

Transforming Public Behavioral Health Care:

Improving Outcome and Efficiency with
Consumer-Driven, Outcome-Informed (CDOI)
Service Delivery

Scott D. Miller, Ph.D.



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The Next trend may be global clinics
Cynthia Masschalek

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ACHIEVING CLINICAL EXCELLENCE

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DAVID HELFGOTT
WHOSE HEARTWARMING STORY
WAS FEATURED IN THE AWARD
WINNING FILM "SHINE"



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DR. SCOTT D. MILLER, PH.D - HUGH MCCUTCHEON
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Transforming Care:

The Turn to “Outcome”



- “Outcome,” “Evidence,” “Effectiveness” & “Accountability” are the watchwords of the day.
- Part of a world wide trend not specific to mental health and independent of any particular type of reimbursement system.

Duncan, B., Miller, S., Wampold, B., & Hubble, M. (Eds.) (2009). *The Heart and Soul of Change* (2nd Ed.). Washington, DC.: APA Press.

Lambert, M.J., Whipple, J.L., Hawkins, F.J., Vermeersch, D.A., Nielsen, S.L., Smart, D.A. (2004). Is it time for clinicians routinely to track patient outcome: A meta-analysis. *Clinical Psychology*, 10, 288-301.



Transforming Care:

The Current Environment



- ✓ Move from inpatient to outpatient, from hospital to community;
- ✓ Shortened lengths of intensive treatment;
- ✓ Increased utilization and performance reviews;
- ✓ Declining reimbursement rates;

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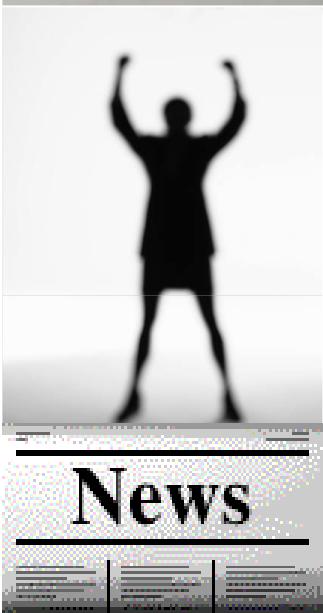
The Current Environment

- ✓ More accountability, responsibility, risk...
- ✓ "Professionalization" of treatment (in addiction treatment especially)
- ✓ Expansion of treatment options, mandated modalities
- ✓ Individualized, clinically-driven, "recovery-oriented" treatment



Improving Effectiveness

The “Good News” about Behavioral Health Services



- In most studies conducted over the last 40 years, the average treated person is better off than 80% of the untreated sample.

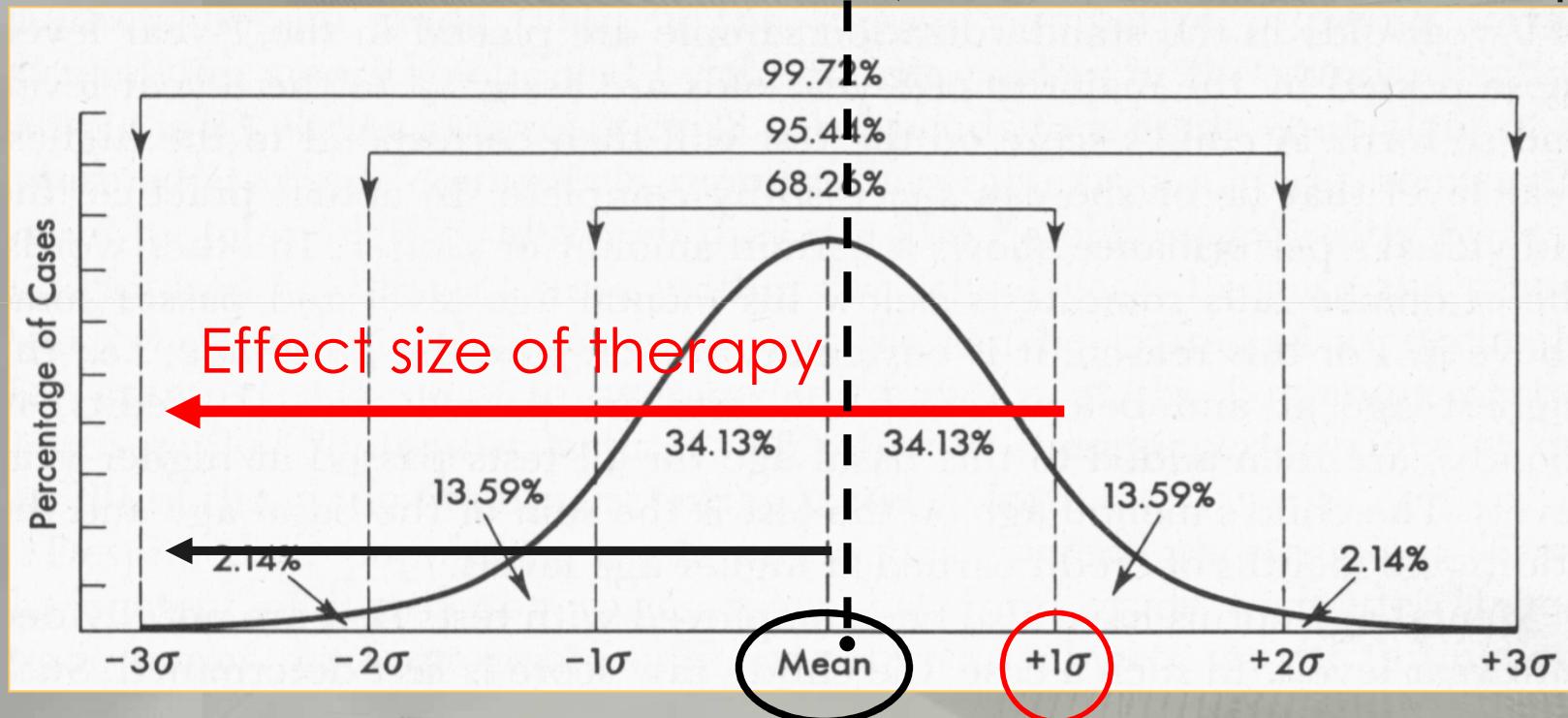
Duncan, B., Miller, S., Wampold, B., & Hubble, M. (Eds.) (2009). *The Heart and Soul of Change* (2nd Ed.). Washington, D.C.: APA Press.



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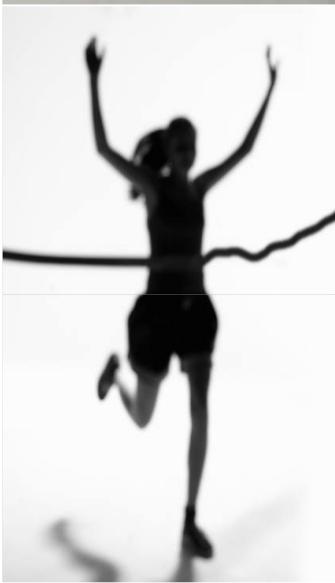
Tutorial on Outcome

Effect size of Aspirin



Rosenthal, R. (June, 1990). How are we doing in soft psychology? *American Psychologist*, 45(6), 775-777.

Improving Effectiveness



The bottom line?

- The majority of helpers are effective and efficient most of the time.
- Average person in care accounts for only 7% of expenditures.



So, what's the problem...

Improving Effectiveness

The “Bad News” about Care



News

- Drop out rates average 47%;
- 1 out of 10 consumers accounts for 60-70% of expenditures;
- Providers frequently fail to identify “at risk” and failing cases.

Duncan, B., Miller, S., Wampold, B., & Hubble, M. (Eds.) (2009). *The Heart and Soul of Change: Delivering “What Works” in Therapy*. Washington, D.C.: APA Press.
Lambert, M.J., Whipple, J., Hawkins, E., Vermeersch, D., Nielsen, S., & Smart, D. (2004). Is it time for clinicians routinely to track client outcome? A meta-analysis. *Clinical Psychology*, 10, 288-301.

Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., & Sutton, S. W. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology/In Session*, 61, 1-9.

Improving Effectiveness

Some Clues to Why we fail

- Study of 6,146 adults seen in real-world clinical practice:
 - Average age of 40;
 - Completed at least 6 months of treatment (average sessions = 10);
 - Diagnosis included depression (46.3%), adjustment disorder (30.2%), anxiety (11%), bipolar disorder, PTSD, and other.
- 581 full-time providers working independently in a networked managed care system:
 - 72.3% female, 27.7% male;
 - Average 21 years of experience;
 - 30.3% doctoral level, 63.7% master's level, 3.6% medical degrees.

Wampold, B., & Brown, J. (2006). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology*, 73 (5), 914-923.



Improving Effectiveness

Some Clues to Why we fail



- Factors widely and traditionally believed to exert strong influence on outcome accounted for little or no variability:
 - Diagnosis after accounting for severity and for case mix (less than 1%);
 - Consumer age and gender (0%);
 - Provider age, experience level, professional degree or certification;
 - Use of medication;
 - Within and between provider regression to the mean.

Wampold, B., & Brown, J. (2006). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology*, 73 (5).

Improving Effectiveness

Some Clues to Why we fail



- Variability in outcomes between providers (5-8%) equaled or exceeded the contribution of factors known to exert a significant impact on therapeutic success:
 - Quality of the therapeutic alliance (5-8%);
 - Allegiance (3-4%);
 - Treatment model or method (1%).
- Medication generally helpful only when given by an effective practitioner.

Wampold, B., & Brown, J. (2006). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology*, 73 (5).

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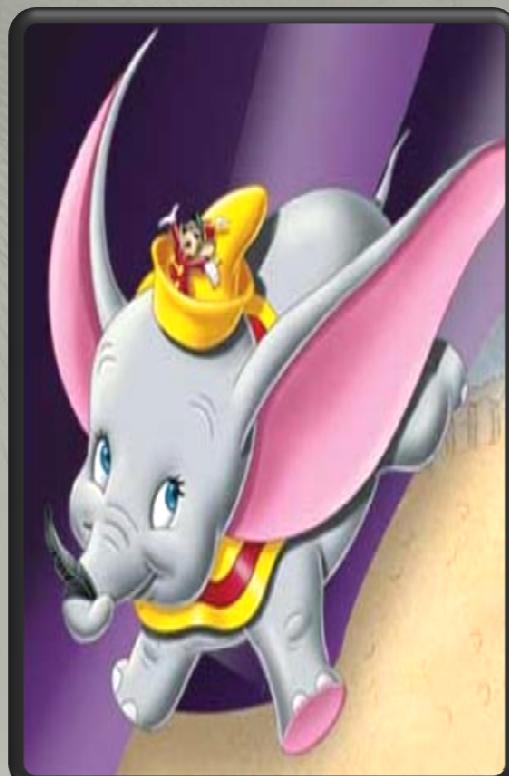
**“You can’t solve a problem
with the same kind of
thinking that created it.”**

Albert Einstein

The Medical Model Equation:

- Evidence-based practice;
- Quality assurance;
- External management;
- Continuing education requirements;
- Legal protection of trade and terminology.

The Results



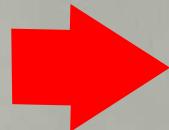
- All approaches work equally well with some clients at some times;
- Diagnosis little help in differential treatment selection and unrelated to outcome.
- QA practices neither improve the quality or outcome of the service;
- External management actually *increases* costs;
- No difference in outcome based on training.

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Changing Paradigms

The Medical Model:

What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?



The “Contextual” Model:

Is this relationship between this consumer and this provider, program, level of care working for this individual at this time and place?

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The Core Principles of CDOI

Contextual versus Medical Orientation

Consumer-driven
Service Delivery

Routine
Monitoring
&
Feedback
regarding
alliance
and
outcome

Restoration and
Recovery versus
Cure of Illness

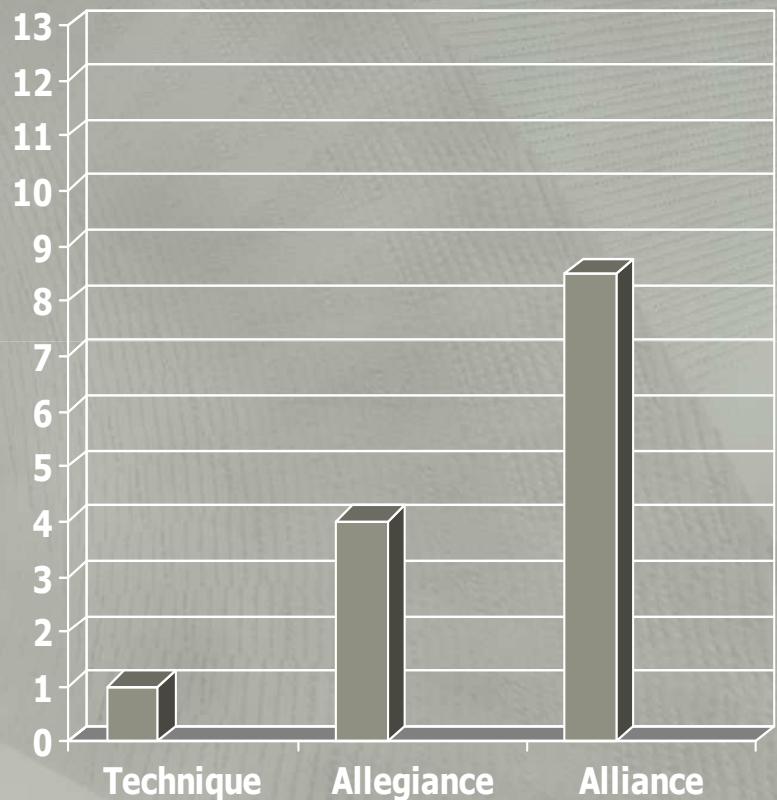
The “Common Factors”
of Effective Behavioral Health Care

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The “Common Factors”

Outcome of Behavioral Healthcare Services:

- 60% due to “Alliance” ([aka “common factors”] 8%/13%)
- 30% due to “Allegiance” Factors (4%/13%)
- 8% due to model and technique (1/13)

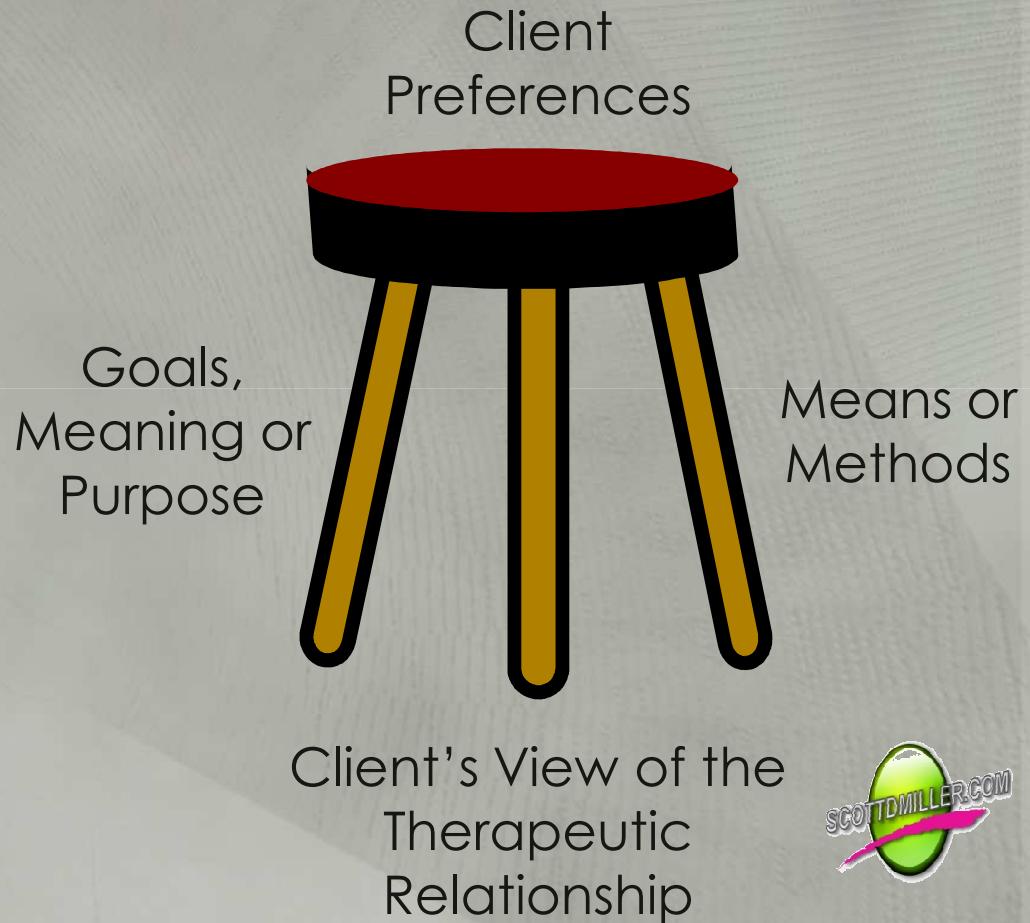


Duncan, B., Miller, S., Wampold, B., & Hubble, M. (Eds.) (2009). *The Heart and Soul of Change* (2nd Ed.). Washington, DC.: APA Press

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Consumer-Directed Service Delivery

- Research on the alliance reflected in over 1100 research findings.

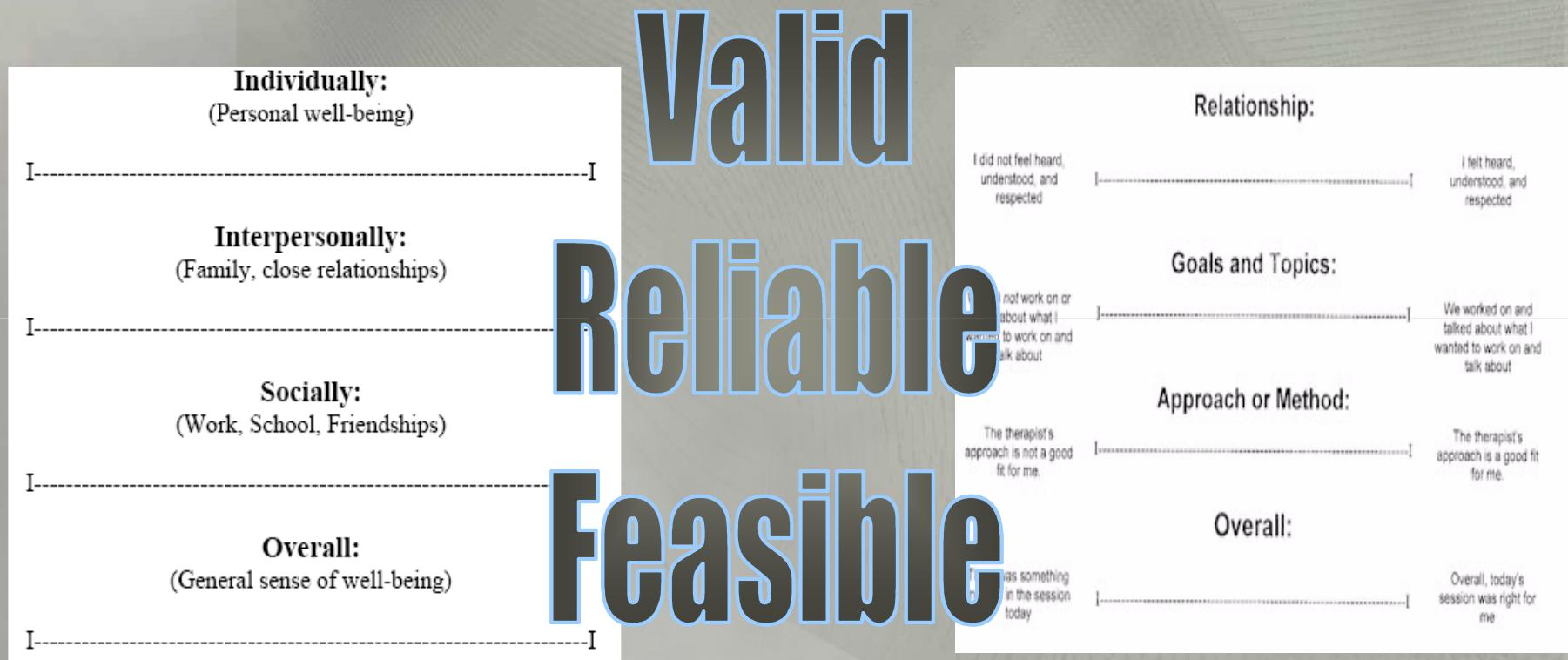


Norcross, J. (2009). The Therapeutic Relationship. In B. Duncan, S. Miller, B. Wampold, & M. Hubble (eds.). *The Heart and Soul of Change* (2nd Ed.). Washington, D.C.: APA Press.



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Routine Outcome Monitoring & Feedback



The O.R.S

The S.R.S

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www.scottdmiller.com/?g=node/6

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Restoration & Recovery



- Historically, in the field of behavioral health, “recovery” was a term reserved for substance abuse treatment programs:
- In CDOI, “recovery” refers to the shift away from “illness,” “treatment,” and “cure” toward an emphasis on consumer desires, the “fit of services” and measureable improvement in individual, relational, and social well being.

Transforming Care

The Evidence

- Currently, 13 RCT's involving 12,374 clinically, culturally, and economically diverse consumers:
 - Routine outcome monitoring and feedback as much as doubles the “effect size” (reliable and clinically significant change);
 - Decreases drop-out rates by as much as half;
 - Decreases deterioration by 33%;
 - Reduces hospitalizations and shortened length of stay by 66%;
 - Significantly reduced cost of care (non-feedback groups increased).

Miller, S.D. (2010). Psychometrics of the ORS and SRS. Results from RCT's and meta-analyses of routine outcome monitoring and feedback: The available evidence. <http://www.scottdmiller.com/?q=blog/1&page=2>.



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The Evidence

- The consumer-driven, outcome-informed approach is being used with broad and diverse group of adults, youth, and children in agencies and treatment settings around the world including:
 - Inpatient
 - Outpatient
 - Residential
 - Prison-based (mandated care)
 - Case management



Bohanske, B. & Franczak, M. (2009). Transforming public behavioral health care: A case example of consumer directed services, recovery, and the common factors. In B. Duncan, S. Miller, B. Wampold, & M. Hubble. (Eds.) (2009). *The Heart and Soul of Change* (2nd Ed.). Washington, D.C.: APA Press.

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The Evidence

- Center for Family Service in Palm Beach County, Florida:
 - Struggled with limited resources, more requests for services than capacity, competing demands from stakeholders, lengthy episodes of care, and high no show and attrition rates.
 - Average length of stay decreased more than 40%, cancellation and no-show rates dropped by 40 and 25%, and the percentage of clients in long-term treatment that experienced little or no measured improvement fell by 80%!



Bohanske, B. & Franczak, M. (2009). Transforming public behavioral health care: A case example of consumer directed services, recovery, and the common factors. In B. Duncan, S. Miller, B. Wampold, & M. Hubble. (Eds.) (2009). *The Heart and Soul of Change* (2nd Ed.). Washington, D.C.: APA Press.

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- Community Health and Counseling Services in Bangor, Maine:
- Consumers traditionally characterized as “severely and persistently mentally ill”;
- No-show and cancellation rates reduced by 30%, average length of stay decreased by 59%, need for long-term, ongoing support in the form of either residential treatment or case management dropped by 50% and 72% (2 years to 6 months)—all this while consumer satisfaction with services markedly improved.

Bohanske, B. & Franczak, M. (2009). Transforming public behavioral health care: A case example of consumer directed services, recovery, and the common factors. In B. Duncan, S. Miller, B. Wampold, & M. Hubble. (Eds.) (2009). *The Heart and Soul of Change* (2nd Ed.). Washington, D.C.: APA Press.

Transforming Care

“The devil is in the details...”



Transforming Care: Changing Systems

Getting from “here”
to “there” → TURN 180

Clinical
Administrative
Info/Doc/IT
Regulatory/Accreditation
Consumers
Funders



Transforming Care: Changing Systems

A Case Example



- Founded in 1961 as an “Information and Referral Service”;
- Gradually added services:
 - 24/7/365 Detox Center
 - Halfway Houses
 - IOP
 - Assessment
 - Inpatient
 - Extended Care
- Now the third largest provider of substance abuse services in the state of Minnesota.

Transforming Care: Changing Systems

A Case Example

The Original Model Used at the CADT:

- Diagnosis-driven;
- Fixed program and lengths of stay;
- Fixed “one size fits all” treatment plans
- 12 Step and A.A. orientation



Transforming Care: Changing Systems

“Tipping Points”

- In the mid-1990's insurance companies and licensure started to demand evidence of individualized treatment and outcomes;
- Difficulty with prior authorization process managed care reducing days of care;
- 50% or greater client drop out rate;
- Low reimbursement.



- Assessments often did not relate to client service;
- Clinical staff took an insular and defensive stance to change;
- Clinical staff did not know how to identify clients early in treatment who were likely to leave or have a poor outcome.

Transforming Care: Changing Systems

Characteristics of Successful Agencies and Treatment Systems

PHASE ONE:

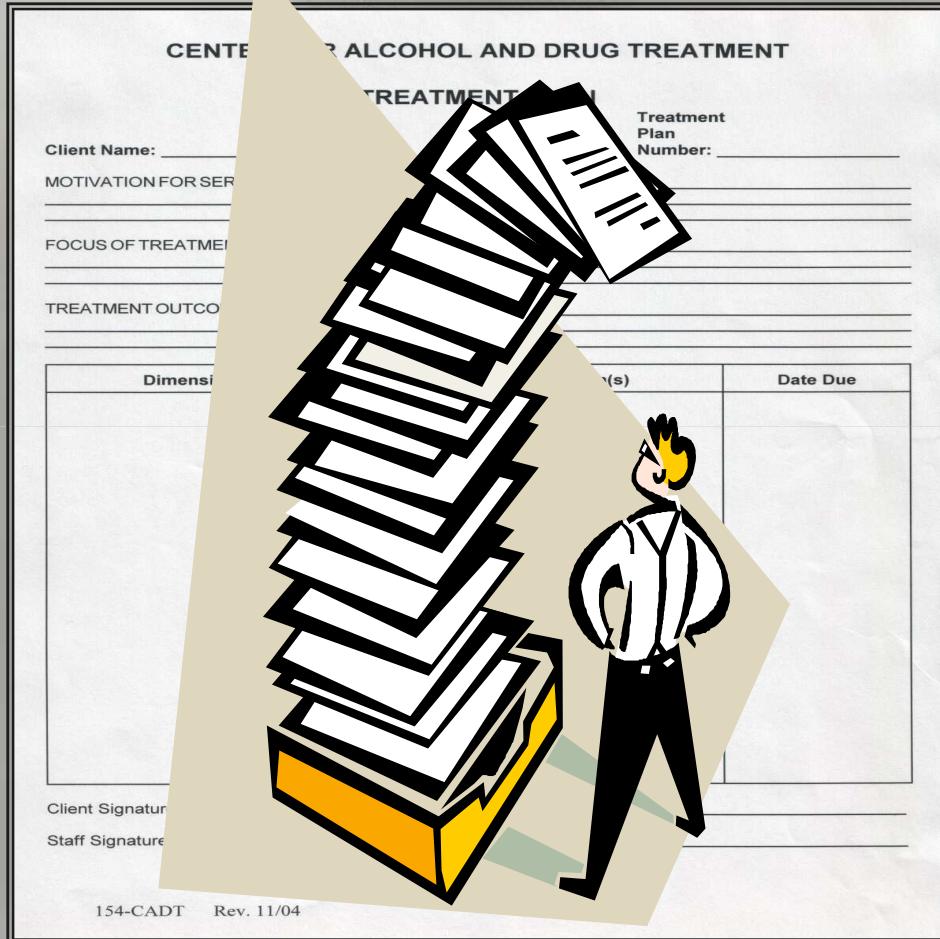
1. Exposure of *all* front line clinicians to the basic ideas and elements of practice;
2. Administration that understands the ideas and elements, has vision of and 3-year commitment to system change;
3. Creation of a “transition oversight group” with clear line of authority and reporting responsibility;
4. Implementation of a “bottom up” pilot project;

Systems Change: Changing Systems

- Agency goals and objectives: of CADT from “program-driven” to a service-delivery system:
 - Improve client retention, completion rates;
 - Individualized treatment/service plans;
 - Link paperwork to service;
 - Be able to measure success rates;
 - Develop clinical supervision mechanisms that were objective and related to client service;
 - Improve the agency “bottom line.”
- Reformed basic philosophy
 - Made consumer motivation and outcome central;
 - Organized services around consumer desires and outcomes;
 - Consumer as partner rather than patient.
- Formed a “transition oversight group.”
- Instituted a “bottom up” pilot project.

Systems Change: Changing Systems

Challenges



- Paperwork and IT system:
 - Intake;
 - Assessment;
 - Treatment planning;
 - Service documentation;
- During the pilot, clinicians reported to the transition oversight group:
 - Conflicts between CDOI and documentation;
 - Paperwork & IT needs.

Transforming Care: Changing Systems

Challenges

- Clinical and programmatic:
 - Operations:
 - Most services were delivered in groups;
 - Content
 - Supervision
 - Training
- During the pilot, clinicians reported to the transition oversight group:
 - Conflicts between CDOI and service content, mode of delivery;
 - Training and supervision needs.



Transforming Care: Changing Systems

Solutions

- In addition to strong administrative support, regular meetings between pilot clinicians and TOG and TOG with administration:
 - Routine continuing education of *all staff* in CDOI;
 - Ongoing telephonic and onsite training, consultation, and support.



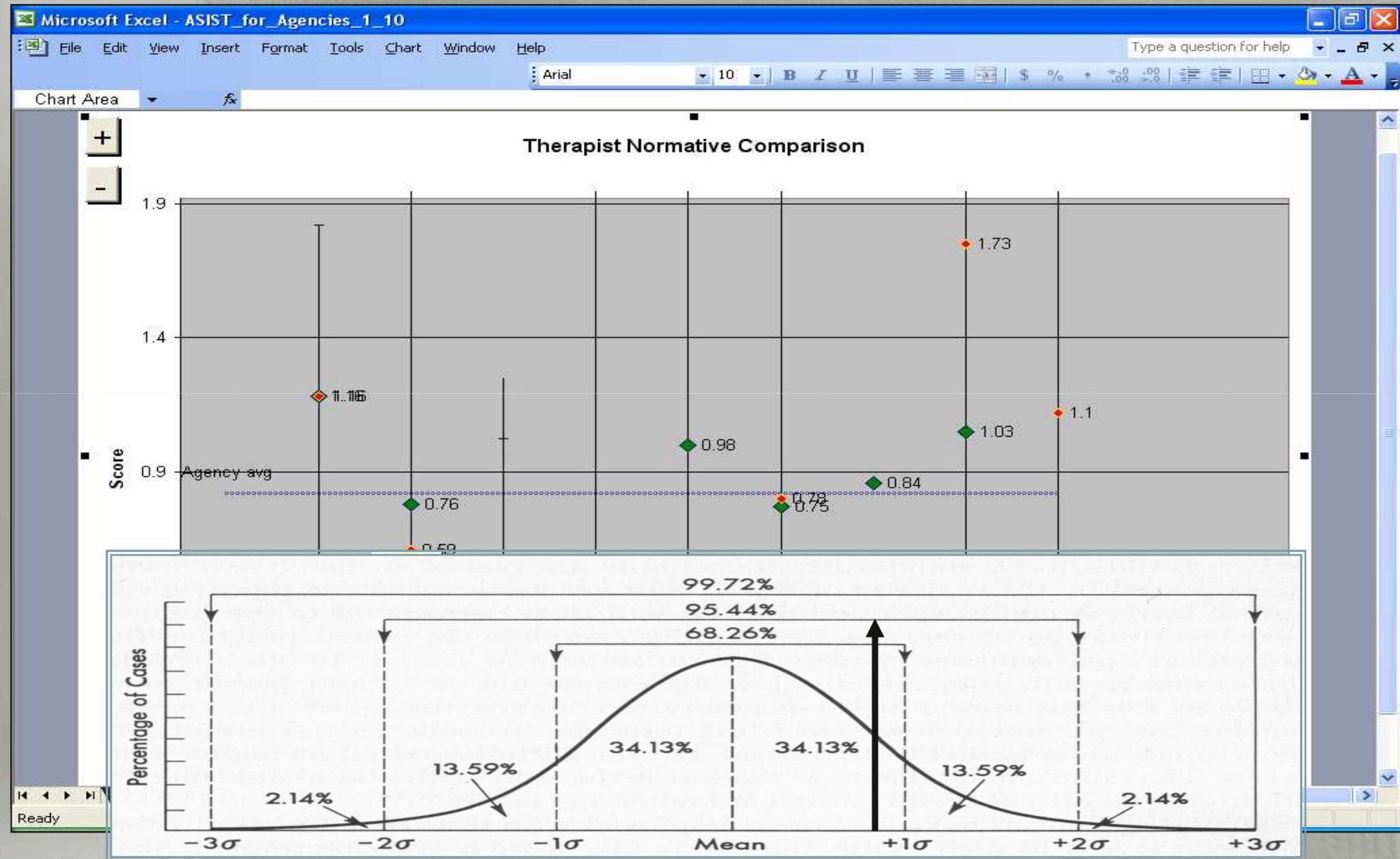
Transforming Care: Changing Systems

Characteristics of Successful Agencies and Treatment Systems

PHASE TWO:

1. Integration of pilot project findings into agency policy and procedure;
 - a. Systematic program including training, manuals, routine outcome consultation.
 - b. Development and standardization of “continuum of care.”
 - c. Clear strategies for ineffective treatment, therapists, programs.

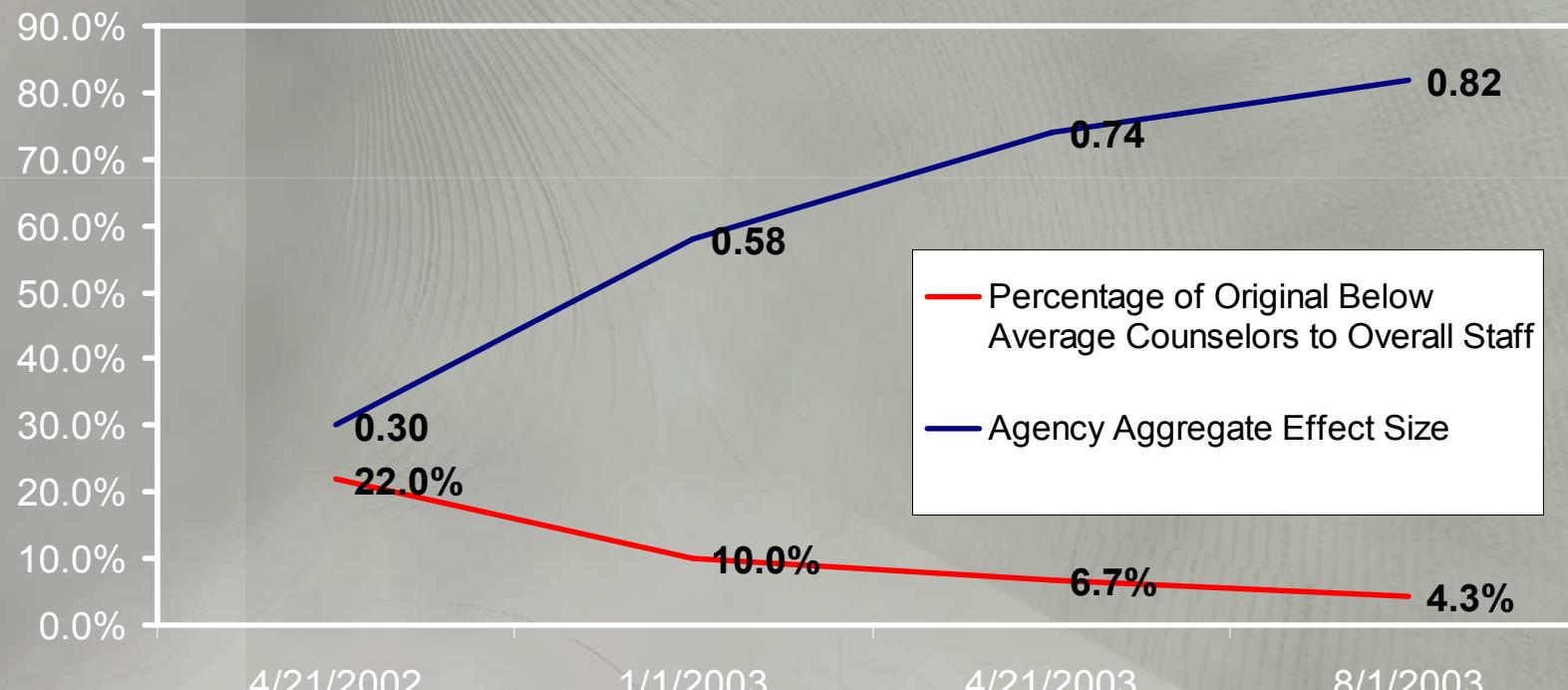
Transforming Care: Changing Systems



Transforming Care: Changing Systems

Challenges

Systemic Effect from Attrition of Below Average Counselors



Transforming Care: Changing Systems

Characteristics of Successful Agencies and Treatment Systems

PHASE TWO (cont):

2. System wide implementation;
3. Development of program and system-specific norms;
4. Launch of automated outcome tracking and feedback system;
5. Ongoing on-site and telephonic consultation throughout.

Transforming Care: Changing Systems

The “Results”

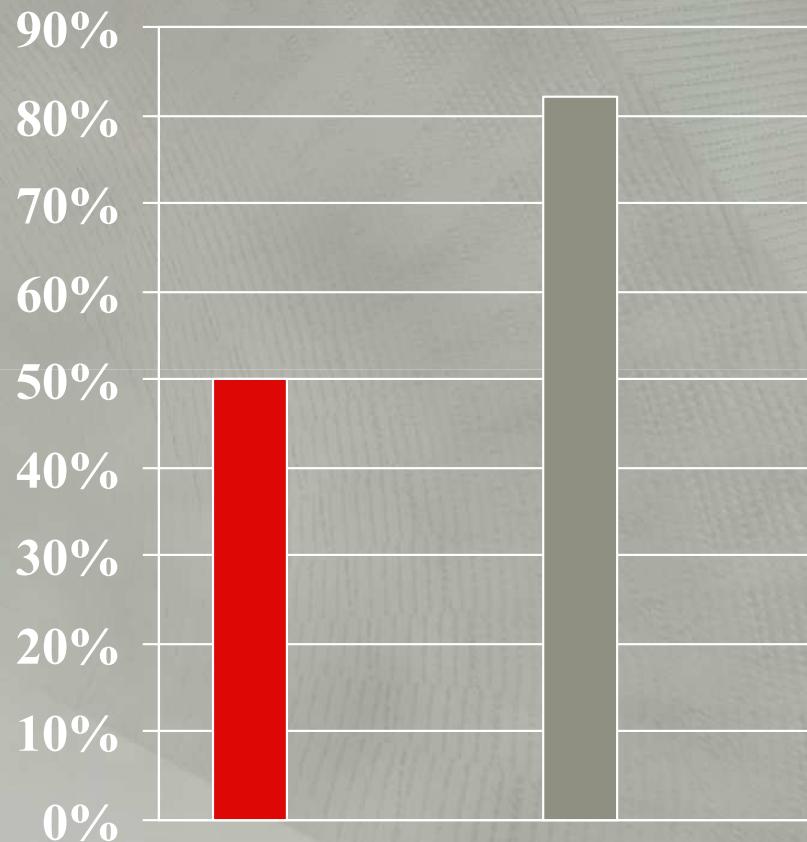


- Between 2002-2006, C.A.D.T.:
 - Significantly improved retention and success rates;
 - Streamlined service delivery;
 - Reduced paperwork;
 - Significantly increased revenue and cash flow.

Transforming Care: Changing Systems

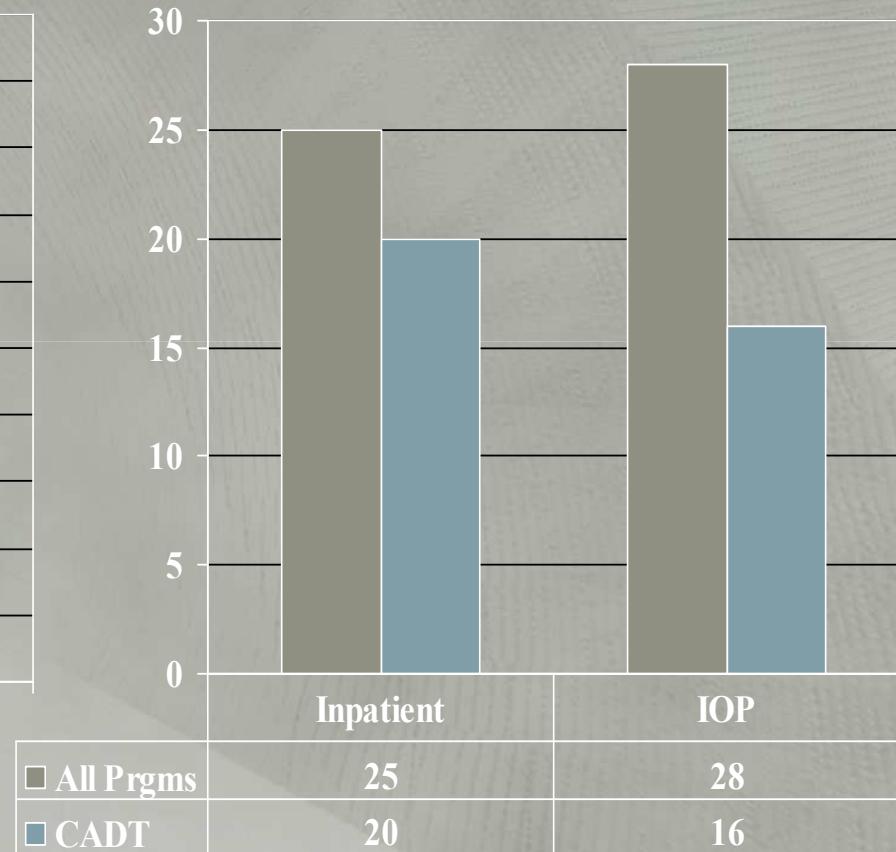
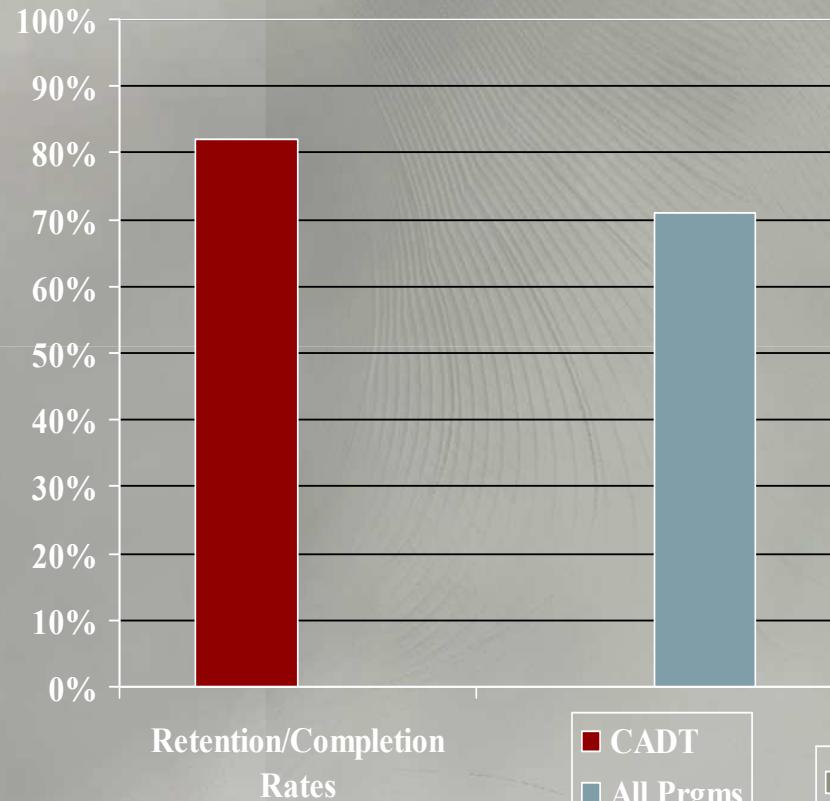
The “Results”

- Improved retention rates:
 - 50% or less with old model;
 - 82% with CDOI.



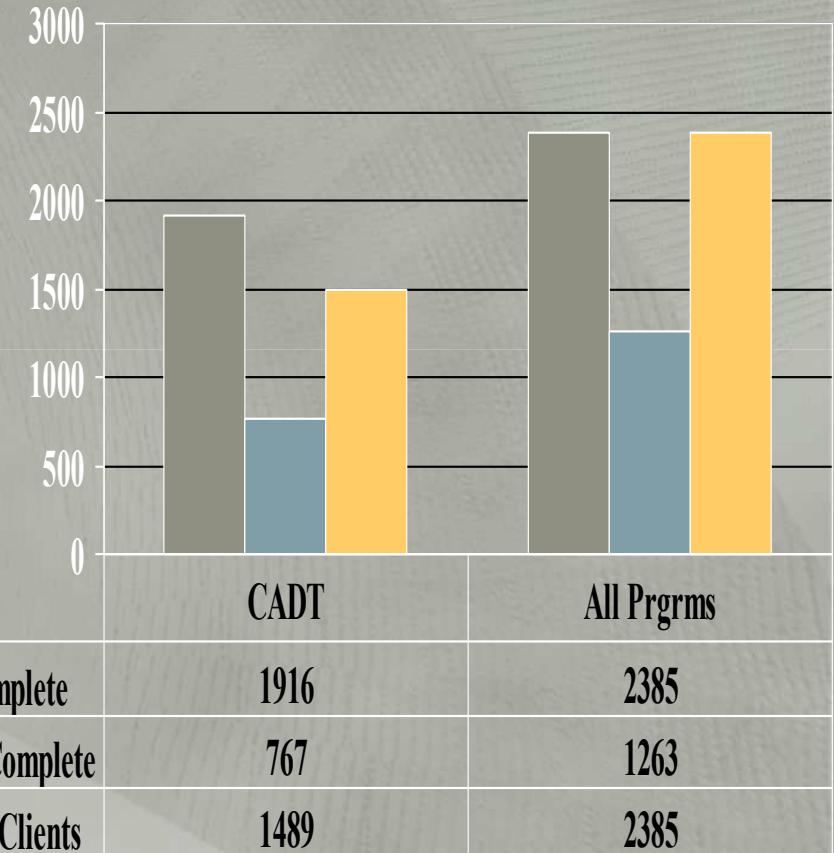
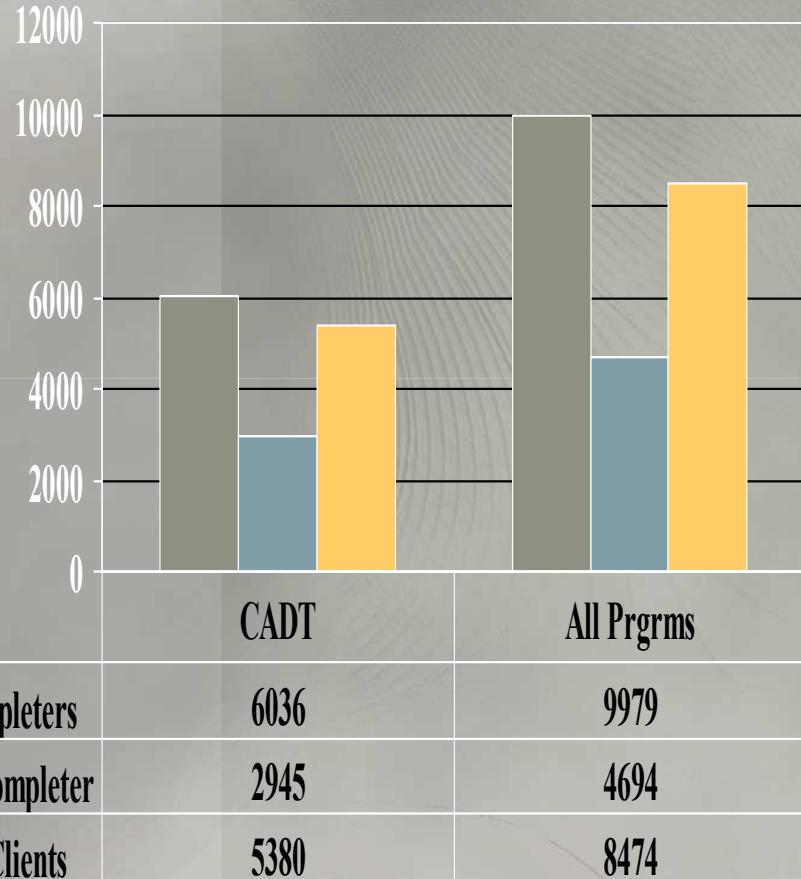
Transforming Care: Changing Systems

The “Results” on Retention & Lengths of Stay



Transforming Care: Changing Systems

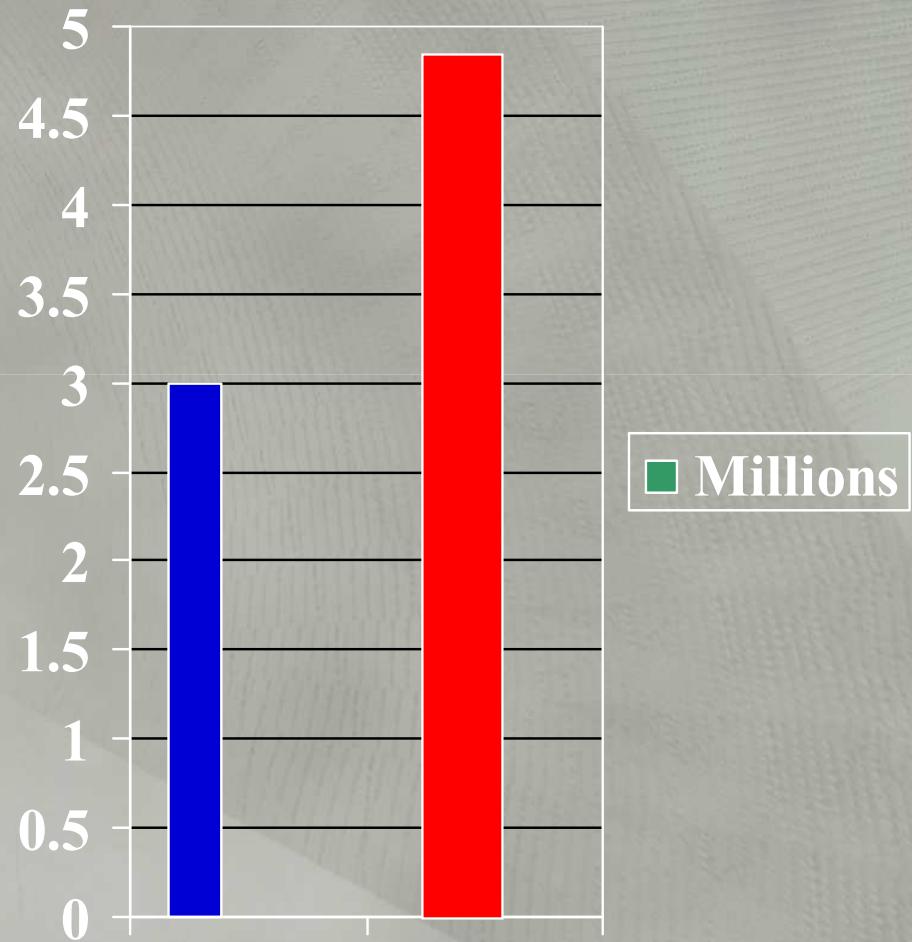
The “Results” on Cost of Inpatient and OP Service



Transforming Care: Changing Systems

The “Results” on Revenue and Funding

- Adopting CDOI forced changes throughout the agency:
 - Billing;
 - Intake/Admission Procedures;
 - Data Collection Systems;
 - Staff Training
- The changes caused some public relation issues:
 - Funders were very supportive;
 - Probation/Corrections did not like the changes;
 - Some conflicts with social service agencies arose around differing perceptions as to client treatment strategies.



That's all folks!

