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Distinguishing Outcomes-Based Treatment and Evidence-Based Practices

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Business Analogy

- Evidence-based: Business plan indicates the business will make money
- Outcomes-based: A certified audit determines the extent to which the business makes money

Both Strategies May Have Similar Problems

- Appropriateness of methods for the population served
- Appropriate staff qualifications
- Fidelity to the model(s) of care
- Appropriate metrics
- Arbitrary metrics

Arbitrary Metrics

- Reliably measured
- Scientifically valid
- Irrelevant to the real world
- Addiction Treatment Examples:
  - Average days of use in past 30 days
  - Scores on a variety of psychological instruments

Reference on arbitrary metrics:
Kazdin, A. E. (2006). *American Psychologist*, 61(1), 42-79.

Arbitrary Metric Example

Programs A and B each treat 100 individuals

Program A:
Before treatment average days of use = 25
After treatment average days of use = 10

Program B:
Before treatment average days of use = 25
After treatment average days of use = 8

Which program has the better outcomes?

Arbitrary Metric Example

Real world results:

Program A:
60 in sustained remission; 40 minimal change

Program B:
Zero remission: All 100 still using – but – just on weekends, but all have continuing problems and meet current criteria for severe SUD (dependence)

To which program would you refer a family member?

Appropriate (?) Baseline Metrics

- Severity: Number of positive criteria as defined by the DSM-5
  - Mild: 2 - 3 DSM-5 criteria
  - Moderate: 4 – 5 criteria
  - Severe: 6 or more criteria
- The categorial differences are arbitrary
- Not all criteria may have equal implications

Original Medical Diagnosis of Alcohol Use Disorder:

You drank more than your doctor.

The Big Five

- Most strongly associated with severe Dx
  - Unsuccessful attempt to stop or cut down
  - Craving/strong desire to use
  - Role obligation failure
  - Sacrifice of activities related to use
  - Withdrawal syndrome
- Compatible with “loss of control”
- Not empirically validated for outcomes

CASE 1: Positive DSM-5 Criteria

3. Great deal of time using

10. Tolerance

1. Unplanned use: more or longer use

8. Use in hazardous situation (impaired driving)

6. Recurrent interpersonal conflicts

Conclusions

- No loss of control indicated
- Misuse and possible irresponsible behavior
- Moderation may be a reasonable initial goal

CASE 2: Positive DSM-5 Criteria

1. Unplanned use: more or longer use
2. Desire/efforts to cut down
4. Craving/compulsion to use
5. Role obligation failures
8. Use in hazardous situation (impaired driving)

Conclusions

- Loss of control indicated
- Positive on 3 of the “Big Five”
- Abstinence likely required for remission

Appropriate Outcome Metrics

- Remission as define by the DSM-5
  - Early Remission: No DSM-5 criteria other than craving for 3 months
  - Sustained Remission: No DSM-5 criteria other than craving for 12 months
- Remission is the primary goal for treatment – not to be confused with recovery

Other Evidence Issues

- Failure to address appropriately the range of clinical severity of conditions
- Severity and prognostic indicators are rarely the focus of outcomes research
- Assessment of the specific characteristics defining treatment needs and prognosis is lacking
- Use of imprecise terms or terms lacking objective or empirical definition

Imprecise Definitions

Heavy Drinkers:

Persons who weight 250 pounds and drink.

Problem Drinkers:

People who spill more than they swallow.

Alcohol Abuse:

Pouring water into good Scotch.

Evidence-based Positives

- Utilize treatment models documented to be effective
- Manuals and training materials often available
- A means to deal with staff turnover and retraining
- May be useful in marketing and securing payment

One of the great mistakes is to judge policies and programs by their intentions rather than their results.

Milton Friedman, economist, Novel laureate (1912-2006)

Evidence-based Negatives

- Model may not be appropriate for the population being treated
- Question of whether the model is (or can be) implemented with fidelity in routine practice
- No guarantees that it will work in routine clinical practice
- No verification of outcomes

The Evidence?

- Often based primarily on reductions in substance use – arbitrary metric
- Substance use is not part of the definition of remission in the DSM-5
- Outcomes may be similar to those documented from good programs 20 years ago
- Methodology often lacks rigor

Lack of Methodological Rigor

- Use of arbitrary metrics
- Assumption that randomization equalizes everything
- Lack of diagnostic and severity documentation for all conditions
- Failure to account for services outside of the research protocol
- Assumption of a “one size fits all” approach – no individualized services

Fallacy of “Best Practices”

- There is no such thing as a “best practice” appropriate for everyone
- Individualized treatment, or client-informed treatment, requires assessment findings coupled with outcome results to tailor treatment to the individual
- Obtaining improved results from treatment requires ongoing monitoring that combines assessment and outcome data to determine what works best for whom

Hypothetical Issues from Project MATCH

- Different patients may require different approaches or emphasis irrespective of the general program model
- Motivational enhancement may be needed for those with low motivation
- 12-Step supports may be more important for those with no current support

Individualized Treatment

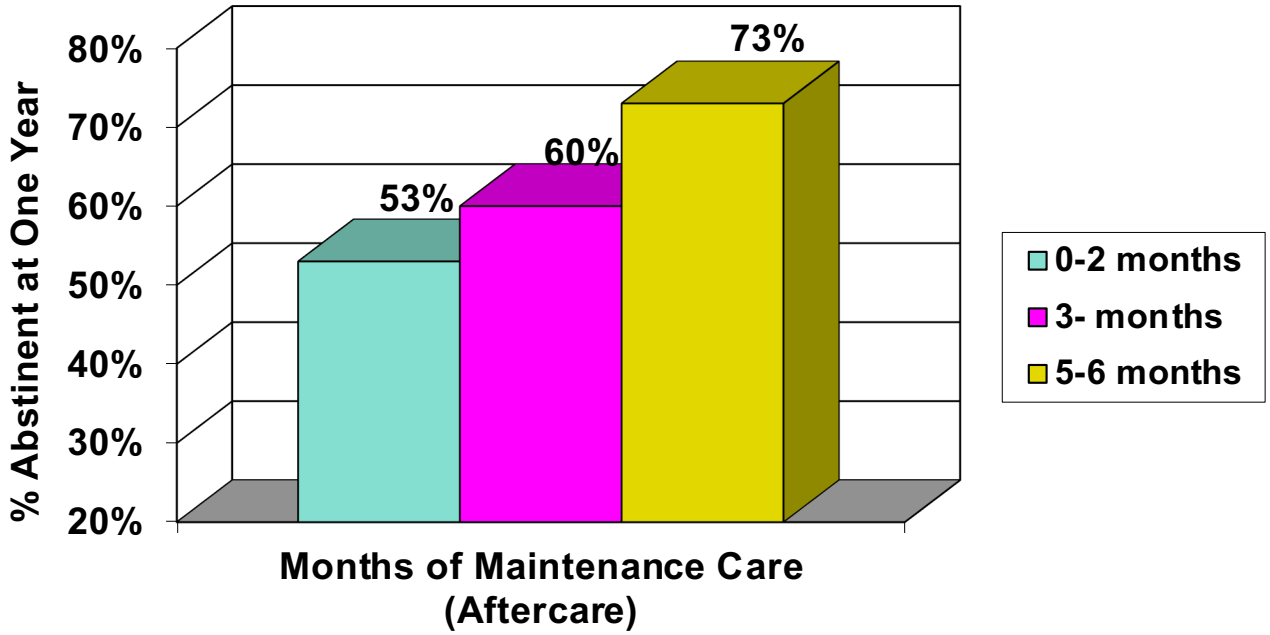
- Requires flexibility in the provision of treatment
- Requires detailed assessment of conditions and needs
- Requires ongoing reassessment of conditions and progress
- Requires staff with high level of expertise

Outcomes-based Positives

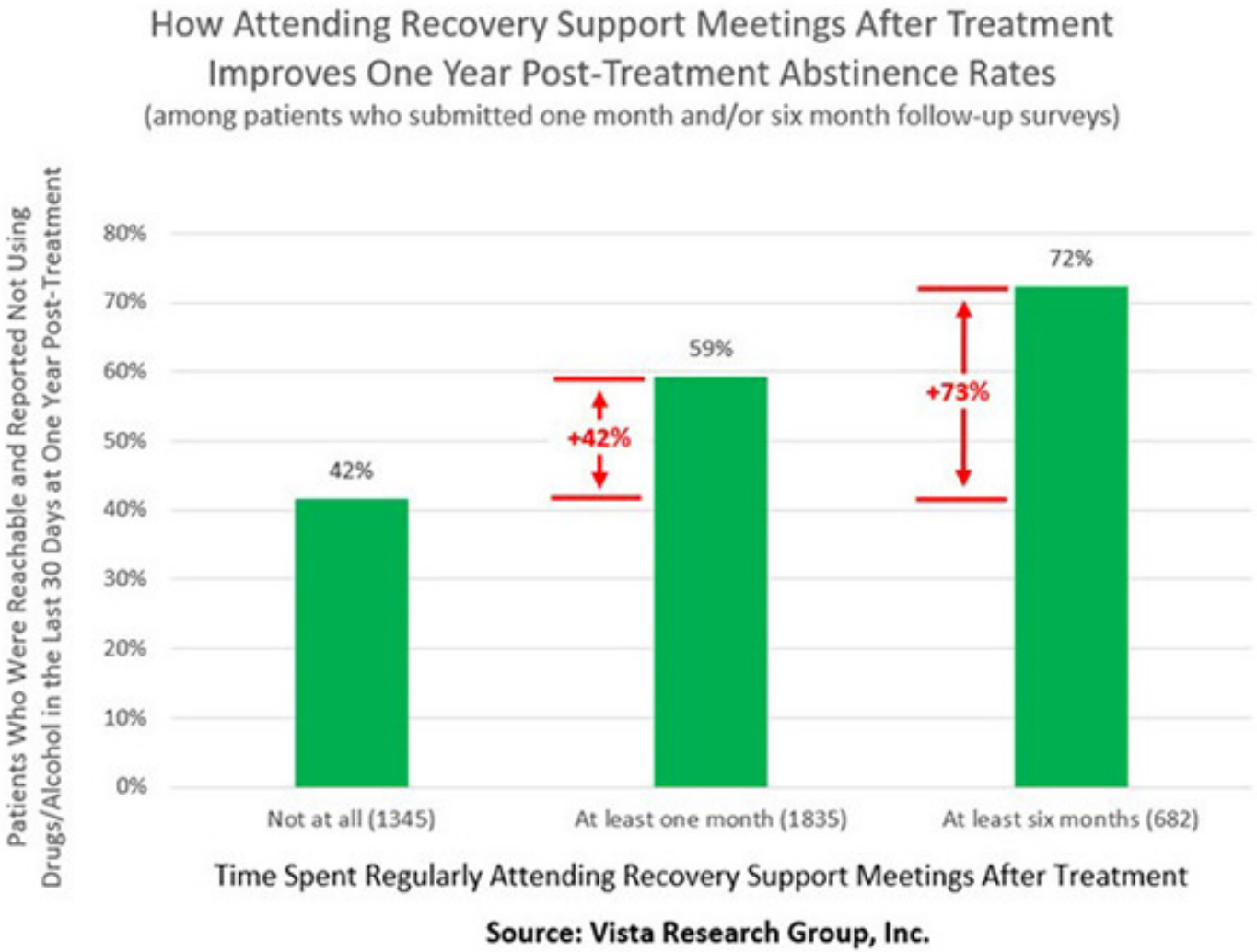
- Has the following potentials:
  - Real world relevant data
  - Continuous improvement strategies
  - Empowerment of patient decision making
  - Realistic marketing

Maintenance Care Thresholds

N = 12,783 Treatment Completers



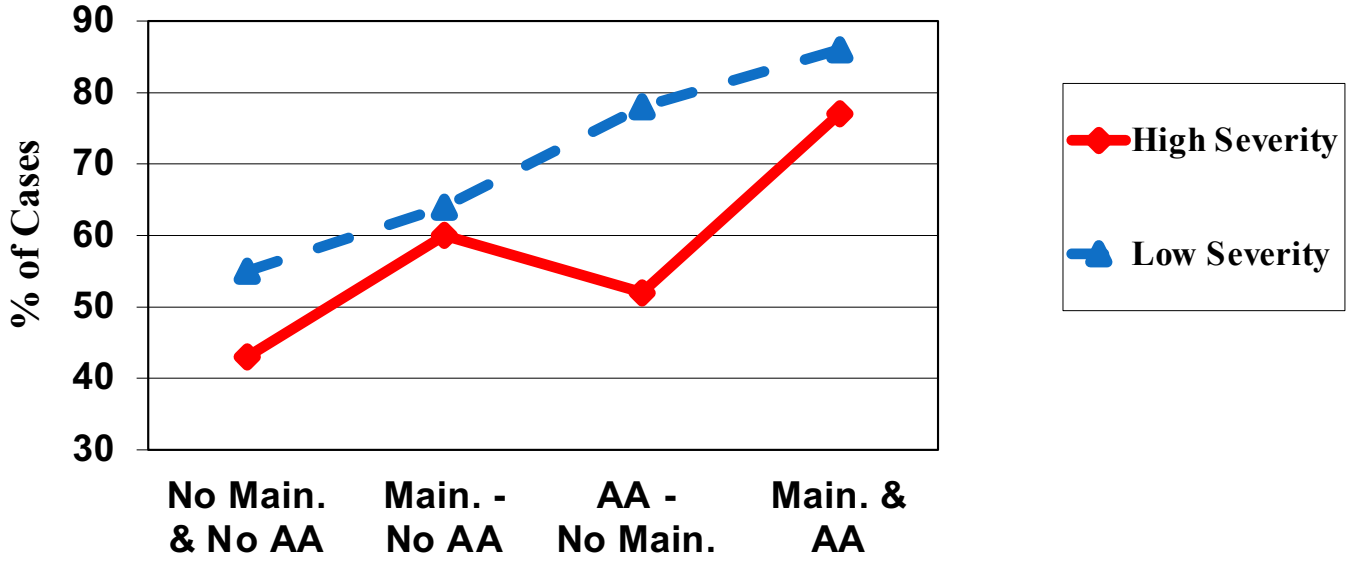
Hoffmann & DeHart (1996). CATOR Fact Sheet


How Attending Recovery Support Meetings After Treatment
Improves One Year Post-Treatment Abstinence Rates
(among patients who submitted one month and/or six month follow-up surveys)
Patients Who Were Reachable and Reported Not Using
Drugs/Alcohol in the Last 30 Days at One Year Post-Treatment
80%
70%
60%
50%
40%
30%
20%
10%
0%
42%
59%
72%
+42%
+73%
Not at all (1345)
At least one month (1835)
At least six months (682)
Time Spent Regularly Attending Recovery Support Meetings After Treatment
Source: Vista Research Group, Inc.

For every complex question there is a simple answer, and its wrong.

Attributed to H. L. Mencken

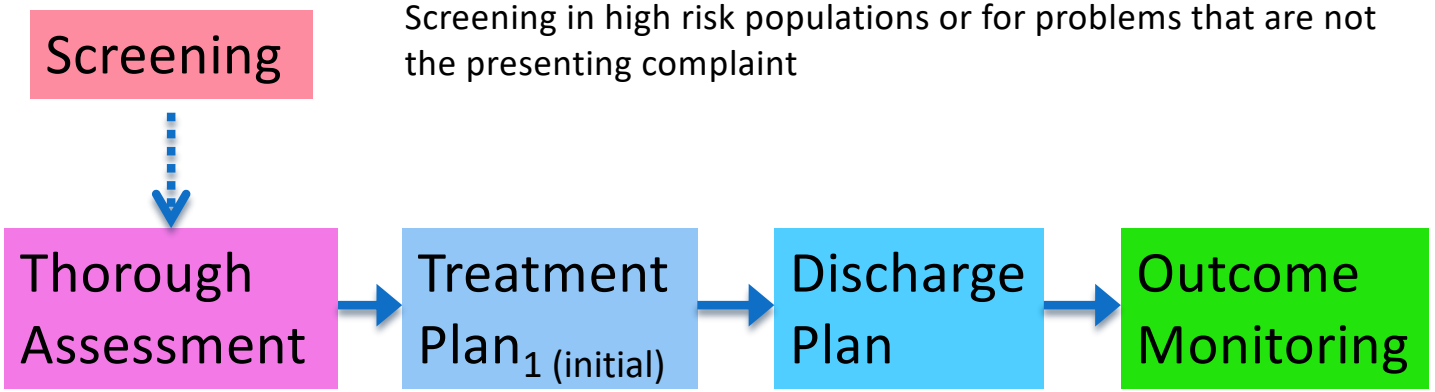
One Year Abstinence Rates for Older Alcohol Dependent Clients



Combinations of 4+ months of Maintenance Care and/or Weekly AA Attendance for 1,350 treatment completers

Hoffmann, DeHart & Gogineni (1998). The Southwest Journal on Aging, 14(1), 57-64.

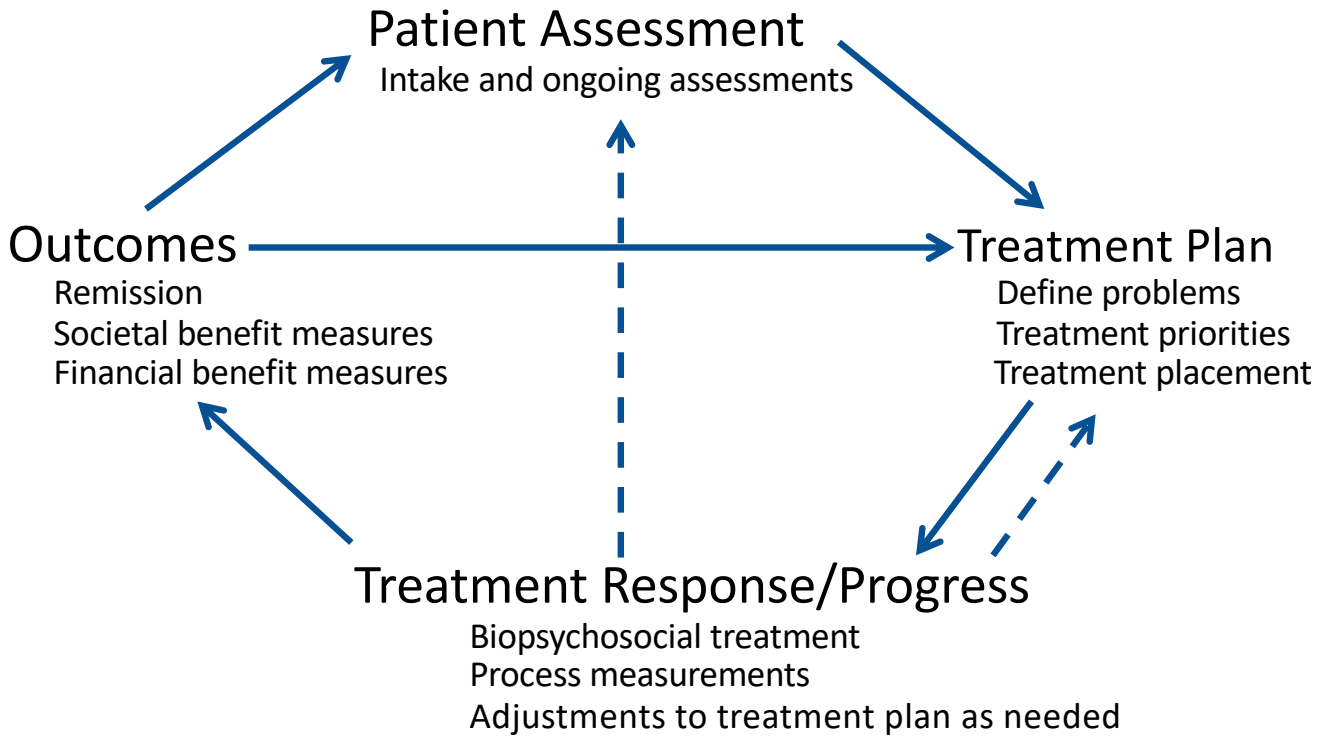
THE ASSESSMENT CONTINUUM



Screening in high risk populations or for problems that are not the presenting complaint

For those presenting for services, a thorough assessment is required beginning with determination of conditions and their severity followed by an initial treatment plan. Treatment plans may require revision based on ongoing assessment. A transfer/discharge plan for when scheduled services end at a given program. Outcome monitoring informs future treatment plans.

CONTINUOUS CLINICAL IMPROVEMENT COMPONENTS



What Clinicians Need

- Diagnoses – you cannot effectively treat what you cannot identify
- Severity & Complications – nature & scope of conditions/complications
- Prognosis – identification of differential needs and expectations
- Action Plan – empirically logical, realistic, & acceptable

V A H A: What Patients Want

- Validation – presence of a condition warranting treatment/attention
- Assurance – the condition is treatable
- Hope – a positive outcome is both possible and likely
- Action plan – logical, realistic, & acceptable

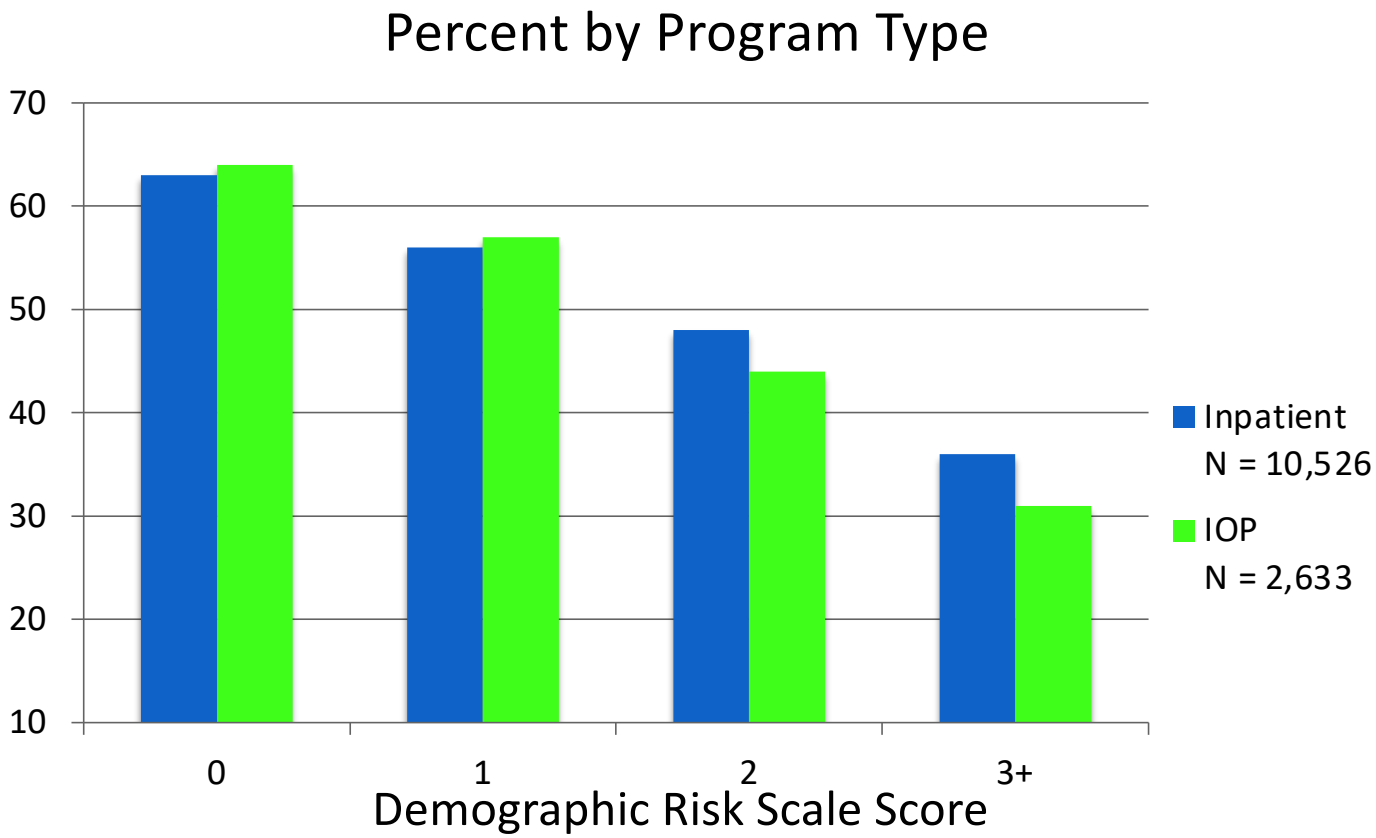
Outcomes-based Negatives

- Costs: Monitoring outcomes will have direct and indirect costs
- Whether to attempt internal monitoring or contract for external services – Key decision
- Ability to collect meaningful data
- Ability to analyze and use the data

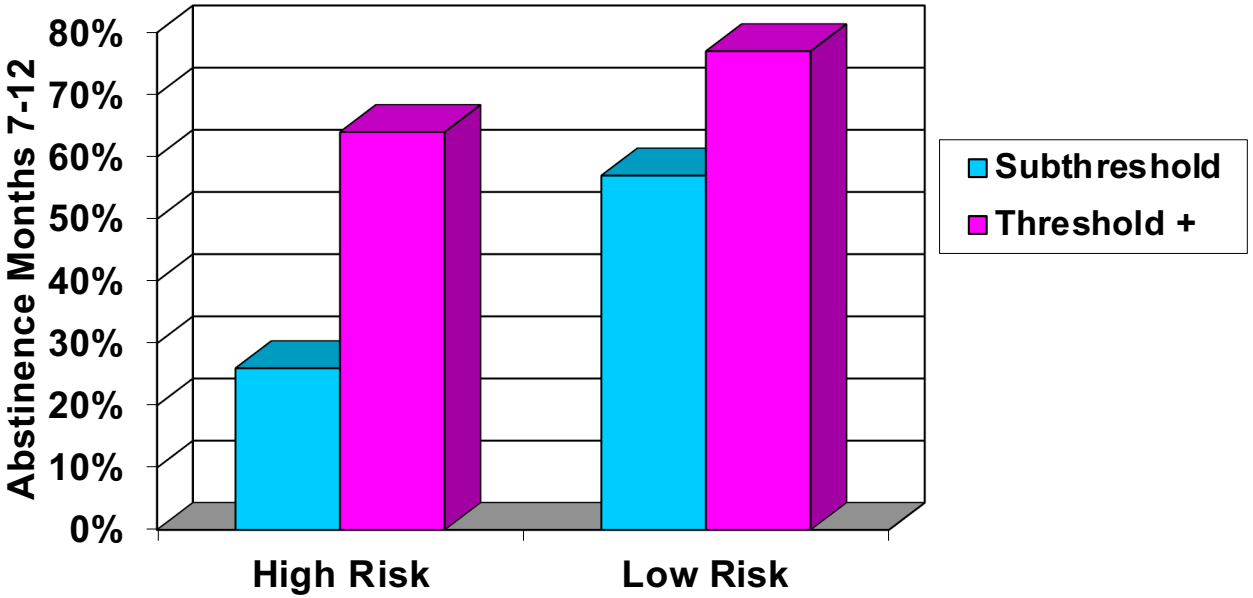
Basic Requirements

- The ability to document remission
- Explore factors related to outcomes
- Basis for supporting clinical recommendations/decisions
- Basis for empowering decisions by patients
- Basis for marketing

Demorisk and Program Placement



Demographic Risk Scale and Observed Outcomes



35 Unites of service = threshold for low risk group

75 Unites of service = threshold for high risk group

Zywiak, Hoffmann, & Floyd. (1999). *Medicine & Health/Rhode Island.*

Outcomes Decision

- Monitor outcomes internally using program staff
- Contract out the outcome monitoring to commercial services

Internal Requirements

- Staff availability
- Useable electronic data – numeric variables
- Consent for continuing contact – including contact individuals
- Analytic capability

Outcomes-informed Treatment

- Monitor baseline and initial relevant outcomes for all clients – outcomes can be clinical and/or societal
- Monitoring done during typical continuum of care (primary + aftercare)
- Outcome documentation – does NOT require a “tool”
- Retrieval of data for analyses

External Requirements

- Transparency
- Does system collect required or desired information
- Confidentiality contracts
- Utility of routine reporting
- Ability to access and/or extract facility data

The truth is rarely pure and never simple.

From *The Importance of Being Ernest*
by Oscar Wilde (1854-1900)

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