

**Implementing Evidence-Based Practices and Performance Measures for
Massachusetts Mental Health Services: An Educational Forum
Wednesday, September 28, 2005**

Hassenfeld Conference Center, Brandeis University
415 South Street, Waltham, MA 02454-9110

TITLES AND ABSTRACTS OF CONFERENCE PRESENTATIONS

Welcome, Agenda, Challenge for the Day

DONALD S. SHEPARD, PH.D., Professor at the Schneider Institute for Health Policy at the Heller School, Brandeis University

In providing the initial welcome for forum participants, this presentation describes the logic behind the agenda, and notes the challenges and potential solutions around implementation. The conference is designed to answer three key questions: (1) What are EBPs? (2) How can they be implemented? And (3) How can we work together to deliver more evidence-based practices?

The conference has 165 advance registrations from seven states, including Massachusetts. The conference framework begins with the context and national experience around evidence-based practices. Talks by Shepard, Keane, Botticelli, Manderscheid, Leff, Lynde, and Ganju address this component. Evidence-based practices require performance measurement to assess both process and outcomes. Talks by Horgan and Hermann address this component. Finally the conference addresses steps towards implementation in Massachusetts. Talks by Childs, Stelk, Lynch, Funk, Delman, and Beinecke all address this component.

This presentation concludes with a suggestion about a tool to encourage EPBs not covered elsewhere in the agenda: incentives. As one promising example, we conducted a before and after study of counselor incentives to improve retention of clients in an aftercare program in Massachusetts, with a \$100 incentive. The percentage of clients attending at least five sessions rose from 33% to 59%, a highly significant increase. As a second example, an ongoing collaboration with the Connecticut Department of Mental Health and Addiction Services plans to test incentives on a larger scale in the public sector. This example suggests how we hope that collaboration between researchers and managers of innovative public programs can contribute both to implementation of evidence based practices and knowledge for future activities.

We call the day's meeting "An Educational Forum" to acknowledge the need to gain knowledge around implementation. While no one-day forum could provide all the answers, we hope this forum contributes to our collective understanding and progress.

Welcome from the Massachusetts Department of Mental Health

ROBERT J. KEANE, PH.D., Deputy Commissioner for Clinical and Professional Services for the Department of Mental Health in the Commonwealth of Massachusetts

Welcome from the Massachusetts Department of Public Health

MICHAEL BOTTICELLI, Assistant Commissioner for Substance Abuse Services at the Massachusetts Department of Public Health.

Transforming the Mental Health System Through Evidence-Based Practices and Performance Measures

RONALD MANDERSCHIED, PH.D., Chief of the Survey and Analysis Branch of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration and Associate Professor at the University of Maryland.

Using Performance Measures for Quality Improvement in Behavioral Health: The Role of Stakeholders

CONSTANCE M. HORGAN, SC.D., Professor at the Heller School for Social Policy and Management, Brandeis University, and Director of the Schneider Center for Behavioral Health.

Identifying and Developing Evidence Based Practices

H. STEPHEN LEFF, PH.D., Senior Vice President at the Human Services Research Institute and an Assistant Professor of Psychology at the Harvard Medical School.

The mental health system is transforming itself to emphasize the delivery of practices that are evidence based. But how will stakeholders in mental health systems - consumers, providers, policy makers, and even mental health services researchers - recognize evidence-based practices when they see them? To answer this question we distinguish between two uses of the word practice. One is the “brand name” approach. Brand name practices are specific – often copyrighted or patented - interventions. The other is the “generic” approach. Generic practices are sets of interventions with specified common characteristics. In the future, brand name practices will tend to be recognized as evidence based if they are so designated on a registry sponsored by the federal government, a state, or some other payer for or regulator of services. Generic practices will tend to be recognized as evidence-based if they have been the topic of a meta-analysis accepted by a scientific research review organization or published in a high ranking peer reviewed journal. These trends will affect the way in which the evidence about interventions is developed, the definition of high quality care, the costs of implementing interventions and other

public policy concerns such as the cultural competency of interventions, disparities, and workforce training.

Implementing Evidence Based Practices in the Mental Health System

DAVID LYNDE, MSW, LICSW, Co-Director of the West Institute at the NH-Dartmouth Psychiatric Research Center.

This presentation will provide an overview regarding observations of implementing evidence based practices from the experiences of the eight states that participated in the national implementing evidence based practices project. Additional experiences with implementing EBPs in other state and public mental health systems are also included. The presentation will also utilize the basic stages of change model as a method to conceptualize the multiple questions, decisions and actions that appear to be crucial for a mental health system to widely adopt EBPs.

Mental Health Quality and Accountability: Evidence-Based Practices and Performance Measurement Initiative

VIJAY GANJU, PH.D., Director of the SAMHSA-funded Center on Mental Health Quality and Accountability at the NASMHPD Research Institute

This presentation provides that national context and an overview of initiatives related to system transformation and the renewed emphasis on mental health quality and accountability.

The presentation first reviews national initiatives related to evidence-based practices and the lessons learned from various implementation efforts. Then the presentation provides a similar context and review for mental health performance measurement initiatives.

Both sets of initiatives are related to each other and are put in an overarching paradigm of quality improvement towards achieving the goals identified in the report of the President's New Freedom Commission on Mental Health.

Implication and Next Steps for Massachusetts: The Department of Mental Health Strategic Plan

ELIZABETH CHILDS, M.D., Commissioner of the Massachusetts Department of Mental Health

Aligning Measurement-Based Quality Improvement with Evidence-Based-Practice Implementation

RICHARD C. HERMANN, MD, MS, Associate Professor of Psychiatry and Medicine at Tufts University School of Medicine and Director of the Center for Quality Assessment and Improvement in Mental Health

Two methods intended to improve mental healthcare are initiatives to implement evidence-based practices (EBP) and local, measurement-based quality-improvement (MBQI) activities. While overlapping in their intent, these methods embody different paradigms for driving organizational change. EBP implementation is generally a “top-down” process, proceeding from research synthesis, to intervention development and dissemination, to adoption and implementation by local provider organizations. In contrast, MBQI is generally a “bottom-up” process, whereby the local provider organization (e.g., a hospital or community mental health center) uses data to identify quality problems, diagnose factors underlying them and intervene to address them. There is ample opportunity for EBP implementation and MBQI activities to achieve greater convergence and synergy. For this to occur there needs to be alignment across multiple levels of the healthcare system. At the *organizational level*, local provider organizations would need to adopt measurable objectives for MBQI that address evidence-based clinical practices. At the *environmental level*, external entities that shape provider decisions (e.g., through incentives or accreditation mandates) would need to prioritize evidence-based measures as well. Their selections should be matched to the availability of toolkits, training and other resources that support uptake of EBPs. And at level of the *microsystem* where care is delivered—e.g., within a hospital inpatient unit—we hypothesize that selected QI objectives need to be concordant with local values, priorities, capabilities and resources. The presentation will further describe this model as well as ongoing research to advance the effectiveness of measurement-based QI.

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Implementing Evidence-Based Practices: Be a Know-It-All!!

WAYNE STELK, PH.D., Massachusetts Behavioral Health Partnership

Evidence-based Practices (EBP) are notoriously difficult to transfer from the research paradigm to the real-world clinic paradigm. There are many barriers to achieving in applied clinical settings the fidelity necessary to replicate a research-based clinical treatment. The implementation of EBPs is most likely to succeed when those responsible for implementation are highly knowledgeable in three areas: knowing the EBP product, knowing the clinical audience, and knowing the implementation strategy. This brief presentation will identify some of the components in each of these areas that are mission-critical to implementing EBPs that will demonstrate fidelity and positive treatment outcomes, and that will be sustainable over time.

Training Human Service Graduate Students and Professionals For Evidence-Based Approaches in Direct Practice: A Conversation About Pedagogical Challenges and Opportunities.

VINCENT J. LYNCH, MSW, PH.D., Adjunct Associate Professor and Director of Continuing Education at the Boston College Graduate School of Social Work

This presentation will address a variety of challenges and opportunities that relate to the teaching of evidence-based strategies to human service graduate students and professionals. Despite the importance which social work and other human service professions theoretically attribute to measuring care and treatment outcomes, there continues to be great resistance among many educators, students and practitioners to incorporating these ideas into teaching and practice activities.

An outline of typical attitudes, myths and beliefs held by many educators, students and professionals about evidence-based approaches will be presented. Bloom *et al*'s (1995) "single-subject" approach to practice, which employs clinical *and* research skills during individual assessment and treatment interviews, will be described as a useful framework for easily incorporating evidence-based strategies in counseling and psychotherapy interviews. Single-system designs essentially involve "...continuing observations of one client-system before, during and after some intervention" (Bloom *et al*, p. 4). This framework calls for measuring the frequency of "target behavior(s)" during a *baseline* period, followed by repeated measurements of those same behavior(s) during and after the *intervention* period. Some easily administered instruments which can be used by the single-subject practitioner for measuring target behaviors will be described (*e.g.* individual rating scales, target problem logs, standardized questionnaires, "do-it-yourself" questionnaires and how to use "anchoring" in general scale construction, etc.). A case example which employs single subject strategies will be presented.

Reference: Bloom, M., Fischer J. & Orme, J.G. (1995). *Evaluating Practice: Guidelines for the Accountable Professional*. Boston: Allyn and Bacon.

Stakeholder Panel Response: Implications for Massachusetts Implementation

ELIZABETH FUNK, MBA, President and Chief Executive Officer of Mental Health and Substance Abuse Corporations of Massachusetts, Inc.

Ms. Funk will offer the community-based providers' perspective on implementing Evidence-Based Practice. She will focus on some key elements in implementing a system change, using the experience of MHSACM's development of its 1995 Outcomes Measurement Project. Finally, she will note some current EBP collaborative efforts and review outstanding concerns relative to broad-scale implementation.

Implications for Massachusetts EBP Implementation

JONATHAN DELMAN, MPH, JD, Executive Director of Consumer Quality Initiatives, Inc

In general, I like EBPs, and prefer many of them to a lot of what is currently offered here in Massachusetts. I'm sure that if well-executed EBPs replaced some non-EBPs, the quality of public mental health care would be much improved.

On the other hand, given the limited resources of our community, I feel the need to explore the cost effectiveness of putting so much energy into EBPs. The question then is: Is there a strategy that will not only improve the quality of care and consumer outcomes, but also develop an infrastructure for continued effective research and improvement? There are two sub-questions I feel the need to address in order to consider the larger question.

Whose research and services are these? Consumers, such as myself, believe that mental health programs/services [practices] have been developed without our meaningful input. In addition, most services research have been conducted without our significant input. So what's the result: 1) a large percentage of research dollars have been wasted on studying non-EBP programs/services which consumers have not seen the actual or comparative need for, 2) if those wasted dollars had been applied to research on services consumers/families ["consumers] had expressed a need for (but not developed due to lack comparative consumer political will), we would not only have more EBPs, but a better process for developing EBPs.

An alternative I offer is greater investment of dollars in mental health Community-based Participatory Action Research (CPAR) projects. For those unaware, CPAR promotes equality between researchers and their community partners (who may also be researchers), with the result being more relevant research and greater buy-in on findings from the community. NIH has embraced this concept, and DMH has supported CQI's efforts to get a center off the ground (<http://www.cqi-mass.org/parc.html>), but greater enthusiasm from the research community at large is necessary to invigorate this alternative.

Can EBPs be implemented with fidelity or otherwise successfully? The literature is just beginning to address these issues, and the answers are wide-ranging and not definitive. My response has me revisiting the White Paper I wrote 1.5 years ago called "*Crossing the Mental Health Quality Chasm in Massachusetts.*" <http://www.cqi-mass.org/quality-chasm.pdf>. Since then, DMH has established a well-thought out strategic plan, and one of the foci is the implementation of a "Comprehensive Quality Improvement Plan." I share DMH's focus, and there is great consistency between its objectives and many of the recommendations I made in the White Paper. However, it needs to be recognized that DMH has been operating in a relatively decentralized fashion for some time now, without an infrastructure for practice standardization and data sharing. Thus, it's my view that for evidenced-based practices to be implemented successfully, there will need to be a DMH Central Office staff person ("Quality Director") whose complete focus is to lead and organize the diffusion of EBPs and other QI activities. Duties would include organizing the right people to be meeting with DMH area staff and providers to offer technical assistance and support. In other part, it's to work with the area quality managers to manage EBP management on a local level.