

TECScript 1

Dealing with Therapist Resistance to Outcomes

Messages from September 1999 – October 1999



An Unedited Compilation of Email Messages from the
Outcomes Evaluation Topical Evaluation Network
(OUTCMTEN) at
OUTCMTEN@MAELSTROM.STJOHNS.EDU



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This **TECScript** was compiled by the Evaluation Center@HSRI. The Center is a grant program of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. The mission of the Evaluation Center is to provide technical assistance to the evaluation of adult mental health system change.

TECScripts are one component of the **Topical Evaluations Networks Program**. The purpose of this program is to provide mental health system stakeholders (consumers, providers, researchers and families) with the opportunity to communicate directly with each other, and with Evaluation Center associates about topics of specific interest in adult mental health system change evaluation. The Networks Program makes use of electronic mailing lists to allow subscribers who have access to the Internet to participate in ongoing discourse about the specific topics listed below. Transcripts of on-line discussion, as well as printed copies of archived documents are made available in **TECScripts** by fax or mail to interested stakeholders; especially those who do not have Internet access.

The **TECScripts** are designed to provide interested persons with unedited compilations of Internet messages from the various mental health listserves that the Evaluation Center operates. The Center operates four listserves that deal with different aspects of mental health evaluation. The Multicultural Mental Health Evaluation Topical Evaluations Network (**MCMHEVAL**) is designed to encourage the discussion of issues related to mental health systems evaluation and ethnocultural identity, cultural competency, and other multicultural issues. The Outcomes Evaluation Topical Evaluation Network (**OUTCMTEN**) is designed to contribute to assessing and analyzing outcomes of intervention aimed at improving mental health systems. The purpose of the Evaluation and Legal and Forensic Issues in Mental Health Topical Evaluation Network (**LEGALTEN**) is to facilitate the implementation and use of rigorous evaluation at the interface of the mental health system, the criminal justice system, and the courts. The purpose of the Managed Behavioral Health Care Topical Evaluation Network (**MBHEVAL**) is to foster discussion of the evaluation of managed care as it affects the delivery, outcomes and cost of mental health care and substance abuse treatment services at the state, local, program, or consumer level.

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Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

Date: Thu, 2 Sep 1999 11:03:26 -0400

From: "Stephen E. Beller" <nhdspres@BESTWEB.NET >

One important thread in this discussion concerns therapist resistance to outcome measurement and how to overcome it. Here's a radical idea: Might not therapist "buy-in" increase if outcome measures were: (a) truly useful to therapists in treating individual patients and (b) actually helped improve their outcomes? Let me explain. Wouldn't it be great if we measured variables at pre-test that helped with diagnosis and treatment planning, and used these same measures at post-test point(s) to determine the results/progress/outcomes of care? That is, if therapists were given substantial, treatment-relevant information at the onset of therapy, they could quickly get a more thorough understanding of the patient's particular problems and needs, which in turn would help focus treatment by identifying the most important issues. This information would be a lot more useful than the few general measures of symptomatology most current outcome instruments employ.

For example, let's say you want to assess patient distress levels. Instead of just asking how anxious and depressed the person feels, it would be much more useful to measure the type, intensity, and duration of emotional distress related to specified life-events, and then determine: (a) the person's thoughts/cognitions about the life events (attributions, appraisals, feelings of helplessness and hopelessness, etc.) and (b) the coping strategies employed and their results. Not only can these measures be used at post-test for outcomes, but the pre-test data is very useful clinical information to many therapists - providing enhanced focus and "grist for the therapeutic mill" - which can speed up the therapeutic process resulting in better outcomes (e.g., lesser "length of stay"). And therapists may have an easier time accepting outcome measures if they were perceived as useful to the treatment process. [Of course, many psychoanalytic therapists would likely oppose this information due to their belief that clinical information must be revealed during a lengthy therapeutic "transference" process ... you can't please everyone!]

Another example concerns measurement of mind-body variables. Rather than just asking how a patient feels physically, it would be much more useful to the therapist if the measures assessed a wealth of physiological/medical/genetic data and analyzing them in light of the patient's psychological problems to show: (a) how specific psychological symptoms may be related to specific medical illnesses and medications taken and (b) how specific physiological symptoms may be related to specific psychological problems. It is important that the therapist have this knowledge at the onset of treatment. The physiological symptoms would again be measured at post-test(s) for outcomes. This alternative approach to outcomes - which relies on comprehensive assessment of useful therapeutic information - is likely to be an easier concept to "sell" to therapists because it can actually help them do their job better more effectively and efficiently from the get-go, and because the things that assess their performance (the outcome measures) can serve as specific treatment targets. These new measures are also more likely to reveal

Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

what's really happening in treatment, which may lead to an answer to Max's question: "What intervention with which therapist under what conditions by which people in the system is effective using which measures to judge effectiveness?"

Also, this approach is consistent with Ivor's comment: "While our work originated in program evaluation and monitoring, it is increasingly focusing on using this kind of performance feedback as a practice development process. It is becoming increasingly clear that without a focus on individual frontline practice system of care implementation is hollow."

And finally, by measuring outcomes using a wealth of clinically-relevant data, we may be able to answer Lee's questions: "What are some things that account for a lot more than 5% of the variance in outcome?"

Steve Beller

Stephen E. Beller, Ph.D.
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Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

Date: Thu, 2 Sep 1999 11:04:27 EDT
From: James Kloss <JKLOSS@LHL.GUNDLUTH.ORG>

Assuming all of the difficulties of collecting and distributing reliable and valid measures of all these things are resolved, there are still two big roadblocks:

- 1) Many (most?) therapists are not trained or disposed to use quantitative information very well. They have difficulty interpreting / using information as "simple" as Brief Symptom Inventory or BASIS-32 scores. I'm not being pejorative -- maybe it's a left brain / right brain sort of thing.

- 2) After 25 years of "supervising" therapists, I'm not convinced they have much flexibility in what they do, especially once therapy with a given client has settled into an idiosyncratic pattern. It is not helpful to tell a therapist that what they're doing isn't working if there are no alternatives in the therapist's repertoire.

James D. Kloss, Ph.D.

Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

Date: Thu, 2 Sep 1999 19:29:37 -0400
From: "Kenneth I. Howard" <k-howard@NWU.EDU>

On Thu, 2 Sep 1999, Stephen E. Beller, wrote:

> One important thread in this discussion concerns therapist resistance to outcome measurement and how to overcome it. Here's a radical idea: Might not therapist "buy-in" increase if outcome measures were: (a) truly useful to therapists in treating individual patients and (b) actually helped improve their outcomes? >

That's what the Compass system is all about.

Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

Date: Fri, 3 Sep 1999 10:57:46 -0400
From: "Stephen E. Beller" <nhdspres@BESTWEB.NET >

Howard and James ... and List,

I appreciate your responses to my message that therapist buy-in to outcome measurement would likely increase if (a) truly useful clinical information is given to therapists at the beginning and end of treatment and (b) if such information actually helped improve outcomes. Here's my reply.

Howard, you stated that Compass system is designed to do what my message suggested. The Compass system's 131-item questionnaire - while one of the best of its class - does not, with all due respect, get at many of the clinical details therapists need for diagnosis and treatment planning. Of those items, only 71 items assess symptoms, levels of functioning, and sense of well-being. Making sense of the complex and multifaceted nature of psychological problems requires a much more comprehensive assessment instrument. Many variables crucial to treatment planning and delivery are NOT assessed by the Compass system, including:

Cognitive processes such as attributions and appraisals; coping skills and deficits; values-goals-ideals and the emotional distress levels associated with each; the interaction between physiological and psychological factors (i.e., psychosomatic or "mind-body" effects and medication effects); and a wide variety of psychosocial factors. Compass data sets could be a part of the kind of omnibus assessment instrument of which I speak.

The kind of clinically useful information I'm talking about must be derived from comprehensive data sets such as listed on the following URL:
www.nhds.com/datasets.htm.

James, you referred to two big roadblocks to therapist acceptance of even the most clinically useful information:

1. Therapists are not trained or disposed to use quantitative information very well. - I basically agree with this observation. Putting quantitative information in a form that is acceptable to most therapists must be an evolving process in which therapists have ongoing input. Those with the difficulty dealing with hard numbers will have to have the data summarized and organized in verbal-conceptual report format. Examples of the kind of information that therapists may find useful can be found at the following URLs: www.nhds.com/upp/upp01.htm for initial (pre-test) information and www.nhds.com/upp/upp02.htm for a chart of overall outcomes. Such information -

Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

which I've been using effectively in my practice for years - could, I believe, be transformed via collaborative efforts into formats that many (most) therapists would accept and could use to improve outcomes.

2. Therapists tend not have much flexibility in what they do, so telling them something isn't working will not be helpful if there are no alternatives in their treatment repertoire. - For very inflexible therapists, possibly nothing can be done to encourage learning alternative treatment approaches. But younger and more open-minded clinicians could use comprehensive patient information at the onset of treatment to help them make better treatment decisions and, if that requires gaining new skills, they may well do so to gain a "competitive advantage" by demonstrating continually improving outcomes.

The trick here is to enlist ongoing therapist input in designing and redesigning assessment instruments and reports that **THEY** find useful.

Steve Beller

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Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

Date: Fri, 3 Sep 1999 15:39:32 EDT
From: "Ed Wise, Ph.D." <Eawmhr@AOL.COM>

As a private practitioner who has just completed a relatively small outcome and satisfaction study for our private practice group, let me chime in on this interesting dialogue. We are interested in outcomes, but our bias is that of course we KNOW what we do is effective, it is the rest of the world that questions our results. Dealing with outcomes has become a necessary evil to promote what we do. It is an added expense that detracts from our bottom line. This is why few practitioners are willing to invest the time, resources, and energy into conducting outcome & satisfaction research. However, if practitioners want to enter the marketplace, which is mco dominated, and are willing to compete in that specific marketplace, the outcomes can become valuable marketing tools. I have found, however, that even then the decision makers are not really interested in outcomes per se, but systemic alternatives that are less costly than existing systems. What I am saying is that for practitioners, even outcome data are not sufficient to get business. It requires an ongoing dedication to basically selling the outcome data, which of course means more of an investment. Hence, doing outcome & satisfaction studies are only the first in a series of investments with no minimum guaranteed rate of return. Maintaining the status quo is less costly.

While we have used our outcome & satisfaction data to make approaches to insurers and mco's, the data simply became vehicles of access and did not make or break a sale. We used them to help us build relationships, but we could just as easily used lunch for the staff, like the pharmaceutical companies do. You notice that while those companies have data on the efficacy of their drugs, which drug is actually used is not dependent solely or even primarily on the data, especially when supply exceeds demand. So, give me something quick, comprehensive, and a tie in to established business and I would be interested. Be the link between the mco's and the practitioners. Meet the mco's ncqa criteria and give us something we can use that will be meaningful to them and won't cost us. BTW, we are continuing to collect data to replicate our results, which we will again use as door openers to re-visit mco's, but the data alone doesn't get the business.

Ed Wise, Ph.D.
Memphis, TN

Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

Date: Fri, 3 Sep 1999 16:23:47 -0500
From: "Ivan S. Williams" <isw@PVI.ORG >

I've found this entire thread on establishing practitioner buy-in to be very interesting and helpful and can not help but respond to Dr. Wise's comments. I might start by noting that our organization has experienced similar frustration with mcos limited interest in our outcomes. It seems that they are still competing primarily on cost and are only giving lip service to quality. I honestly think and hope that that will change in the not too distant future since prices can't go much if any lower.

Now for the tough part. Though many clinician's "know" that what they do is effective do they "know" when they are ineffective or is it like Alice in Wonderland where all have won? Does it really matter what you "know" if no one else knows it? If the clinician "knows" that the patient is better or worse but the patient, family, payor, or colleagues don't "know" this your not too far from joining the clinician's equivalent to the flat earth society. Outcomes is about measurement. Would you even think of having an expert very experienced contractor whose a great judge of distance build your house, without a measuring device? Sure therapy is an art, is more complex and less known then building a house. It is also a science. Was Frank Lloyd Wright an artist or a scientist? I would say both, he mastered form and function so that what he designed stands up to and even plays off the laws of nature and is beautiful to look at. What is therapy without at least scientific foundation if not ongoing and continuous validation?

Outcomes data has multiple uses and marketing is only one relatively minor one. A primary role should be improving the quality of care for each and every patient, in each and every treatment program. This often requires identifying and reducing unnecessary, unhelpful, and unjustifiable variations in treatment processes (given individual differences there are numerous appropriate variations in treatment, the trick is sorting out the wheat from the chaff).

If anyone still believes that clinicians "know" what is effective (or what is ineffective) please explain the unreliability of the GAF (sans special training on doing these ratings). Do clinicians suddenly and forever after "know" their patients better after receiving this training?

If so the whole world of outcomes would be much simpler since we could all just collect and compare GAF scores. How do we explain incongruences between patients and clinicians ratings of outcomes? Is it always that the patient was resistive to treatment? If their outcomes ratings show they aren't better or even worse and the clinician says they are clearly better which do you believe? They may even be quite satisfied with their outcomes but if their ratings of their functioning, symptoms or

Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

other valid outcomes aren't any better in some quantifiable way it seems that something is missing.

"In times of change, learners inherit the earth,
while the learned find themselves beautifully
equipped to deal with a world that no longer
exists."

Eric Hoffer

I believe that the learner clinicians will utilize their outcomes data to improve their practices when the data is presented appropriately in a supportive environment. Meanwhile the learned clinicians to mix metaphors will stick their heads in the sand and hear no evil (or good), see no evil (or good) and speak no evil (or good) about outcomes. Unfortunately they'll miss out on the vast amount of good news provided by outcomes data.

Ivan S. Williams
Outcomes/PI Coordinator
Prairie View, Inc.

Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

Date: Sat, 4 Sep 1999 14:45:02 EDT
From: "Ed Wise, Ph.D." <Eawmhr@AOL.COM>

Harriet,

Thanks for your kind words. I love the idea of a parallel GAF for Axis II d/o's, but agree that it would certainly be a time consuming, demanding task that would require adding

another cost center in your budget, which is precisely why clinicians are not doing these sorts of activities. Now, if we could figure out a way to get reimbursed for it....

Best Regards,

Ed Wise, Ph.D.
Memphis, TN

Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

Date: Sat, 4 Sep 1999 14:49:17 EDT
From: "Ed Wise, Ph.D." <Eawmhr@AOL.COM >

In a message dated 09/04/1999 8:45:51 AM Pacific Daylight Time,
mllumpe@mail.utexas.edu writes via backchannel:

> Although I believe it marginally ethical to feed burgeoning datasets, whose growth seem driven by the premise that all questions can be answered and all needs met if enough data is gathered, I also find it peculiar at best to think of using outcome data strictly as a marketing tool. I sort of expect business merchants (mco's, mangled care corporations, and the like) to be corrupt, but I would expect private mental health care providers to be interested in vagaries of quality of care and have systems that follow and document quality and improvement in internal operations as well as direct service. >

This is not my position. I do not view such research "strictly as a marketing tool". As a matter of fact, our outcome & satisfaction study grew out of our attempt to begin getting in line w/ncqa standards and processes.

Regarding your implication that the use of this research as a marketing tool borders on the unethical, I find this offensive. As a small private practice group, it is highly unusual that we conducted this research at all, due to the extreme proportional increase in overhead, with no return. I know of not a single small private practice group that has conducted any psychotherapy or mh program outcome or satisfaction studies in my community, nor do I know of any large institutions that have done so. This means that we are the only group in town that has empirically demonstrated our outcomes.

The pilot research project has been accepted for publication as a book chapter and the replication research project has been provisionally accepted in an APA approved, peer review journal, including the section on using the research as a marketing tool. Suffice it to say that these reviewers and Editors did not have any questions about the ethics involved in using this research to promote our practice.

To get back to the main theme, as I said in my original post, "We are interested in outcomes, but our bias is that of course we KNOW what we do is effective, it is the rest of the world that questions our results." and as Dr. Meek echoed,

>this hardly seems worth the time and energy because I'm already quite convinced that what I do makes a difference in these people's lives.>

Given this mind set, why would therapists make additional investments in outcome research when their incomes are being driven down and their overhead is going up? If your budget were being cut, would you be taking on new projects that were guaranteed to increase your costs considerably with no demonstrated return on investment? Most organizations in this position try to save positions and maintain the

Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

status quo, not take on more and outspend their budget. To do the latter would, in most circumstances, be considered poor organizational and fiscal management.

Ed Wise, Ph.D.
Memphis, TN

Date: Sun, 5 Sep 1999 15:15:25 -0700
From: Lee B Sechrest <sechrest@U.ARIZONA.EDU >

On Fri, 3 Sep 1999, Ed Wise, Ph.D. wrote:

> As a private practitioner who has just completed a relatively small outcome and satisfaction study for our private practice group, let me chime in on this interesting dialogue. We are interested in outcomes, but our bias is that of course we KNOW what we do is effective, it is the rest of the world that questions our results. Dealing with outcomes has become a necessary evil to promote what we do. It is an added expense that detracts from our bottom line. >

You are right, of course. The only problem is that you (i.e., professional practitioners) want the rest of the world to reimburse you for what you do. If your transactions were strictly between you and your patients, there would be no problem. But when you and your patients want to be given money that has been collected from other people and when your use of that money may limit the uses that can be made of it by those others (it is a zero-sum game), then those others have an understandable interest in your ability to fulfill the implicit contract you have to deliver effective services.

Lee Sechrest

Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

Date: Sun, 5 Sep 1999 22:08:56 EDT
From: MJohn66480@AOL.COM

Are other practitioners held to the same level of outcome standards to those that pay for services? If someone goes to a family doctor and a battery of tests come back negative are they accountable for ordering tests that did not show the difficulty even if they "knew" clinically that was the appropriate course of action to be taken. Do they have to tack outcome data for the services they provide to be provided for audit to those picking up the costs? Is mental health not held to a higher level of accountability for outcomes in the work we do than other private practitioners?perhaps a good thing in the long run?

Melinda

Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

Date: Tue, 7 Sep 1999 10:50:44 -0400
From: John Kastan <john_kastan@SMTPLINK.MSSM.EDU>

to the extent that this is true, stigma, the fact that mental illness itself is still viewed somewhat suspiciously (moral failure, etc.), as is mental health treatments ("talking"), may be interrelated factors.

On the other hand demonstrating the outcomes of treatment (and using the results of good outcome studies to improve practice) seems like a worthwhile endeavor, whatever the societal context. It might even be persuasive in some settings in increasing the perceived legitimacy of the treatment enterprise.

John Kastan, Ph.D.

Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

Date: Mon, 6 Sep 1999 08:36:55 -0700

From: Lee B Sechrest <sechrest@U.ARIZONA.EDU >

On Sun, 5 Sep 1999 MJohn66480@AOL.COM wrote:

> Are other practitioners held to the same level of outcome standards to those that pay for services? If someone goes to a family doctor and a battery of tests come back negative are they accountable for ordering tests that did not show the difficulty even if they "knew" clinically that was the appropriate course of action to be taken. Do they have to tack outcome data for the services they provide to be provided for audit to those picking up the costs? Is mental health not held to a higher level of accountability for outcomes in the work we do than other private practitioners?perhaps a good thing in the long run? >

It may be that mental health service providers are held to higher standards. So? Mental health service providers can respond by (1) trying hard to meet those standards, (2) trying to get the standards lowered, or (3) whining. But, on the whole, I think it is a good thing that the standards are higher. Incidentally, though, other providers do not get off quite so easily as you imply. If their patient is from managed care, they must get prior approval for most procedures; they cannot just order up an MRI to be doing something. And their practice is profiled, and if they prove to be much out of line with other practitioners like themselves, they will be informed about it and may come under closer surveillance..

Lee Sechrest

Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

Date: Mon, 6 Sep 1999 13:00:17 EDT

From: "Tim Tumlin, Ph.D." <TRTUMLIN@AOL.COM>

I agree it is good to measure outcomes in clinical work. In a perfect world, the stakeholders will help monitor treatment success and encourage practitioners to use empirically supported treatments. We who put money into the insurance accounts will see that it is wisely spent on good health care.

OK, now getting more real.

In my practice, none of the stakeholders have shown an interest in empirically measured outcomes of the work they underwrite. They sometimes say they'll approve more sessions "if the patient makes progress" but that is determined from progress notes or consultation with me. Workers' compensation cases sometimes have a nurse-case-manager, whose job mainly seems to be to find ways to suggest the patient should return to work.

Third-party payors, in my experience, have shown no interest in outcome or efficacy research. (In fact, they don't care about cost-effectiveness research because they run mental health accounts and I can show that I save money for medical expenses, which is not their concern.) They never inquire if I am doing anything empirically supported. I could be putting on a wooden mask and dancing in chicken feathers and as long as the CPT and the Dx billing codes are right, they pay. Oftentimes they don't want to pay, but those reasons, again, have nothing to do with the quality or alleged effectiveness of my work or the type of treatment I use. That has to do with referrals, membership on provider lists, U&C fee schedules for my zip code, and the such. They have never shown an interest in my offers to send them research articles supporting my work.

I'm sure there are exceptions to what I've just said, but they are just that.

Similarly, when they choose professionals for a panel, they show little to no interest in my training, my adherence to manualized treatments or my philosophy of psychology, science or clinical treatment. They certainly never ask for any kind of confirmation of the efficacy of my work. The primary criterion is whether there is room on the panel. They typically refuse admission without knowing anything about me.

It seems strange, but then insurance companies are not health-care organizations, they are financial institutions. Their algorithms for a success appear to be very short-term and based only on financial statistics rather than the rationale of healthcare expenditures. I feel certain they pay more attention to such things as the benefits of delaying and challenging payments, limiting numbers of providers, fine-tuning the U&C charges, renegotiating capitations and re-bundling DRG's than to whether a

Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

treatment actually works. That really isn't their expertise and attending to treatment outcomes is not how they are going to meet their criteria of success.

Tim Tumlin, Ph.D.

Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

Date: Mon, 6 Sep 1999 13:49:53 -0700
From: Lee B Sechrest <sechrest@U.ARIZONA.EDU>

I do not know why it seems to be so difficult to understand the insurance industry.

> In my practice, none of the stakeholders have shown an interest in empirically measured outcomes of the work they underwrite. >

That is true of all types of insurance. Automobile collision insurance companies do not try to determine whether the repairs on your car are done properly. That is your business. They do not want to pay for unnecessary repairs or for fraudulent claims.

> Oftentimes they don't want to pay, but those reasons, again, have nothing to do with the quality or alleged effectiveness of my work or the type of treatment I use. >

Insurance companies are generally willing, sometimes even eager to pay for anything for which the cost can be passed along to the rate payor. They do not want to pay for things that will affect their profits. Is that odd? I read regularly the complaints of providers about the paper work they must do without direct compensation, i.e., that comes out of their profits.

>It seems strange, but then insurance companies are not health-care organizations, they are financial institutions. Their algorithms for a success appear to be very short-term and based only on financial statistics rather than the rationale of healthcare expenditures. >

It is not strange at all. Automobile insurance companies are not in the repair business. Life insurance companies are not in the business of saving lives. They are businesses, capitalized like other businesses and having to make a profit in order to keep attracting investors and keep going.

And, yes, medical/health insurers try to locate and sign up good risks. Just as do, for example, life insurance and automobile collision/liability companies. What life insurance company have you ever heard of that is willing to give large amounts of insurance to all comers and all at the same price? What auto liability companies are willing to insure teenagers at the same price as older drivers? Or DUI probationers at the same price as sober drivers? The health insurance industry is regulated in such a way as to make it a bit more difficult for them to cream the population, but it should be no surprise that they would try.

The problem here is that *as a society* we have decided to treat medical/health care in the same way as any other industry. That being the case, then we should expect that

Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

investors in that industry would try to make profits and be very reluctant to engage in any business practices that would cut into their profits.

That said, the fact is that the health/medical insurance industry is not all that profitable. If it were, then its shares would have soared in price or its price-to-earnings ratio would be very low. But anyone who thinks that the industry is enormously profitable is free to buy shares on the market. Many companies are publicly traded. People in financial sectors of business would regard such purchases as very sensible hedges.

If we want to reform the health/medical sector, we will need to persuade our fellow citizens to vote for legislators who share those views and who are willing to work and vote for them. Then we can have a health care system like the UK's, or Canada's, or Germany's.

There are not any easy answers, which is what everyone actually wants. We want bone marrow transplants, long-term inpatient care for mental patients, endless psychotherapy for the walking well/wounded, repeated rehabilitation interventions for substance abuse, transplants of every organ imaginable, etc., etc. *at affordable costs*. That latter invariably refers to the cost to the recipient, but someone has to pay. One transplant surgery at \$100,000 requires 99,999 other people each to scratch up a dollar to pay for it (plus administrative costs). And so must each other intervention be paid for. It may not cost much extra to do any one thing, but it costs a hell of a lot to do many of them.

Expenditures

on just one drug for treating allergy/hayfever reached about \$2,000,000,000 last year. That comes to about \$8 for every man, woman, and child in the US. Just for one drug. So shall we have a system that covers drug costs for everyone?

One of the things that is *regularly* missing from all this litany of complaints is any semblance of a plan for how to deal with the very large problems of health care in this country (let alone in the rest of the world). Get rid of MC and go back to fee-for-service? It is to laugh! Build a national health care system? Look at what happened to the post office. Look at the sad shape that many of our schools are in.

I hasten to assure that I do not know what to do, but I know what not to do--moan about the iniquities of the insurance industry that is doing exactly what it ought to be doing and that was given license to do it by the people, through their duly elected representatives in the U.S. Congress.

We have met the enemy and surrendered--to ourselves.

Lee

Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

Date: Mon, 6 Sep 1999 22:40:05 EDT
From: "Tim Tumlin, Ph.D." <TRTUMLIN@AOL.COM>

Fixing the Big Picture is beyond me. I agree that a national health or fee-for-service system doesn't look workable. I do think the system has some loopy aspects that make it less functional.

My hope for change is that the users of private health insurance have a part in buying and choosing their policies, and that they also take a meaningful role in planning and paying for their medical care. That will restore the economic feedback system that consumerism (true market forces) and accountability (e.g., outcome) can offer. It may funnel the health care underwriters and providers in the direction of giving care that is more effective and service that is more responsive to the consumers.

Tim Tumlin, Ph.D.

Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

Date: Mon, 6 Sep 1999 20:38:52 -0700

From: Lee B Sechrest <sechrest@U.ARIZONA.EDU >

On Mon, 6 Sep 1999, Tim Tumlin, Ph.D. wrote:

> Fixing the Big Picture is beyond me. I agree that a national health or fee-for-service system doesn't look workable. I do think the system has some loopy aspects that make it less functional. My hope for change is that the users of private health insurance have a part in buying and choosing their policies, and that they also take a meaningful role in planning and paying for their medical care. That will restore the economic feedback system that consumerism (true market forces) and accountability (e.g., outcome) can offer. It may funnel the health care underwriters and providers in the direction of giving care that is more effective and service that is more responsive to the consumers. >

Tim, your general idea is probably sound, but we need to think hard, those of us on the provider side, about just how a system could be developed that would work. I have had a lot of dealings with the health care system and various providers over the past couple of years, and, although I am not by any means completely happy about everything, I have not had a lot of the problems with MC that many people report. That is probably because I still have a semi-indemnity health care policy. Which I strongly recommend. On the other hand, I pay a lot of extra money for it. People have problems with MCOs because they are not willing to pay for indemnity policies. They would rather feed and clothe their families, own fancy homes, drive \$35,000 SUVs, vacation in Las Vegas, and so on rather than pay what the kind of health care they want would cost. I do not mean to belittle the problems that people have and the difficult choices they must make. But our entire society must make such choices in one way or another and sooner or later.

Incidentally, or not so incidentally, I have had problems with the health care system that are attributable to managed care even though I am not in managed care. The system makes almost no distinction between MCO and indemnity, or even cash, patients except in their relief in not having to make so many phone calls in the latter cases. But health care providers are so swamped with cases and work assignments that they have very little time or patience for anyone. I can decide whether I want to see a specialist or not, but I cannot demand that the specialist see me sooner than anyone else or that the specialist spend any more time with me than with anyone else. So, I wait three weeks for appointments and then get my 15 minutes just like the HMO Joe.

Lee

Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

Date: Tue, 7 Sep 1999 02:19:14 -0400

From: bet1 <bet1@ACD.NET >

SECONDED!

Nice articulation, Tim, of my view of MC as well. It seems to me that a major economics/market place mistake is made by separating the health care consumer from the process of managed economy as Managed Care seems to do. The MCO consumer has become either itself or the Health Benefit Coordinator of any Inc. you wish to name. The true people with health problems are not even in the scenario unless they wish to jump all of the hoops. What about placing some of the old checks and balances back into the game of competitive enterprize so "We The People..." can again vote with our pocket books?

I actually think that the model for insurance has soon to be on it's way out. In prior times insurance represented a bet; I bet I'm going to have a financially difficult time with my health (Why else would I buy it?); The insurer bet that I would remain healthy and they would thus profit from my dollars. (Why else would they sell it?) Today with the commercial "risk management" concepts and data profile information it seems the corporations are playing the game with loaded dice and consequently they always will win the profits and the payee (If it is the individual...) will always loose. It is very evident for some time that MCO's and HMO's recruit and cull their memberships from the most healthy among us, and why not... you get all those dollars and don't have to spend many of them. It is also evident, even in Public Services, that the mission has changed from providing health care to collection of data elements for administrators and MCO statisticians to do their thing, patients be damned!

In our community the HMO's have discovered for instance the cost of providing mental health services to Medicaid and Medicare populations which are both traditionally more costly for health care than the average member. A couple years ago there was a mandated rush for all of these people to change to HMO benefits with all the discontinuity of care you can imagine, and now, barely two years later the HMO's are eager to contract with public services to send these folks back. And of course we are eager to receive, for among other motives, to retain business and preserve the agency! (Admittedly, not a very moral motive either!)

I think it is time for all of us to save our pennies from birth to create our own accounts for health care and forget the insurance industry which uses it's data to milk everyone and then provide no return when the product is needed. (I don't have the proper statistics and I know I am severely overgeneralizing with the comments above, but I do

Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

think they reference some very serious problems in our health care economic system which has turned a mutually beneficial system appropriate to democratic/capitalistic principles into a predator system based upon personal greed and short-term benefits for the insurer while disempowering the potential recipients from the fruits of their efforts, expenditures and forethought.

Bruce

Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

Date: Tue, 7 Sep 1999 22:53:13 -0400
From: stephen rose <srose1@maine.rr.com >

Lee,
Thank you for this bit of reason.
Steve Rose

Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

Date: Tue, 7 Sep 1999 08:48:49 EDT
From: "Tim Tumlin, Ph.D." <TRTUMLIN@AOL.COM>

Digressing a bit into health insurance: Our system in which employers provide employees health care coverage as a standard perk seems to be benevolent at first glance. Admittedly, it does provide coverage for people who likely wouldn't buy it if it were at their discretion. But I have also seen it as the root of a warped market system.

1. Consumers don't buy their policies, so the marketing force moves to pleasing the purchaser of the group policies - the employers. Often, that means offering nominal coverage, something that looks shiny on the outside (\$5 copays) and is junk on the inside. Employers and other self-insurers, such as labor unions, see group health as a cost to keep down and there is little advantage to them to spend more except as a special perk for valued employees. Employees often cannot upgrade their health insurance but pretty much take what is given to them and are therefore out of the market loop.
2. Consumers often don't understand the quality and breadth of their coverage. Because they didn't buy the policy, they don't get much service. For example, my insurance agent wants me to be his long-term customer and he tells what I want to know about my policies.
3. Insurance companies have no reason to be responsive to the employees. They profit by creating obstacles to their relationship with the insured while still calling it Health Care Coverage. Many patients are baffled and overwhelmed by the claims system.
4. Insurance companies also have no reason to be responsive to the providers, so for many of them it is to their advantage to obfuscate the claims and certification system as much as possible. They profit from delays, challenges and demands for more paperwork from the providers. I have been shocked to see how many people are employed in providers' offices to do nothing but cut through the tangles of unnecessarily convoluted claims systems.

And, to get back to the point: The warps and marketing disconnections in the overall health care underwriting system also seems prevent a feedback loop in which treatment outcomes and empirical support for treatments help guide decisions for underwriting health care.

Tim Tumlin, Ph.D.

Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

Date: Tue, 7 Sep 1999 12:10:36 -0400
From: "Stephen E. Beller" <nhdspres@BESTWEB.NET >

WOW!!! This thread is making it painfully clear that many (most) therapists just don't (and won't) buy into outcomes research; reasons include:

1. Therapists reject outcomes research because they're averse to dealing with quantitative data.
2. Therapists reject outcomes research because they rigidly adhere to a particular treatment approach and are closed-minded to considering empirically-justified (evidenced-based) alternatives.
3. Therapists regard outcomes research as only marginally ethical because they don't believe empirical information can ever accurately reflect the quality and efficiency of care.
4. Therapists believe that they know they are doing very good work and are offended when their professional decisions and competence are questioned.
5. Therapists fear that outcomes data will make them look bad.
6. Empirically minded, flexible therapists -- like Ed Wise and his group -- are doomed to go broke if they continue their outcomes research because;
 - (a) They are not compensated financially by MCOs/payors for the expense of their research efforts
 - (b) MCOs do business with therapists who cost the least -- little else matters
 - (c) MCOs drive up overhead and paperwork time, leaving little money and energy left for outcomes research.

With all these negative forces -- ignorance, doubt, ego, fear, greed, financial constraints, time pressures, and unrewarded efforts -- it seems unlikely that therapist resistance to outcomes is going to be overcome! In this light, I've been too optimistic suggesting that therapist buy-in may increase if outcome measures were actually useful to the therapist.

So the status quo is likely to prevail:

Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

1. Therapists will fight against outcomes research; focusing instead on complaining about managed care abuses and supporting ineffective political actions
2. Pressure from MCOs (and purchasers) will extend the use of *insubstantial* outcome measurement instruments, because such measures are relatively quick and inexpensive, and give the appearance of doing something to improve outcomes
3. These insubstantial measures will continue to be of little or no use to the therapist in diagnosis and treatment planning
4. These insubstantial measures will never provide the knowledge needed to determine best practices
5. These insubstantial measures will never lead to a useful diagnostic system that matches Dx to evidence-based treatment prescription
6. Without firm scientific evidence that therapists know how to select and deliver the most cost-effective care to each patient, decisions will continue to be made based on cost, not quality
7. The mental/behavioral healthcare profession and patients will continue to suffer; the vast potential of the profession for improving the mind, body, and society will remain unrealized.

It's unfortunate that therapists don't (won't) realize the self-defeating nature of this path and move in a different direction.

Real power and positive change can only come from knowing which intervention with which therapist under what conditions is most effective/efficient for each patient and from demonstrating the actual benefits of mental healthcare! If this knowledge was readily available to all, therapists could deliver the best care consistently and efficiently, and patients would have a realistic understanding of what they can expect to gain. The profession could monitor itself! How then could MCOs claim that their fiscally focused controls are necessary?!? **IT'S IGNORANCE THAT STRENGTHENS MCOS AND WEAKENS THERAPISTS.**

Gaining this profound knowledge, however, requires a great deal of empirical information and a sincere commitment to continuous quality improvement. It means having enough valid, reliable data to detect meaningful patterns in the relationship between patient problems, diagnosis, treatment, and outcomes. It means using these data to reach some consensus on how best to diagnose and treat each patient. And it means continually updating preferred practice protocols with new outcomes data.

Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

The best way to achieve this is through evolving science, therapist-researcher-patient collaboration, and massive powerful marketing to the public. In addition, developers of assessment tools ought to collaborate to establish an omnibus instrument that addresses all patient types and problems and provides useful information for all therapists and researchers.

Key concepts for this continuous quality improvement effort should be:

- Completeness, Comprehensiveness
- Openness, Flexibility, Adaptability
- Factual Accuracy, Honesty, Evidence-Based
- Rational/Logical/Compassionate
- Efficiency, Affordability
- Patient-centered.

But it seems that this vision is to remain a pipe dream ... at least for now.

The hope for the long-term health of the profession, as I see it, is for open-minded therapists, researchers, outcome instrument developers, and business advisors to form a large network with the funds and focus enabling it to conduct well-organized, comprehensive outcomes research. This network would offer a meaningful alternative to the current day ignorance-based path. Will this ever happen? I don't think things have gotten bad enough yet & but they will! In the mean time, it's nice to dream &

Steve Beller

Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

Date: Tue, 7 Sep 1999 12:38:47 EDT
From: "Ed Wise, Ph.D." <Eawmhr@AOL.COM>

In a message dated 09/07/1999 9:15:26 AM Pacific Daylight Time,
nhdspres@BESTWEB.NET writes:

> The hope for the long-term health of the profession, as I see it, is for open-minded therapists, researchers, outcome instrument developers, and business advisors to form a large network with the funds and focus enabling it to conduct well-organized, comprehensive outcomes research. >

Steve,

As always, your synthesis of the issues is appreciated. I believe the network you refer to is already in place and in roads are already being made to standardize comprehensive outcomes research, as you suggested. The networks are the mco's, who have the only economic incentive and provider access to do this. My fear is that it will result in paper pushing and not meaningful outcome data. Another fear is that, as one mco was monitoring a high profile case I was involved in, they actually called the client while treatment was in progress and did a phone survey with him to assess his satisfaction. Perhaps this happens routinely, but I have only heard of it after therapy was finished. Anyway, I am concerned that if the it is imposed from those too far removed from the day to day clinical concerns that it will only represent more for clinicians to complain about and devalue, while they themselves were unwilling to take on the task. After all, ignoring the runaway inpatient costs for adolescents and A&D in the '80's got us into this mc mess. Dismal picture, but fits with your scenario of things getting worse.

Ed Wise, Ph.D.
Memphis, TN

Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

Date: Tue, 7 Sep 1999 17:44:23 -0500
From: "Ivan S. Williams" <isw@PVI.ORG>

On Fri, 3 Sep 1999, Ivan S. Williams wrote:

> Though many [clinicians](sic) "know" that what they do is effective do they "know" when they are ineffective or is it like Alice in Wonderland where all have won? Does it really matter what you "know" if no one else knows it? If the clinician "knows" that the patient is better or worse but the patient, family, payor, or colleagues don't "know" this your not too far from joining the clinician's equivalent to the flat earth society. >

> Ivan, excuse me, but I think the real judge of whether the patient is better is the patient themselves. And, I think there is generally agreement between patients and therapists when there is improvement. I don't really think it is the insurance company's business if both patient and therapist agree that things are better. If we were able to measure and "validate" the efficacy of all we do, that would be one thing, and I'm all for continuing to try. But to pretend that our current measures are adequate and to use them as if they actually measure therapeutic progress sufficiently just seems silly. -Harriet >

I agree completely with the idea that the patient is the real judge of whether they are better or not. Actually that was one of the points I was trying to make and apparently did not do so adequately/successfully. Though I'm no fan of managed care, particularly micro-managed/mismanaged care, they do have a responsibility to serve all of those they cover equitably and fairly (not to presume that they do) and are stewards of the insurance funds. If just pay for any treatment with anyone whether or not it has a chance of working they are acting irresponsibly.

I don't expect our outcomes instruments to measure efficacy but to document effectiveness. I don't expect them to measure all that happens in therapy but to measure the most important outcomes/results of treatment such as self-reported functioning (i.e. self-esteem, coping skills, quality of life, quality of relationships), symptom level or other appropriate valid outcomes domains. If we're not helping people function better and/or suffer less from their symptoms then what are we doing? If we are doing something else lets find/create an appropriate relevant measurement of it. If what we do remains an unquantifiable mystery wrapped in and enigma it is only going to become more and more difficult to get people to pay us for it. It's just too abstract, intangible and unknown to most people for them to want to pay us for it without some numbers showing that it works. Yes the data must be integrated with the clinical assessment and ongoing observations. I don't expect the applied science of outcomes to replace

Dealing with Therapist Resistance to Outcomes *TECScript*
October 4, 1999

the art of caring for people though I do believe that a healthy dose of the applied science of outcomes can/will improve care and provide important data on quality to counter the volumes of data on cost.

- Ivan

Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

Date: Thu, 16 Sep 1999 04:11:34 -0500
From: David Goldfoot <goldfoot@MHSOLUTIONS.COM>
Organization: Mental Health Solutions, S.C./PsychSolutions, LLC

We've successfully handled the resistance problem at our clinic of 10 therapists by making outcomes a therapy tool, essentially using the known therapeutic benefits of self-monitoring, but converting the data to outcomes statistics and graphs for BOTH our therapists and our patients. We start with the idea that we monitor progress during therapy and that we share that information with the patient. Thus, we aren't at all concerned if our measures affect outcome -- we are TRYING with these measures to affect outcome. Every one of our therapists now uses short, treatment-specific rating scales with patients about every other session. We've developed our own scales (0 to 4 intensity ratings of DSM criteria in most cases) and keep them to 15 items or less. We typically administer them during sessions interactively by asking clients to rate each item, getting not only the quantitative measure, but also discussion about symptoms or therapy goals. Ratings are then entered directly by the therapist into a program which draws a color-coded stacked bar graph of the ratings, both for the current as well as past ratings previously supplied by the client. In that way, our clients instantly see what their progress looks like, where they are stuck, etc. The graph is discussed, a copy is given to the patient, etc. This system is enthusiastically embraced by our therapists and by our customers. Typical patient comments include "finally, I have a clear idea of what I'm supposed to be doing in therapy." Our program has the capability of doing linear regressions on the rating scales, and we have started to use a combination of the slope and the calculated R-squared value to make statements about efficacy of treatment. We've recently added the capability of being able to aggregate the data along any number of intake or treatment dimensions (for example, gathering all rating data for all female patients diagnosed with major depression, treated with cognitive-behavioral therapy) and then running either a single linear regression on all data points or taking an average of each separate regression for each patient in the aggregate. We let all our therapists have access to these programs and we've integrated intake, progress notes, diagnostics, etc. into the same program to make it substantially easier and faster for the therapist to keep records, chart according to practice standards, etc. We can also export any aggregate data to a statistical package for complete analysis, giving us the ability to do research based on these data. Therapists will do a lot when they are shown that changes required of them clinically actually help their clients instead of burden themselves with additional record keeping. I don't know if it is appropriate on this list serve or not to plug a product, but we've just

Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

started to commercialize the program we've developed, which is called GoalMinder. You can see more about GoalMinder or our little clinic either at www.goalminder.com or www.mhsolutions.com. I'd appreciate any comments you have about our approach and would especially welcome any help about whether we are ok using linear regression as an initial estimate of progress. Thanks.

David Goldfoot, PhD
Mental Health Solutions, SC/PsychSolutions, LLC

Dealing with Therapist Resistance to Outcomes *TECScript*

October 4, 1999

Date: Thu, 16 Sep 1999 09:59:15 -0400
From: Max Molinaro <maxm2@IX.NETCOM.COM>

Thanks very much for the detailed and useful description.

I have found that using measures such as the BDI or BAI (Beck Depression/Anxiety scales) on a regular basis with clients refocuses us on symptom change, gives me details that I might overlook or forget to ask about in unstructured conversations, helps both of us to see positive gains (when they have occurred) or to reassess a lack of progress.

Not to mention

having another form of documentation of therapy-related symptoms.

--Max Molinaro