Scaling EBPs in State Systems: The Sisyphean Problem

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Institute of Medicine-National Research Council Forum on Promoting Children’s Cognitive, Affective, and Behavioral Health
April 1-2, 2014
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

• 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

Is your state using managed care to provide behavioral health services?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, neither mental health nor substance abuse services are being delivered via managed care</td>
<td>11.54%</td>
</tr>
<tr>
<td>Yes, both mental health and substance abuse services are being delivered via managed care</td>
<td>28.85%</td>
</tr>
<tr>
<td>Yes, but only mental health services are being delivered via managed care</td>
<td>59.62%</td>
</tr>
</tbody>
</table>

²NASMHPD 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\textsuperscript{1,2}

• 7,400 practicing child psychiatrists\textsuperscript{3}

• 2,606 child psychologists registered in the APA directory\textsuperscript{5}

• 93,000 practicing psychologists\textsuperscript{4}

• 55\% of counties nationally have no practicing psychiatrists, psychologists, or social workers\textsuperscript{2}

• 14-15 million children have a diagnosable psychiatric disorder\textsuperscript{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)

<table>
<thead>
<tr>
<th></th>
<th>2001-4</th>
<th>2007-9</th>
<th>2010-2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>TFC</td>
<td>40.40%</td>
<td>63.50%</td>
<td>55.80%</td>
</tr>
<tr>
<td>MST</td>
<td>25%</td>
<td>40.40%</td>
<td>40.40%</td>
</tr>
<tr>
<td>FFT</td>
<td>32.70%</td>
<td>32.70%</td>
<td>28.80%</td>
</tr>
<tr>
<td>SH</td>
<td>80.80%</td>
<td>80.80%</td>
<td>73.10%</td>
</tr>
<tr>
<td>SE</td>
<td>63.50%</td>
<td>82.70%</td>
<td>82.70%</td>
</tr>
<tr>
<td>ACT</td>
<td>76.90%</td>
<td>80.80%</td>
<td>78.80%</td>
</tr>
</tbody>
</table>

Source: NASMHPD Research Institute State Profile Survey
Total Number of Clients Receiving Adult and Child EBPs: Preliminary
(Bruns et al)

<table>
<thead>
<tr>
<th></th>
<th>2001-4</th>
<th>2007-9</th>
<th>2010-2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>TFC</td>
<td>2307.00</td>
<td>15448.00</td>
<td>15777.00</td>
</tr>
<tr>
<td>MST</td>
<td>2556.00</td>
<td>8487.00</td>
<td>8448.00</td>
</tr>
<tr>
<td>FFT</td>
<td></td>
<td>7226.00</td>
<td>10478.00</td>
</tr>
<tr>
<td>SH</td>
<td></td>
<td>71674.00</td>
<td>73201.00</td>
</tr>
<tr>
<td>SE</td>
<td>39513.00</td>
<td>49029.00</td>
<td>48872.00</td>
</tr>
<tr>
<td>ACT</td>
<td>31327.00</td>
<td>59067.00</td>
<td>65383.00</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Initiative</th>
<th>2001-2004</th>
<th>2009-2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness/training</td>
<td>84%</td>
<td>100%</td>
</tr>
<tr>
<td>Consensus building among stakeholders</td>
<td>92%</td>
<td>100%</td>
</tr>
<tr>
<td>Incorporation in contracts</td>
<td>60%</td>
<td>94%</td>
</tr>
<tr>
<td>Monitoring of fidelity</td>
<td>64%</td>
<td>94%</td>
</tr>
<tr>
<td>Financial incentives</td>
<td>36%</td>
<td>68%</td>
</tr>
<tr>
<td>Modification of IT systems &amp; data reports</td>
<td>58%</td>
<td>88%</td>
</tr>
<tr>
<td>Specific budget requests</td>
<td>48%</td>
<td>70%</td>
</tr>
</tbody>
</table>
### Use of Research Data

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

<table>
<thead>
<tr>
<th></th>
<th>2001-2004</th>
<th>2009-2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the SMHA produce a directory of research and/or evaluation projects?</td>
<td>36%</td>
<td>28%</td>
</tr>
<tr>
<td>Does the SMHA operate a Research Center/Institute?</td>
<td>20%</td>
<td>16%</td>
</tr>
<tr>
<td>Does the SMHA fund a Research Center/Institute?</td>
<td>26%</td>
<td>36%</td>
</tr>
</tbody>
</table>
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
Kimberly Eaton Hoagwood, PhD,  
Director  
Mary McKay, Ph.D., Co-Director  
Funded by NIMH P30 MH090322  
www.ideas4kidsmentalhealth.org
Conceptual model of global factors affecting implementation in public service sectors

Source: Aarons, Hurlburt & Horwitz, 2011
# IDEAS Center Studies (N=19)

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

Innovation System Fit/Innovation Organization Fit

Characterizing Clinic Adoption of Trainings in New York State
Clinic Technical Assistance Center (CTAC)

McSilver Institute for Poverty Policy and Research
NYU Silver School of Social Work

CCSI - Coordinated Care Services Inc

Families Together in New York State

The Coalition of Behavioral Health Agencies, Inc.

ICL Institute for Community Living
Improving Lives, Building Hope, Empowering People

IDEAS

NYAPRS: Partners in Recovery

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.

Ratio of billable hours to paid hours

- Benchmark
- Actual Avg.
- Target
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

CTAC Adopter Categories of 346 OMH Clinics

- Non-adopters (n=78): 22.5%
- Low (n=109): 31.5%
- Medium (n=67): 19.4%
- High (n=59): 17.1%
- Super (n=33): 9.5%
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)

![Bar chart showing the distribution of trainings adopted among different adopter groups.]

- **Low** (n=109):
  - 1-4 Trainings: 85%
  - 5-8 Trainings: 14%
  - ≥9 Trainings: 1%

- **Medium** (n=67):
  - 1-4 Trainings: 42%
  - 5-8 Trainings: 31%
  - ≥9 Trainings: 15%

- **High** (n=59):
  - 1-4 Trainings: 15%
  - 5-8 Trainings: 37%
  - ≥9 Trainings: 15%

- **Super** (n=33):
  - 1-4 Trainings: 85%
  - 5-8 Trainings: 0%
  - ≥9 Trainings: 0%

*p < .001*
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