Scaling EBPs in State Systems: The Sisyphean Problem

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The National Context: Healthcare Restructuring and Integration of Mental Health and Primary Care

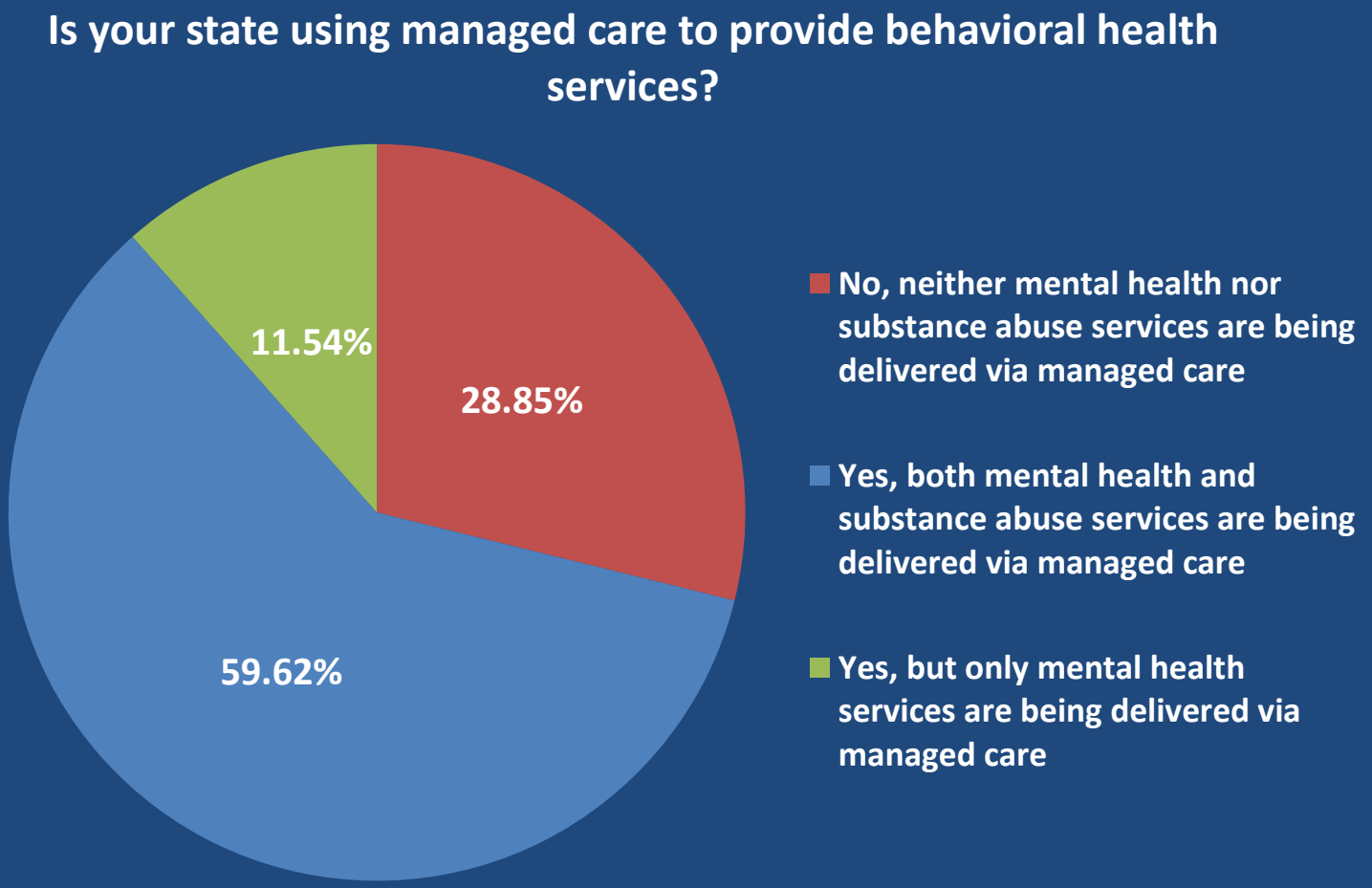
- Important Federal initiatives
  - 2008: Mental Health Parity and Addiction Equity Act
  - 2010: The Patient Protection and Affordability Care Act (PPACA)
- Impact on States
  1. Medicaid Managed Care
  2. Concern with costly services, high end users, access
  3. Growing involvement of consumers
  4. Workforce shortages and task shifting
  5. Health homes and care coordination
  6. Data monitoring, EHRs
  7. Quality measurement
  8. Accountability and outcomes

State Context: Fiscal Crises for State Mental Health Systems[1]

- Budget cuts (mainly State General Funds and Medicaid): FY09-FY12 totaling $4.35 billion
- 76% of 47 state mental health agencies reported budget cuts in 2011
- 73% of 47 state mental health agencies reported budget cuts in 2012
- State mental health agencies' response to budget cuts in 2011-12:
  - 24% reduced community mental health services
  - 27% reduced the number of clients served in the community
  - 39% reduced funds to community providers
  - 52% cut staff
  - 64% had hiring freezes
  - 82% reduced administrative expenses

[1]NASMHPD Research Institute (2012). The impact of the state fiscal crisis on state mental health systems: Winter 2011-2012 update. Available at:
http://www.nri-inc.org/reports_pubs/pub_list.cfm?getby=State%20Systems

State Context: Mental Health Managed Care[2]



[2]NASMHPD Research Institute (2013). State mental health agency profiling system: 2013. Available at: http://www.nri-inc.org/projects/profiles/ProfilesDataReport.cfm?Field=M_1&Year=13&ReportSelect=M_1,%20M_2,%20M_3a,%20M_3b,%20M_3b1,%20M_3c,%20M_3c1,%20M_3d,%20M_3d1&Ptable=P13ManagedCare1

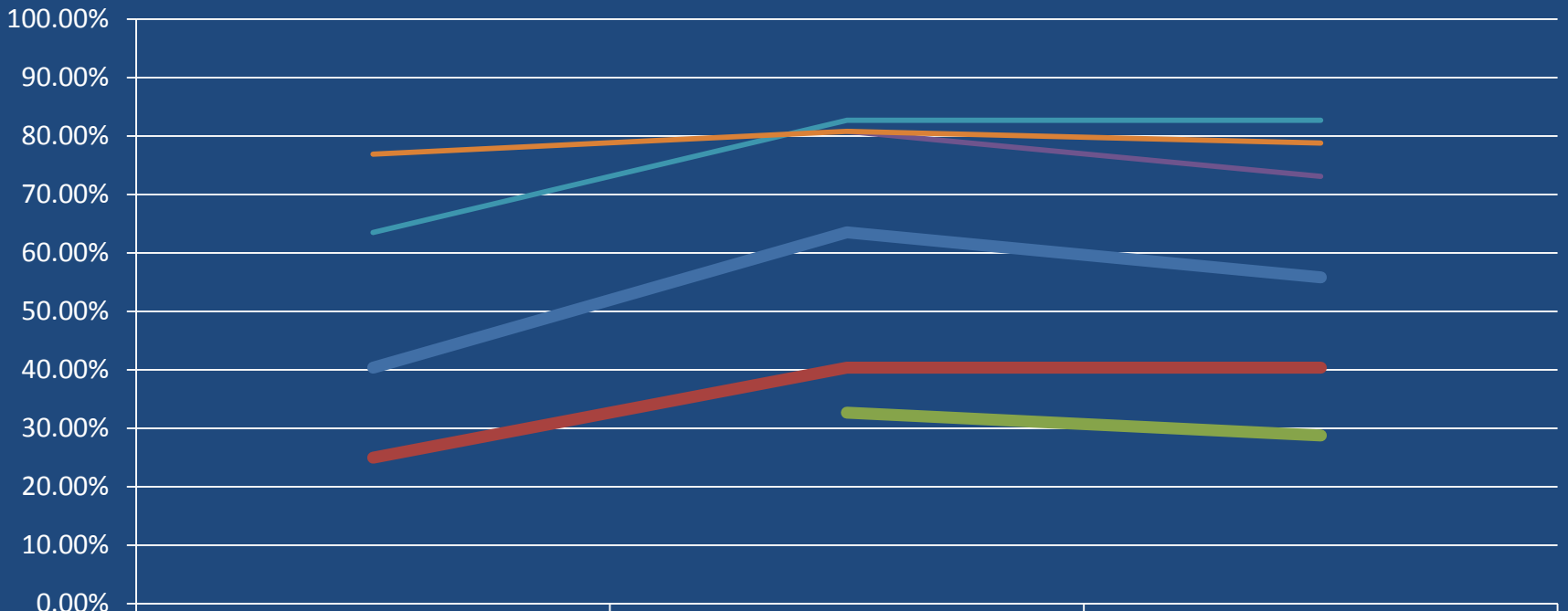
State context: Workforce shortages

- Most severe shortages are in children's mental health[1,2]
- 7,400 practicing child psychiatrists[3]
- 2,606 child psychologists registered in the APA directory[5]
- 93,000 practicing psychologists[4]
- 55% of counties nationally have no practicing psychiatrists, psychologists, or social workers[2]
- 14-15 million children have a diagnosable psychiatric disorder[3]

Trends in State EBP Implementation: Child EBPs vs Adult EBPs (**Preliminary)**

Bruns et al., in progress

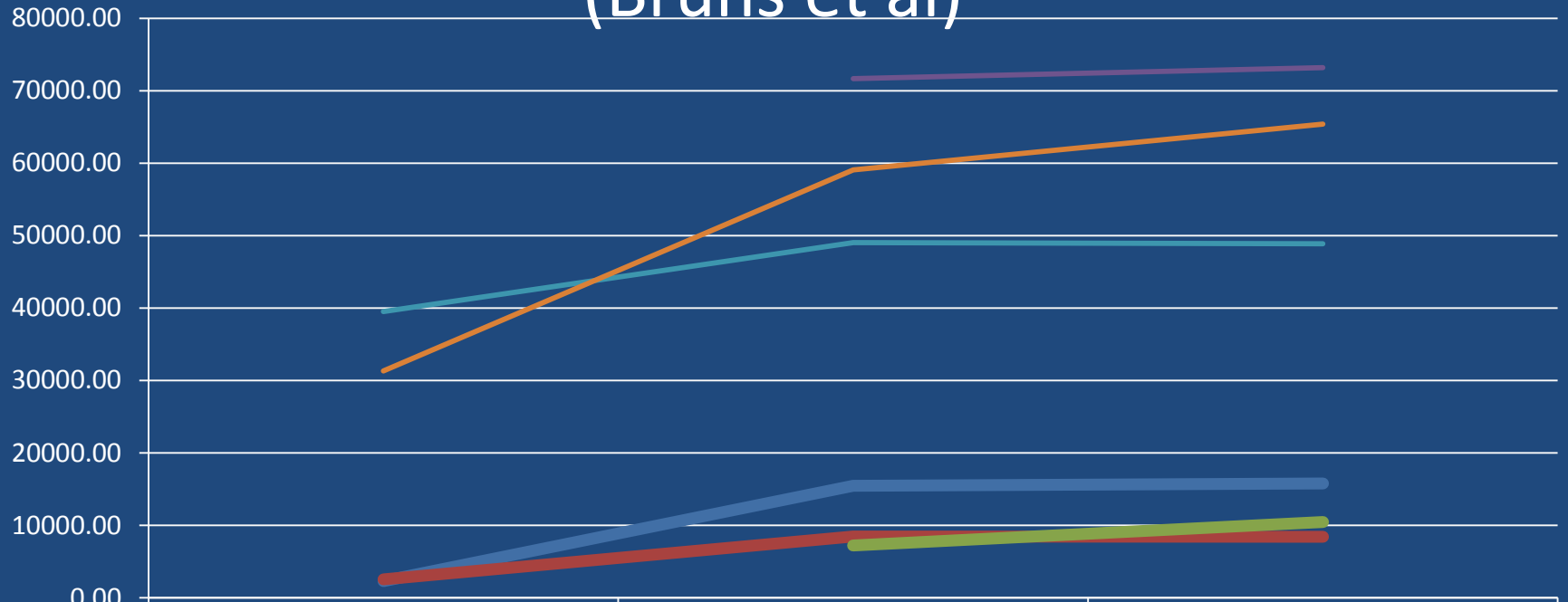
Percent of States Implementing Adult and Child EBPs: Preliminary (Bruns et al)



	2001-4	2007-9	2010-2012
TFC	40.40%	63.50%	55.80%
MST	25%	40.40%	40.40%
FFT		32.70%	28.80%
SH		80.80%	73.10%
SE	63.50%	82.70%	82.70%
ACT	76.90%	80.80%	78.80%

Source: NASMHPD Research Institute State Profile Survey

Total Number of Clients Receiving Adult and Child EBPs: Preliminary (Bruns et al)



	2001-4	2007-9	2010-2012
TFC	2307.00	15448.00	15777.00
MST	2556.00	8487.00	8448.00
FFT		7226.00	10478.00
SH		71674.00	73201.00
SE	39513.00	49029.00	48872.00
ACT	31327.00	59067.00	65383.00

Source: NASMHPD Research Institute State Profile Survey and Uniform Reporting Survey 2001-2012

Initiatives to support EBP implementation

Preliminary: Reported by states on NRI state surveys (Bruns et al)

What initiatives, if any, are you implementing to promote the adoption of evidence-based practices (EBPs)?	--	2001-2004	2009-2012
Awareness/training		84%	100%
Consensus building among stakeholders		92%	100%
Incorporation in contracts		60%	94%
Monitoring of fidelity		64%	94%
Financial incentives		36%	68%
Modification of IT systems & data reports		58%	88%
Specific budget requests		48%	70%

Use of Research Data

Preliminary: Reported by states on NRI state surveys (Bruns et al)

	2001-2004	2009-2012
Does the SMHA produce a directory of research and/or evaluation projects?	36%	28%
Does the SMHA operate a Research Center/Institute?	20%	16%
Does the SMHA fund a Research Center/Institute?	26%	36%

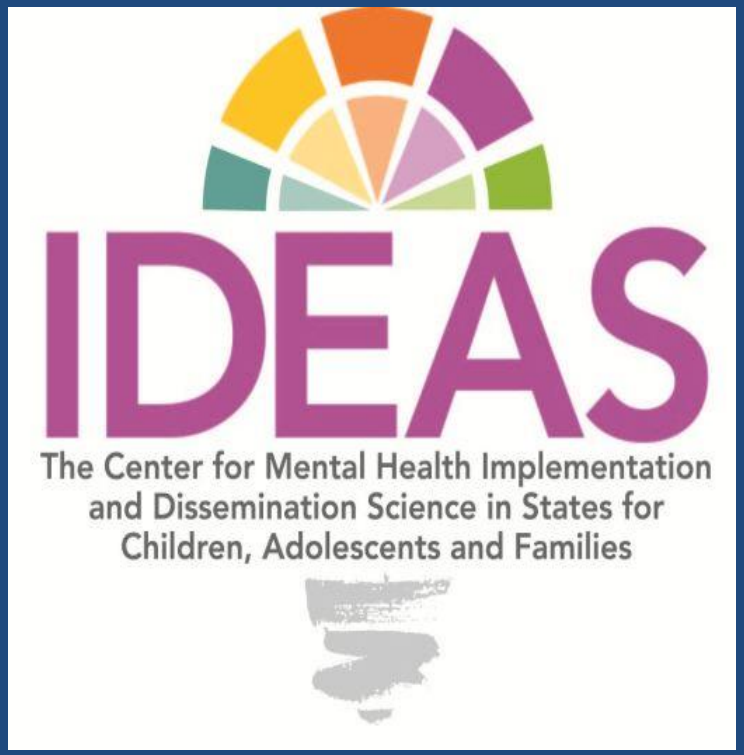
Other Child EBPs

Asked about but not tracked: 2009-2012

- School-based interventions
- Incredible Years
- PCIT
- Brief Strategic Family Therapy
- Problem Solving Skills
- Coping Power
- CBT for Depression
- CBT for Anxiety
- TF-CBT
- Interpersonal Therapy

Implications

- Despite budgetary crisis, states are investing in EBPs but trend line is flat
- EBP investment in adult services is 2 to 6 times higher than for child services
- EBP implementation tracking for child services is narrow (N=3)
- States collect data but not systematically related to EBP implementation
- Implications for developers and researchers:
  - Addressing the business case: What is the added value?
  - Attending to innovation system and innovation organization fit, not only installation and fidelity
  - Addressing workforce issues: New staff models
  - Aligning with performance metrics



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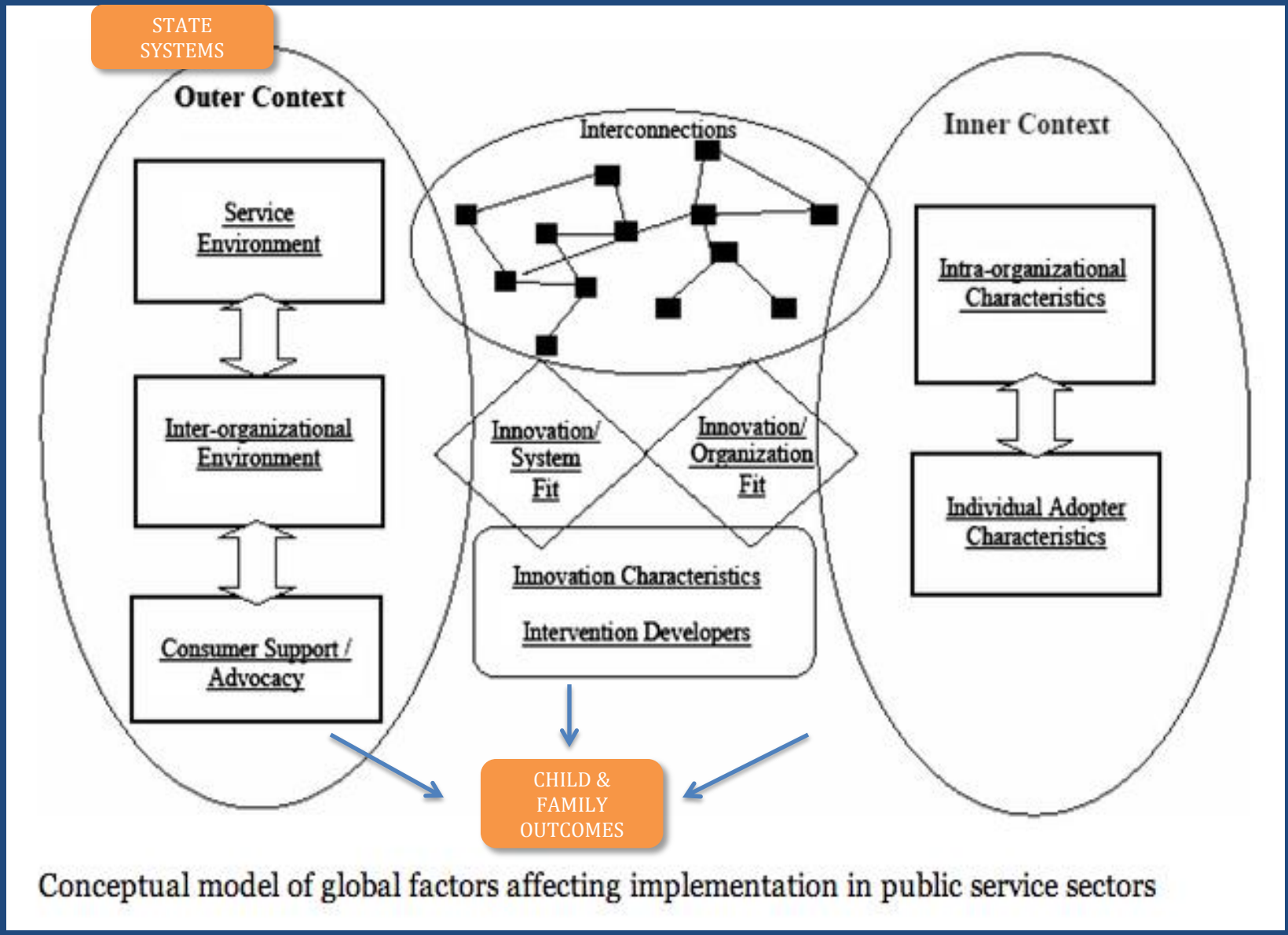


Conceptual model of global factors affecting implementation in public service sectors

Source: Aarons, Hurlburt & Horwitz, 2011

IDEAS Center Studies (N=19)

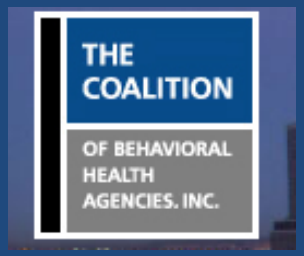
Engagement	Data Support	Mixed Methods
Improving Family-to Family (F2F) Services (R01)	Evidence-Based Treatment Dissemination Center (EBTDC) (OMH)	Adoption Study / CTAC (P30 Pilot)
Developing and Testing a Peer-Delivered Intervention for Maternal Depression (R21)	The Clinic Technical Assistance Center (CTAC)	
Developing a Training Curriculum to Improve the Integration of F2F Support Services in OMH Clinics	Managing and Adapting Practice (MAP) Implementation in OMH Clinics	
Improving Implementation of Evidence-Based Trauma Care in Schools through Community Partnership (K23)	Implementation of Feedback System to Improve EBTs for Children in MH (R18)	
Strengthening Quality in School Mental Health (R01 Subcontract)	Quality Improvement Implementation in Child MH: A 2-State Comparison (R01)	
Supporting Implementation of EBP for Children: A Micro-Analysis of Supervisory Consultation Calls (OMH Policy Scholar)	National Collaborative for Innovation in Quality Measurement (NCINQ) AHRQ CHIPRA (U18 Subcontract)	
Prevention of Postpartum Traumatic Stress in Mothers with Preterm Infants (R34)	Pediatric Psychiatric Prescribing Practices Quality Improvement Initiative (PSYCKES)(OMH)	
Collaborative Model Addressing Mental Health in the Perinatal Period (R34)	Decision Analytic Model to Assist Child Welfare Directors In Adopting and Implementing EBPs	
The Partnering Through Crisis Project (Innovation grant)	Longitudinal Assessment of Manic Symptoms (U01 subcontract)	

One Example

Innovation System Fit/Innovation Organization Fit

Characterizing Clinic Adoption of Trainings in New York State

Clinic Technical Assistance Center (CTAC)



The Clinic Technical Assistance Center

EFFICIENT PRACTICES. EFFECTIVE CARE.

Clinic TA Center (CTAC)
Hoagwood & McKay (Co-directors)

- **Goals:** Provide training, support, and quality improvement strategies to all NYSOMH licensed clinics **(N=346)** serving children and families. Address both clinical and business needs

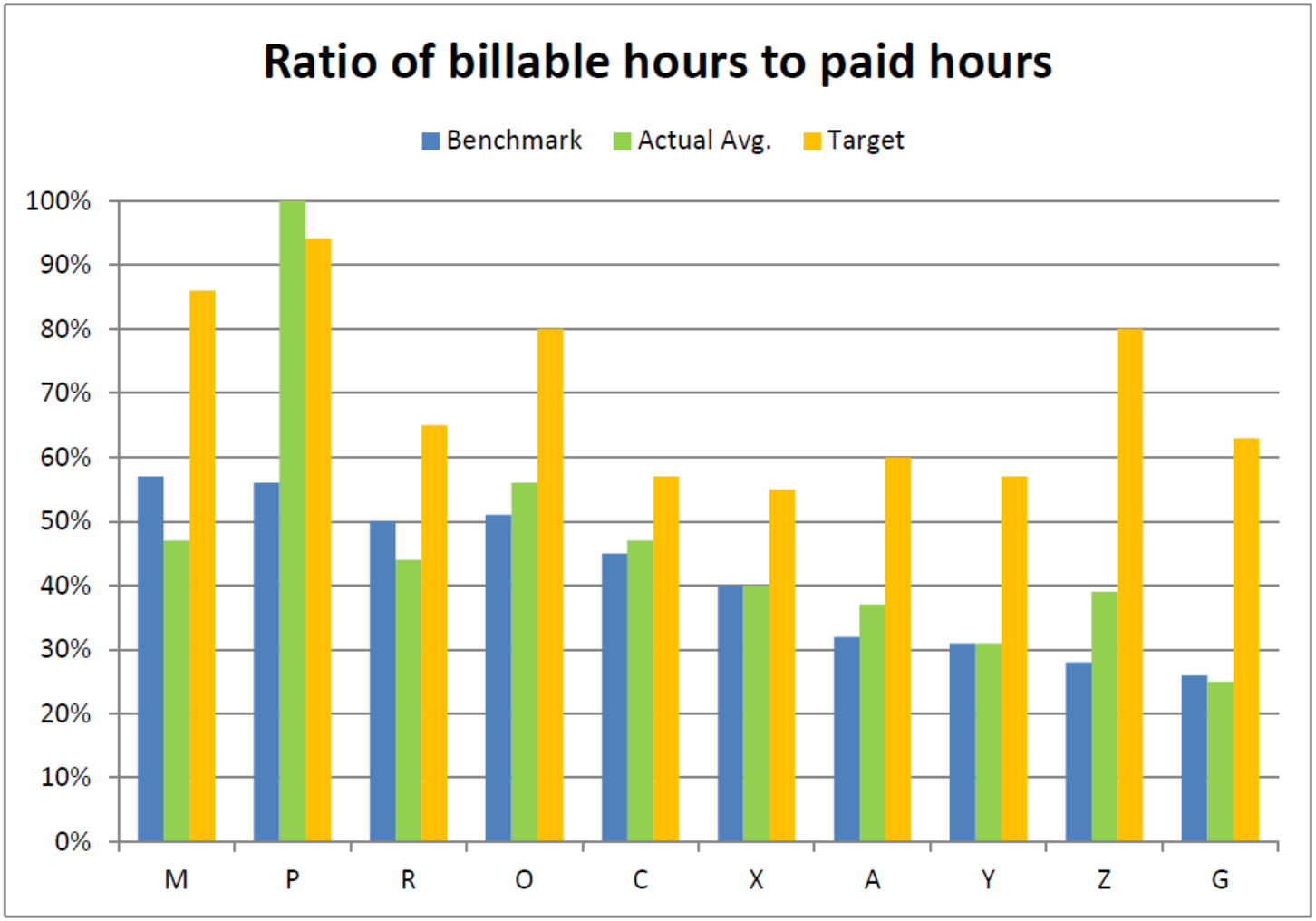
- **Type of training**
  - Business improvement practices (Lloyd, 2012)
    - Open access
    - Centralized scheduling
    - Concurrent documentation
    - Volume and productivity
  - Evidence-informed clinical practices
    - Engagement training (McKay et al., 2012) addressing no show rates
    - Multi-family Groups for Disruptive Behavior Disorders (Chacko et al., in press)
- **Intensity of training**
  - Webinar *(1 hour)*
  - In-person training *(Full-day)*
  - Learning collaborative (LC) *(Year-long)*

Characterizing Clinic Adoption of Trainings in New York State (Chor, Olin, Horwitz et al., in press)

- **Aim:** Expand adoption definitions beyond “yes/no”. Identify predictors of adoption
- **Approach:** Based on CTAC attendance data of the 346 clinics, adoption defined 4 ways:

1. By **number** of trainings adopted
2. By **intensity** of trainings adopted
3. By **type** of trainings adopted
4. By classifying clinics into **distinct adopter groups:**
   - **Low** (Webinar = Highest intensity adopted)
   - **Med** (In-person training = Highest intensity adopted)
   - **Hi** (1 LC = Highest intensity adopted)
   - **Super** (>1 LC = Highest intensity adopted)

The following charts do not include those who did not give baselines and targets.

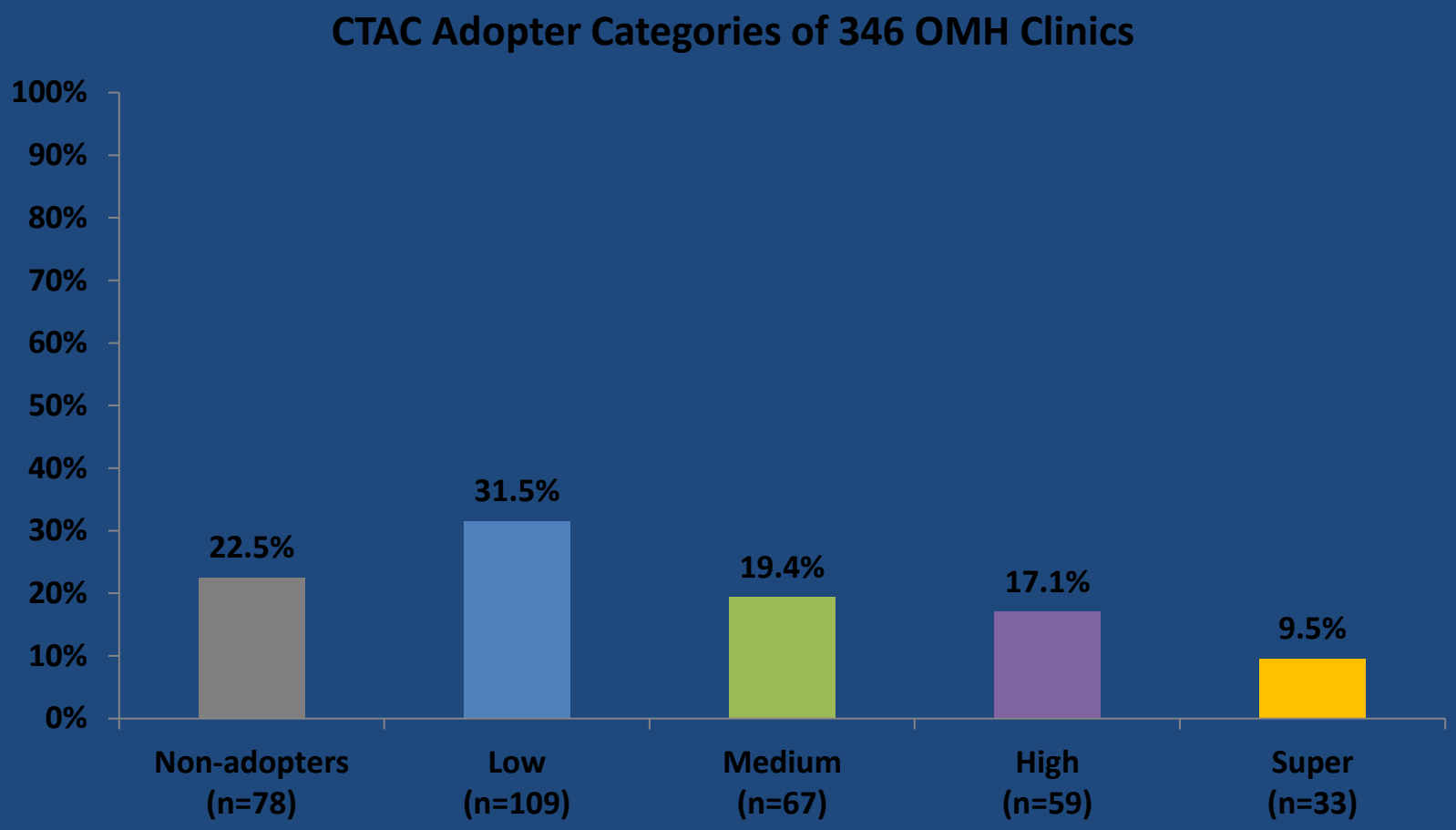


Adoption Literature

- Large-scale state and national roll-outs of EBP initiatives have inconsistent and often inadequate data collection (Bruns & Hoagwood, 2008; McHugh & Barlow, 2010; Panzano & Roth, 2006)
  - Numerators without denominators
  - No attention to outcomes beyond yes/no
  - No examination of adoption by type of initiatives
  - No attention to whether adopted initiative changed practice or patient outcomes

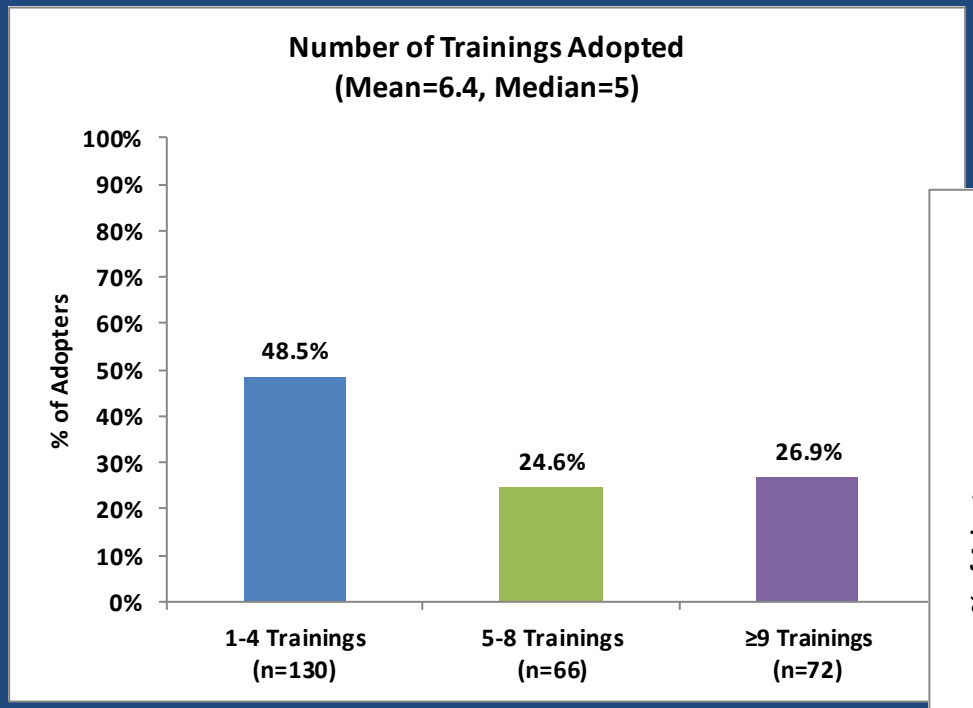
- Key factors influencing adoption are multi-level (Aarons et al., 2011; Wisdom et al., 2013)
  - External influences
  - Organizational characteristics
  - Innovation characteristics
  - Individual characteristics – staff, client
- Measures for predictors of adoption vary from study to study, from innovation to innovation, and from field to field (Chor et al., in press)

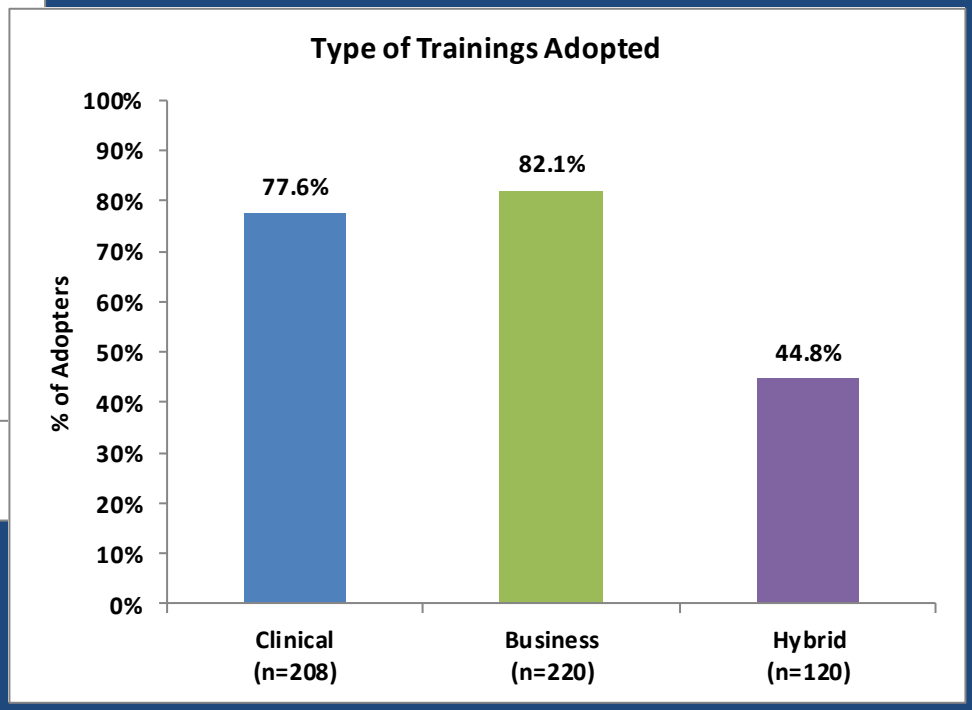
Overall Adoption Pattern



Number & Type of Trainings Adopted

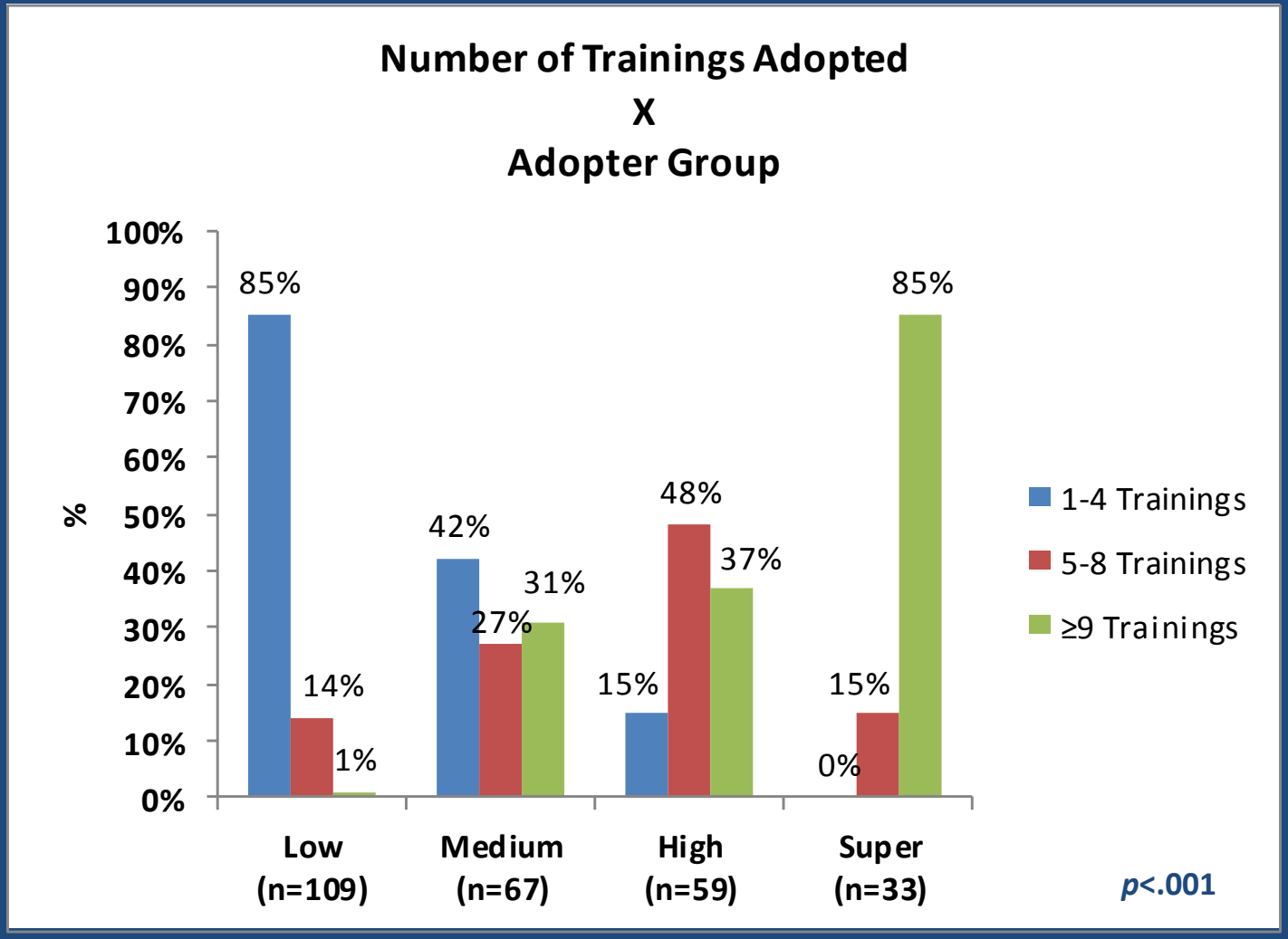
- **Of the 346 clinics, 268 (77%) adopted ≥1 CTAC training**
  - –1-4 trainings most popular
  - –Clinical and business trainings equally preferred





Adopter Group Profiles

- Positive relationship between number of trainings adopted & adopter groups (from low to super)



Implications for State EBP Implementation

- **Number: Increasing sheer number of trainings is unlikely to improve uptake**
  - Median = 5 trainings
- **Preference: Intensity and accessibility**
  - Webinar uptake > In-person uptake > Learning collaborative uptake
  - Trialability: Clinics that adopted an LC were likely to have sampled a webinar first
- **Type: Business and clinical trainings equally important**
  - Business vs. Clinical: Comparable rate of uptake (78-82%)
  - Address climate of accountability and quality
- **Adopter groups communicate meaningful profiles**
  - From low- to super-adopters, the continuum represents an increase in quantity and intensity of trainings adopted
- **States can develop different strategies for different roll-outs**
- **Next step: Predict clinic adoption behavior**

Concluding Remarks

- Sisyphean (and cascading) downdrafts and updrafts from federal to state to provider levels
- ACA creating fixed points of regional authority
- What do plans want: Behavioral health under managed care
- Federal Incentives target workforce, data systems, performance metrics.
- Emphasis on team based and patient-centered (i.e., family- centered) approaches
- E-health tools important part of these system changes
- EBP scaling esp targeting low income populations shifting to managed care with SMHA taking a lesser or at least different role
- EBP scaling needs to attend to innovation system and organizational fit
- EBP scaling needs to be linked to productivity, accountability, added value, workforce issues, and reductions in costly services

Closing Thought

"We are often better served by connecting ideas than … by protecting them."

Source:Steven Johnson, 2010.

IDEAS Center

http://www.ideas4kidsmentalhealth.org

Clinic Technical Assistance Center

http://www.ctacny.com