Developing Adaptive Health Interventions
Getting SMART

Daniel Almirall\(^1,2\) Scott N Compton\(^3\)
Susan A Murphy\(^1,2,4\)

\(^1\)Institute for Social Research, University of Michigan
\(^2\)The Methodology Center, Penn State University
\(^3\)Psychiatry and Behavioral Sciences, Duke University Medical Center
\(^4\)Department of Statistics, University of Michigan

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Outline

Adaptive Interventions
What? Why?

Evaluating versus Building an Adaptive Intervention?

Sequential Multiple Assignment Randomized Trial (SMART)
What are SMARTs?

SMART Design Principles
Keep it Simple
Choosing Primary and Secondary Hypotheses

Discussion
Definition: An Adaptive Intervention is

- a sequence of individually tailored decision rules
- that specify whether, how, and/or when
- to alter the intensity, type, dosage, or delivery of treatment
- at critical decision points in the course of care.

Adaptive Interventions operationalize sequential decision making with the aim of improving clinical practice.
Concrete Example of an Adaptive Intervention
Pediatric Anxiety Example (SAD, GAD, SoP)

Goal is to minimize the child’s symptom profile/trajectory.
What makes up an Adaptive Intervention?

1. Critical decisions: treatment options and more
2. Tailoring variables: to decide how to adapt treatment
3. Decision rules: inputs tailoring variable, outputs one or more recommended treatments

Also known as: dynamic treatment regimes, adaptive treatment strategies, treatment algorithms, structured treatment interruptions (HIV/AIDS), practice parameters (child psych.), ASAM PPC, stepped care intervention models...
Example: A More Richly-tailored Adaptive Intervention

Tailoring Variable at Intake
- Sub-dx for Generalized Anxiety Disorder
- Sub-dx for Social Phobia or Separation Anxiety Disorder

First-line Txt: Weeks 0-12
- CBT
  - Full Responder if CGI = 1
  - Partial Responder if CGI = 2
  - Non-responder if CGI > 2
  - F or P Responder
  - Non-Responder

Wk12 Tailoring Variables:
- Full Responder if CGI = 1
- Partial Responder if CGI = 2
- Non-responder if CGI > 2

Second-line Txt: Weeks 12-24
- Maintain: CBT (Boosters)
- Augment: CBT+MED
- Step Down: CBT (Boosters)
- Maintain: CBT+MED
- Augment: CBT+MED+FT
Why Adaptive Interventions?

Necessary because...

- Chronic nature of substance use/mental health disorders
  - Waxing and waning course (multiple relapse, recurrence)
  - Genetic and non-genetic factors influence course
  - Co-occurring disorders may arise

- High patient heterogeneity in response to treatment
  - Within person (over time) differential response to treatment
  - Between person differential response to treatment
  - Ex: Not all kids need CBT+MED up front

All require sequences of treatment decisions.
GENERATING HYPOTHESES vs BUILDING vs EVALUATING ADAPTIVE INTERVENTIONS?
3 Different Research Questions/Aims

= 3 Different Research Designs

- **Aim 1**: When generating hypotheses to build an Adaptive Intervention: e.g., Does augmenting txt (as observed in a previous trial) for non-responders correlate with better outcomes?

- **Aim 2**: When building an Adaptive Intervention: e.g., What are the best tailoring variables and/or decision rules?

- **Aim 3**: When evaluating a particular Adaptive Intervention: e.g. Does the AI have a statistically significant effect as compared to another AI or TAU/control?
3 Different Research Questions/Aims = 3 Different Research Designs

**Ex. Q1**: Does augmenting txt for non-responders (as observed in a previous trial) correlate with better outcomes?

**Ex. Q2**: What are the best tailoring variables or decision rules?

**Ex. Q3**: Does the Adaptive Intervention have a statistically significant effect as compared to control intervention?

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<th>Aim</th>
<th>Observational Studies</th>
<th>Experimental Studies</th>
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SEQUENTIAL MULTIPLE ASSIGNMENT RANDOMIZED TRIALS (SMARTs)
What is a Sequential Multiple Assignment Randomized Trial (SMART)?

- Multi-stage trials; same participants throughout
- Each stage corresponds to a critical decision point
- At each stage, subjects randomized to set of treatment options
- The goal of a SMART is to inform the development of adaptive interventions.

I will give you an example SMART, but first...
Motivation for an Example SMART
Child-Adolescent Anxiety Multi-modal Study (CAMS)

- CAMS: acute-phase, efficacy, RCT for child anxiety
- CBT+MED > MED ≈ CBT > Placebo
- However, some families and clinicians remain concerned about the use of MED in this population
- So an important next question for clinical practice is “Can we delay the use of MED?” ”If so, for whom?”
- Some children may do fine w/ CBT only and not need MED.
Concrete Example of a SMART: Pediatric Anxiety
Courtesy of Scott N Compton, Duke University Medical Center

- **Add Treatment:**
  - CBT + MED + FT
  - Non-Responders
- **Maintain:**
  - CBT + MED
- **Step Down:**
  - CBT Only
- **Add Treatment:**
  - CBT + MED
- **Maintain:**
  - CBT
- **Switch Treatment:**
  - MED

**Tailoring Variable**
First-line Txt
Second-line Txt
O1
One Adaptive Intervention Within the SMART

CBT + MED

Non-Responders

Add Treatment: CBT + MED + FT
Maintain: CBT + MED
Step Down: CBT Only

Responders

Maintain: CBT
Add Treatment: CBT + MED
Switch Treatment: MED

Non-Responders
Another Adaptive Intervention Within the SMART

CBT + MED
Non-Responders

CBT
Responder
Non-Responders

Add Treatment:
CBT + MED + FT
Maintain:
CBT + MED
Step Down:
CBT Only

Maintain:
CBT
Add Treatment:
CBT + MED
Switch Treatment:
MED
4 Embedded Adaptive Interventions in this SMART

AI 1

CBT + MED

Non-Responders → Add Treatment: CBT + MED + FT

Responders → Step Down: CBT Boost

AI 2

CBT + MED

Non-Responders → Add Treatment: CBT + MED + FT

Responders → Maintain: CBT + MED

AI 3

CBT

Responders → Maintain: CBT Boost

Non-Responders → Add Treatment: CBT + MED

AI 4

CBT

Responders → Maintain: CBT Boost

Non-Responders → Switch Treatment: MED
SMART DESIGN PRINCIPLES
SMART Design Principles

- KISS Principle: Keep It Simple, Straightforward
- Power for simple important primary hypotheses
- Take Appropriate steps to develop an more deeply-individualized Adaptive Intervention
Keep It Simple, Straightforward

Overarching Principle

At each stage, or critical decision point,...

- Use low dimensional summary to restrict subsequent treatments
  - Use binary responder status
  - Should be easy to use in actual clinical practice

- Restrict class of treatment options *only* by ethical, feasibility, or strong scientific considerations

- Collect additional, auxiliary time-varying measures
  - To develop a more deeply-tailored Adaptive Intervention
  - Think time-varying effect moderators
SMART Design: Primary Aims

Choose a **simple primary aim/question** that aids development of an adaptive intervention.

Power the SMART to test this hypothesis.
Primary Aim Example 1
What is the main effect of first-line treatment? End of study outcome (e.g., ANOVA).

CBT + MED | Responders | Non-Responders
---|---|---
Add Treatment: CBT + MED + FT
Maintain: CBT + MED
Step Down: CBT Only

CBT | Responders | Non-Responders
---|---|---
Add Treatment: CBT + MED
Add Treatment: CBT + MED
Switch Treatment: MED

Power
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\[ \alpha = 0.05 \]
\[ \beta = 0.20 \]
Primary Aim Example 2

What is the main effect of first-line treatment? Longitudinal outcome (e.g., LMM).

Add Treatment: CBT + MED + FT
Non-Responders

Maintain: CBT + MED

Step Down: CBT Only

Maintain: CBT

Add Treatment: CBT + MED

Switch Treatment: MED

CBT + MED

Responders

Non-Responders

Power

<table>
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<tr>
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$\rho = 0.60$

$\alpha = 0.05$

$\beta = 0.20$
SMART Design Principles

Do not use Early Non/Response as Primary Outcome

Why choose a longitudinal or end-of-study outcome, or a within-person summary of outcomes over time?

- These are chronic disorders
- Outcome should incorporate time to initial response as a component
- Quick initial relief of symptoms should be valued
- Examples: growth (slope), pre-post change, survival, end of study, AUC
SMART Design: Secondary Aims

Choose **secondary aims/questions** that further develop the Adaptive Intervention and take advantage of sequential randomization to eliminate confounding.
Secondary Aim Examples 1 and 2
Best second-line treatment and second-line treatment tailoring aim.

First-line Txt  ———— O2 + Primary Tailoring Variable  ———— Second-line Txt  —— Y

CBT

→ Non-Responders

R

Add Treatment: CBT + MED
Switch Treatment: MED

O2 = CBT adherence, time to non-response, allegiance with therapist, changes in home environment
Secondary Aim Example 3
Build a more deeply tailored adaptive intervention.

- **O1** = demographics, genetics, sub-diagnoses, co-morbidities, etc...
- **O2** = adherence, time to NR, changes at home, etc...

```
CBT + MED

Non-Responders

Responders

R

CBT

Non-Responders

Responsers

R

R

Add Treatment: CBT + MED + FT
Maintain: CBT + MED
Step Down: CBT Only
Maintain: CBT
Add Treatment: CBT + MED
Switch Treatment: MED

O2 + Primary Tailoring Variable

R
```

- **Add Treatment**: CBT + MED + FT
- **Maintain**: CBT + MED
- **Step Down**: CBT Only
- **Maintain**: CBT
- **Add Treatment**: CBT + MED
- **Switch Treatment**: MED
DISCUSSION
Adaptive Interventions vs Adaptive Designs?

- These ideas are not directly related. Confusing!
- Problem 1: word “design” often used in 2 different ways
  - Intervention design
  - Experimental design
- Problem 2: word “adaptive” often used in 2 different ways
  - Is experimental design adaptive?
  - Is experimental design used to build an adaptive intervention?
Adaptive Interventions vs Adaptive Designs?

- Adaptive interventions are a type of intervention design
- Adaptive experimental designs are a particular type of experimental design
- SMARTs are not Adaptive Experimental Designs
- SMARTs do inform development of Adaptive Interventions
Take Home the Following

- Adaptive Interventions individualize treatment up-front and throughout
- Adaptive Interventions are guides for clinical practice
- SMARTs are used to build better Adaptive Interventions
  - Next trial: SMART-optimized Adaptive Intervention vs. state-of-the-art treatment
- SMARTs do not necessarily require larger sample sizes
- Existing RCTs can be used to begin to learn about adaptive interventions
  - Observational study
Adaptive Treatment for Children with ADHD
PI: Pelham, Florida International University

- **Medication**
  - Responders
  - Non-Responders

- **Behavioral Intervention**
  - Responders
  - Non-Responders

**R**

- Continue Medication
- Increase Medication Dose
- Add Behavioral Intervention
- Continue Behavioral Intervention
- Increase Behavioral Intervention
- Add Medication
Early Trigger for NR: 2+ HDD

Late Trigger for NR: 5+ HDD

8 Week Response

Non-Response

8 Week Response

Non-Response

Treatment for Alcohol Dependence
PI: Oslin, University of Pennsylvania

Naltrexone

TDM + Naltrexone

CBI

CBI + Naltrexone

Naltrexone

TDM + Naltrexone

CBI

CBI + Naltrexone
Thank you! Questions?

Find papers on SMART:
- http://www.lsa.stat.umich.edu/~samurphy/ (Susan Murphy)
- http://methcenter.psu.edu (Linda Collins)

These slides will be posted on my website:
- http://www-personal.umich.edu/~dalmiral/

Email me with questions about this presentation:
- Daniel Almirall: dalmiral@umich.edu
Back Pocket Slides
Hypothesis-generating Observational Studies
Post-hoc Analyses Useful for Building Adaptive Interventions

- Variety of study questions can be examined using data from a previous 2-arm RCT

- Standard observational study caveats apply:
  - No manipulation usually means lack of heterogeneity in txt options (beyond what is controlled by experimentation in original RCT)
  - Some RCTs use samples that are too homogeneous
  - Confounding by observed baseline and time-varying factors
  - Unobserved, unknown, unmeasured confounding by baseline and time-varying factors
There exists a literature for examining the impact of time-varying treatments in observational studies:

- Marginal Structural Models (Robins, 1999; Bray, Almirall, et al., 2006) to examine the marginal impact of observed time-varying sequences of treatment.
- Structural Nested Mean Models (Robins, 1994; Almirall, et al., 2010, 2011) to examine time-varying moderators of observed time-varying sequences of treatment.
- Marginal Mean Models (Murphy, et al., 2001): to examine the impact of observed adaptive interventions.
Early precursors to SMART

- CATIE (2001) Treatment of Psychosis in Patients with Alzheimer’s
- CATIE (2001) Treatment of Psychosis in Patients with Schizophrenia
- STAR*D (2003) Treatment of Depression
Other Alternatives

▶ Piecing Together Results from Multiple Trials
  - Choose best first-line treatment on the basis of a two-arm RCT; then choose best second-line treatment on the basis of another separate, two-arm RCT
  - Concerns: delayed therapeutic effects, and cohort effects

▶ Observational (Non-experimental) Comparisons of AIs
  - Using data from longitudinal randomized trials
  - May yield results that inform a SMART proposal
  - Understand current treatment sequencing practices
  - Typical problems associated with observational studies

▶ Expert Opinion
Why Not Use Multiple Trials to Construct an AI

Three Concerns about Using Multiple Trials as an Alternative to a SMART

1. Concern 1: Delayed Therapeutic Effect
2. Concern 2: Diagnostic Effects
3. Concern 3: Cohort Effects

All three concerns emanate from the basic idea that constructing an adaptive intervention based on a myopic, local, study-to-study point of view may not be optimal.
Why Not Use Multiple Trials to Construct an AI
Concern 1: Delayed Therapeutic Effects, or Sequential Treatment Interactions

Positive Synergy Btwn First- and Second-line Treatments

Tapering off medication after 12 weeks of use may not appear best initially, but may have enhanced long term effectiveness when followed by a particular augmentation, switch, or maintenance strategy.

Tapering off medication after 12 weeks may set the child up for better success with any one of the second-line treatments.
Why Not Use Multiple Trials to Construct an AI

Concern 1: Delayed Therapeutic Effects, or Sequential Treatment Interactions

Negative Synergy Btwn First- and Second-line Treatments

Keeping the child on medication an additional 12 weeks may produce a higher proportion of responders at first, but may also result in side effects that reduce the variety of subsequent treatments available if s/he relapses.

The burden associated with continuing medication an additional 12 weeks may be so high that non-responders will not adhere to second-line treatments.
Why Not Use Multiple Trials to Construct an AI

Concern 2: Diagnostic Effects

Tapering off medication after 12 weeks initial use may not produce a higher proportion of responders at first, but may elicit symptoms that allow you to better match subsequent treatment to the child.

The improved matching (personalizing) on subsequent treatments may result in a better response overall as compared to any sequence of treatments that offered an additional 12 weeks of medication after the initial 12 weeks.
Why Not Use Multiple Trials to Construct an AI

Concern 3: Cohort Effects

- Children enrolled in the initial and secondary trials may be different.
- Children who remain in the trial(s) may be different.
- Characteristics of adherent children may differ from study to study.
- Children that know they are undergoing adaptive interventions may have different adherence patterns.

**Bottom line:** The population of children we are making inferences about may simply be different from study-to-study.