Strategies for Integrating Services:
Linking Evidence Based Practices Together with Data and Training

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“In times of change, the learners inherit the earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists.”

-- Eric Hoffer

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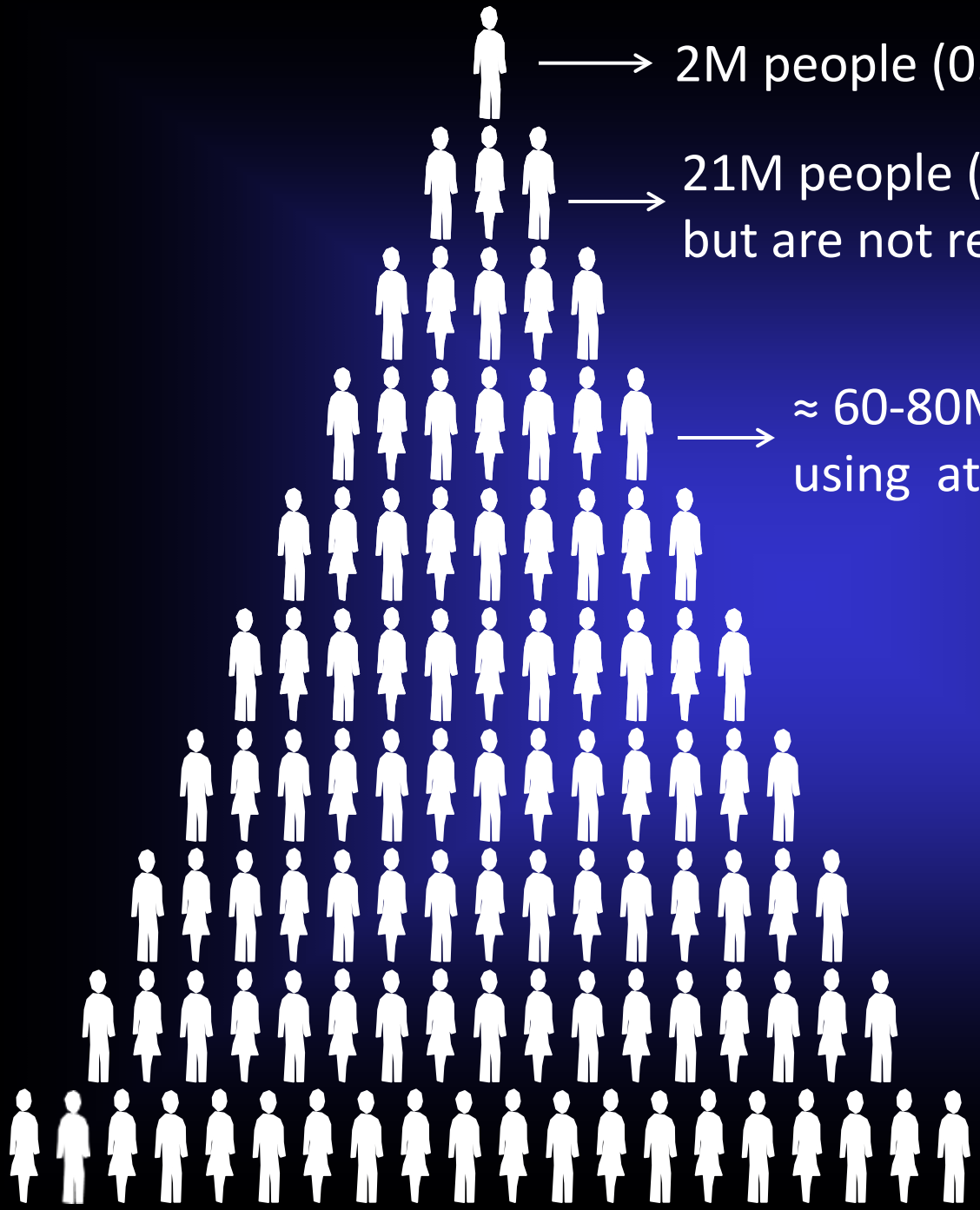


2M people (0.8%) receiving treatment*

21M people (7%) need treatment, but are not receiving it*

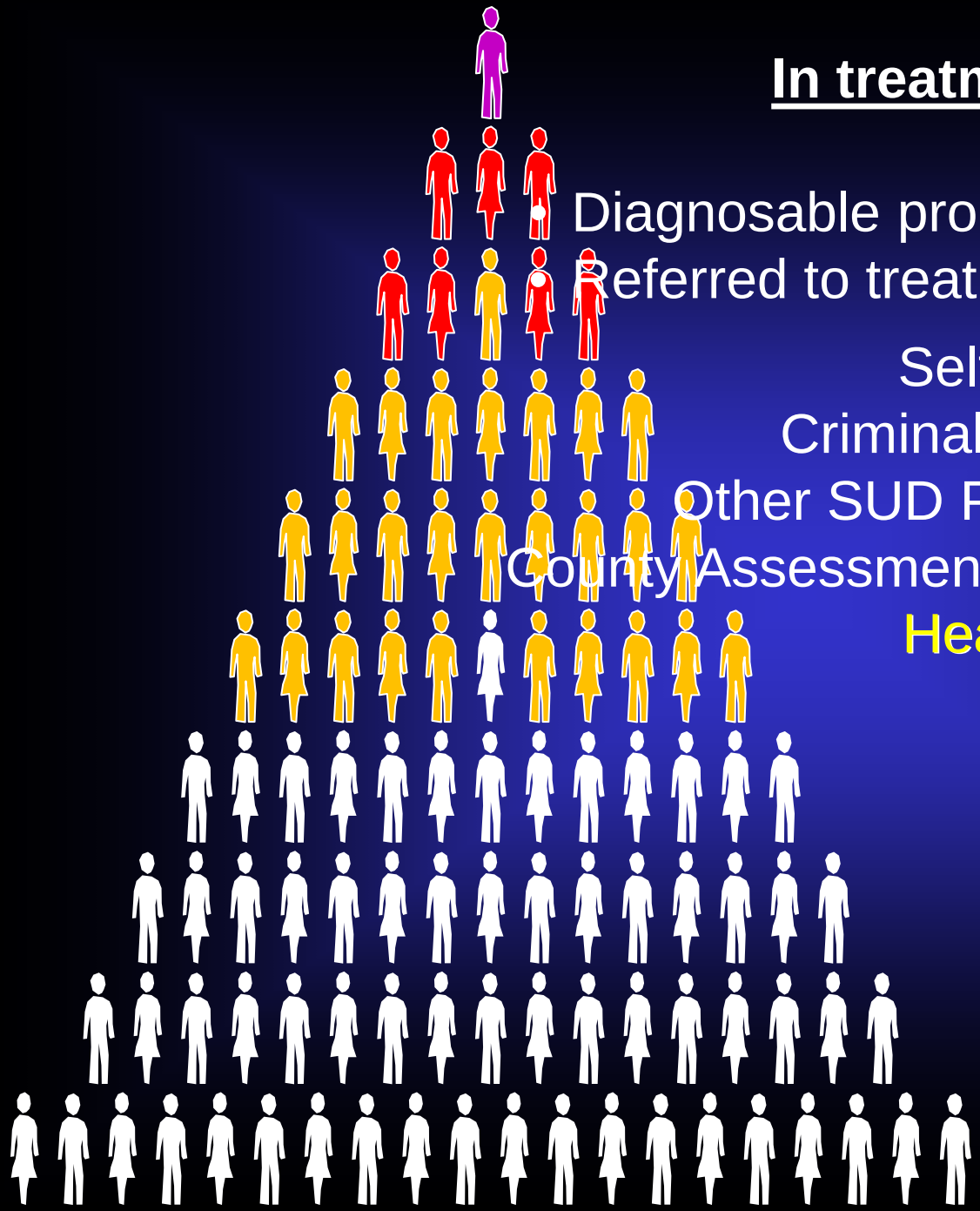
≈ 60-80M people (≈20-25%) using at risky levels

US Population:

307,006,550

US Census Bureau, Population Division
July 2009 estimate

*NSUDH, 2008



In treatment (2 Million)

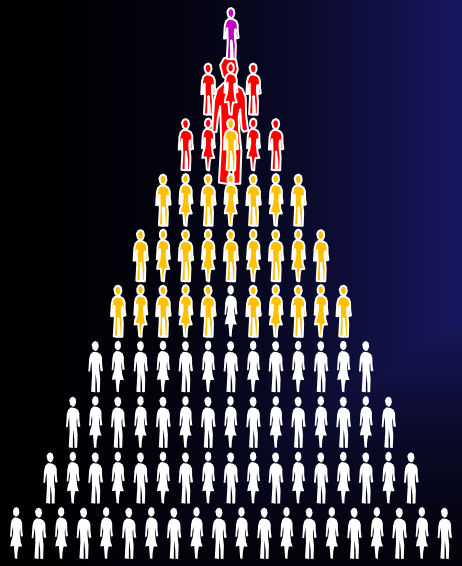
Diagnosable problem with substance use
Referred to treatment by:*

Self/Family	37%
Criminal Justice	25%
Other SUD Program	8%
County Assessment Center	19%
Healthcare	3%
Other	8%

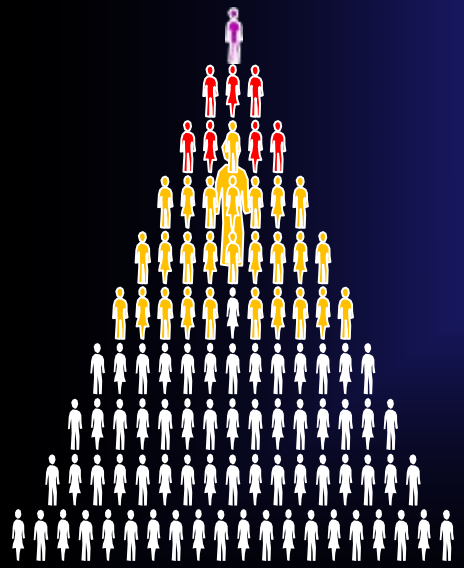
*Los Angeles County Data

In need of treatment (21 Million)

- Reported problems associated with use
- Not in treatment currently
  - 1.1% Made an effort to get treatment
  - 3.7% Felt they needed treatment, but made no effort to get it.
  - 95.2% Did not feel that they needed treatment



These people need services, but will never enter the treatment system



Using at risky levels (60-80 Million)

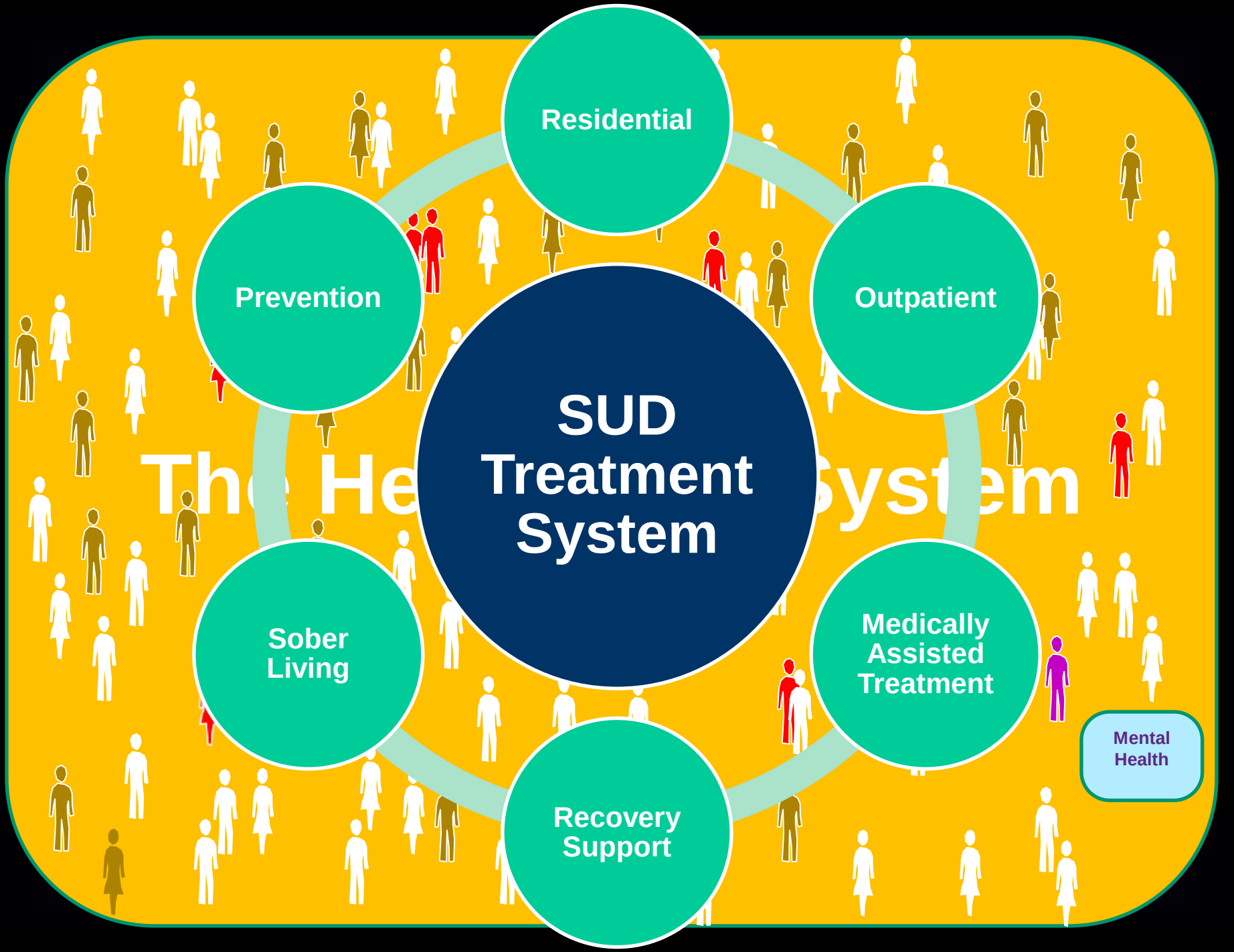
- Do not meet diagnostic criteria
- Level of use indicates risk of developing a problems.
- Some examples…

Drinks 3-4 glasses of wine a few times per week

Pregnant woman occasionally has a shot of vodka to relieve stress

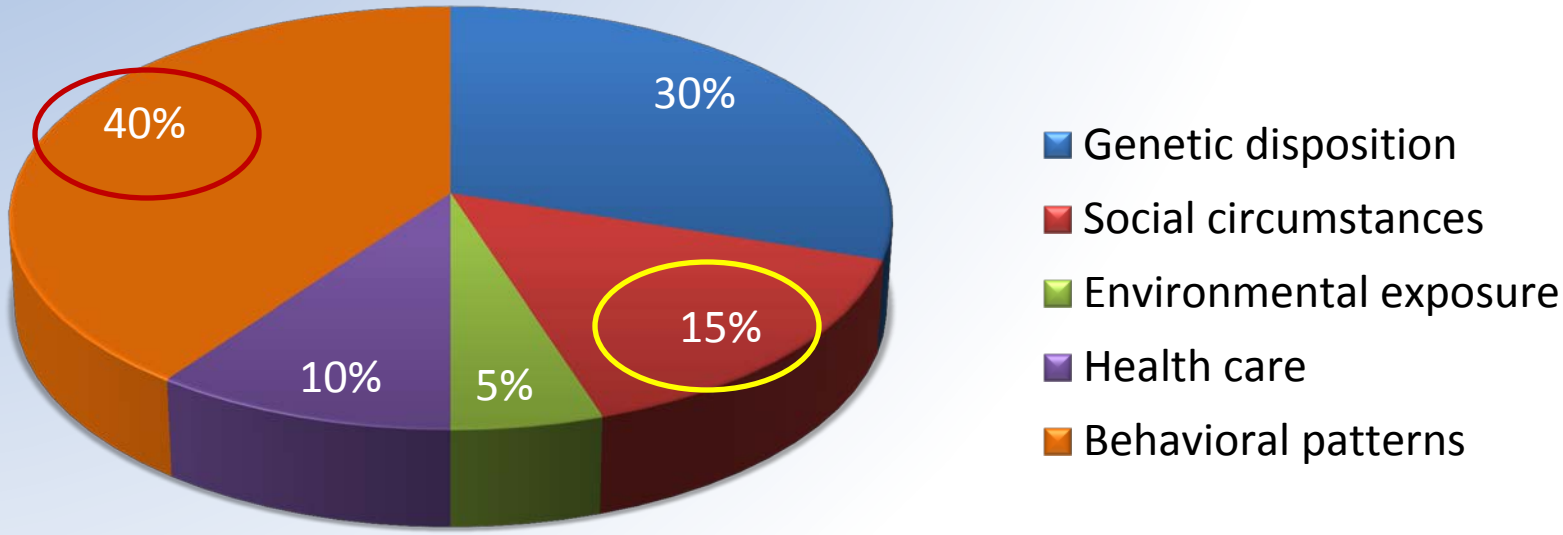
Adolescent smokes marijuana with his friends on weekends

Occasionally takes one or two extra vicodin to help with pain


Residential
Outpatient
Medically Assisted Treatment
Recovery Support
Sober Living
Prevention
SUD Treatment System
Mental Health

Problem: Causes of Premature Death in the General Population

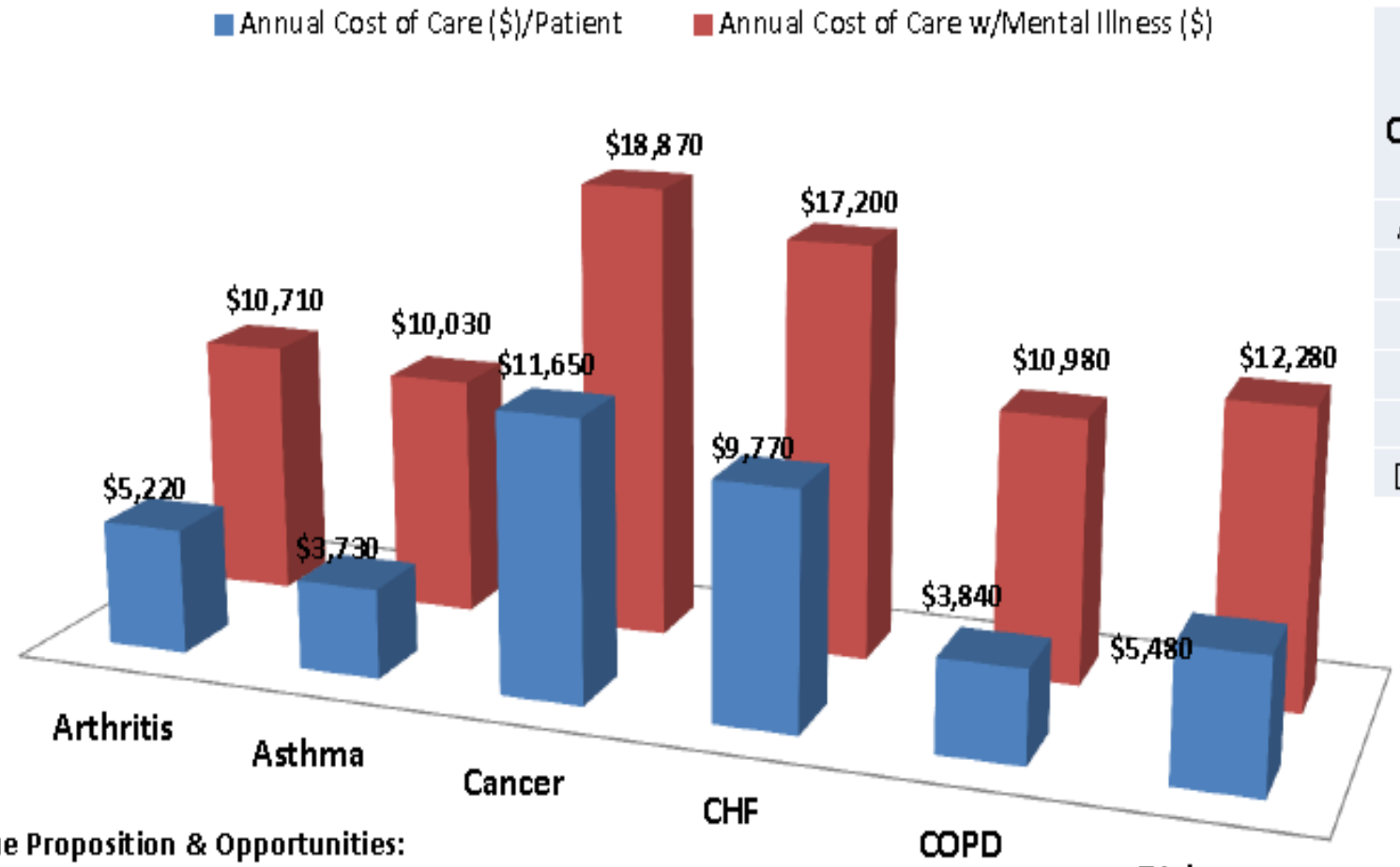
Proportional Contribution to Premature Death



N Engl J Med. 2007 Sep 20;357(12):1221-8.

Value of Behavioral Health

Increased Cost of Chronic Disease w/Mental Illness Comorbidity[1]



Chronic Disease Condition	% Cost Increase w/Mental Illness
Arthritis	105%
Asthma	169%
Cancer	62%
CHF	76%
COPD	186%
Diabetes	124%

[1]Data Source: Cartesian Solutions, consolidated claims data

Value Proposition & Opportunities:

1. To manage complex behavioral health patient populations via innovative value-based system approaches.
2. To reduce costs via integrated, scalable provider networks between acute care and behavioral health systems.
3. To build scalable, integrated provider networks achieving economies-of-scale to create opportunities in rural networks.

Source: Wyatt Matas, 2013

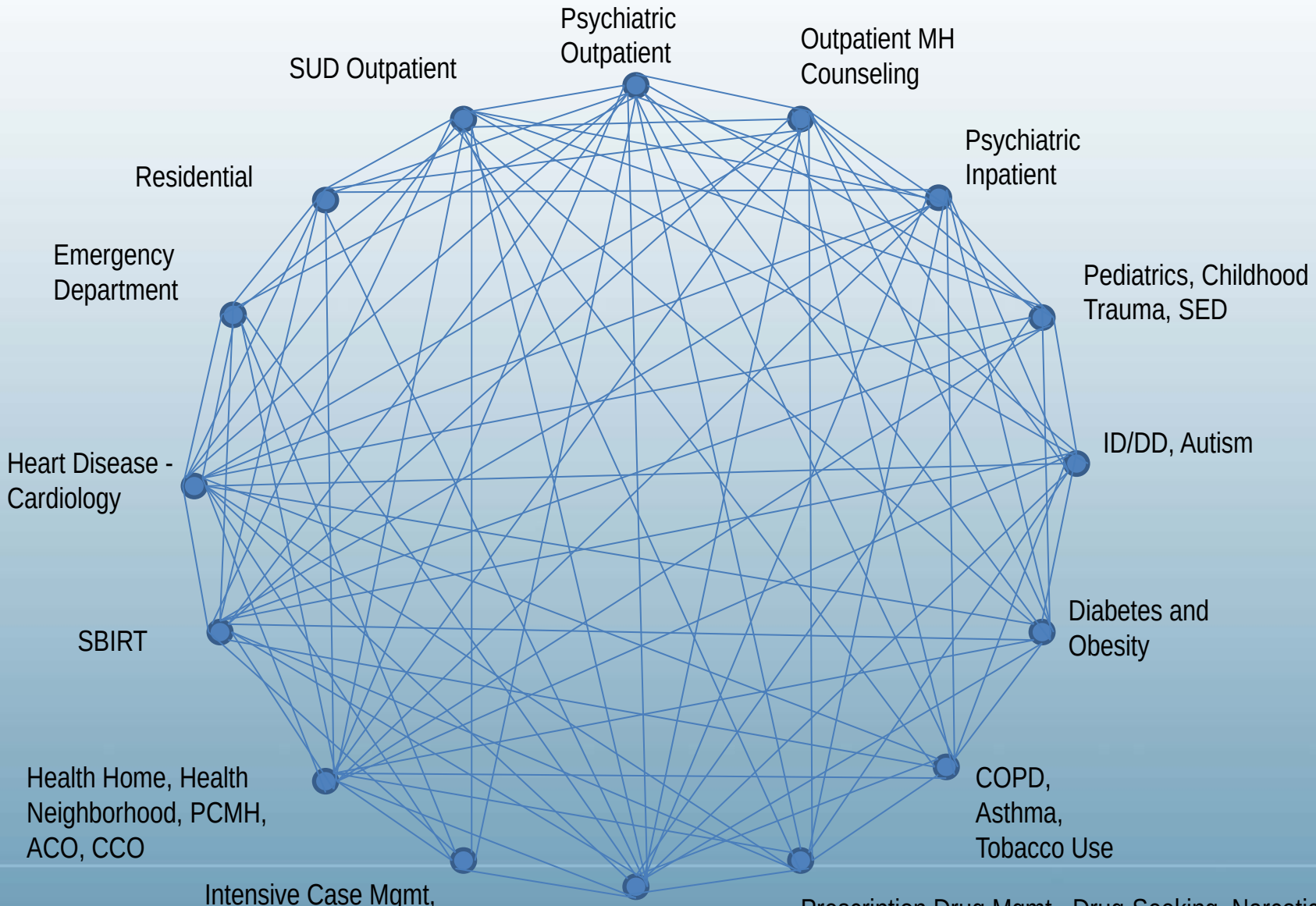
Value of Behavioral Health

49% of Medicaid Beneficiaries with disabilities have a psychiatric illness. Top 3 behavioral dyads:

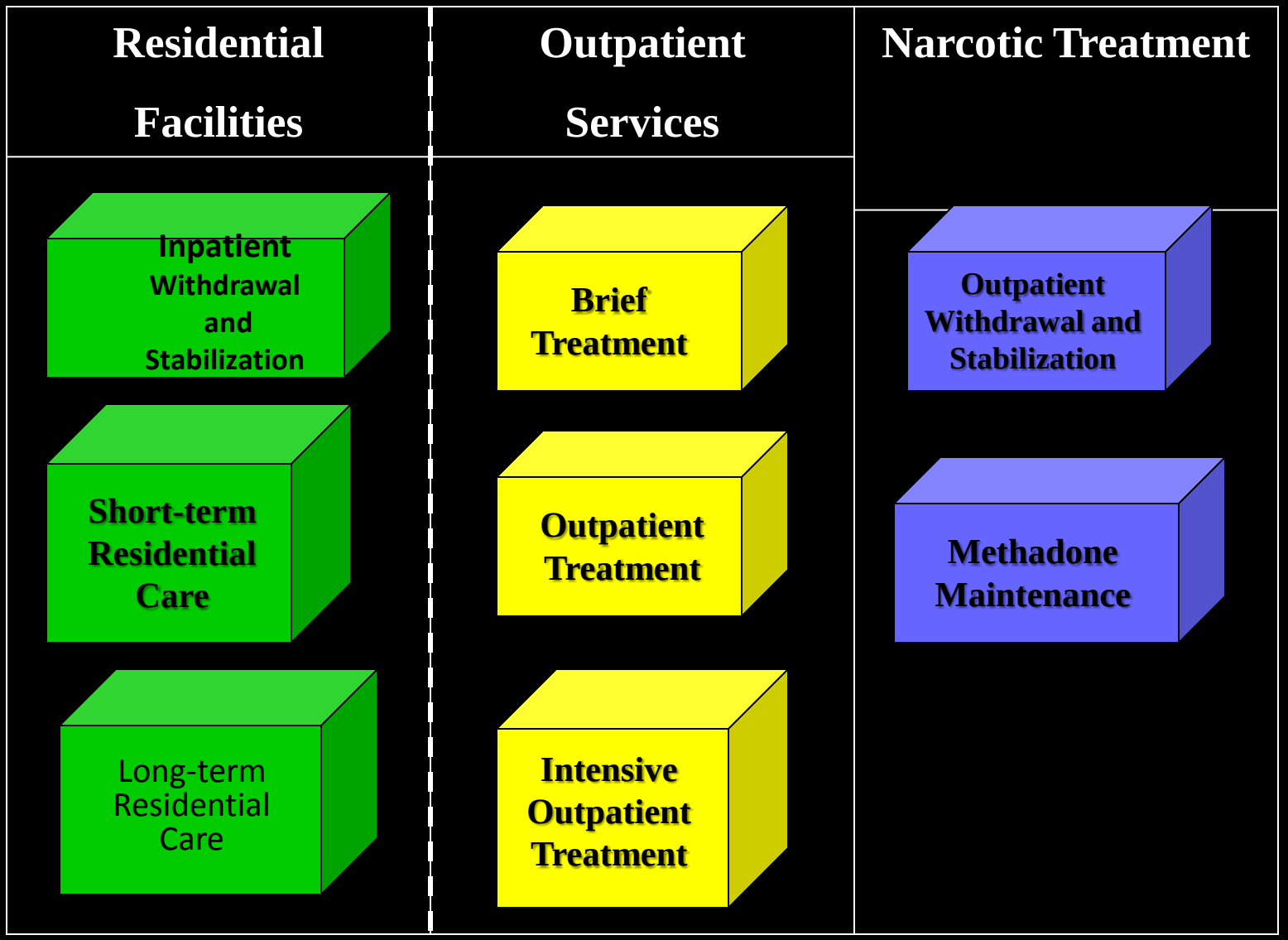
1. Psychiatric/Cardiovascular
2. Psychiatric/Central Nervous System
3. Psychiatric/ Pulmonary

Get the Big Picture

How Many Opportunities for Innovation Might There Be?

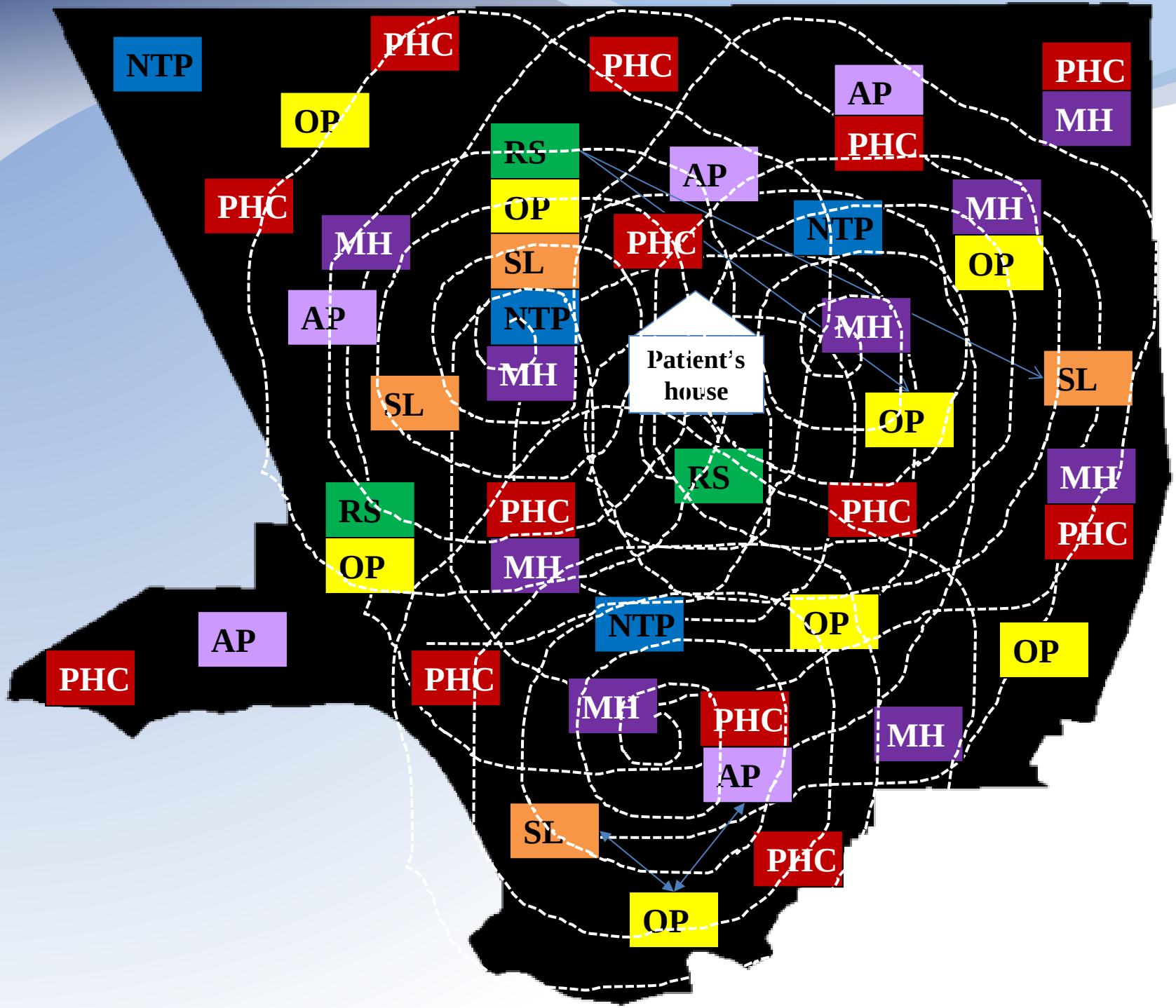


Elements of an Organized System of Care



Other Possibly Useful Service Components

Sober Living Facilities	Addiction Physicians	Continuing Care Services
Sober Living Facilities	Medication Assisted Treatment for Opiate Addiction: Suboxone, Naltrexone	Recovery Centers
	Medication Assisted Treatment for Alcohol Abuse and Dependence: Vivatrol, Acamprosate, Ondansetron	Recovery Check-ups
		Telephone Support Services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Some Requirements of an Integrated "System" of Care

- Individuals are treated with the most appropriate, evidence-based treatment approaches and in the appropriate level of care.
- Workforce recognizes the benefits of all evidence based treatment approaches and attempts to place individuals in most effective form of care.
- Workforce is informed and knowledgeable about treatment services delivered by other treatment organizations and other specialties in the service area.

Some Requirements of an Integrated "System" of Care

- Patients will be transferred ***along the continuum of care*** with communication and cooperation ("warm referral") between treatment organizations.
- Patients will be transferred ***to other specialty services*** with communication and cooperation between treatment organizations.
- Performance data will be collected and used to monitor progress toward achieving an Organized System integrated services.
- Performance data must not add substantial data burden to service providers and data must be given back to service providers in a timely manner and in a form that is clear and meaningful.

Guiding Principles for an Organized System of Care

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Basic Principles (example)

- Treatment of substance use disorders involves a *continuum of care* and a long-term perspective that is based on a *chronic care model* for individuals who are severely ill.
- Treatment of severe substance use disorders requires comprehensive services with multiple interventions.
- Treatment should be coordinated with primary care and mental health care settings (as appropriate).
- Treatment should incorporate evidence-based practices.

Domains (examples)

- **Identification of Substance Use Disorders:** screening/case finding, diagnosis and assessment
- **Initiation and Engagement in Treatment**: brief interventions, engagement in treatment, and withdrawal management
- **Therapeutic Interventions**: psychosocial interventions and pharmacotherapy
- **Continuing Care Management:** long-term, coordinated, adapted management of care
- **Identification of other service needs:** primary care and mental health screening and linkage to services

Selection of Specific Practices

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Priority Areas for Selection of Practices

- Apply broadly to multiple populations and age groups
- Have a substantial evidence base
- Support immediate improvement and are appropriate for widespread adoption
- Measureable
- Have the greatest effect on people's lives if the practice is implemented

Criteria for Evaluation of Practices

- **Evidence of Effectiveness**: will improve outcomes based on research studies, broad expert opinion or professional consensus, and data from other settings
- **Generalizability**: able to be used in multiple clinical settings with multiple types of patients
- **Benefit**: will improve patient outcomes or the likelihood of improved outcomes if more widely utilized

Criteria for Evaluation of Practices

- **Readiness**: needed technology and trained staff are available in most organizations; practice provides an opportunity for measurement
- **Specificity**: practice is clearly defined, target outcome is identified, and to the extent possible for whom indicated, by whom carried out, and in what setting.

Other Recommendations

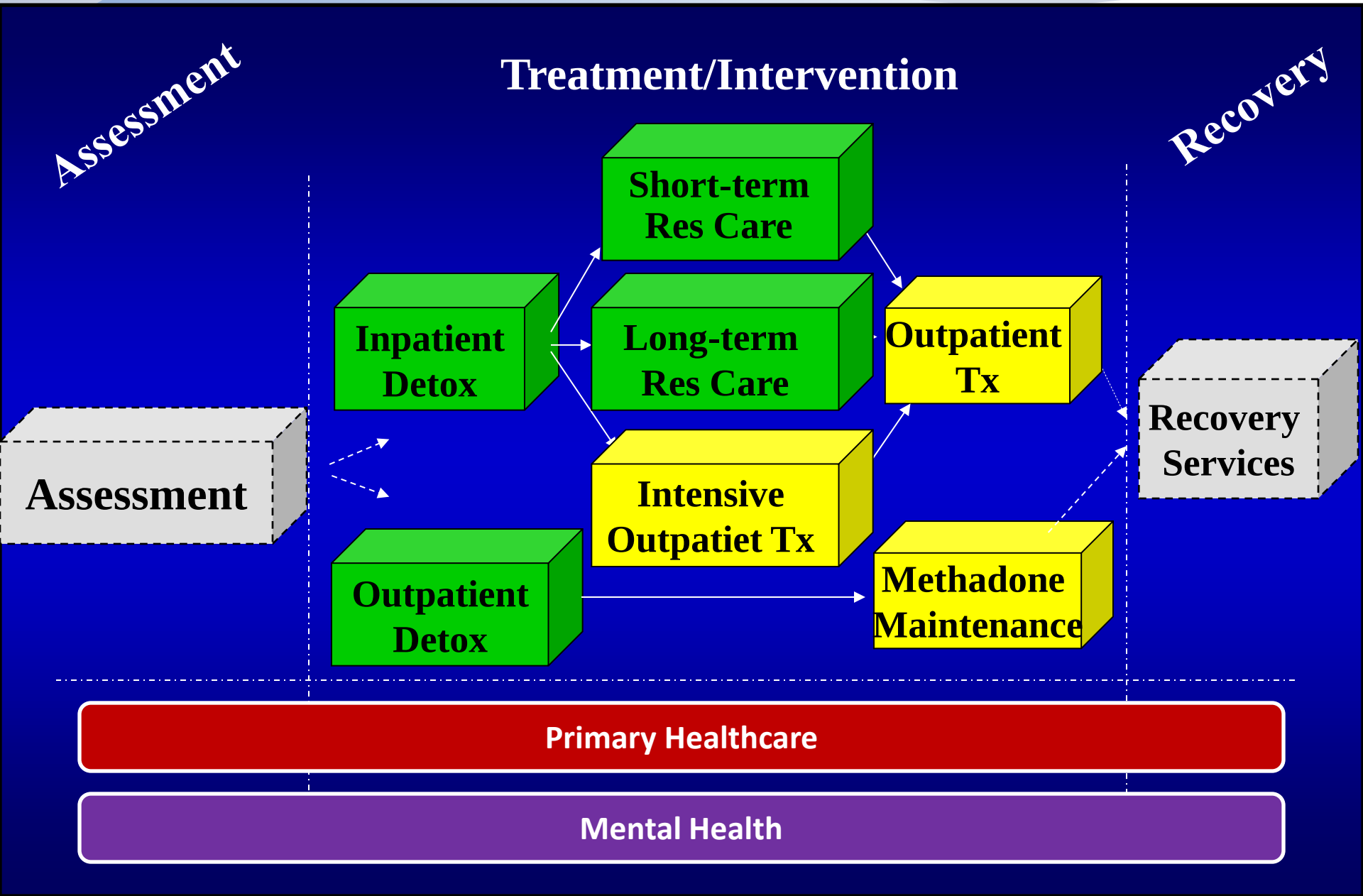
- *Implementation* of the full set of practices (adoption of individual practices is insufficient) and provider support for adoption, including clinical supervision

- *Policy Development,* including alignment of payment/reimbursement and coverage, legal and regulatory policies and management in primary care

What Should A Program Evaluation Contain?

1. Understanding of the SUD treatment system
2. Understanding of the MH and PHC systems
3. Patient Outcomes Measures
   A. Drug use, Alcohol use, Health problems, Legal problems, Family problems, Employment status, Psychiatric symptoms
4. Treatment Service Performance Measures
   A. Access to treatment, engagement into treatment, retention in treatment, success in transfer between levels and systems of care
5. Patient feedback
6. Follow-up of sample

Elements of Continuum of Services



A Source of Confusion: Outcomes vs Performance

- Outcomes: OUTCOME MEASURES ARE USED AT THE *PATIENT LEVEL* AND MEASURE CHANGES IN PATIENT BEHAVIOR OR FUNCTIONING OVER TIME

- Performance: PERFORMANCE MEASURES ARE USED AT THE TREATMENT PROGRAM LEVEL AT THE TREATMENT SYSTEM LEVEL TO EXAMINE THE FUNCTIONING OF THE TREATMENT SERVICES

Outcomes vs. Performance

Patient Outcomes

- Measure how much a patient has improved (or not) from treatment.
- Reductions in substance use
- Improved employment (or education)
- Housing (no longer homeless)

Treatment Agency Performance

- Refers to areas under the control of the program
- The extent to which evidence-based practices are used
- Movement from intensive levels of care to less intensive levels of care (residential to outpatient)
- Time spent waiting for treatment (Access)
- How successfully the program engages patients in treatment
- Time spent active in treatment (attending sessions)

Creating a Culture of Evidence

Developing an institutional "culture of evidence" requires **helping staff and stakeholders at all levels learn to interpret data,** recognize program activities that create impact value and align resources that support improved client services… to effectively engage in data-driven decision making.

GDTA
GRANTEE DATA TECHNICAL ASSISTANCE

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Creating a Culture of Evidence

- Portray data findings as neutral evidence.
- Use a mix of data visualization tools — charts, data infographic tools, etc. — to simplify complex, interrelated data outcomes.
- Focus on key findings that are important, presenting the data as a story that quantifies and illuminates a population-based context.
- Do not hide “bad news” when data indicates poor program performance. Encourage meaningful discussion about improvements.

Creating a Culture of Evidence

- Do not select and present only evidence that advances a particular desired point of view or use data to assign blame.
- Encourage various stakeholders to be presenters of the data, reducing fear by engaging in the ownership of the findings.
- Frame data findings with questions rather than answers to invoke knowledge sharing across all critical collaborators.
- Use a neutral facilitator when necessary to ensure questions and discussions stay productive.

Thank You!

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