# Evidence-Based Practices in VA: What Do We Know, and What Do We Not Yet Know – The Role of Guidelines and Measurement-Based Care

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Addictive Disorders,
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# Disclosure Statement

- Membership on APA Clinical Treatment Guidelines Advisory Steering Committee
- Chair, VA/DoD Working Group for VA/DoD Guideline of Treatment of Substance Use Disorders (original and revised)
- Not speaking on behalf of APA or OMHS, but as a member of AVAPL
- Previous funding from VA HSR&D and VA Quality Enhancement Research Initiative, NIAAA,NIDA
- An inactive (humbled and recovering) clinician

# Simon and Perlis

## (*Am J Psychiatry 2010; 167:1445–1455*)

"We have several good treatment options to choose from. On average, they have about the same chance of success. But you are not an average; you are an individual.

At this time, there is no scientific way to predict which treatment will work best for you.

Together, we will look at your options and decide what treatment to start with.

But it is important to remember that there are other options. If the first treatment we pick does not work out for you, some other treatment might work well.

Regular follow-up over the next several weeks will tell us whether to stay with our first choice or try something else"

# 2009 APA Presidential Summit Recommendations

- **Development of treatment guidelines and accountability measures**
- Psychological models for integrated/primary health care
- Mobility and licensure barriers to practice
- Increased use of technology - Electronic health records, and delivery of services
- Changing the face of psychology for the public by rebranding and marketing our uniqueness

# APA's Strategic Planning Goals: Relevance of Guidelines

## Goal 2 - Expand Psychology's Role in Advancing Health

- Key stakeholders realize the unique benefits psychology provides to health and wellness, and the discipline becomes more fully incorporated into health research and delivery systems.

## Goal 3 - Increase Recognition of Psychology as a Science

- The APA's central role in positioning psychology as the science of behavior leads to increased public awareness of the benefits psychology brings to daily living.

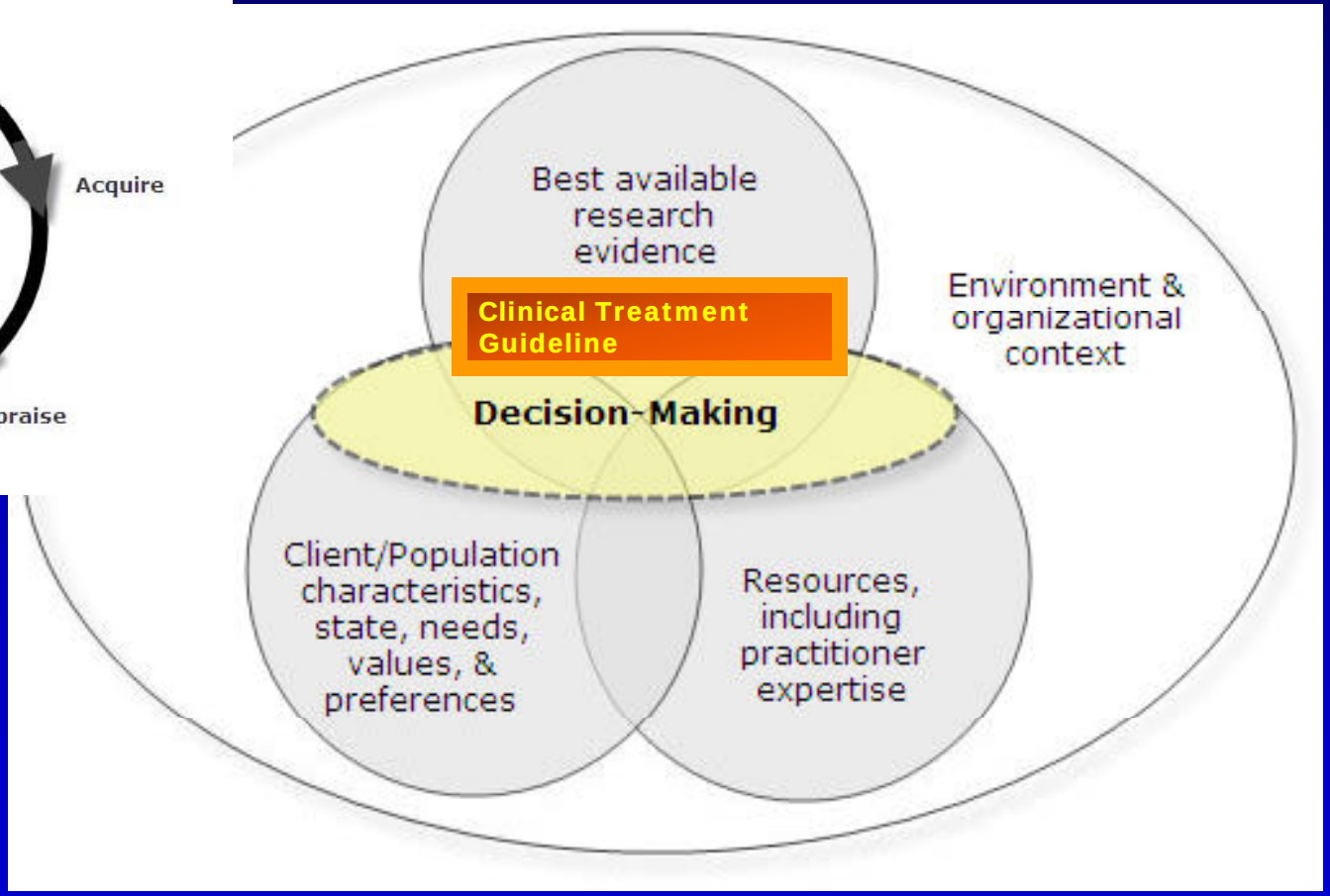
# APA Strategic Initiatives to be "scoped out" for costs & staffing needs

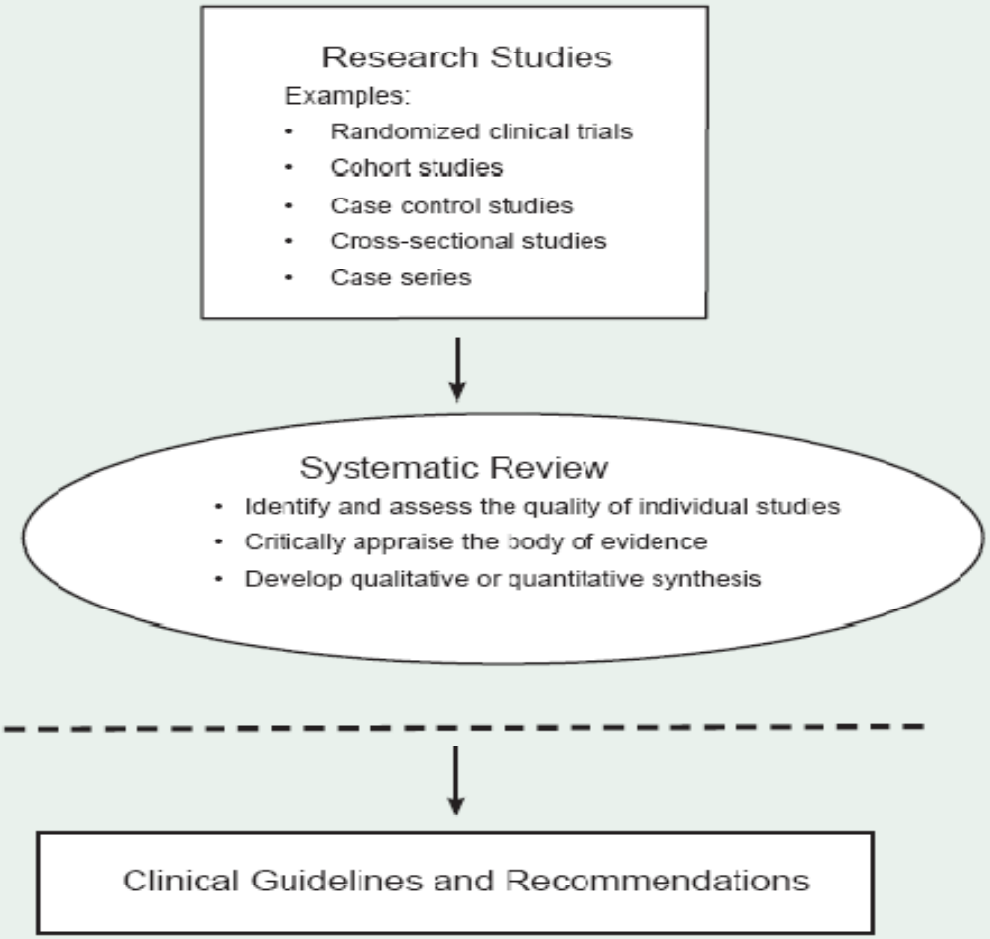

- "Continue to develop and promulgate treatment guidelines to promote translation of psychological science"

# Where do guidelines fit in to the evidence-based practice process?

**Evidence-Based Practice in Psychology (APA, 2006)**

**"The synthesis of best available research with clinical expertise in the context of patient characteristics, culture and preferences"**




**Continuum from research studies to systematic review to development of clinical guidelines and recommendations**

NOTE: The dashed line is the theoretical dividing line between the systematic review of the research literature and its application to clinical decision making, including the development of clinical guidelines and recommendations. Below the dashed line, decision makers and developers of clinical recommendations interpret the findings of systematic reviews to decide which patients, health care settings, or other circumstances they relate to.

SOURCE: Adapted from West et al. (2002).

OPEN ACCESS Freely available online

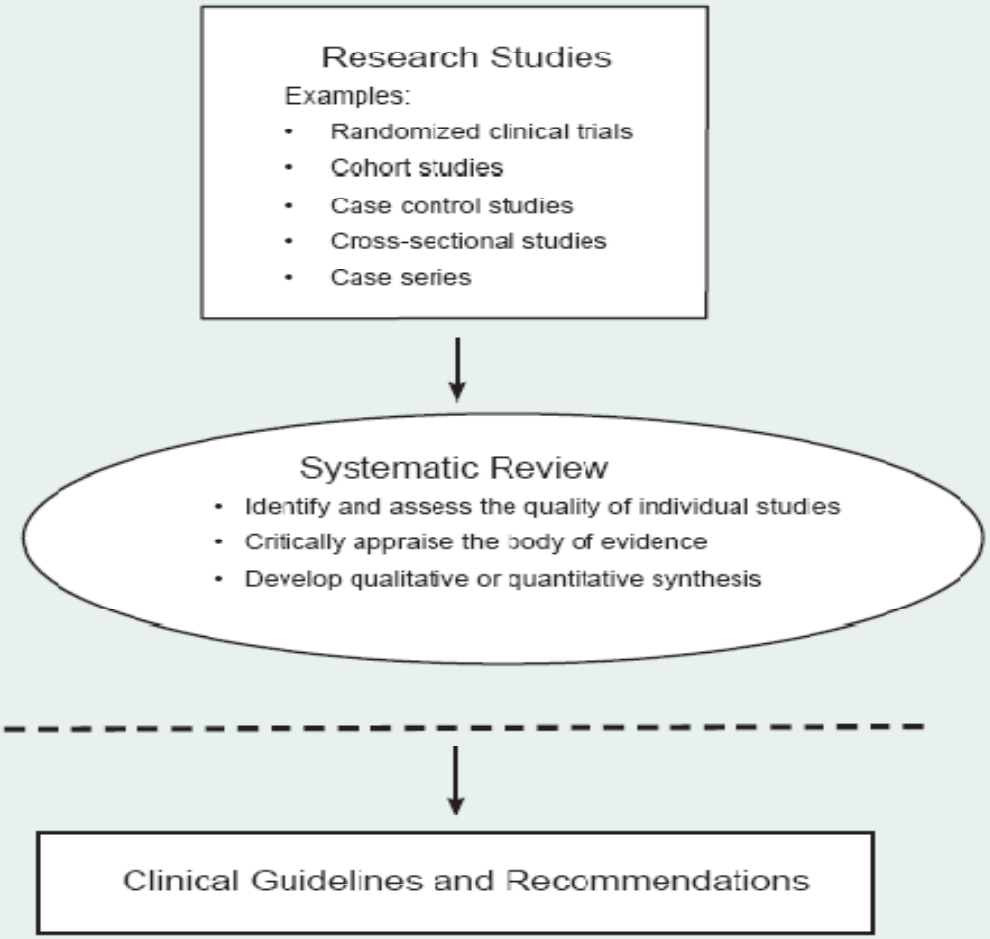
PLoS MEDICINE

Policy Forum

# Seventy-Five Trials and Eleven Systematic Reviews a Day: How Will We Ever Keep Up?

**Hilda Bastian[1]*, Paul Glasziou[2], Iain Chalmers[3]**

**1** German Institute for Quality and Efficiency in Health Care (IQWiG), Cologne, Germany, **2** Centre for Research in Evidence-Based Practice, Faculty of Health Sciences, Bond University, Gold Coast, Australia, **3** James Lind Library, James Lind Initiative, Oxford, United Kingdom

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# Making recommendations (1)

- To make recommendations, a number of factors should be considered:
  - **Quality of evidence**
    The higher the quality of evidence, the more likely is a strong recommendation.
  - **Balance of benefits versus harms and burdens**
    The larger the difference between the desirable and undesirable consequences, the more likely a strong recommendation warranted.

# Making recommendations (2)

- To make recommendations, a number of issues should be considered:
  - **Values and preferences**
    The greater the variability in values and preferences towards different outcomes, or uncertainty in values and preferences, the more likely a weak recommendation is warranted.

  - **Are the net benefits worth the costs**
    The higher the costs of an intervention – that is, the more resources consumed – the less likely a strong recommendation is warranted.

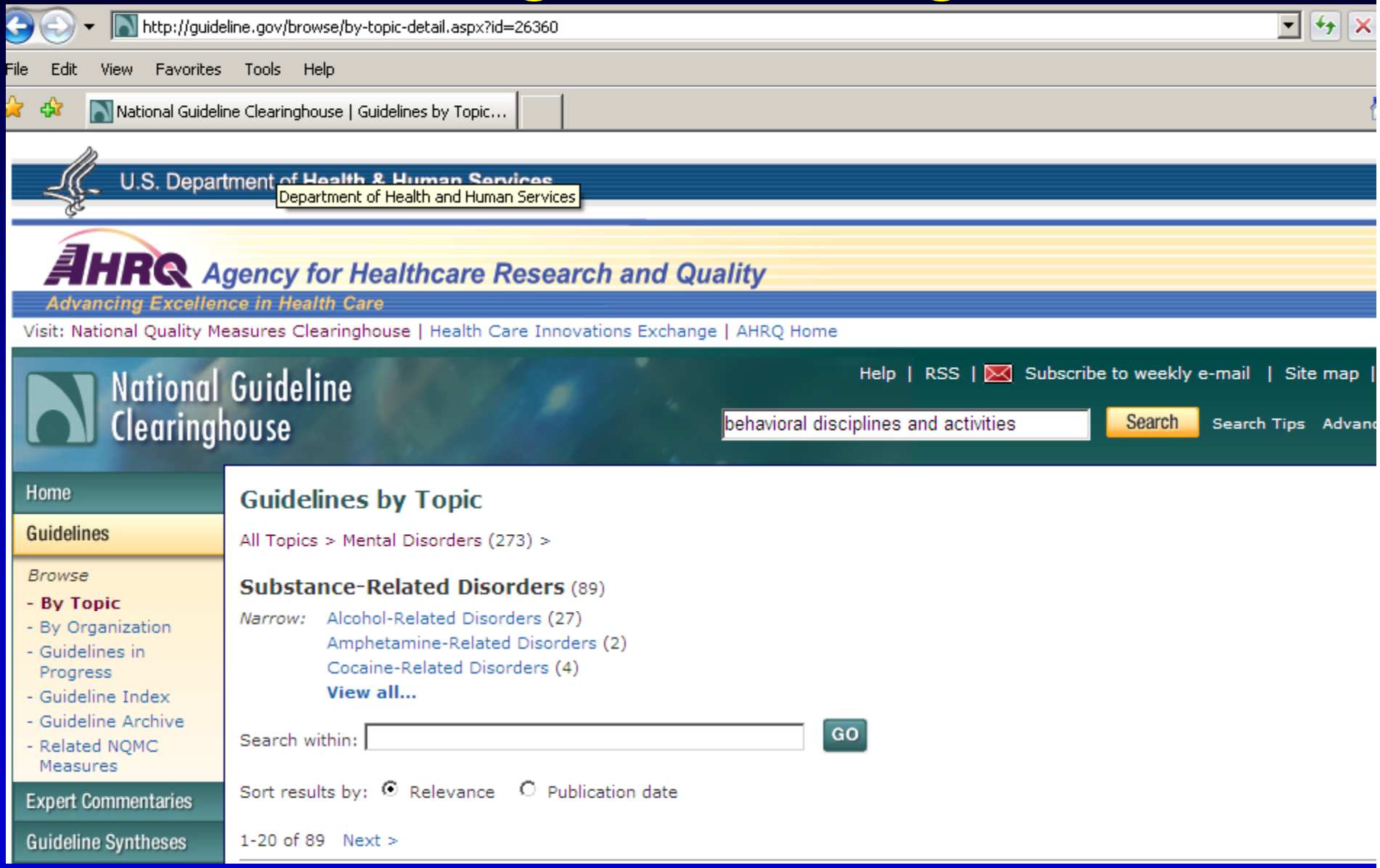
# Clinical Treatment Guidelines are NOT

- Performance measures or standards
- Legal precedents or standards of care
- Treatment manuals, protocols, or cookbooks
- A substitute for good clinical judgment
- Sole determinants of treatment plans
- Reimbursement policies

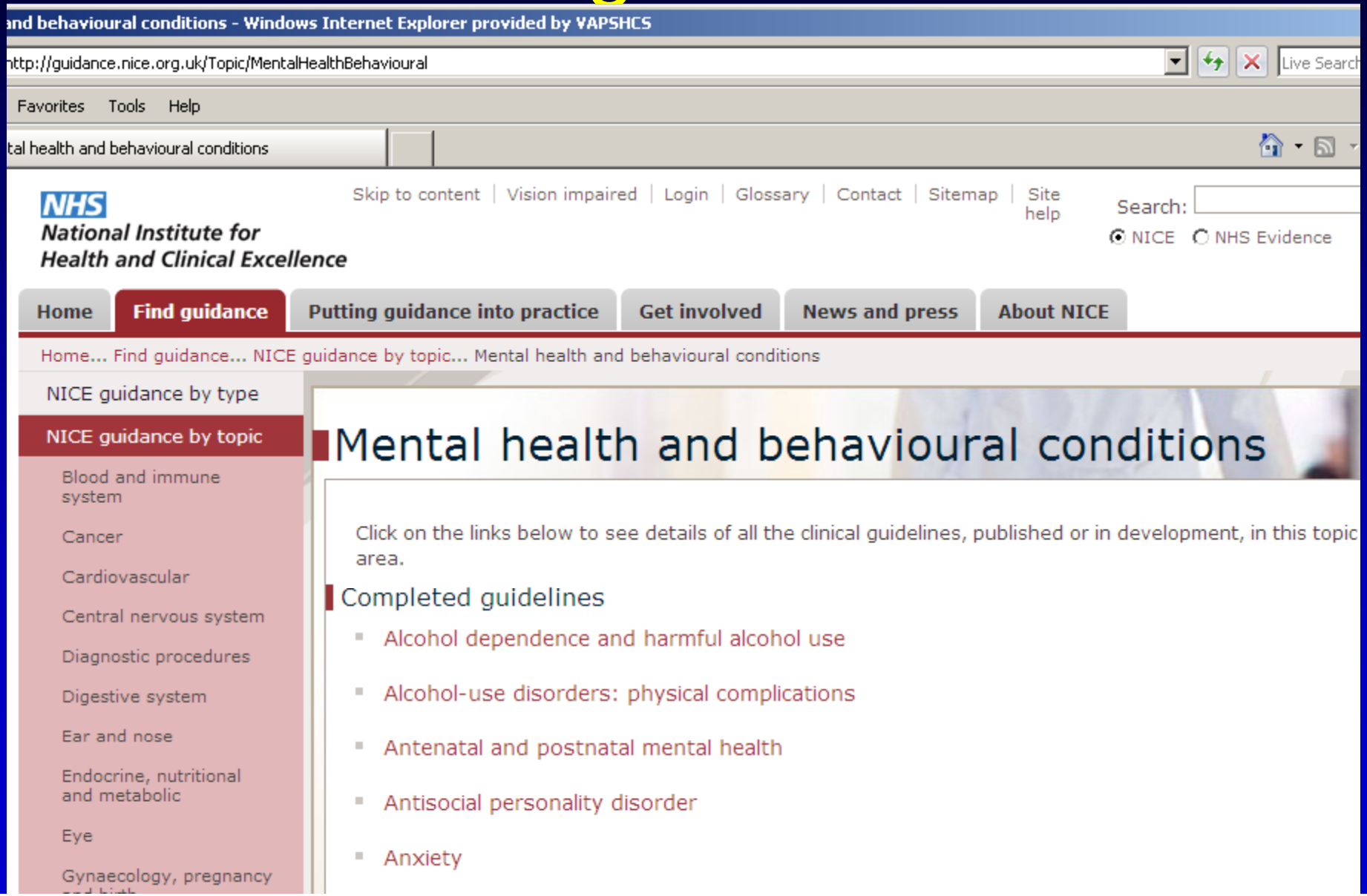
# Clinical Treatment Guidelines ARE

- Evidence-based and clinically informed resources
- Helpful educative tools for practitioners & patients
- Clear, concise & actionable recommendations
- Guidance to facilitate clinical decision making and to improve patient care
- A critical link between research & practice

# www.guidelines.gov



# www.nice.org.uk/Guidance/CG/



Clinical Practice Guidelines We Can Trust (Free Summary)
http://www.nap.edu/catalog/13058.html

# Free Summary


## Clinical Practice Guidelines We Can Trust

Robin Graham, Michelle Mancher, Dianne Miller Wolman, Sheldon Greenfield, and Earl Steinberg, Editors; Committee on Standards for Developing Trustworthy Clinical Practice Guidelines; Institute of Medicine

ISBN: 978-0-309-16422-1, 300 pages, 6 x 9, paperback (2011)

# IOM Standards for Developing Trustworthy CPGs

1) Establishing Transparency
2) Management of Conflict of Interest (COI)
3) Guideline Development Group Composition
4) Clinical Practice Guideline–Systematic Review Intersection
5) Establishing Evidence Foundations for and Rating Strength of Recommendations
6) Articulation of Recommendations
7) External Review
8) Updating

# IOM Standards for Developing Trustworthy CPGs

5.1 For each recommendation, the following should be provided:

An explanation of the reasoning underlying the recommendation, including:

- A clear description of potential benefits and harms.
- A summary of relevant available evidence (and gaps), description of the quality (e.g., applicability), quantity (e.g., completeness), and consistency of the aggregate available evidence.
- An explanation of the part played by values, opinion, theory, and clinical experience in deriving the recommendation.

# IOM Standards for Developing Trustworthy CPGs

5.1 For each recommendation, the following should be provided:

A rating of the level of confidence in (certainty regarding) the evidence underpinning the recommendation.

A rating of the strength of the recommendation in light of the preceding bullets.

A description and explanation of any differences of opinion regarding the recommendation.

# IOM Standards for Developing Trustworthy CPGs

6) Articulation of Recommendations

6.1 Recommendations should be articulated in a standardized form detailing precisely what the recommended action is, and under what circumstances it should be performed.

6.2 Strong recommendations should be worded so that compliance with the recommendation(s) can be evaluated.

# Then

- 1980's – 1990's
- Uncertain role of GLs in health care
- Practitioner focused
- Practitioners need information for clinical decision-making
- Need more definitive data
- APA Policy: Evaluating external GLs
- GLs may ↓ patient access to psych care
- GL Development – Concerns:
  - No standards for methodology
  - Research validity - Bias in evidence
  - How GLs will be used by MCOs
- We missed the boat ☹

# Now

- Now (2008 – ???)
- New era - GLs here to stay
- Patient centered
- Information overload
- Robust scientific evidence base
- APA Policy: Developing APA GLs
- GLs needed to ↑ patient access to care
- GL Development – Concerns:
  - New IOM & International standards
  - Bias from Conflicts of interest
  - How GLs are used by MCOs
- Now's the time! ☺

# Clinical Treatment Guidelines Advisory Steering Committee

- Steven D. Hollon, PhD (Chair)
- Patricia A. Areán, PhD
- Michelle G. Craske, PhD
- Kermit A. Crawford, PhD
- Daniel R. Kivlahan, PhD
- Jeffrey J. Magnavita, PhD, ABPP
- Thomas H. Ollendick, PhD
- Thomas L. Sexton, PhD, ABPP
- Bonnie Spring, PhD, ABPP

# DRAFT Mission

Improve mental, behavioral, and physical health by promoting clinical practices based on the best available evidence. Identify interventions that are effective and can be implemented in the community. Develop treatment guidelines that are scientifically sound, clinically useful, and informative for psychologists, other health professionals, training programs, policy makers, and the public.

# DRAFT Vision

- Improve mental, behavioral and physical health.
- Improve patient experiences of care.
- Improve the effectiveness, quality, and value of healthcare services.
- Inform shared decision-making between patients and health professionals.
- Improve practice by health professionals.
- Enhance training of psychologists and other health professionals.
- Enhance competency of psychologists and other health professionals.
- Educate health professionals, consumers, and policy makers about effective interventions.
- Identify gaps in the evidence base to be addressed by future research.

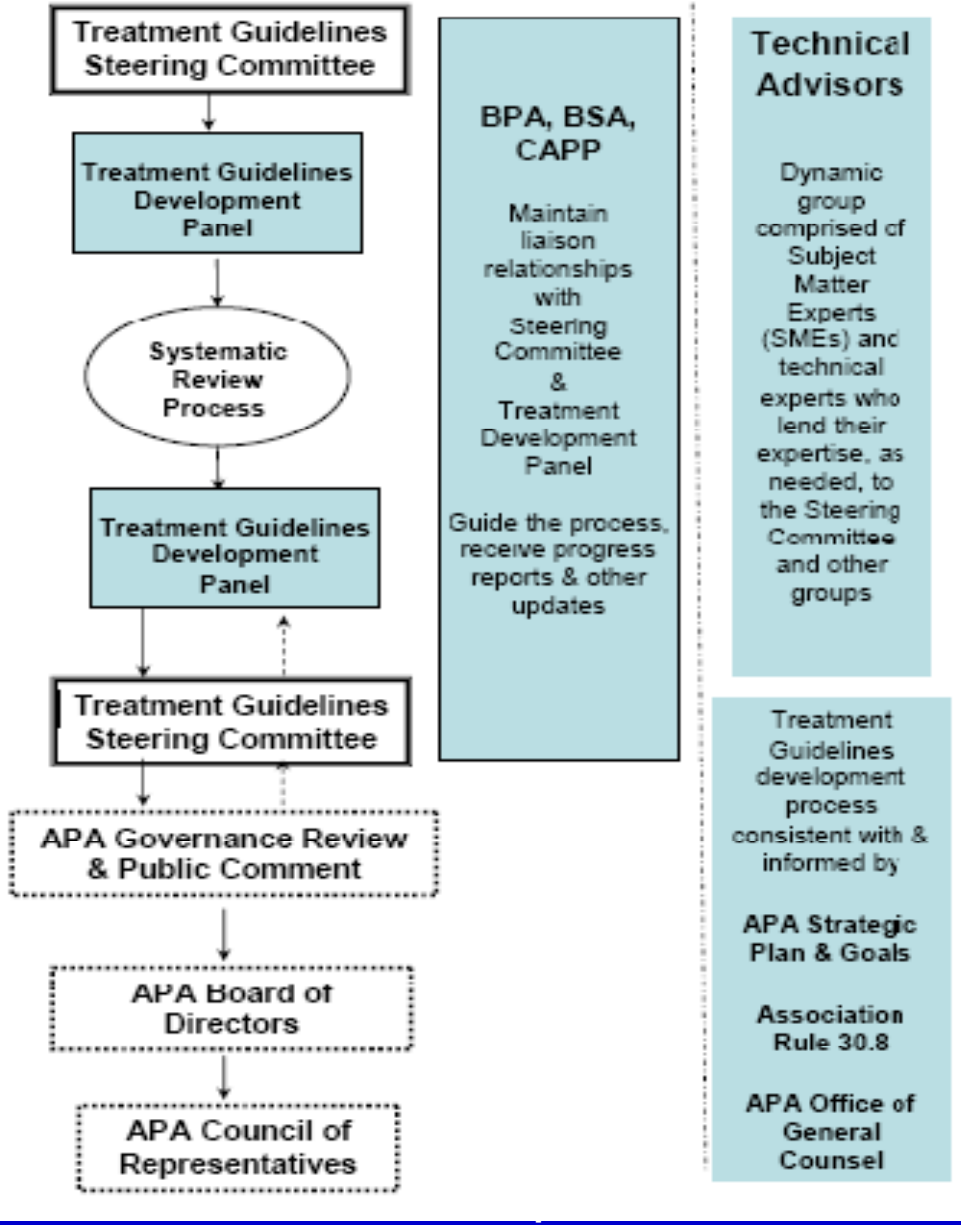
# DRAFT Operational Principles

- Focus on treatment efficacy and clinical utility for specific problems or disorders.
- Utilize transparent rationale and procedures for guidelines development.
- Solicit input from health professionals, consumers, educators, payers, and policy makers.
- Focus on prevention, treatment, or management.
- Address common factors and therapeutic relationships associated with effective interventions.
- Consider the full range of research evidence.

# DRAFT Operational Principles

- Evaluate the quality of the evidence and identify areas where it is lacking.
- Identify potential harms and benefits.
- Consider outcomes across multiple domains.
- Consider setting, sociodemographics, multicultural issues, and patient preferences.
- Acknowledge the clinician's responsibility for individualized clinical care decisions.
- Provide recommendations that are advisory (vs. compulsory).
- Update guidelines periodically to reflect developments in research and practice.

# APA Clinical Treatment Guidelines Development Process



# http://www.healthquality.va.gov

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## VA/DoD Clinical Practice Guidelines

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### Chronic Disease (in Primary Care)

- Asthma
- Chronic Heart Failure (CHD)
- Chronic Kidney Disease (CKD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes Mellitus (DM) *New*
- Dyslipidemia (LIPIDS)
- Hypertension (HTN)
- Ischemic Heart Disease (IHD)
- Obesity and Overweight (OBE)
- Tobacco Use (MTU)

### Mental Health

- Bipolar Disorder in Adults (BD)
- Major Depressive Disorder (MDD)
- Post Traumatic Stress Disorder (PTSD) *New*
- Substance Use Disorder (SUD)


Clinical practice guidelines are increasingly being used in health care to improve patient care and as a potential solution to reduce inappropriate variations in care. Guidelines should be evidence-based as well as based upon explicit criteria to ensure consensus regarding their internal validity.

# Key Recommendations from VA/DOD SUD Guideline

- Pharmacotherapy and psychosocial interventions are important treatment options for Veterans with SUD.
- Regardless of the particular intervention chosen, **use motivational interviewing style** during therapeutic encounters with patients and emphasize the **common elements** of effective interventions
  - promoting a therapeutic relationship,
  - enhancing patient motivation to stop or reduce substance use,
  - improving self-efficacy for change,
  - strengthening coping skills,
  - arrange added benefits of recovery, and
  - enhancing social support for recovery

# VHA Handbook on Uniform MH Services (p 24)

(k) Patients with substance use illness need to be offered long-term management …. The patient's condition needs to be monitored in an ongoing manner, and care needs to be modified, as appropriate, in response to changes in their clinical status.

# Measurement-Based Care

***"Enhanced precision and consistency in disease assessment, tracking, and treatment to achieve optimal outcomes"***

Measurement-Based Care in Psychiatric Practice:
A Policy Framework for Implementation

Kelli Jane K. Harding, MD; A. John Rush, MD; Melissa Arbuckle, MD, PhD;
Madhukar H. Trivedi, MD; and Harold Alan Pincus, MD

J Clin Psychiatry. 2011 Jan 11. [Epub ahead of print]

# Measurement-Based Care: Key Elements

| | |
|---|---|
| Assessments that are | Specific |
| | Targeted to a specific issue (Is *X* working?) |
| | Tailored to the individual |
| | Psychometrically and conceptually sound |
| | Brief |
| | Inexpensive |
| Action plans that are | Specific |
| | Evidence based (whenever possible) |
| | Flexible—provide an array of reasonable options |
| | Evaluable |

# Measurement-Based Care: Limitations

Efficacy has not been established in larger numbers of comparative trials
Excessive assessments are burdensome
Risk of oversystematizing and depersonalizing
Replaying a clinical question with a lengthy scale is not useful
Without an action plan, measurement is unhelpful
Many action plans are not evidence based

# Preliminary Recommendations on PTSD Symptom Monitoring

- Evidence-based psychotherapy protocols for PTSD now incorporate weekly symptom monitoring with PCL
- Aspirational goal is routine measurement-based care at each scheduled visit for all PTSD treatment
- Incremental proposal pending informatics tools:
  - 17-item PCL-S at intake for all new episodes of PTSD treatment
  - Reassessment at least once 30-90 days from intake for those who remain active in treatment
  - Data in national data base for clinical review and aggregate analyses

# Proposal in development for systematic outcome evaluation

- Centralized follow-up assessment regardless of treatment retention
- Re-assessment not by treating clinician
- Achievable more efficiently by appropriate sampling

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**Table 3**
Possible factors important to successful treatments of PTSD.

| |
|---|
| Cogent psychological rationale that is acceptable to patient |
| Systematic set of treatment actions consistent with the rationale |
| Development and monitoring of a safe, respectful, and trusting therapeutic relationship |
| Collaborative agreement about tasks and goals of therapy |
| Nurturing hope and creating a sense of self efficacy |
| Psychoeducation about PTSD |
| Opportunity to talk about trauma (i.e., tell stories) |
| Ensuring the patient's safety, especially if the patient has been victimized as in the case of domestic violence, neighborhood violence, or abuse |
| Helping patients learn how to avoid revictimization |
| Identifying patient resources, strengths, survival skills and intra and interpersonal resources and building resilience |
| Teaching coping skills |
| Examination of behavioral chain of events |
| Exposure (covert in session and in-vivo outside of session) |
| Making sense of traumatic event and patient's reaction to event |
| Patient attribution of change to his or her own efforts |
| Encouragement to generate and use social supports |
| Relapse prevention |