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

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Alhambra, California
March 13, 2015
“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
Hypothesis-Driven Research vs Discovery Science
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 problem.
- 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
The Healthcare System

Mental Health

SUD Treatment System

Residential

Outpatient

Prevention

Sober Living

Recovery Support

Medically Assisted Treatment

Prevention

Mental Health
Problem: Causes of Premature Death in the General Population

Proportional Contribution to Premature Death

- Genetic disposition: 30%
- Social circumstances: 15%
- Environmental exposure: 5%
- Health care: 15%
- Behavioral patterns: 40%
Value of Behavioral Health

Increased Cost of Chronic Disease w/Mental Illness Comorbidity\(^1\)

<table>
<thead>
<tr>
<th>Chronic Disease Condition</th>
<th>% Cost Increase w/Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>105%</td>
</tr>
<tr>
<td>Asthma</td>
<td>169%</td>
</tr>
<tr>
<td>Cancer</td>
<td>62%</td>
</tr>
<tr>
<td>CHF</td>
<td>76%</td>
</tr>
<tr>
<td>COPD</td>
<td>186%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>124%</td>
</tr>
</tbody>
</table>

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?

- Psychiatric Outpatient
- Outpatient MH Counseling
- SUD Outpatient
- Psychiatric Inpatient
- Residential
- Emergency Department
- Pediatrics, Childhood Trauma, SED
- Heart Disease - Cardiology
- ID/DD, Autism
- Diabetes and Obesity
- COPD, Asthma, Tobacco Use
- Prescription Drug Mgmt., Drug-Seeking, Narcotic Medication Abuse (pain meds, sleep meds, anxiety meds), Pharmacy Consult/Education
- SBIRT
- Health Home, Health Neighborhood, PCMH, ACO, CCO
- Intensive Case Mgmt, Care Coordination, ACT
- Disease Mgmt

How Many Opportunities for Innovation Might There Be?

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## Elements of an Organized System of Care

<table>
<thead>
<tr>
<th>Residential Facilities</th>
<th>Outpatient Services</th>
<th>Narcotic Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Withdrawal and Stabilization</strong></td>
<td><strong>Brief Treatment</strong></td>
<td><strong>Outpatient Withdrawal and Stabilization</strong></td>
</tr>
<tr>
<td><strong>Short-term Residential Care</strong></td>
<td><strong>Outpatient Treatment</strong></td>
<td><strong>Methadone Maintenance</strong></td>
</tr>
<tr>
<td><strong>Long-term Residential Care</strong></td>
<td><strong>Intensive Outpatient Treatment</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Legend:**
- Green cubes represent residential care services.
- Yellow cubes represent outpatient treatment services.
- Blue cube represents narcotic treatment services.
### Other Possibly Useful Service Components

<table>
<thead>
<tr>
<th>Sober Living Facilities</th>
<th>Addiction Physicians</th>
<th>Continuing Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sober Living Facilities</strong></td>
<td><strong>Medication Assisted Treatment for Opiate Addiction:</strong> Suboxone, Naltrexone</td>
<td><strong>Recovery Centers</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Medication Assisted Treatment for Alcohol Abuse and Dependence:</strong> Vivatrol, Acamprosate, Ondansetron</td>
<td><strong>Recovery Check-ups</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Telephone Support Services</strong></td>
</tr>
</tbody>
</table>
Patient's house
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
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
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
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 **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.
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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