The healthcare marketplace has witnessed an increased interest on the part of third-party
payers, both public/governmental and private, in the development of pay-for-performance and
other “quality improvement” programs for the purpose of improving the health care outcomes of
patients. These programs vary in design, program implementation, and quality measures.
Psychologists who are fee-for-service health care providers will soon find themselves, if they
have not already, confronted with having to make a decision about participating in one or more of
these programs.

This document provides a set of criteria to be used by psychologists in evaluating quality
improvement programs that have been promulgated by health care organizations, government
agencies, professional associations, or other entities. These criteria also address the privacy and
confidentiality issues evoked by the intended use of patient data gathered by such quality
improvement program. Although developed for psychologists, these criteria may be applicable
across health service areas and professions.

Recognizing that psychologists have considerable expertise in program development and
evaluation, we also believe that APA can make a useful contribution to the evaluation of such
programs. To date, the available quality improvement programs have been of varying quality and
relevance to the practice of psychology. Insofar as the goal of quality improvement programs is
to increase the benefits of healthcare services to the public and to improve the quality of services
provided, psychologists are supportive of such programs. However, quality improvement
programs should achieve these goals while also protecting the rights of patients (e.g.,
confidentiality) and respecting the professional responsibilities and clinical judgment of
psychologists.

These criteria are considered to be guidelines pursuant to the APA Association Rules. APA
guidelines are statements that suggest or recommend specific professional behavior,
endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are
mandatory and may be accompanied by an enforcement mechanism. Guidelines are aspirational
in intent. They are intended to facilitate the continued systematic development of the profession
and to help facilitate a high level of practice by psychologists. Guidelines are not intended to be
mandatory or exhaustive and may not be applicable to every professional situation. They are not
definitive and they are not intended to take precedence over the judgment of psychologists.

1 To be consistent with discussions of quality improvement in other areas of health care, we use
the term patient to refer to the recipient of psychological services. However, we recognize that in
many situations there are important and valid reasons for using such terms as client, consumer or
person in place of patient to describe the recipients of services.

2 These guidelines are scheduled to expire 10 years from [the date of adoption by APA Council of
Representatives]. After this date, users are encouraged to contact the APA Practice Directorate
to determine whether this document remains in effect.
Quality Improvement Programs in the Public and Private Sectors

Quality is defined by the Institute of Medicine (2001) as the degree to which services and treatment increase the likelihood of desired outcomes and are consistent with current professional knowledge. “Quality Improvement” programs (QIPs) include all programs that systematically collect information from providers or patients with the intention of drawing conclusions about the quality of care provided and improving provider performance, treatment outcome, or efficiency. Quality improvement program activities are both prospective and retrospective, including ongoing assessment of change models, and continuous reevaluation of process and outcome targets that QIPs aspire to change.

The federal government has various programs designed to improve quality in healthcare. The Agency for Healthcare Research and Quality (AHRQ) supports research to improve the quality of healthcare and to assist consumers and policymakers in making more informed healthcare decisions. The Centers for Medicare and Medicaid Services (CMS) utilize a national network of Quality Improvement Organizations (QIOs) to promote delivery of “the right care for every person every time.” CMS contracts with QIOs in each state to insure that Medicare services are reasonable and necessary and that the care provided to Medicare beneficiaries meets professionally recognized standards.

CMS has instituted quality improvement initiatives for hospitals, home health agencies, and nursing facilities. In addition, federal regulations require managed care organizations contracting with state Medicaid plans to have ongoing quality assessment and performance improvement programs.

More pertinent to individual providers, Medicare instituted a pay for reporting program in July 2007. Known as the Physician Quality Reporting Initiative (PQRI), the program awards eligible professionals a bonus payment for successful reporting on a designated set of quality measures. It is likely that the PQRI will evolve into a pay for performance program with a larger set of quality measures.

In the private sector, more than half of commercial health maintenance organizations have already begun using pay for performance. Pay for performance (PFP) operates on the principle that providing financial rewards will promote improvement and excellence in the delivery of health care. These programs vary in design, but typically involve some type of incentive payment for psychologists or other health care professionals who meet specified objectives. Many of the initial PFP programs focused on hospitals but over time the trend has shifted to include individual health care professionals. Quality assessment mechanisms include:

- Structural measures that examine professional and technical resources or infrastructure
- Process measures that reflect treatment protocols or procedures
- Performance measures that assess the level of care provided, measure patient outcomes and/or identify areas in need of improvement

Need for Criteria

A number of important issues are raised by QIPs, relating to the types of data collected, the ways in which data are used, program design and program implementation. These issues are briefly reviewed in this section.

Concerns have been raised regarding the appropriateness of the types of measures that have been used in QIPs. The variables that are the focus of measurement, which may include clinician behavior and targeted outcomes, may not be linked to improvement or excellence in the delivery of health care. Poor or irrelevant measures or targets of change may have little bearing on treatment outcomes or delivery of health care. Inappropriate measures may inadvertently
incent behavior that is not appropriate for all clinical situations, increasing the use of certain clinician behaviors (e.g., administering a particular treatment or an assessment instrument to every patient with a given diagnosis) that may not be in the best interest of every patient treated. A QIP that discourages or eliminates responding to the individual needs of the patient may actually result in decreased quality of care.

Moreover, satisfactory models for ensuring privacy and confidentiality in the collection and use of data have not always been used in these programs. Personal health information is protected under federal law and information related to psychotherapy notes is generally afforded extra protections. It is unclear whether information collected in a QIP would also be afforded any extra protection and, if not, who would have access to what kind of information?

Pay for Performance (PFP) programs are a type of QIP that seeks to link health care costs with quality of service through the use of financial incentives. These incentives are intended to improve the performance of health care providers, with the goal of achieving more favorable outcomes. While this principle provides a rationale for many PFP and QIP programs, the literature has been equivocal regarding whether or not financial incentives will promote improvement in health care. Small financial incentives may be insufficient for motivating any change in delivery of services and larger incentives may result in compliance with protocols unrelated to patient outcomes. Furthermore, many are not convinced that individual clinician behavior is the appropriate level of focus in attempting to effect improvement in the health care delivery system.

Many other concerns have been raised about the potential negative consequences that may result from the implementation of PFP and other similar QIPs. These additional concerns include questions regarding the effectiveness, fairness, and accuracy of such programs; the relevance of certain types of measures to the practice of psychology; possible conflicts of interest or other interference with the psychologist-patient relationship as a result of financial incentives; the potential bias against patients with complex or chronic conditions (which could discourage providers from treating these patients and potentially reduce access to services); the possible negative impact on health disparities; and how to insure that the programs are voluntary and do not penalize those who choose not to participate. In addition, concerns have been raised about how data gathered by QIPs about individual providers are analyzed and presented. Several recent lawsuits by physicians have challenged the rationale and fairness of “quality” ratings that were made available to the public.

Given the importance of the concerns and issues described above, we believe that it would be useful to provide a set of criteria for psychologists to use when evaluating or considering participation in a QIP.

**Purpose of Criteria**

Psychologists work to provide the best possible care to their patients and support efforts to improve the quality of healthcare. In this document, however, it is not assumed that QIPs are inherently beneficial or detrimental and the document is not intended either to encourage or discourage their development. The burden of proof of the utility and usefulness of such systems relies on those implementing them. Clear demonstration that the particular QIP benefits patient care is needed in order to justify the time and expense of implementing such a program.

QIPs have the potential to influence the provision of care to many patients and therefore their processes and development should be open to public scrutiny. Moreover, failure to disclose information related to the rationale, development of the QIP and the intended uses of the collected information is likely to lead to low participation rates and inferior data quality. Disclosure of this type of information to both patients and providers should increase the likelihood that programs will achieve their aims. It will also enable psychologists to evaluate programs according to the criteria described below.
The purpose of this document is to provide criteria to assist in the determination of the
strengths and weaknesses of proposed QIPs. These criteria are intended to provide structure
and guidance for those individuals or groups that evaluate the quality and appropriateness of
QIPs. Each criterion describes an important issue that program developers should aspire to
address in the best possible manner. This document is not intended to promote or discourage
psychologists’ participation in QIPs, nor is it intended to imply that psychologists should be
responsible for reviewing each of these criteria prior to participating in any QIP. Rather, it
provides a framework for psychologists to evaluate proposed programs and determine whether
their participation is warranted. Additionally, it provides policy guidance for advocacy efforts at
the federal and state level regarding the design of QIPs that may impact psychologists.

QIPs should be evaluated along four dimensions: (I) Program Design; (II) Indicators Used
to Measure Quality; (III) Program Implementation; and (IV) Privacy and Confidentiality.

I. Program Design

Criterion 1.0 The primary goal of a QIP should be improving quality of care. Programs
should be designed to insure and promote quality of care. Programs should not be developed for
the sole purpose of cost containment.

Criterion 1.1 Representatives from affected stakeholder groups, including practicing
psychologists and recipients of psychological services, should be included in program
design. Involvement of these groups insures that various perspectives are represented, ideally
resulting in a program that is relevant and acceptable to all stakeholders.

Criterion 1.2 Programs should include an articulated model for improving quality, based
on the best available research evidence. Program rationale should be clearly written and
readily available to psychologists and patients. The rationale should be based on sound
psychological principles and research evidence. The definition of quality should balance patient
and clinical perspectives. How data is to be used to improve quality should be clearly stated in
the rationale.

Criterion 1.3 Design of QIPs should conform to the principles of evidence-based practice
in psychology (EBPP). According to the APA, EBPP “is the integration of the best available
research with clinical expertise in the context of patient characteristics, culture, and preferences.”
Accordingly, QIPs should balance the three elements of EBPP such that clinical expertise and
patient preference inform the interpretation of data collected. QIPs should allow for the role of
professional judgment in determining treatment interventions for individual patients. For example,
waivers or exclusions for particular treatment protocols may be appropriate in some cases.

Criterion 1.4 Design of QIPs should insure that reporting systems protect the integrity of
data collected so that it is as accurate and complete as possible. Means of verifying
accuracy should be specified in advance of data collection. Protections to prevent “gaming” of
the system, such as selectively reporting data only on patients who are progressing well in
treatment or who report high levels of distress in order to obtain additional services, should be
considered in the design of reporting systems.

Criterion 1.5 Data analyses and presentation of results should be appropriately designed
and statistically sound. Data analyses should be conducted using appropriate methods for the
questions being studied. Sample sizes should be sufficient to produce stable estimates. All
decisions about quality improvement should account for sampling and measurement error. For
example, decisions about individual psychologist quality should be derived from data for an
adequate number of representative patients. Confidence intervals should be provided for all
estimates of quality and inform whether decisions should be made based upon these data.
Criterion 1.6 **Data should account for patient characteristics and context.** QIPs should take into account the diversity of patients and the contexts in which they live. Patients will have differential outcomes based on the health and environmental challenges they face. Therefore, adjustments should be made to insure comparability of data across psychologists, patients and settings by taking into account patient characteristics and context and adjusting estimates accordingly. These adjustments include all relevant variables, including severity at intake, history of hospitalization, environmental stressors, complicating physical illnesses, SES, race, benefit plan, co-pay and diagnosis. Cultural background and ethnicity data are not generally collected and are not part of the public or private healthcare claims reporting data.

Criterion 1.7 **Programs should be designed to reduce health disparities.** QIPs should not only improve overall quality of service, but should reduce the disparity between the quality of services for traditionally underserved populations. Unless carefully designed, QIPs may have the unintended negative consequence of increasing racial or ethnic disparities. Therefore, QIPs should include appropriate methods of risk-adjustment and should consider their potential impact on health disparities. (See Criterion 1.3 for additional information on risk adjustment.)

Criterion 1.8 **Programs that make determinations about the quality of care provided by individual psychologists or that provide ratings or rankings of psychologists should do so in a way that is accurate, fair and designed primarily to improve quality of care.** Psychologists should be given the opportunity to decline to participate without being directly or indirectly penalized. Unless the program is carefully designed to accommodate small or solo practices, it may not be feasible for some psychologists to participate. The amount of relevant data and sample size (e.g., all or a subset of an individual psychologist’s case-load) may not be sufficient to accurately calculate individual quality ratings (see Criteria 1.5). If a psychologist works in a community that suffers from health disparities or works with patients diagnosed with particularly complex or chronic disorders, this data should be risk-adjusted, per Criterion 3.1 below, in order to provide a fair representation of the quality of care provided. Any disclosure of information about individual psychologists to the public or to other third parties should be specified in advance and should have a valid rationale that supports quality improvement.

Criterion 1.9 **Programs should provide a clearly articulated procedure to allow individual psychologists to comment on or appeal any quality ratings.** This mechanism would insure that psychologists have the ability to challenge any rating that they believe to be misleading, inaccurate or unfair.

Criterion 1.10 **The costs of implementing the quality measurements should not be overly burdensome, especially for psychologists in solo or small practices.** The potential financial benefits to the psychologist for participation in a QIP should be greater than the costs of participation. For example, costs associated with any technology needed for gathering or reporting data may require expenditures that are not feasible for a solo or small group psychological practice or that place a disproportionate burden on these practitioners.

Criterion 1.11 **PFP programs should provide financial incentives in addition to payments that psychologists are otherwise entitled to receive as usual and customary fees.** PFP programs should not reduce or delay payments that psychologists are otherwise entitled to receive. PFP programs that are primarily aimed at improving quality of care should increase the overall payments to psychologists who are reaching program goals and should not impose financial penalties or decrease payments to other psychologists who provide appropriate care but have not met program targets. Psychologists should not be subject to financial penalties if they choose not to participate, are unable to participate, or treat patients who decline to participate.

Criterion 1.12 **Programs should consider effective non-monetary incentives for quality improvement.** Alternative approaches to quality improvement may also be more cost-effective than PFP. Depending on the treatment setting, education programs, infrastructure subsidies,
II. Program Implementation

Criterion 2.0 Ongoing evaluation of the effectiveness of quality improvement programs should take place, incorporating new information and modifying the programs accordingly. QIPs should regularly demonstrate ongoing effectiveness in improving quality outcomes as measured by the chosen indicators in order to justify continued implementation. For example, if after a certain period of time almost all providers meet the program targets, new goals should be introduced to stimulate improvements in another aspect of care. If a QIP does not demonstrate improvements in quality after a reasonable amount of time, that program should be modified or discontinued.

Criterion 2.1 QIPs may focus on attainment of benchmarks or demonstrable improvements in efforts to meet benchmark indicators. Benchmarks are typically thought of as measurement references, a goal against which improvement or progress is measured. In certain settings, demonstrating improvement may be a more appropriate goal than meeting pre-specified targets. Rewarding improvement instead of or in addition to reaching a benchmark could help to diminish the potential negative impact of QIPs on health disparities, on patients with complex or chronic conditions and on psychologists who provide services for these populations.

Criterion 2.2 Incentives, such as payment for performance (PFP), should be structured to reward the maintenance of care meeting benchmark indicators, as well as to encourage continued improvement for lower performing psychologists. Equity issues may also arise when incentives are only used to reward improvement. Psychologists at or above benchmarks should not be disadvantaged for consistently meeting or exceeding quality indicators.

Criterion 2.3 Benchmarks should be based on empirical evidence, statistically sound, clinically informed, reasonable and achievable in the context in which the services are delivered. Benchmarks should reflect the level of complexity of the problems being treated and should be appropriate for the patient population receiving services. (More detailed requirements for statistically sound benchmarks and other quality indicators are described in Criterion 3 below.)

Criterion 2.4 Incentives for meeting benchmarks or making progress toward benchmarks should be sensitive to sources of error. Sampling error arises when the sample differs in comparison to the population from which it was drawn and represents (e.g., mean standard deviation, etc.). Other sources of error, such as patient refusal to complete the surveys, on which benchmarked improvement is based, administration protocols (telephone, face-to-face, self-report, etc.), weighting (e.g. geographic) and variation in patient screening protocols distort data interpretation.

Criterion 2.5 Program design should involve timely and ongoing feedback to psychologists about their performance. Research has shown that feedback improves effectiveness and efficiency of care.

III. Indicators Used to Measure Quality

Criterion 3.0 Indicators Used to Measure Quality should be psychometrically sound, relevant, actionable, auditable and feasible.

1. Psychometric properties: Measures used to assess quality should produce the same results when repeated in the same populations and settings (reliability). While there are accepted estimates of reliability, there is no single estimate of validity. Assumptions of validity rely on the evidence that the instrument is appropriate for the population and intent of its use. For example, quality indicators should correlate well with other measures of the same aspects of care. In
addition to meeting accepted criteria for reliability and validity, indicators should have
documented links between the clinical processes and the outcomes addressed by the measure.

2. Sensitivity to change: The quality of the data has marked implications for investigating
change over time as a result of intervention of treatment of some type. Items do not contribute
equally to the construct continuum of interest. For example, patient endorsement of suicidality is
indictive of severe depression as compared to an endorsement of feeling sad once in a while. In
addition, the Likert-type response options (e.g., strongly agree, agree . . . strongly disagree)
provided for patient responses are typically interpreted as being equally spaced (interval data),
but seldom is this the case. As a result, the use of raw score change should be examined
carefully. More sophisticated measurement models (e.g., Item Response Theory) transform
Likert-type response categorical data into interval data. The IRT measurement models clearly
indicate that change over time has differential impact depending where on the construct
continuum of interest it occurs – a score change moving from a severe impairment position on the
measured construct may be more clinically meaningful than the same score change at a more
moderate/mild position on the measured construct. Because score changes using raw scores are
not intervalized, a change of 10 points may not have equivalent meaning independent of where
the change occurs on the measured construct.

3. Indicator relevance: Indicators should be meaningful to practicing psychologists and to
patients for making treatment choices. Quality measurement efforts may assist practicing
psychologists in understanding both the clinical and economic significance (e.g., efficiency) of the
information provided by the indicator or benchmark. Indicators should yield data that targets
aspects of care that can be changed and information about how to strategically improve service
delivery. Indicators and benchmarks may also be used to stimulate patients’ internal
improvement efforts and encourage activities that maximize patient well-being.

4. Indicators should be auditable. Indicators should not be susceptible to manipulation or
“gaming” that would be undetectable in an audit.

5. Indicator feasibility: Indicators and benchmarks should be precisely specified in terms
of data sources and methods for data collection and reporting. The costs associated with data
collection should not impose an inappropriate burden on practicing psychologists or practice
networks. The collection of data should not violate any accepted standards of patient
confidentiality. Indicators should also be logistically feasible and the data required for the
indicators should be available. For example, administrative documentation should be accessible
and clinician and/or patient self-report should be feasible in the treatment context.

Criterion 3.1 Indicators Should be Appropriately Risk Adjusted. Risk adjustment is
essentially the process of adjusting the outcome probabilities for unlike groups so that
comparisons can be made. Treatment outcomes are adjusted to produce greater accuracy in
interpreting outcomes when external influences on treatment such as age, gender, SES,
chronicity, acuity, and comorbidity are non-randomly distributed across the groups to be
compared. Methods for achieving this goal may include adjusting for case mix (types of patients
seen), service mix (types of services provided), and risk-adjustment.

Typically risk adjustment focuses on two distinct categories: (1) predicting service
utilization and cost, and (2) comparing treatment outcomes. Utilization and cost estimates are
adjusted with the goal of yielding more precision in setting capitation, case and premium rates
and the like. Adjusting treatment outcomes is a complex endeavor. Multiple factors, including
demographic characteristics, clinical and functional attributes, diagnosis, presence of co-morbid
conditions and quality of the services received by an individual are likely influences on both
treatment and service utilization/cost outcomes. While individual attributes are significant in
articulating risk adjustment strategies, other considerations are also important if risk adjustment
techniques are to be meaningful. The unit of analysis (e.g., individual clients, client groups,
psychologists, etc.) and the interval of time observed are critical considerations. Our ability to
more precisely estimate outcomes with risk-adjusted probabilities is constrained by what data are
available, and by the methodological designs employed to address outcome questions of interest.

Criterion 3.2 Indicators should be comparable across practice settings and should
measure aspects of care under the psychologists’ control. Indicators should not be
significantly affected if different systems use different approaches to handling the data. Indicators
should accurately measure what is actually happening in treatment and should not be affected by
any variables that are beyond the practicing psychologist’s or practice network’s control. Risk
stratification or a validated model for calculating an adjusted result can be used to insure
comparability across practicing psychologists and psychologist networks (see also Criteria 1.6
and 3.1.)

Criterion 3.3 Relevant measures are related to patient health or well-being. Measures may
include both psychologist and patient measures. Patient measures might include, for example,
indicators of patient functioning, well-being and symptom severity. Psychologist measures might
include the delivery of important intervention components (e.g., appropriate screening for
suicidality, gathering information of the patient’s support system) or reflect important therapy
principles (e.g., formation of a therapeutic alliance, collaboratively setting of goals, evaluating
patient motivation).

Criterion 3.4 Representatives from affected stakeholder groups, including practicing
psychologists and recipients of psychological services, should be involved in the
development of indicators relating to mental/behavioral health services. Involvement of
these groups insures that various perspectives are represented, ideally resulting in the
development of measures that are relevant and acceptable to both patients and providers.

IV. Privacy and Confidentiality Issues:

Criterion 4.0 Informed consent forms should be clear, thorough and easily understood by
patients. Psychologists should be aware of the extent to which the consent form safeguards
confidentiality as well as the potential privacy risks to patient (e.g., the ways in which this
information may be used to the detriment of the patient’s welfare).

Criterion 4.1 Patient and psychologist participation in any QIP should be voluntary. QIPs
should clearly inform patients and psychologists that participation is voluntary. Psychologists
should keep the patients’ best interests in mind regarding whether or not to encourage patient
participation in any quality improvement program. QIPs should not pressure or penalize patients
or psychologists if a patient chooses not to provide self-report data. Patients and therapists
should not be directly or indirectly coerced to participate in QIPs. If the therapist is paid for
his/her patients’ participation, there is a potential conflict of interest (e.g., psychologist’s level of
remuneration depends upon a particular percentage of case-load completing survey).

Criterion 4.2 Safeguards are needed to protect the confidentiality of data used in QIPs.
Data that is identified with a particular patient is protected by HIPAA regulations. While identified
patient data are covered under protected health information (PHI), these data may not be
protected under HIPAA psychotherapy notes provision and may not be privileged. Instruments
sometimes record data in ways in which a psychologist would not in their own records. Data
collected should not be made public without the express written consent of psychologists/patients
and a valid rationale. Only minimum necessary performance or quality data should be reported to
third parties and only with patient’s express written consent. This does not prohibit use of HIPAA-
compliant, anonymous aggregate data for research or quality improvement purposes, including
data-sharing arrangements where appropriate safeguards are used to protect psychologist and
patient confidentiality.

Criterion 4.3 A clear rationale, empirically documented utility, and appropriate
confidentiality safeguards are required for the collection of particularly sensitive patient
Criterion 4.4 The ways in which individually identified patient data are collected and used should be specified and fully disclosed to patients and psychologists prior to its collection. If the third party will be sharing the information with other parties, such as other health care providers, health insurers, or other types of insurers (life, disability, etc.), the third party should disclose all such data-sharing in advance and give the patient the opportunity to opt out. Decisions about individual psychologists or patients should be limited to the uses specified in the written quality improvement program.

Criterion 4.5 If the survey data uses codes identified with a particular patient, codes should be assigned such that it is not possible to decode the identity of the patient by using collateral data. This is a particularly important concern with small sample sizes. For example, if data are being collected for only a few patients being treated by a particular psychologist, very little additional information may be necessary to decode a patient’s identity.

Criterion 4.6 Psychologists should be aware that there are other situations under which sensitive information could be revealed. For example, this information may subpoenaed in custody or personal injury litigation, or requested on employment applications for military, government positions, or jobs requiring a security clearance.

Criterion 4.7 Psychologists should be clearly and fully informed about any data that is collected directly from the patient relating to treatment by that psychologist. The more the psychologist is involved in the process (administration of the survey, discussion of the survey content with the patient, review of the survey) the more the data may be subject to privilege, even though not afforded the same level of privilege as psychotherapy notes.

Conclusion

This document presents an overview of pay-for-performance and other quality improvement programs and outlines criteria to be used by psychologists in evaluating these programs and/or their participation in them. This document does not assume that quality improvement programs are inherently beneficial or detrimental. It is hoped that this information will be useful to psychologists who are considering participation in these programs or who are involved in their development. Although these criteria are written for psychologists, many of the concepts are equally relevant to other healthcare providers and their patients.

As professionals who strive to provide the best possible treatment for their patients, psychologists support continuous quality improvement and professional development. However, significant concerns have been raised about the design and implementation of some quality improvement programs. These concerns should be adequately addressed in order to protect both patients and psychologists. The patient-psychologist relationship, assurances of confidentiality, and an appreciation of the individual patient’s characteristics and context are some of the essential elements of psychological services. Therefore, they should be carefully taken into account in order for these programs to effectively improve quality of care while avoiding unintended negative consequences to the patient and/or the therapeutic relationship

REFERENCES


