Evidence-Based Systems of Care: How Do We Get There From Here?

Arthur C. Evans, Ph.D.

Deputy Commissioner
Connecticut Department of Mental Health and Addiction Services

February 10, 2002
Overview

- Why should we be interested in developing an Evidence-Based System of Care?
- What is evidence?
- What does an Evidence-Based System of Care look like?
- Moving towards an Evidence-Based System of Care?
Why should we be interested in developing an *Evidence-Based System of Care*?

- We need to:
  - Improve Policy Development and Decision-Making
  - Address health disparities
  - Improve care quality within limited resources
  - Serve clients with the most complex problems
    - Address increased Acuity/Chronicity
  - Support providers who are under intense pressure to Perform
  - Address the need for Increased Accountability
EBP^n ≠ EBSC

- EBP-Evidence-Based Programs
- EBSC-Evidence-Based Systems of Care
What is evidence?

- Scientific evidence - What can it tell us?
  - Helpful, but with limitations
  - Outside the “lab” too many variable are uncontrolled
    - experimental effect diluted due to changes in
      - resources, staffing, training, shifts in client population
  - Delays in dissemination of research findings to applied settings
What is evidence?

- Evidence is information used to assist in Decision-Making and Evaluation
  - Highly Controlled Studies
  - Evaluation Research
  - Data from State or Program Databases
  - Consumer Input and Feedback
  - Consensus Panels
What is an Evidence-Based System?

- A system that:
  - Promotes implementation and maintenance of evidence-based practices
    - provides support and incentives for use of EBPs and monitors fidelity
  - Focus at Multiple Levels of Analysis
    - Eg, Practitioner, Program & System
  - Uses Data as Basis for Decision-Making throughout the System
What is an **Evidence-Based System**?

- A system that:
  - That is Oriented to Using Evidence and Has the Infrastructure to do so
    - Expectations of Stakeholders, the Predominant Paradigm, Tools, Language, Evaluation is Routine, etc.
  - Is recovery-orientation
  - Involves consumers in the selection and monitoring of evidence-based practices
  - Makes system adjustments based on consumer feedback
  - Improves treatment outcomes and the quality of life for consumers
Broad Uses of Evidence

- Evidence should guide Program Design and Policy Development
- Evidence should guide what Program Directors and Policy Makers Pay Attention to
  - Eg., Health Disparities, Co-Occurring, etc.
- Evidence should inform Evaluation Strategies
Some evidence-based practices are known, but are they being followed?

- Schizophrenia PORT
  - Although most patients were treated with antipsychotics, 1/3 were over-medicated and 1/3 were under-medicated
  - Antidepressants were prescribed to only 1/2 despite known suicide risk in this population
    - 15% of people with schizophrenia commit suicide
  - African Americans were twice as likely to be over-medicated and twice as likely to be denied antidepressants as Whites
Why hasn’t research moved more quickly to practice?

- Most research to practice/treatment efforts have focused on practice effectiveness.
- But effectiveness is often not a major consideration in determining what people actually do.
Why hasn’t research moved more quickly to practice?

Host of Reasons Determine Practice Patterns

- Funding Mechanisms
- Payor & Regulator Policies
- Staffing
- Program Culture and Philosophy
- Cost & Resources
Why hasn’t research moved more quickly to practice?

Need:

**UTILITY STUDIES**

Information that provides guidance around the practical aspects of implementation as well as effectiveness

A good Regression Equation
THE REAL REASON
ANY DEAD HORSES IN YOUR ORGANIZATION?
Dakota tribal wisdom says that when you discover you are riding a dead horse, the best strategy is to dismount. However, in human services, we often try other strategies with dead horses, including the following:
Saying things like “This is the way we have always ridden this horse.”
Appointing a committee to study the horse.
Providing additional funding to increase the horse's performance.
Arranging to visit other sites to see how they ride dead horses.
Harnessing several dead horses together for increased performance.
Increasing the standards to ride dead horses.
Creating a training session to increase our riding ability.
Changing the requirements; declaring “this horse is not dead.”
Declaring the horse is “better, faster and cheaper” dead.
Finding a consultant knowledgeable about dead horses.
Promoting the dead horse to a supervisory position.
Strategy for Developing an Evidence-Based System of Care

- Shaping the Culture
- Increasing the Use of Evidence-Based Practices
- Focusing on System Interventions and Policy Development
#1 Shaping the Culture

- Use Data as Change Agent
Shaping the Culture: Data as a Systems Change Agent

Acute Inpatient Care

- Statewide
- Hospital A
- Camden Hosp
- Hospital C
- Hospital D

ALOS  AMA  % Clients Transferred

Arthur C. Evans, Ph.D.  Connecticut DMHAS  arthur.evans@po.state.ct.us
#1 Shaping the Culture

- Use Data as Change Agent
- Highlight Disparities
  - Co-Occurring, Racial, Gender, etc.
- Move from Training to Technology Transfer Model
- Academic Partnerships
- EBP is requirement for all New Funding
Health Disparities
Anti-psychotic Prescription Practices for Psychiatric inpatients

Patients receiving any type of antipsychotic

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Groups</td>
<td>67.7%</td>
</tr>
<tr>
<td>White</td>
<td>67.0%</td>
</tr>
<tr>
<td>B/AA</td>
<td>74.5%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>60.4%</td>
</tr>
</tbody>
</table>
Which CT patients get the more costly “atypical” anti-psychotics?*

* Among psychiatric inpatients prescribed antipsychotic
Which CT patients with schizophrenia get the “atypical” anti-psychotics?

- All Groups: 72.9%
- White: 76.9%
- B/AA: 65.4%
- Hispanic: 74.3%
Which CT groups are using psychiatric inpatient services?

<table>
<thead>
<tr>
<th></th>
<th>FY00</th>
<th>FY01</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>23.9%</td>
<td>23.1%</td>
</tr>
<tr>
<td>Black</td>
<td>13.7%</td>
<td>15.4%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4.4%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Other</td>
<td>57.9%</td>
<td>56.4%</td>
</tr>
</tbody>
</table>

Arthur C. Evans, Ph.D.
Connecticut DMHAS
arthur.evans@po.state.ct.us
What about the utilization of community-based services in CT?

Outpatient, case management, assertive community treatment, psychosocial rehab, etc.
#2 Increasing the Use of Evidence-Based Practices

- Consensus Building
  - Preferred Practice Workgroups
- Removing Barriers/Increasing Incentives
  - Change Reimbursement Policy
- Promoting Adoption & Adaptation of EBP
  - Dame la Mano
Adaptation: Dame la Mano

- Involves modifying an Evidence-Based Program for Latinos
- Focused on developing a consensus about treatment and support services for Latinos with co-occurring psychiatric and substance use disorders
#3 Focusing on System Indicators & Policy Development

- Resource Allocation Decisions
  - ACT Fidelity Study
- System Level Interventions
A System Level Intervention: Opioid Agonist Treatment Protocol

- Frequent users of acute inpatient detoxification:
  - 4 or more detox admissions in 6 months
- Data indicated that 70% had DSM-IV, Axis 1 diagnosis of Opiate Dependence
- Clients flagged in utilization management data system
- Offered Evidence-Based alternatives to standard detoxification (e.g., methadone maintenance, residential treatment, wrap around supports)
Effectiveness of the OATP Approach?

Use of Opioid Agonist Treatment Protocol (OATP)

Connect to Care

- OATP Group
- Standard Treatment

Acute Readmission

- OATP Group
- Standard Treatment
A System Level Intervention:

BEHAVIORAL HEALTH UNITS

- Care and Case-Management Program for High Utilizers of Acute Service
- Evaluation found Weak Overall Effect
- However, Teasing out Data Found:
  - Success related to organizational structure
  - 60% Improvement (networked) in connect to care vs No Difference (free-standing Programs)
  - De-funded Programs and Reallocated resources through different organizational Structure
How do we strike the right balance?

- Politics and Policy
- Confidentiality versus Information Sharing
- New versus Existing Resources
- Science versus Experience
- Top-down versus Bottom-up Approach to Selection of EBPs
SUMMARY
Contact information for the presenter:

Arthur C. Evans, Ph.D., Deputy Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue - MS: 14/COM
Hartford, CT 06106

Phone: 860-418-6958      FAX: 860-418-6691

Email: arthur.evans@po.state.ct.us