Outcomes Management

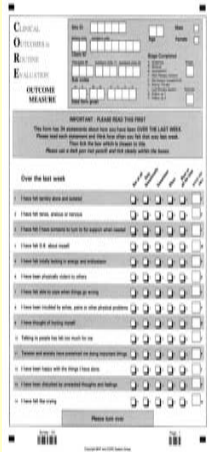
Developing Quality at the Heart of Therapy

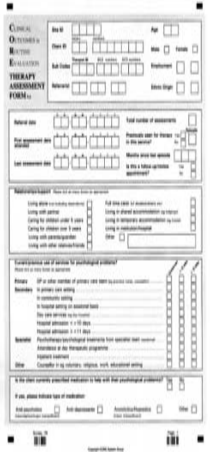
What is CORE?

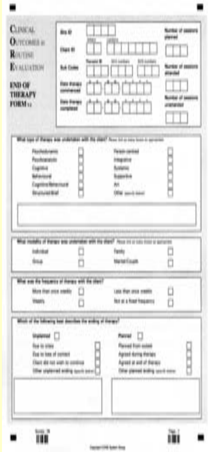
Historical Developments

1995 CORE Development Starts

1998 CORE System Launches







2001 CORE-PC software launches

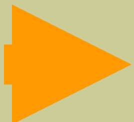
2005 CORE-PC achieves 2500 users

2006 CORE Net Beta launches

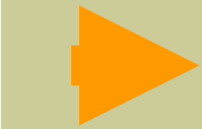
2007 CORE Net wins 1000 demonstrators

June 2008 CORE Net officially launches

The CORE Net Methodology

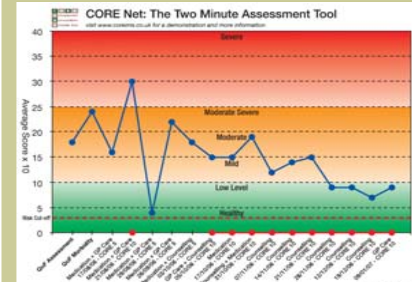


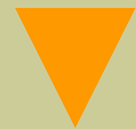
STEP 1: GP or PoH use the CORE 10 on-line screening tool (*optional*)



STEP 2: Therapist uses CORE-OM and Therapy Assessment Form to summarise clinical presentation

STEP 3: Therapist uses CORE 10 or CORE 5 to track clinical progress openly





STEP 4: Therapist uses CORE-OM and End of Therapy Form to summarise therapeutic processes and outcomes

Growing of a CORE Network

400
350
300
250
200
150
100
50
0

2001 2002 2003 2004 2005 2006

Services using CORE Software
Cumulative data (in '000s)

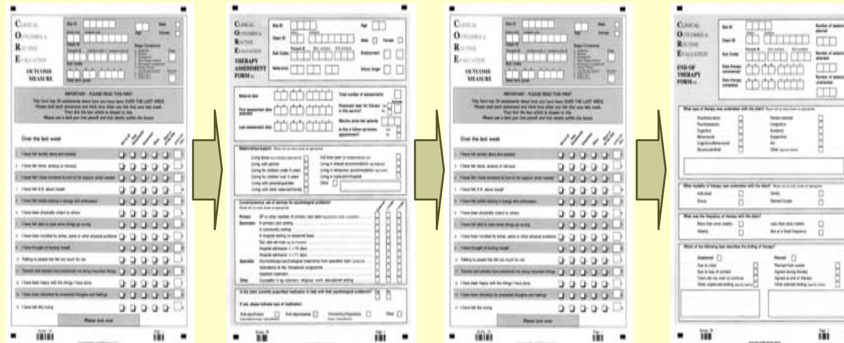
Who are CORE?

The CORE Infrastructure

CORE System Trust provide free CORE System tools to support the development and growth of practice-based evidence

CORE National Research Database helps develop practice-based evidence, benchmarks and service quality management guidelines

The CORE Methodology



CORE System Quality Development Tools

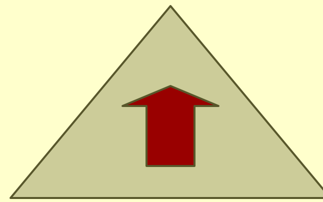
CORE Net

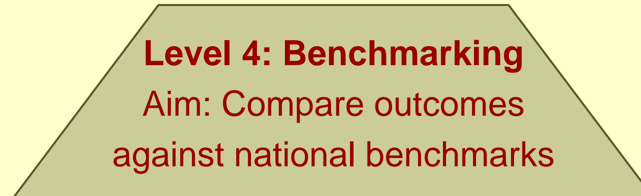
CORE IMS provide CORE software and change management support

CORE Network meets to explore and share good practice

The Benefits Pyramid

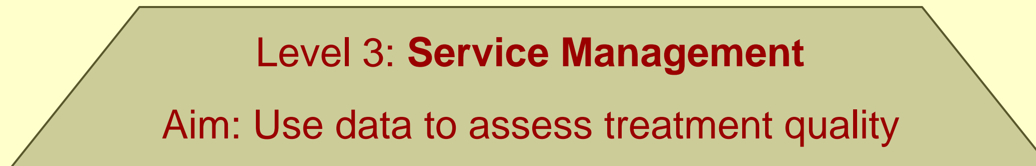
NiMHE Outcomes Measures Implementation Best Practice Guidance. April, 2005





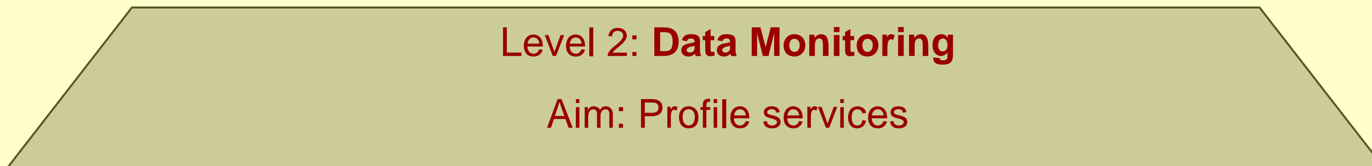
Requirements for Level 4

Appropriate normative data & expert review group



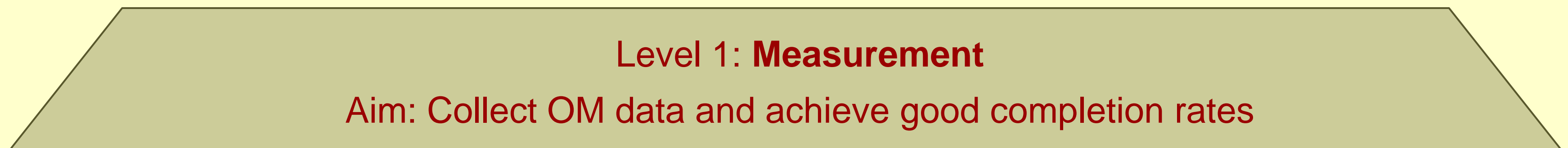
Requirements for Level 3

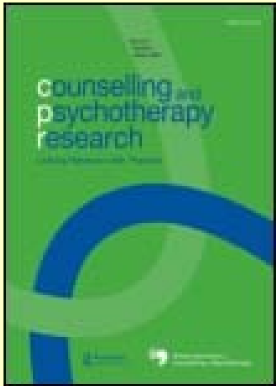
Contextual data & governance interpretation



Requirements for Level 2

Quality checks on data & ability to aggregate data

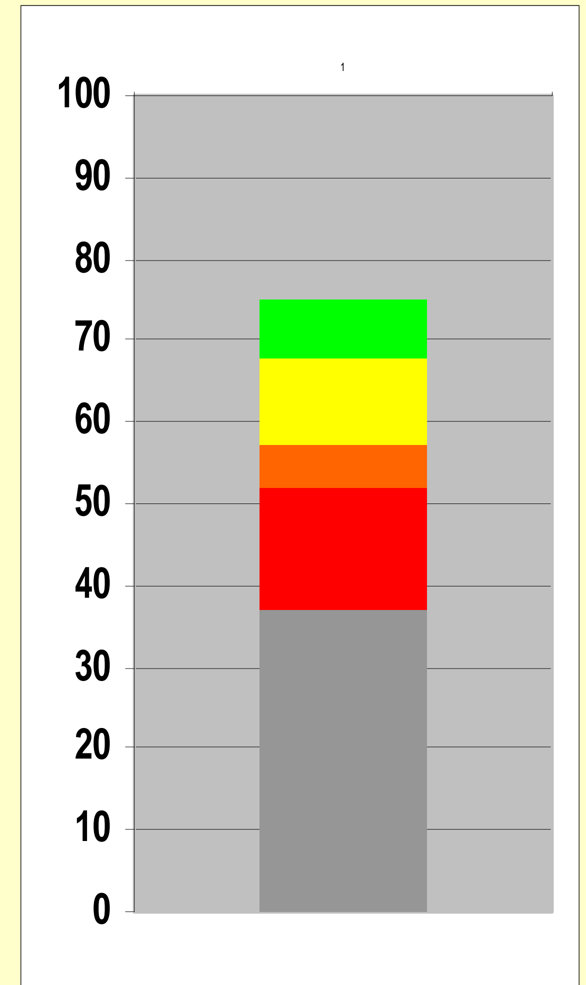




CORE System Benchmarks

Volume 6 Number 1 March 2006

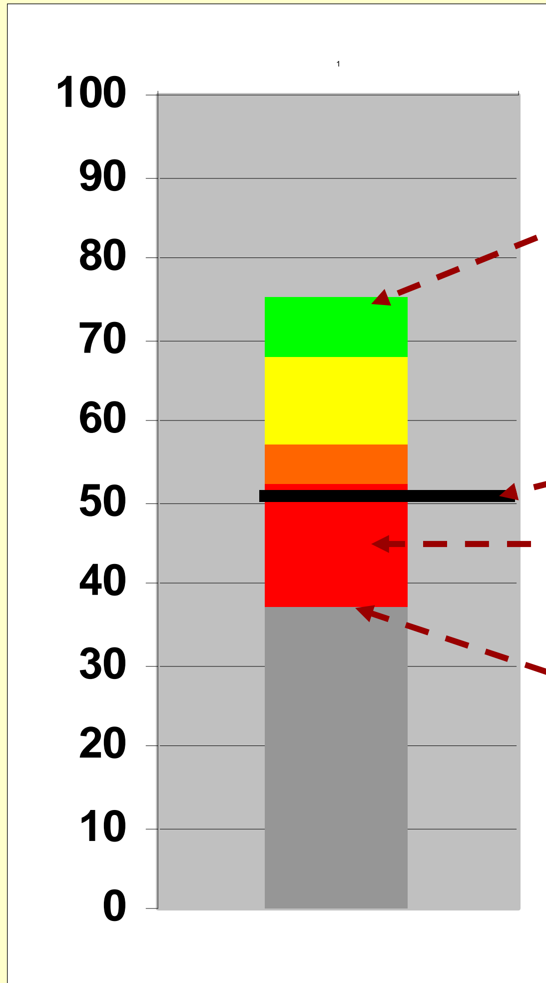
- ❑ Outcome Measure completion
- ❑ Waiting times for counselling
- ❑ Intake into counselling
- ❑ Planned endings
- ❑ Clinical effectiveness
- ❑ Risk assessment



What is a Performance Indicator or Benchmark ?

% patients achieving clinical & reliable change

A specific measure of service performance



Highest performing service

Implicit message “green = good”

National Average

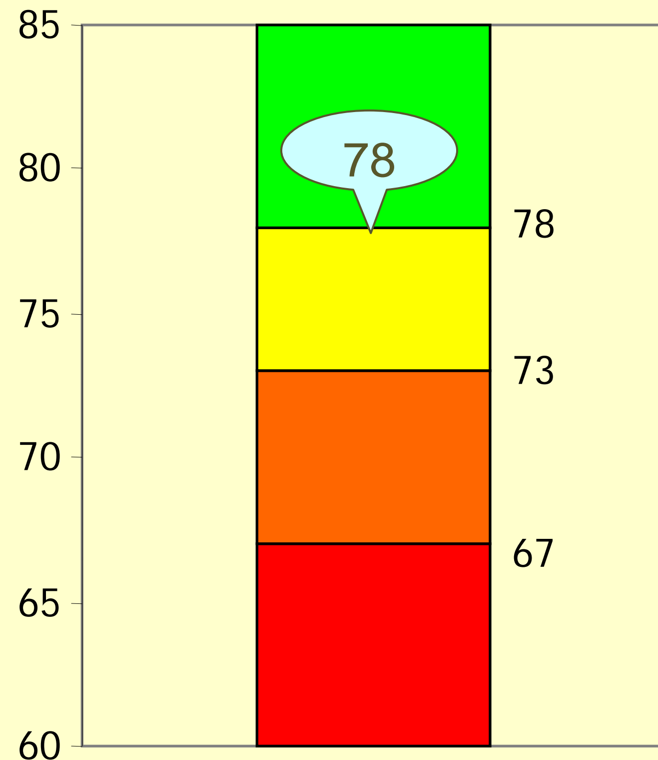
Performance of lowest 25% of services

Lowest performing service

“Thermometer” comparing performance of 43 services (primary care counselling)

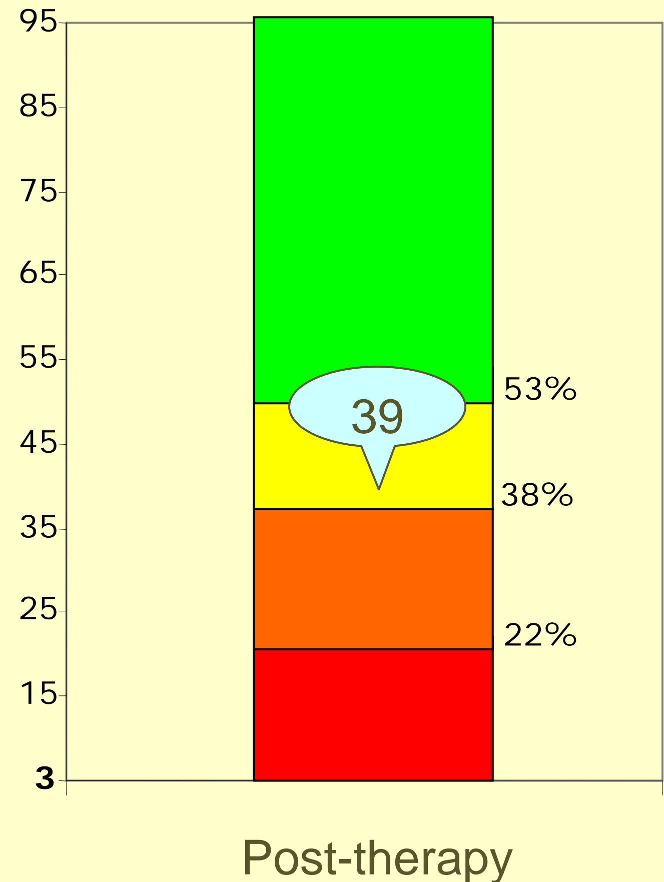
Benchmarking Recovery & Improvement

Mullin T, Barkham M, Mothersole G, Bewick BM, Kinder A (2006). Recovery and improvement benchmarks in routine primary care mental health settings. *Counselling & Psychotherapy Research, 6,* 68-80. [B]



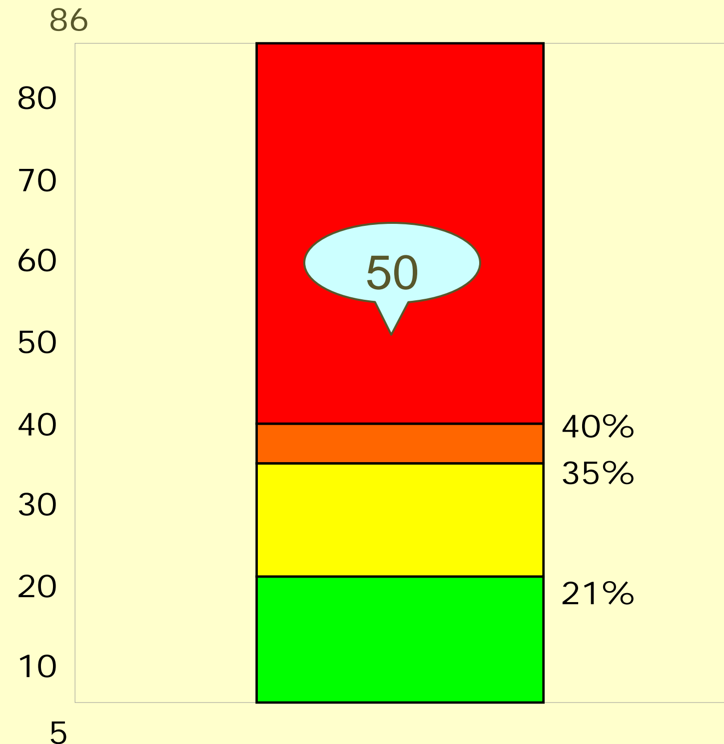
Benchmarking Outcomes Measurement

Bewick, B. M., Trusler., K., Mullin, T., Grant, S., Mothersole, G. (2006). Routine outcome measurement completion rates of the CORE-OM in primary care psychological therapies and counselling. Counselling & Psychotherapy Research, 6(1): 50-59.



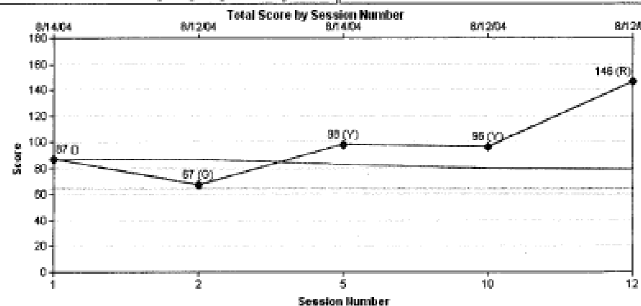
Benchmarking Treatment Pathways

Connell J, Grant S, Mullin S (2006). Client initiated termination of therapy at NHS primary care counselling services. *Counselling & Psychotherapy Research, 6,* 60-67



Why CORE Net?

Outcomes Management



Name:	Jones, Meridith	**ID:**	32685423
Session Date:	8/12/2004	**Session:**	12
Clinician:	Admin, APCS	**Clinic:**	Clinic A
Diagnosis:	Chemical Dependency		
Algorithm:	Empirical		

Alert Status:	**Red**
Most Recent Score:	146
Initial Score:	87
Change From Initial:	Reliably Worse
Current Distress Level:	High

Most Recent Critical Item Status:

Item	Response
8. **Suicide** - I have thoughts of ending my life.	**Almost Always**
11. **Substance Abuse** - After heavy drinking, I need a drink the next morning to get going.	**Almost Always**
26. **Substance Abuse** - I feel annoyed by people who criticize my drinking.	**Frequently**
32. **Substance Abuse** - I have trouble at work/school because of drinking or drug use.	**Almost Always**
44. **Work Violence** - I feel angry enough at work/school to do something I might regret.	**Almost Always**

Subscales	Current	Outpat. Norm	Comm. Norm
Symptom Distress:	82	49	25
Interpersonal Relations:	31	20	10
Social Role:	33	14	10
Total:	**146**	**83**	**45**

Graph Label Legend:
(R) = Red: High chance of negative outcome (Y) = Yellow: Some chance of negative outcome
(G) = Green: Making expected progress (W) = White: Functioning in normal range

Feedback Message:
The patient is deviating from the expected response to treatment. They are not on track to realize substantial benefit from treatment. Chances are they may drop out of treatment prematurely or have a negative treatment outcome. Steps should be taken to carefully review this case and identify reasons for poor progress. It is recommended that you be alert to the possible need to improve the therapeutic alliance, reconsider the client's readiness for change and the need to renegotiate the therapeutic contract, intervene to strengthen social supports, or possibly alter your treatment plan by intensifying treatment, shifting intervention strategies, or decide upon a new course of action, such as referral for medication. Continuous monitoring of future progress is highly recommended.

Figure 2. OQ-Analyst screen shot illustrating feedback graph and report of patient progress. OQ = Outcome Questionnaire.

Journal of Clinical Psychology

Vol 61 Issue No 2 Feb 2005

"Enhancing psychotherapy outcome through feedback"

Michael J Lambert (Ed)

8 papers

www.interscience.wiley.com

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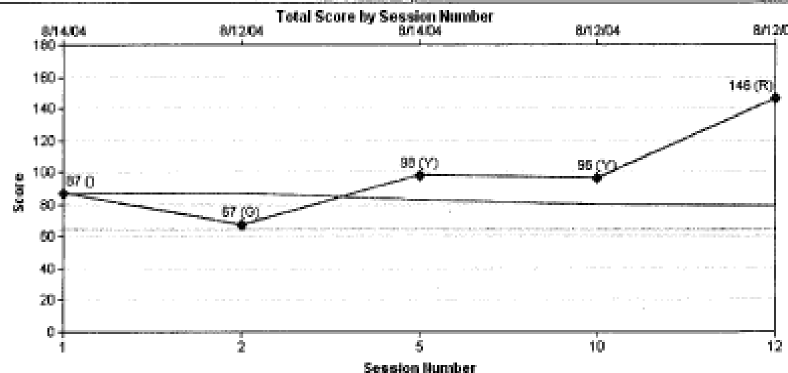

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Figure 2. OQ-Analyst screen shot illustrating feedback graph and report of patient progress. OQ = Outcome Questionnaire.

Within the 20-30% of clients 'not on track' rapid clinical feedback results in :-

- **Significant reduction in % of patients deteriorated at end of therapy**
- **Significant increase in % of patients improved (who would otherwise not have changed)**
- **In some studies the number of clients in that 'not on track' group who achieved a successful outcome doubled**

The Partners for Change Outcome Management System

Scott D. Miller and Barry L. Duncan
Institute for the Study of Therapeutic Change

Ryan Sorrell
Resources for Living

George S. Brown
Center for Clinical Informatics

A number of systems provide feedback regarding client progress and experience of the therapeutic alliance to clinicians. Available evidence indicates that access to such data improves retention and outcome for clients most at risk for treatment failure. Over the last several years, the team at the Institute for the Study of Therapeutic Change has worked to develop an outcome management system that not only provides valid and reliable feedback, but also is as user-friendly as possible for therapists and consumers. In this article, we describe the system and summarize current research findings. © 2004 Wiley Periodicals, Inc. J Clin Psychol/In Session 61: 199–208, 2005.

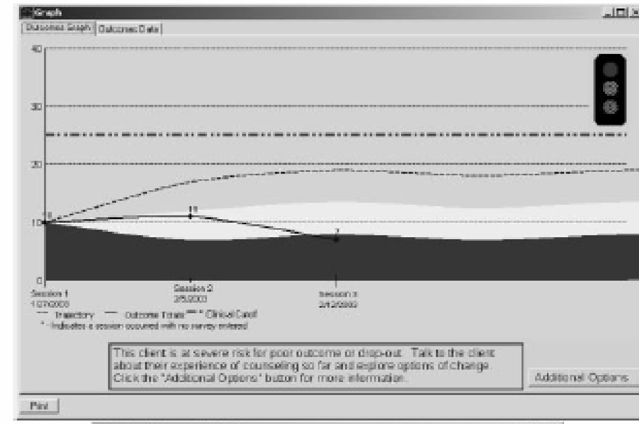
Keywords: psychotherapy; therapeutic alliance; outcome measurement

> What can be done with fewer means is done in vain with many.
> —William of Ockham

More than any previous time in the history of the field, policy makers and payers are stridently insisting that therapists and the systems of care in which they operate must "deliver the goods." Accountability is the watchword of the day, and "return on investment" the guiding metric. Like it or not, psychotherapy has become a commodity and those footing the bill want proof of the effectiveness and value of the product being purchased.

A special thanks to Mark Hubble, Ph.D. for his valuable editorial review and suggestions.
Correspondence concerning this article should be addressed to: Scott D. Miller, Ph.D., Institute for the Study of Therapeutic Change, P.O. Box 578264, Chicago, IL 60657-8264; e-mail: scottdmiller@talkingcure.com.

JCLP/In Session, Vol. 61(2), 199–208 (2005)
© 2005 Wiley Periodicals, Inc.
Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/jclp.20111



Claimed results :-

- **Outcome effectiveness improved by up to 65%**
- **DNA's reduced by 40%**
- **Cancellations reduced by 25%**
- **Number of sessions reduced by 40%**

Implementation of a Feedback System in a Managed Care Environment: What Are Patients Teaching Us?

George S. Brown
Center for Clinical Informatics

Edward R. Jones
PacifiCare Behavioral Health

Lessons about patient treatment response from a large-scale outcomes management project are summarized. More than 7,000 clinicians contributed outcome data. Overall, the data demonstrated that patients who have clinical levels of psychological distress and impairment showed a relatively rapid response to treatment. Furthermore, although it appears that the duration and intensity of treatment vary widely from case to case, clinicians and patients make sound judgments as to how much and what kind of treatment is appropriate. Results supported the conclusion that the most effective method to manage costs is to ensure that each patient receive effective care. There are large and stable differences in the effectiveness of clinicians, and outcomes can be improved by referring patients to effective clinicians. The data also suggested that patients who had a poor initial response to treatment eventually had positive outcomes, provided that they remained engaged in treatment. This finding suggests that outcomes can be improved by identifying at-risk patients and proactively keeping them engaged in treatment. © 2004 Wiley Periodicals, Inc. J Clin Psychol/In Session 61: 187–198, 2005.

Keywords: psychotherapy effectiveness; managed care; feedback; psychotherapy research; treatment duration; Outcome Questionnaire-30

The purpose of a feedback system in a managed care environment is to improve treatment outcomes measurably among clinicians providing treatment as usual in the community. In order to achieve this goal, it is necessary to understand what drives outcomes in the real world of managed care.

Correspondence concerning this article should be addressed to: G.S. (Jeb) Brown, Ph.D., Center for Clinical Informatics, 1821 Meadowmoor Drive, Salt Lake City, UT 84112; e-mail: jebbrown@clinical-informatics.com.

JCLP/In Session, Vol. 61(2), 187–198 (2005) © 2005 Wiley Periodicals, Inc.
Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/jclp.20110

For clients doing well

Treatment length is shorter

80% patients get 1 session less

"Don't over treat relatively healthy clients"

For clients identified as potential treatment failures (20%)

20% get average 3 sessions more

20% of the potential failures achieve improved outcomes

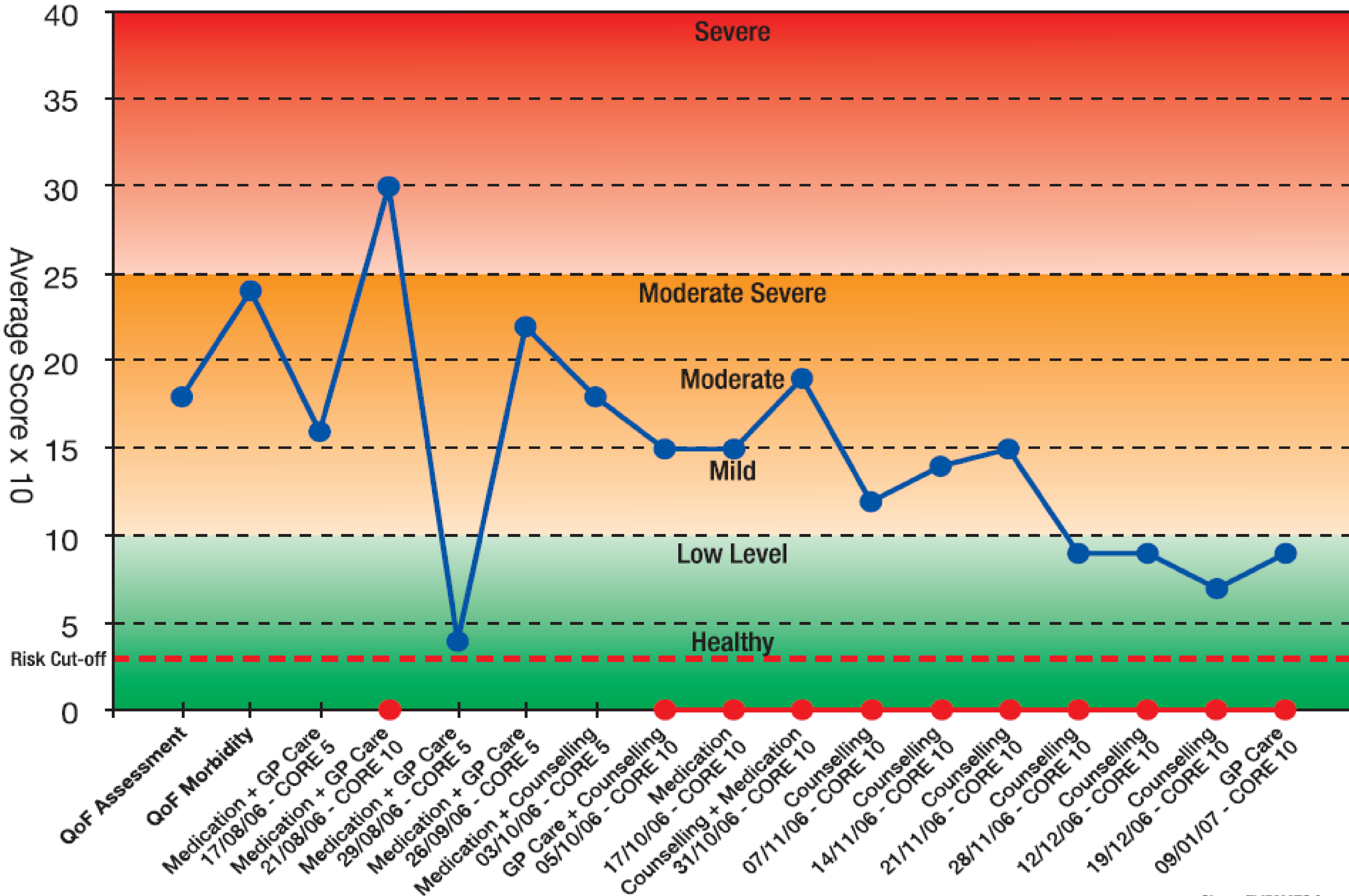
"Don't under treat clients who are relatively ill"

3:08.07
TANDEM COMPUTERS

12:07

ACCOSON

XENICAL


CORE Information Management Systems Ltd
CORE Net: The Two Minute Assessment Tool
visit www.coreims.co.uk for a demonstration and more information
Average Score x 10
40
35
30
25
20
15
10
5
0
Risk Cut-off
Severe
Moderate Severe
Moderate
Mild
Low Level
Healthy
QoF Assessment
QoF Morbidity
Medication + GP Care 17/08/06 - CORE 5
Medication + GP Care 21/08/06 - CORE 10
Medication + GP Care 29/08/06 - CORE 5
Medication + GP Care 26/09/06 - CORE 5
Medication + Counselling 03/10/06 - CORE 5
GP Care + Counselling 05/10/06 - CORE 10
Medication 17/10/06 - CORE 10
Counselling + Medication 31/10/06 - CORE 10
Counselling 07/11/06 - CORE 10
Counselling 14/11/06 - CORE 10
Counselling 21/11/06 - CORE 10
Counselling 28/11/06 - CORE 10
Counselling 12/12/06 - CORE 10
Counselling 19/12/06 - CORE 10
GP Care 09/01/07 - CORE 10

Patient Presents –

Clinician suspects' depression or mental health issue
CORE 10 Assessment of severity and risk completed (>17 QOF claim)
Assessment 1

CORE 10 ASSESSMENT RESULT (influenced by clinical opinion)

Score 10-15	Score 15-20	Score 20 +	Complex/ High Risk
Options Watchful Waiting Stepping Stones Books on Prescription Wigan in Mind cCBT Steps for Health Bibliotherapy Self Help	**Options** PC Graduate Worker - Guided Self Help **Signpost to**: DIAS. Relate Self-Help Clinic Occupational Therapy ETC	**ALW PCT** Risk assessment, if risk is high If no risk, Watchful Waiting Offer all services in mild to moderate box and review	**Consider: Complex** Primary Care Liaison Nurse **High Risk:** Locality Mental Health Team/ Crisis Resolution/Mental Health Act assessment (Referral protocols to be agreed Tel 01942????)

Menu

User: admin

Sign Out

Patient List

Patient KitTest

Consultation Info

Patient ID KitTest

Consultation Details

Session Date 17/04/2007 Hr

Status Attended

Staff Member CP-PC

Sub codes

Treatment Code 1 none

Treatment Code 2 none

Which Core Outcome Measure do you want for this consultation?

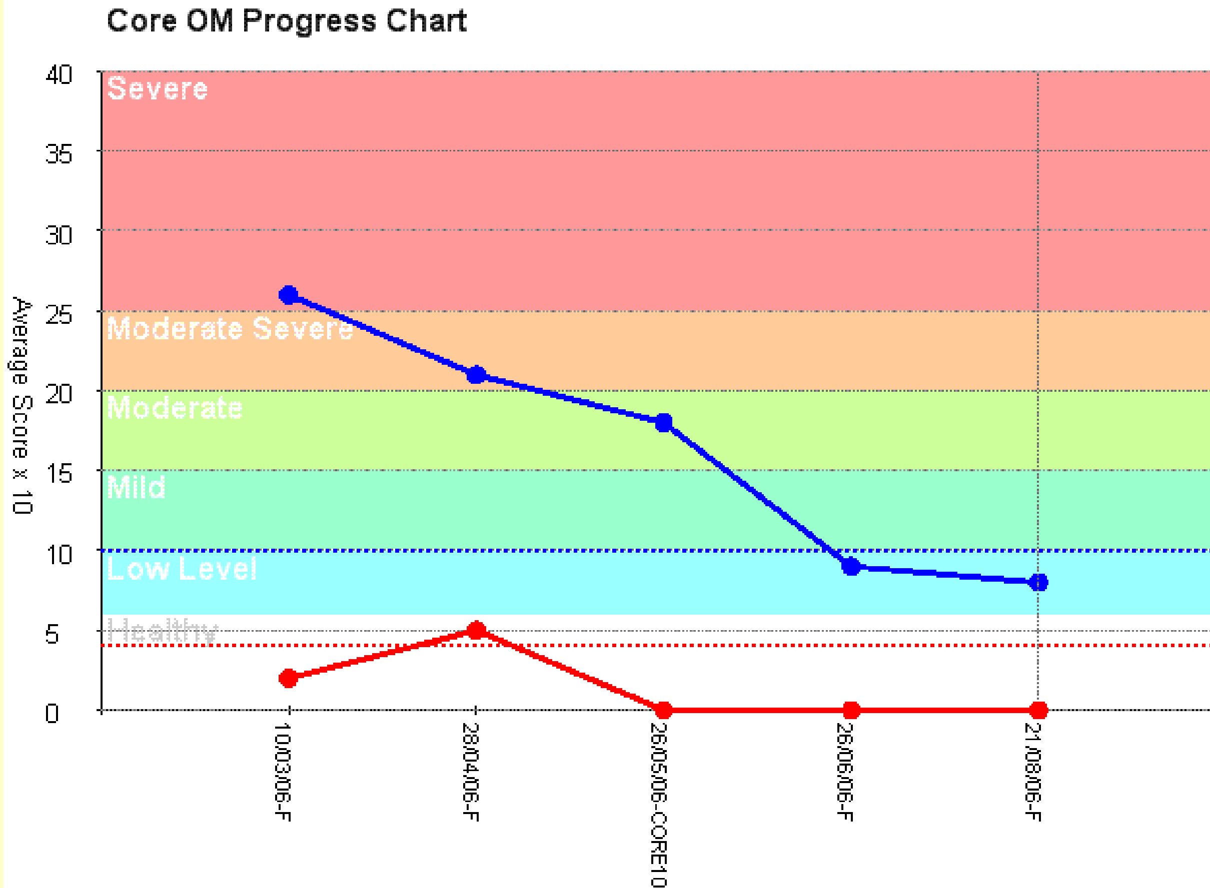
Screening Measure - 10 Question

What screen do you want to go to next?

- (●) Outcome Measure for the patient to complete now
- ( ) Outcome Measure where I can enter the answers from a paper form
- ( ) This patient's home page

Save and Continue

Core Net case example (A2)



A typical case of an appropriate referral for primary care counselling.

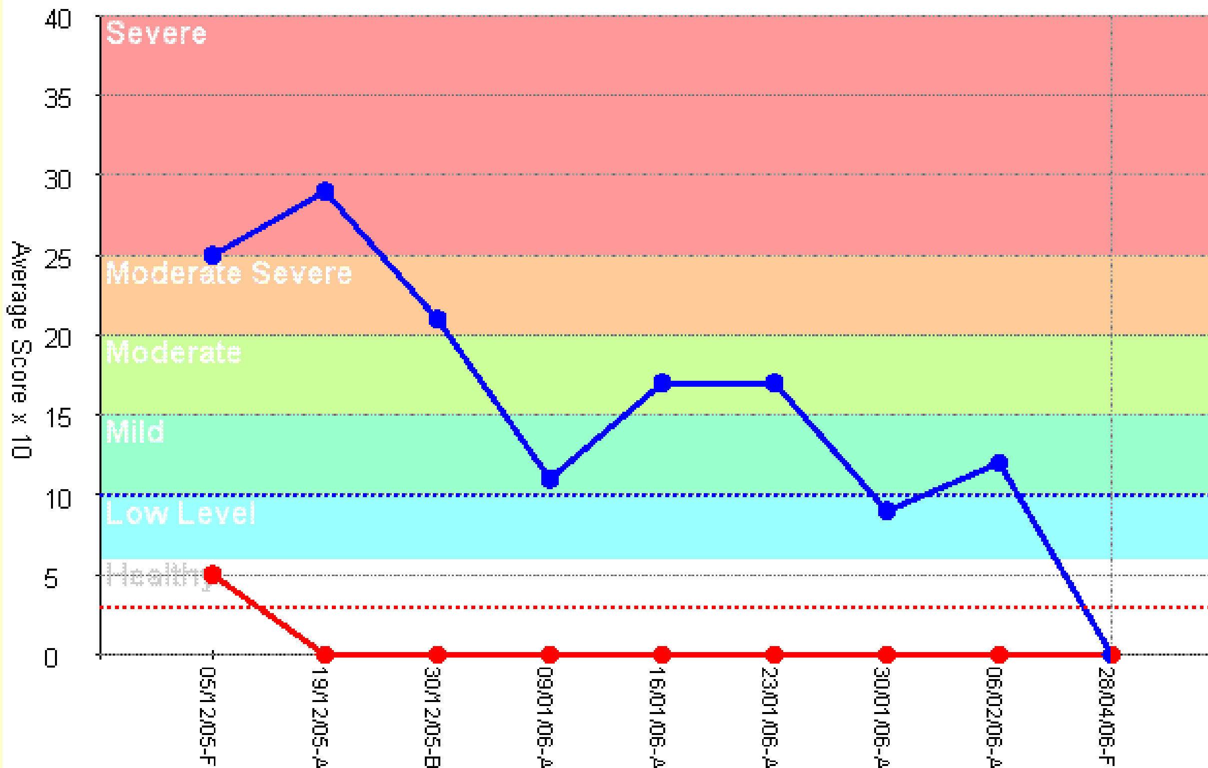
A person with no previous history of psychological difficulty experiences a job loss with subsequent consequences for self esteem and self image. The person struggles to come to terms with this and is referred by the GP to 'talk things through'.

In five sessions of counselling they make a steady week on week improvement and cross the clinical cut-off line indicating 'clinical and reliable improvement'

The client themselves says 'I don't think I need any more sessions' and later got in contact to say they had got another job and were continuing to feel good.

These sorts of curves are quite typical of simple, single issue cases, that respond well to brief counselling in a primary care setting. They have become known as 'ski slope' trajectories because of the characteristic curve.

Core Net case example (A8)



A typical primary care referral by a GP of a person who has been experiencing depressive symptoms for a couple of years. They are deeply unhappy and feel it is 'all their fault'.

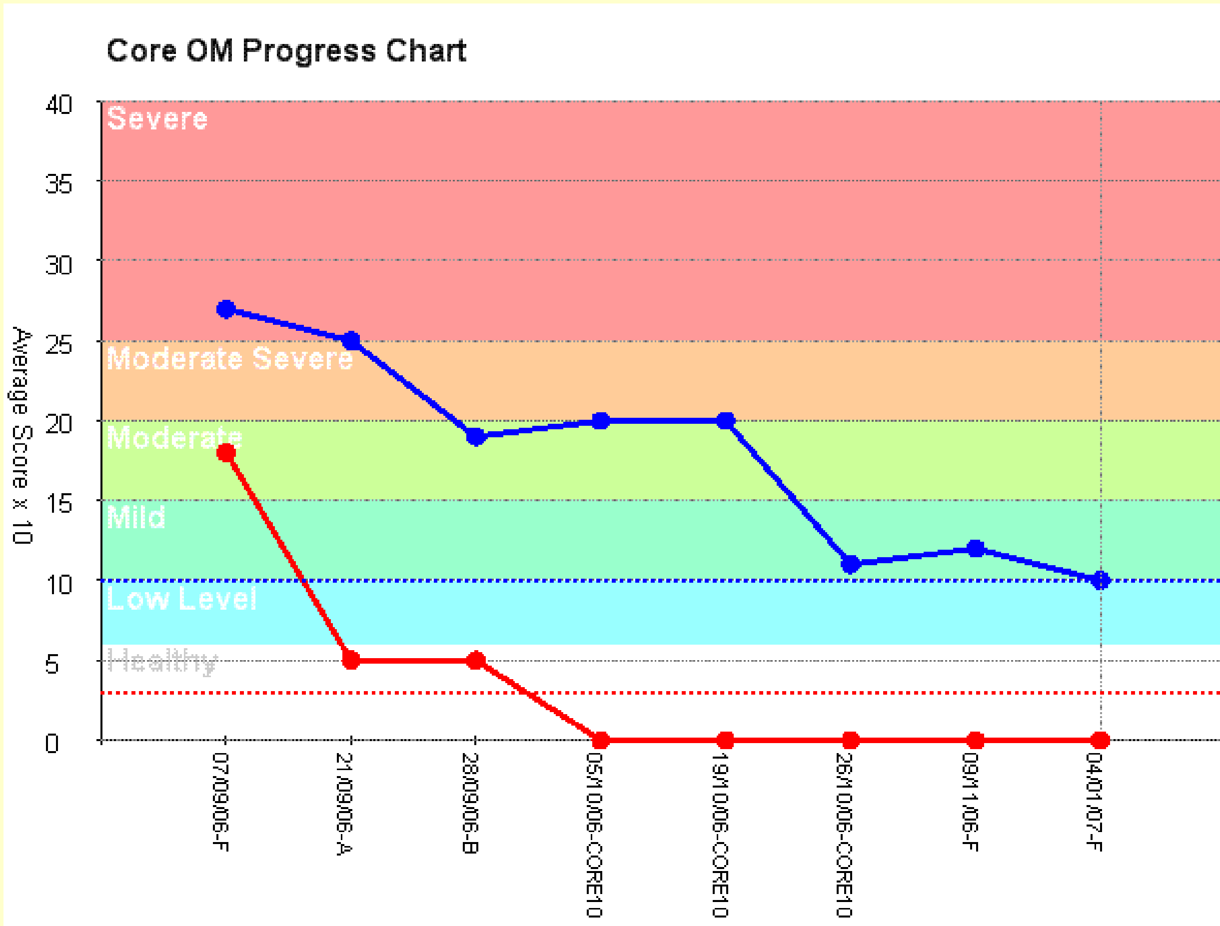
Attends weekly counselling sessions and it quickly emerges the person lives in an abusive marriage and is frightened. After the first session the score goes up as they face up to their situation. The client decides to leave the relationship and their mood steadily improves while they develop a plan and the courage to do make the break.

In the middle of the chart the score begins to rise again when the partner to the client becomes increasingly abusive on discovering the client is leaving them.

The score drops again after the client has actually left and begins to consolidate their new situation.

Seen for ten sessions in total and measures taken on nine of these. The last measure is a three month follow up when the client reports feeling the 'best they have for years' and their score has dropped to zero. Client made contact a year later to express thanks and say they were continuing to do well.

Core Net case example (A9)



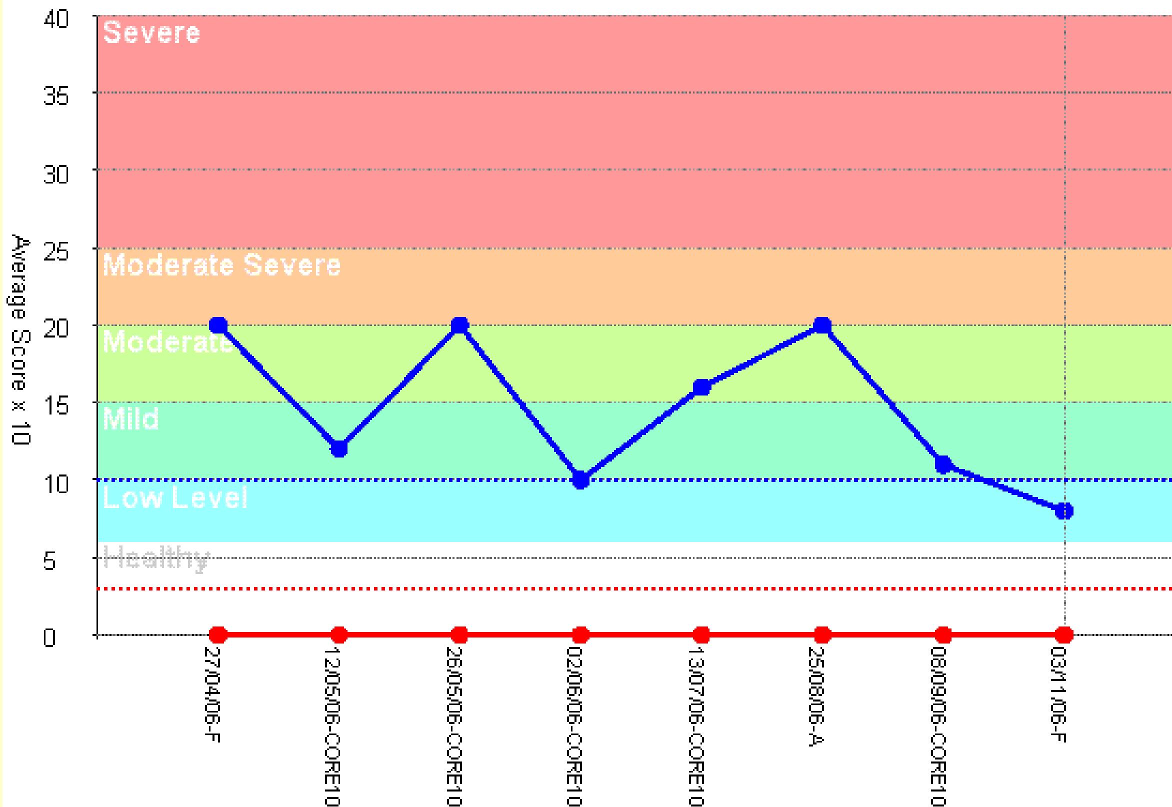
A GP referral of person with severe anxiety and depression. Client has an unsupportive partner and two teenage children that are highly challenging.

Initial risk score is high and admits to stockpiling medication and having frequent impulsive thoughts of killing their self. The initial work focuses on a reducing risk and developing practical support.

The work continues on, to explore family dynamics and underlying beliefs and personality style. Client begins to practice a more assertive parenting style and starts to feel more in control. As mood steadily improves so does their ability to communicate more effectively with the family. Client becomes aware of how their personality style makes them vulnerable to being bullied.

Seen for nine sessions in all and measures taken on eight of these. The last measure is a two month follow-up and client reports that life is much improved and they no longer experience suicidal thoughts.

Core Net case example (B1)



An apparently typical GP referral in which a person is referred with relationship difficulties and chronic depressive symptoms, but practice turns out to be more complex.

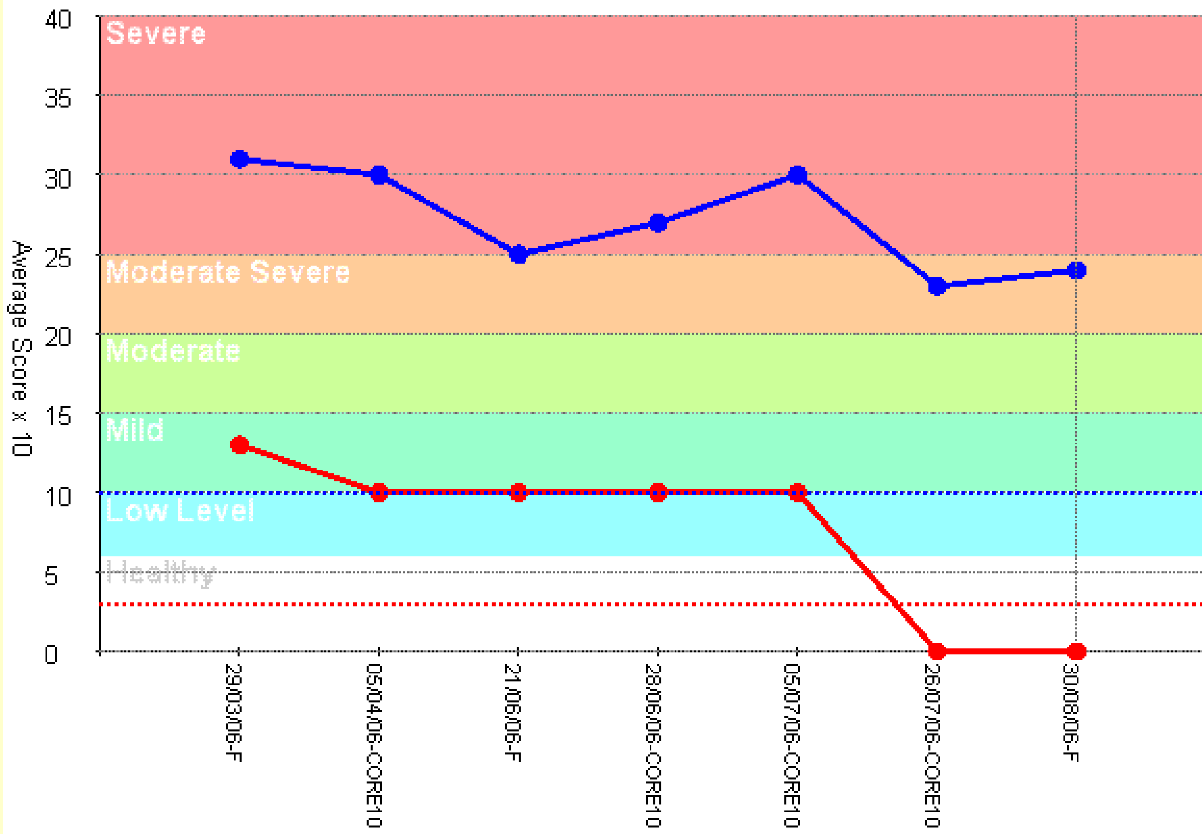
Counselling initially focussed on relationship dynamics where it emerged that they had a loving partner who found it difficult to cope with the clients rapid mood changes and so had progressively withdrawn from the client.

As the client engaged more deeply in counselling, a pattern of idealising and devaluing emerged along with other characteristics consistent with 'borderline personality difficulties'.

We reflected together on the frequent fluctuations in CORE scores and this seemed to help the client gain an external perspective on their difficulty in regulating mood state.

Met for eleven sessions in total and took eight measures. The last measure is a two month follow-up at which they reported a range of improvements including returning to work. However there was also acknowledgment of ongoing mood instability and so discussed how they might seek longer term specialist therapy.

Core Net case example (B3)

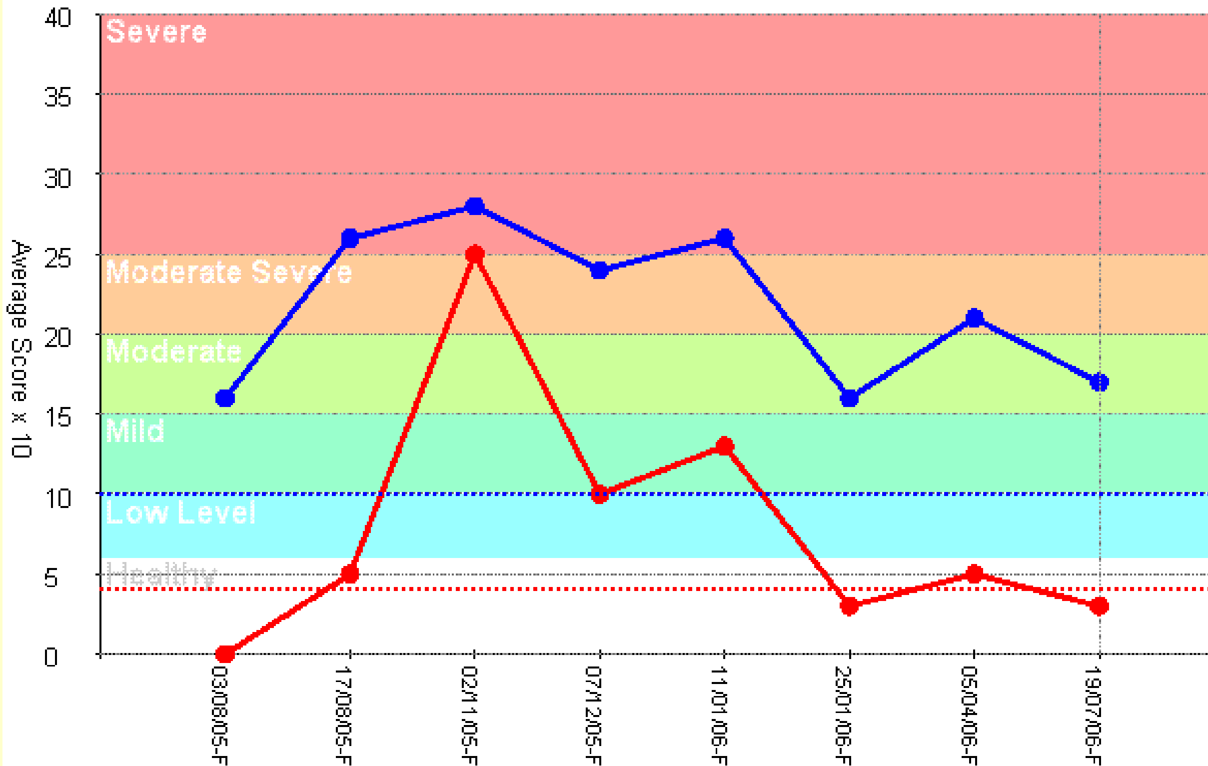


A complex case of severe long term depression that had been managed by the GP with anti-depressant medication. The client was very resistant of engaging with secondary care services but had agreed to 'try' counselling.

Was seen for 14 sessions in all and measures were taken on 7 of these. Client was difficult to engage and expressed significant suicidal ideation. Early work focussed on building the therapeutic alliance and risk management. As trust and rapport was established we began to develop a meta perspective of the many problems, past and present. This led to a willingness to engage with some practical problem solving of immediate crises. Success with this led to a raising of the clients sense of hope and a willingness to further engage with professional agencies.

The main impact of the work was to reduce risk and help the client to consider the value of making a commitment to engaging with longer term specialist services. Eventually they agreed to a referral to secondary care.

Core Net case example (B4)



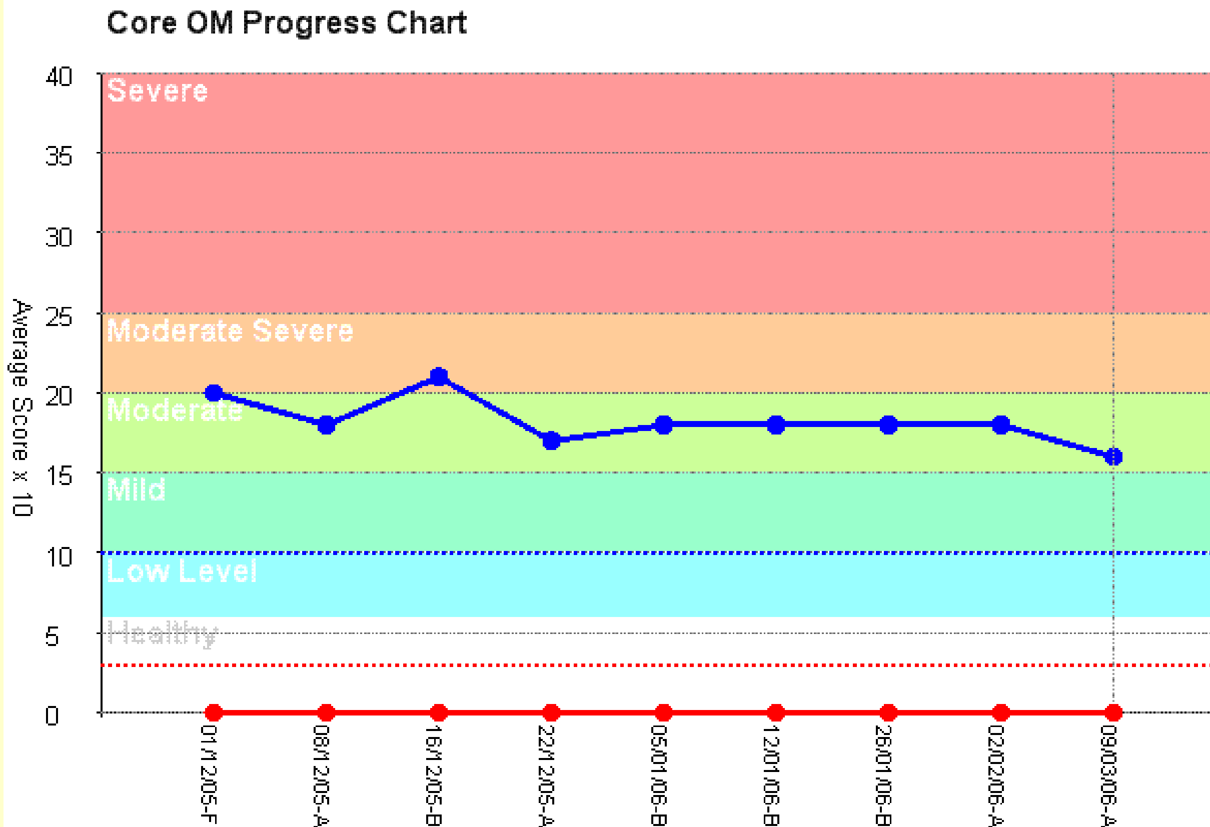
A PTSD case initially referred because of depression and problems at work. This however turned out to be a rather more complex case needing a specialist psychiatric assessment and subsequent referral for both EMDR and CBT

In the early stages the client was fearful & paranoid and scored relatively low on the CORE scale and apparently with no risk, however as trust and rapport was gained the client admitted to not answering the questionnaire honestly at first for fear they might be 'locked up'.

Involved in a serious road accident a year earlier the client had sustained major injuries resulting in chronic pain and severe PTSD symptoms. This seemed to be further complicated by underlying personality difficulties and a ridged belief system.

In due course the client agreed to a psychiatric assessment and my role became one of facilitating the transition to specialist therapy. The focus of our work became one of developing strategies to help cope with strong suicidal thoughts. In this regard the risk score was a particularly useful aid. Supervision was a significant feature of managing this complex case.

Core Net case example (C2)



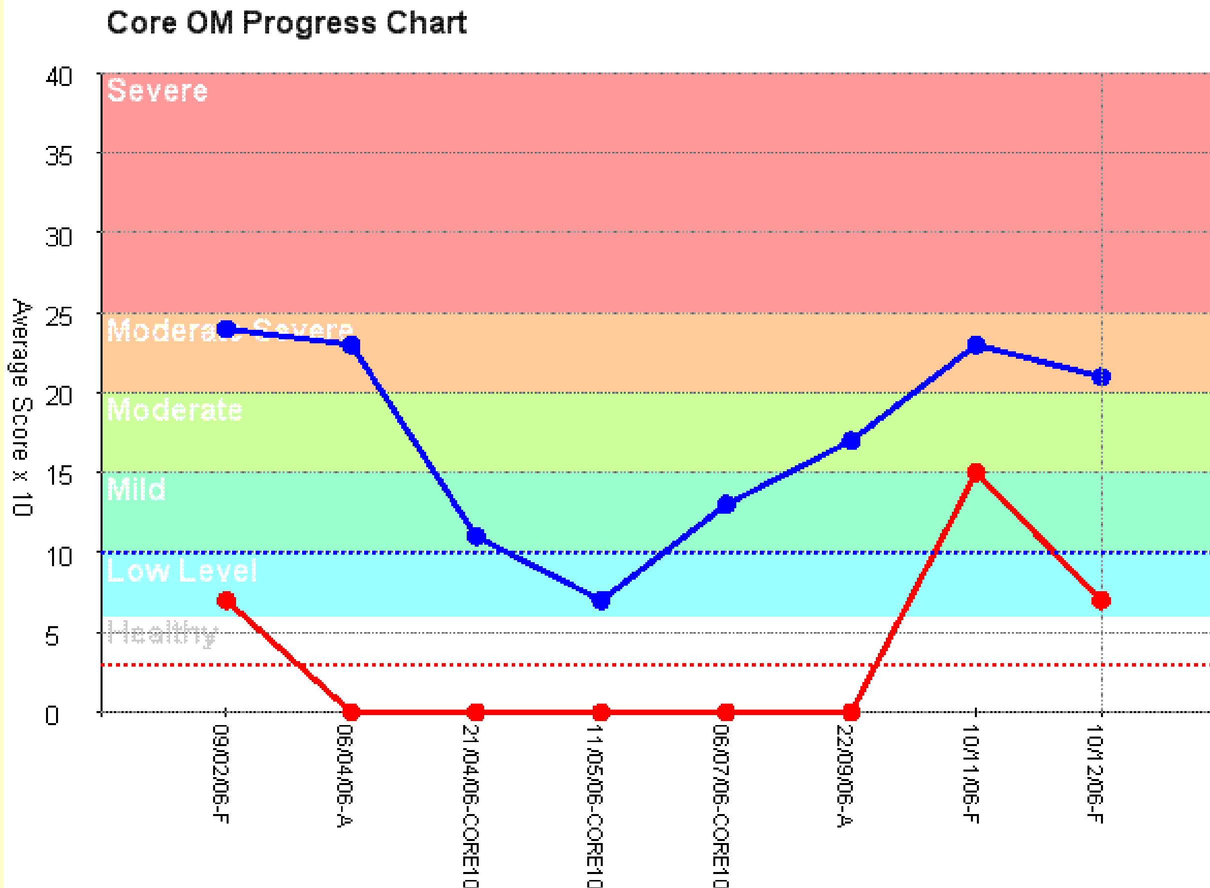
The case of a person referred with chronic depression and relationship difficulties.

Engaged well and was keen to have counselling but proved to be low on psychological mindedness and have little capacity for self awareness. Continually externalised problems and could only see their self as a 'victim'.

In all had eleven sessions of counselling which as the chart shows had very little impact, although they clearly 'enjoyed' coming to counselling and expressed much appreciation.

On reflection this is a case where I continued to offer sessions even though it was apparent they were making no impact. By seeing this pattern on a few other cases it has increased my awareness of treatment failure early on in the process. I subsequently learnt to close such cases sooner.

Core Net case example (D3)



A case of moderately severe, recurrent depression in which the client had refused medication and would not engage with secondary care. Was referred for counselling by GP.

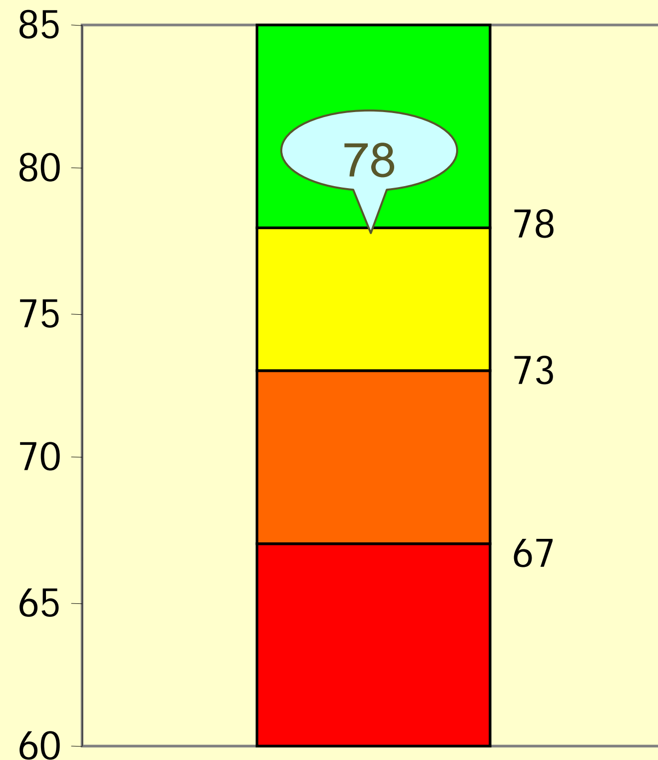
Seen for eleven sessions across a nine month period. Eight measures were taken in all.

The client made reference at assessment to a 'seasonal' pattern to their depression. However they initially responded well to six sessions of problem solving and basic CBT and by May was much improved. Agreed to follow-up sessions to review progress through the year where upon it was apparent that the client was progressively reverting to their former depressed state.

Reflecting on the chart was useful to the client in helping to acknowledge the need for a more specialist assessment by secondary care. The client also began to accept anti-depressant medication from the GP. Unfortunately no more CORE data is available to track the progress over a longer period or to see the relative effect of medication or whether there was indeed a seasonal factor to this case.

Benchmarking Recovery & Improvement

Mullin T, Barkham M, Mothersole G, Bewick BM, Kinder A (2006). Recovery and improvement benchmarks in routine primary care mental health settings. *Counselling & Psychotherapy Research, 6,* 68-80. [B]



putting quality at the **heart** of therapy