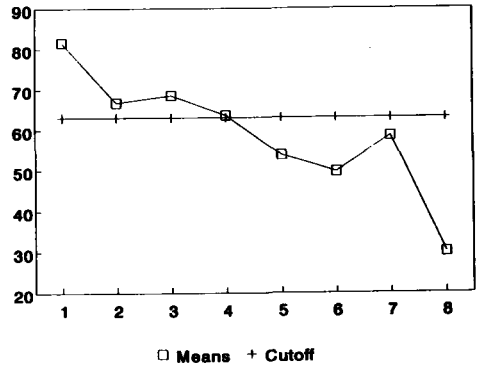

Figure 8. Dose Response Curve: Total Score

in outcomes since beginning the use of the Session Rating and OQ-45. There seems to be a tendency for the therapist to think harder and develop better interventions and therapeutic homework when there is some way of tracking the results of each session. Furthermore, these data, however sparse, incomplete, and scientifically lacking, form a type of baseline against which future efforts can be compared.

Continuous Quality Improvement appears to be a useful and accessible technology. Psychologists particularly should enjoy an ease of understanding, given our training in statistics, research design, and the scientific method. The data collected can be used to substitute for the kind of data which are now demanded by managed care. At this time it is evident that intensive review of outpatient psychotherapy is not cost-effective. However, the managed care organizations must do something to address the need for accountability for the resources spent on outpatient treatment. Substituting objective data for the verbal reports now required would be a step in the right direction. Wouldn't it be so much more simple for objective test data and session satisfaction data to completely substitute for the verbal or written reviews that are now required? There is certainly no universal agreement on how one could judge good therapy via written reports, and to imagine that a case reviewer distant from the therapy session can sift through artifact and artifice to distinguish, Solomon-like, which therapy should continue and which should be denied, is to strain credibility to the limit.

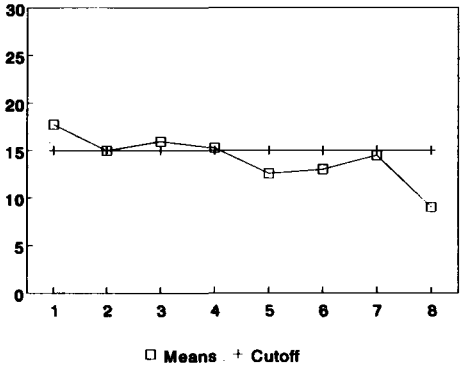

Figure 7. Dose Response Curve: Interpersonal Relations

Eliminating OP Review with Objective Data

Sessions where the patient is in the normal range should automatically be spaced out and terminated. If the patient wishes to continue, the patient should pay for that, just as if a patient who once needed physical therapy wants to join a health club. After the need for the physical therapy is resolved, the insurance company would not pay for further treatment just to make the patient more and more fit.

Sessions where the patient is showing elevations but progress should automatically continue until the patient can achieve a criterion level of adjustment and behavior. This doesn't require an expensive OP MCO review. Only in a case where there is substantial dysfunction, measured by objective data, and where there is no progress after several sessions should a review be necessary, not for the purpose of denial, but for the purpose of consultation.

Using objective data can therefore reduce the number of OP reviews that must be done. Further

improvements can be achieved by eliminating reviews altogether. This has been achieved in relation to one MCO at the BTC. As mentioned earlier, an MCO was approached with the outcome data in this article and the proposal was made to eliminate outpatient reviews with the outpatient reviewers. In place of those verbal reviews, OQ-45 and Session Rating data would be kept for each patient. Collapsed data would be reported each quarter, and individual data would be available for inspection. It was then agreed that the patients would be seen on a *case rate* basis, meaning that each patient referred to BTC would be paid at a flat rate, based on average costs for outpatient treatment in the Salt Lake area. While not a large contract, such relief from intrusive outpatient reviews is welcome. We are currently negotiating with a second MCO to provide service on the same basis, saving therapist time (no reporting and asking for continuing authorizations for treatment) and eliminating the need for the MCO to pay a reviewer, a supervisor, and support staff to manage the case.

The question of unreliable results due to biased administrations of outcome measures must be addressed. A therapist could conceivably influence patients to rate their improvement as more than they actually felt. An unscrupulous therapist could even fill out forms for the patient, in order to create a false impression of high quality. This can only be corrected by backup procedures such as measurement by third parties, audits via telephone interviews, or mail out follow up surveys, but a discussion of bias correction procedures is beyond the scope of the present discussion.

Cooperating with MCOs

With therapists in charge of improving their own quality, the MCO can shift to what it does best, communicating with its customer, namely the business entity that has contracted with the MCO. MCO leadership generally recognizes that quality improvement must come at the level of the therapist, and welcome an opportunity to get out of the case-review business. Cost savings in IP care can be communicated. The MCO can combine the data from many therapists and show customers the results of treatment in terms of improvements in symptoms, increased ability to work productively, and increased satisfaction with relationships. Such outcome data allow the customer to understand what it is achieved from the nervous and mental disorders coverage in its health coverage. Using objective data in place of verbal reports eliminates a source of "noise" in the review process. Currently, reviews are done via written or spoken reports by the therapist. Verbally skilled therapists are likely to obtain more authorizations than therapists who may be skilled but inarticulate in dealing with reviewers.

Other advantages accrue to the MCOs with this model. As pointed out earlier, OP review is not cost-effective. While officially MCOs have not conceded that point, informally MCO officials who reviewed an early version of this article did agree. We can assume MCOs would like to be out of the OP review business. Developing contracts with groups demonstrating a CQI practice, the business of review devolves onto the practitioners, where is should have been all of the time. The MCO saves money by eliminating the loss leader of OP review, and can concentrate on maintaining good IP review standards.

Cooperating with Reluctant Therapists

While measurement of each session is now part of every BTC therapist's work, such dedication is not automatic. Not all therapists in a system welcome a Continuous Quality Improvement model. On the contrary, some will resist any such measure, claiming the resulting therapy is shallow or ineffective or will result in symptom substitution. When the first author was presenting these ideas to a group of HMO psychologists, one claimed giving process (session satisfaction) and outcome (clinical improvement) measures after each session would yield artifactual data, since he expected patients (within a specific diagnostic group) to get worse before they got better. His resistance to the process is based on fears that his model of treatment will be devalued and he will not be seen as a valued provider.

Clinical psychology already has models for engaging resistant clients. For example, Szapocznick, Perez-Vidal, Brickman, Foote, Santisteban, Hervis, and Kurtines (1988), have outlined protocols for engaging resistant adolescents into family therapy programs. Can psychologists develop similar guidelines, based on understanding the basis of that resistance, for engaging reluctant therapists into quality improvement efforts?

As in the example above, one resistance may be based on a fear that all therapists will be forced to endorse a particular model of therapy. Cognitive-behavioral treatment appears to be preferred by MCO reviewers because of ease of understanding

the interventions and rationale, and therapists may fear dynamic models will become anathema. The truth is quite the opposite.

Demands that all therapists adhere to a particular model is an artifact of the QA oriented process of concurrent OP review. If we substitute quality improvement for QA, and in-house documentation of process and outcome for remote reviews, therapists can follow any model that produces good process (client satisfaction) and outcome CQI models generally allow or even encourage "cheating" within the values of the organization. Adherence to a theoretical model, whether cognitive-behavioral or object relations, is not required. Thus, a therapist who expects patients to get worse before getting better is within the limits of CQI, as long as the *final* outcomes are (1) effective, that is, result in resolution of the presenting complaint, and (2) efficient, that is, requires the same or less ALOT as other methods. The therapist who believes patients must get worse rather than better can examine that theory by comparing outcome data with other therapists in the same group. If patients who do not deteriorate first demonstrate equally positive and stable outcomes, then both the expectation of deterioration and efforts on the therapist's part to achieve this deterioration can be seen as an unnecessary step which can be eliminated. Conversely, if patients who do not show deterioration are less stable, then that step is presumably necessary and must be part of a critical therapeutic path for those patients.

Summary

CQI in OP psychotherapy offers many advantages. Within a group practice setting, the most effective and efficient therapists can be identified and possibly "cloned" through examination of successful cases, live supervision, and development of critical pathways. Individual psychotherapy courses are improved by regular examination of data. Outpatient managed care is obviated; time consuming verbal or written reports are eliminated and reliable and valid data are used in their place.

TQM/CQI must come from within the profession and within the organization for it to have any impact. Chowanec (1996) has documented how implementing CQI in response to perceived demands by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), resulted in confusion and resentment. Re-inventing CQI to meet the needs and goals of the hospital staff was successful. Managed care overtook psychotherapy and we have been reacting ever since. Psychotherapy must be proactive, not reactive in improving services and increasing reliability and customer satisfaction.

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