

Developing a Spectrum of Care for Pediatric OCD

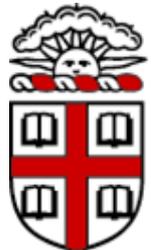
The Bradley Model

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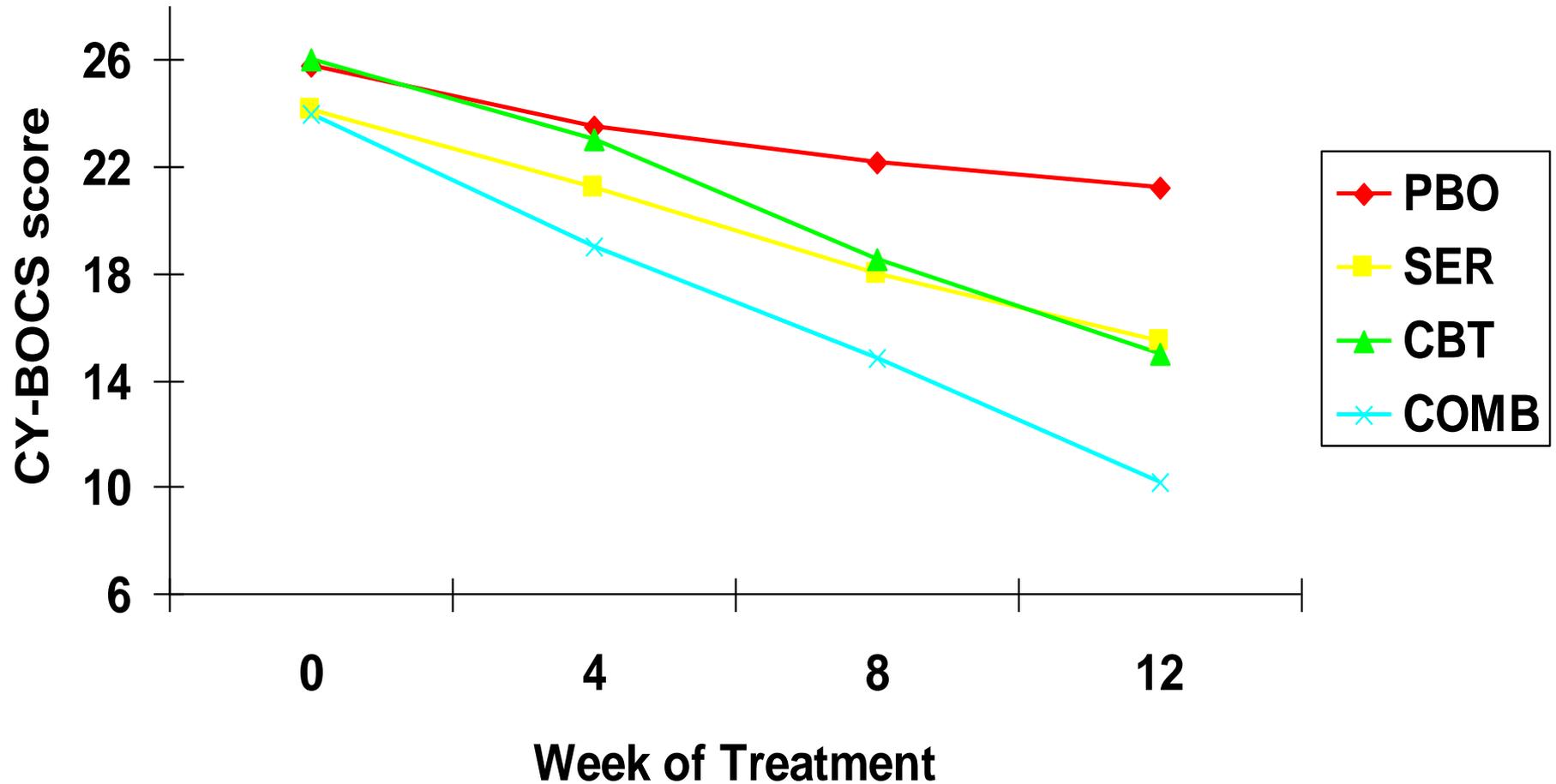
Agenda

- Review the evidence base from the Pediatric OCD Treatment Studies (POTS I, II, and Jr)
- Review challenges with traditional models of treatment
- Describe the program at Bradley Hospital
- Review our clinical outcome data
- Preliminary conclusions
- Q & A

Evaluating OCD Treatments: POTS I Goals

- Compare the relative efficacy of CBT, medication (SER), combined treatment (COMB), and placebo (PBO) in a treatment naïve sample
- Explore predictors of treatment response and maintenance of gains

POTS I Treatment Outcomes: Intent-to-Treat



POTS I Results: Predictors & Moderators

- Predictors of outcome (from baseline measures):

- Lower OCD severity
- Less OCD-related functional impairment
- Greater insight
- Fewer comorbid externalizing symptoms
- Lower levels of family accommodation

- Moderators of outcome (from baseline):

- Family history of OCD in the CBT monotherapy group

Conferred > 6x decrease in effect size

Garcia et al (2010) JAACAP

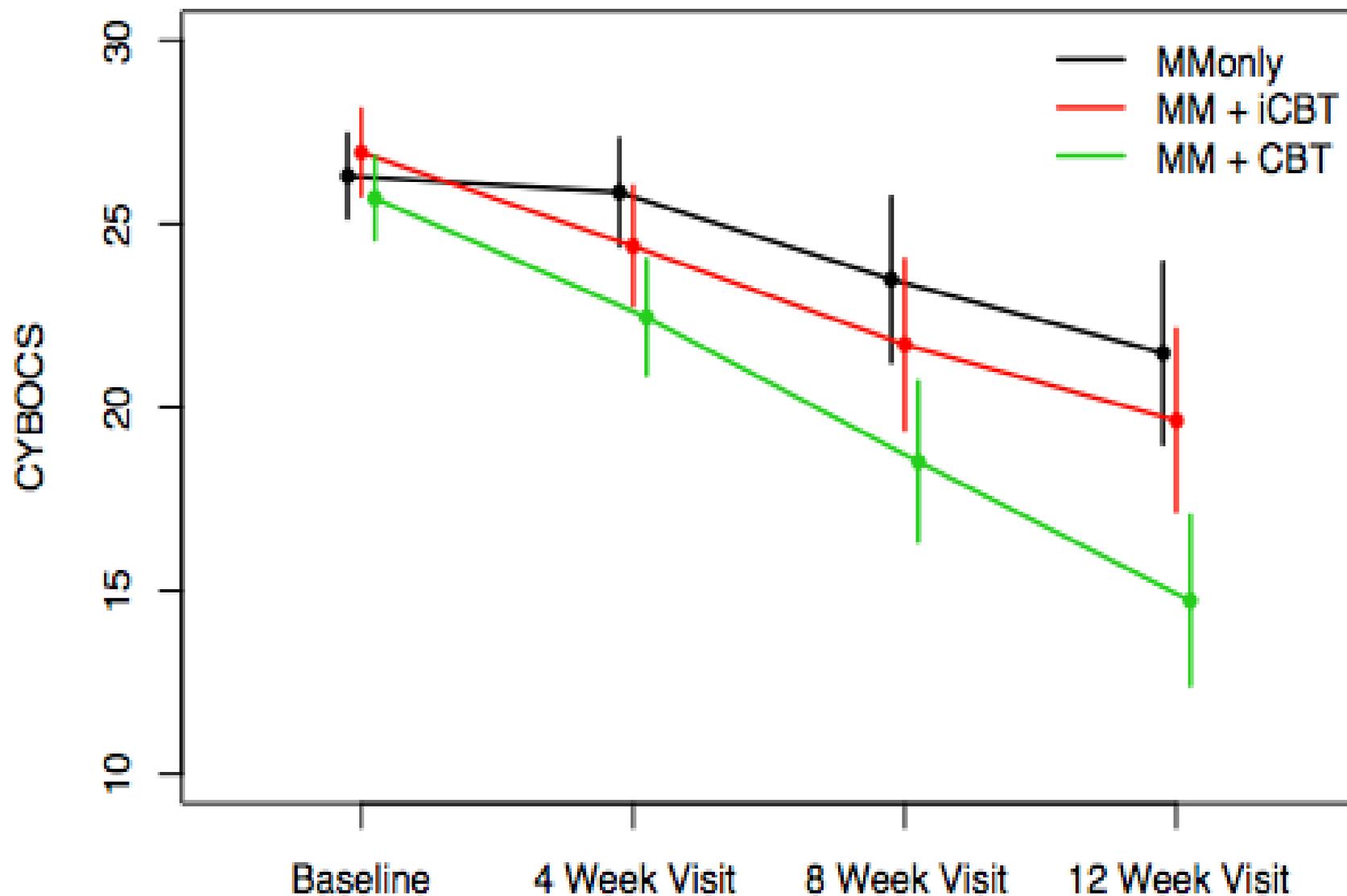
POTS I: Take Home Points

- Medication alone is helpful, but few patients remit
- CBT alone produces greater chance of remission than medication alone
- Combination of CBT and medication gives best initial response
- Children and adolescents with OCD should start with either CBT alone or in combo with meds

POTS II: Rationale

- Many kids are prescribed a medication, in part because it may be difficult to find a CBT therapist in the community.
- Partial response to medication treatment (i.e., significant residual OCD symptoms) is the norm.
- How can we get more practitioners to do CBT?
- Is it possible to do CBT in the context of a medication management visit?

POTS II: CY-BOCS by Visit Week



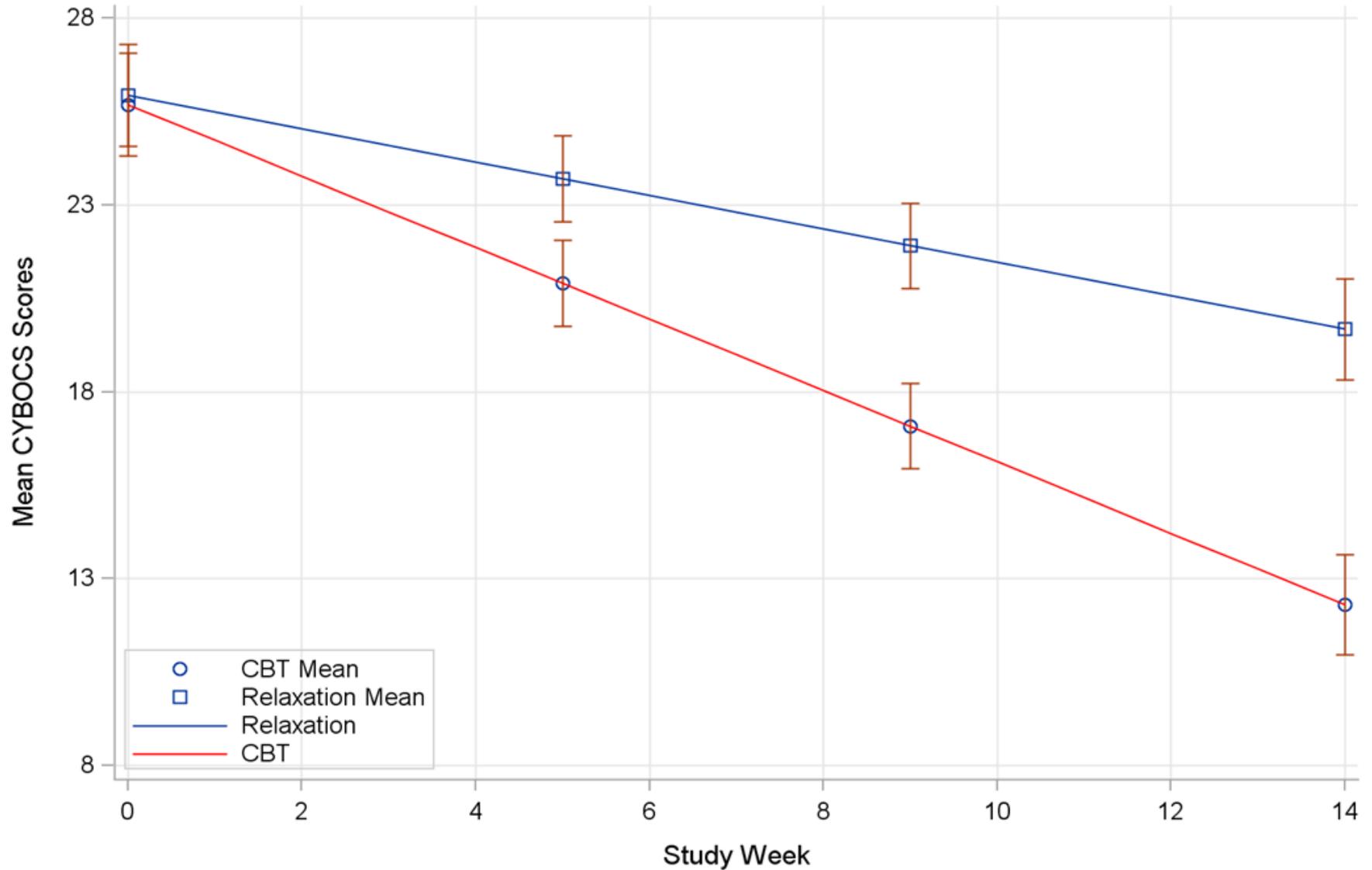
POTS II: Take Home Points

- Adding CBT to routine medication management may offer modest benefit, but statistically the results were not different from continued medication alone
- Adding full CBT from an experienced CBT therapist provides outcomes comparable to initial treatment with CBT + Medication
- Training child psychiatrists to deliver a honed version of a manualized treatment was not as efficacious as hoped

POTS Jr: Rationale

- POTS I & POTS II did not adequately address young children with OCD
- Developmental differences
- Family context and inclusion of parents
- Unique symptom correlates
- Initial contact with the mental health system

POTS Jr: CYBOCS by Visit Week



POTS I, II, & Jr: Take home points

- CBT and SRIs are efficacious for pediatric OCD; combined treatment may be superior to monotherapy
- Children and adolescents with OCD should start with either CBT alone or in combo with meds
- Augmenting medication maintenance (MM) with CBT results in symptom improvement
- Brief CBT isn't enough: you can't cut the corner
- CBT is efficacious even with young children
- From a public health perspective, the POTS trials argue forcefully for a strong CBT dissemination effort

Challenges with Traditional Outpatient Treatment

- Unfortunately, numerous and onerous

Access to EX/RP in Community Settings

- Little data on treatment capacity and community practices
- Not all CBT practitioners are competent to provide EX/RP without additional training
- While reasonably prevalent, OCD is rare enough that it may not make sense to mount full-scale dissemination efforts as have been done for other childhood anxiety disorders
- Waitlists for our outpatient clinic (PARC) have been as long as 9 months; these waitlists moved especially slowly when the sickest youth monopolized outpatient slots while making slow progress

Insufficient Dose of In Vivo EX/RP

- Inadequate session duration
 - Habituation to more severe exposures may exceed visit duration, leaving child vulnerable to ritualizing after leaving sessions
 - “Just right” symptoms are especially difficult to trigger reliably in a 45 minute office visit
- Inadequate frequency of EX/RP
 - patient & family unable to conduct quality exposures outside session
- In-office EX/RP is often contrived and may not be potent
 - Timing and location of naturally occurring symptoms does not match outpatient clinic setting

Family Involvement

- Parental involvement in symptoms is a crucial part of what needs to be reworked in treatment
- In 2-parent families it is rare for both parents to attend sessions
- This work is only as good as the parent/patient report of their behavior, and is often limited due to:
 - Lack of insight
 - Attempts to present as more functional than they really are
- Opportunities to learn, model and practice changes in parenting strategies and get information about symptoms are often missed

Peer Supports

- Individual and family modalities do not allow therapists to harness the resources that peers can provide
 - Increased insight and motivation
- Outpatient group treatments have not been financially sustainable in our setting and are logistically difficult

Intensive treatment as a solution: A patient

- Heather's story
- Intensive treatment as heroic, individual action
- Intensive treatment as private practice
- Intensive treatment as a systematic, reproducible, accessible, scalable intervention capable of responding to public health need

The goal: Hit each treatment obstacle

- Expert conceptualization of illness and treatment
- Flexible conduct of *in vivo* ERP in ecologically/functionally relevant settings with potent cues
- Sufficient durations for habituation and symptom occurrence
- Family based treatment to reduce conflict and support consistent approach to family accommodation
- School engagement
- Minimally disruptive to family function in time and financial cost
- Integrated pharmacologic management sensitive to the goal of maximizing ERP adherence and outcomes

Paying for it – outpatient?

- Fundamental commitment to work with third party payers (commercial and Medicaid)
- But outpatient codes are profoundly inconvenient
- Discourage leaving the office
- Discourage group therapies
- Preclude psychosocial treatments by multiple providers or modalities on the same day
- A modern paradox – the most cheaply reimbursed services are the most rigid and administratively cumbersome

Paying for it – IOPs and Partialials

- Bundled services defined by visit frequency (3-5 days a week), duration (3-6 hours a day), symptoms and impairment (moderate-severe)
- Available definitions are often confusing, inconsistent across payers
- Focus on safety (“SI/HI”) and avoiding inpatient stays inevitably leaks into discussions of these programs
- That said, specific treatment content/structure is usually loosely defined
- Regional/founder effects seem to matter

Sample IOP Eligibility Requirements

“Must meet either 1 or 2, and 3 to qualify:

1. Serious symptoms or impairment in social, occupational or family functioning requiring intensive, structured intervention.
2. A well-defined clinical rationale explaining why Covered Individual would not be a reasonable for outpatient therapy combined with community supports.
3. The Covered Individual has adequate cognitive abilities to assume responsibility for behavioral change, and is capable of developing skills to cope with their symptoms.”

Sample IOP Treatment Requirements

1. Provide multidisciplinary program of at least three (3) treatment hours per day at least three times per week
2. Multidisciplinary assessment
3. Seen by a qualified physician by the third day of attendance, monitoring of psychotropic medications
4. Family assessment and therapy by a licensed behavioral health provider. For children, at least one a week.
5. Treatment is individualized and not determined by a programmatic timeframe.”

Our clinical design – what and when

- Two day programs – 4 hours daily and 6 hours daily
- Daily after-school milieu, 3-6pm
 - Milieu-based therapies: Family session weekly, individual sessions twice weekly, group exposures daily, physician visit at least weekly and more as needed, art therapy
- Community visit, 2.5 hours, 2 or 5 days a week
 - Community-based exposure therapy in home, school, or elsewhere, school observations and meetings
 - Visits before and after day program, start at 6am and end at 10pm to capture morning and evening rituals
 - Will drive as far as approximately 1 hour to conduct visits

Our clinical design – who

- Team consists of
 - psychologists (clinical lead)
 - social worker (clinical-administrative lead)
 - psychiatrists (medical lead)
 - bachelor’s level “MTs” (milieu therapists, who might as well be called exposure therapists) who staff milieu and conduct most community visits
 - nutrition, OT, art therapy, pediatrics, utilization management
 - trainees from psychiatry and triple board residency, psychology post-docs, and medical students
- Team meetings for 1 hour a day
- Weekly supervision for MTs by psychologists and SW

Core innovation – The mobile MT

- MTs are the bridge between traditional hospital based medical treatments and community mental health treatment
- MTs' understanding of OCD and EX/RP and thoughtful observation of behavior in the community and milieu are essential to program success
- Akin to directly observed therapy in TB or HIV

Third party reimbursement – Negotiation

- Many payers have little understanding of pediatric mental illness or its treatment
- Most have little experience with OCD, and are horrified if you describe specific symptom content and impairment
- They are generally unfamiliar with EX/RP, some are confused about the role of relaxation/distraction/coping
- All of this is at least partly our fault
- This is a dangerous situation: uneducated consumers understandably veer between naiveté and paranoia; we are currently in a paranoid period

Successful negotiation

- Market power
- Relationships
- Educate the consumer (in this case, the payer)
- Honest commitment to outcomes and transparency
- Persistence
- The question of saving payers money “in the long run”

Program performance: Severity at admission

- Median CY-BOCS = 31 (“severe” is 24-31)
- 46% are “extreme” at admission (CY-BOCS \geq 32)
- Most have failed multiple medication trials and many have failed outpatient exposure therapy

Improvement

- Median reduction in CY-BOCS of 37.1%, from 31.0 to 19.5 (“moderate” is 16-23)
- 69.2% of patients are responders, using the response definition of 30% reduction used in POTS-II
- If you trust our numbers, we match/beat the response rate for the POTS-II combination treatment (69.2% vs 68.6%) with sicker kids (mean entry CY-BOCS 29.8 vs 25.5)
- Who are the non-responders?

Length of Stay

- Median LOS = 30 days, or 6 weeks
- Some have stayed for up to 6 months

Uses of outcomes data

- Negotiation with payers to improve reimbursement (already)
- Predictors of non-response, testing program changes to address these populations

Evolution: Longer stays with sicker patients

- Median stays grew from 26 to 33 days (about 5 to 6.5 weeks)
- Median intake CY-BOCS increased from 28.5 to 31.5
- Median CY-BOCS reductions have fallen from 11.1 to 10.0
- This occurred during a period when we have increasingly served treatment resistant patients from other states and countries who have moved to RI for care
- Census has grown from 9 to 12 to 18 kids

Unanticipated consequences

- Clinical team can now function as an inpatient service, providing intensive care for kids too disabled or unsafe for day programs.
- The flexible use of cost effective treatment strategies in day programs is facilitating discussion of similar “step down” care arrangements which may supplant traditional OP care altogether
- This all looks like preparation for a capitated future of integrated health homes, where providers provide a spectrum of services and take on cost-related risks

Big Picture(s)

- Intensive treatments for severe, “treatment-resistant” pediatric OCD can be financially sustainable, scalable, and clinically effective
- Payers are hungry for performance data, and their standards are much lower than NIH’s or JAACAP’s. If we measure and share outcomes, we may be able to educate payers into a virtuous cycle of paying for—and getting—quality care.
- If capitated payments and integrated services are the future, providers experienced in developing high quality spectrums of care will have the advantage

¡Viva México!

(Grito de dolores, John O’Gorman)

