

Uniting practice-based evidence with evidence-based practice

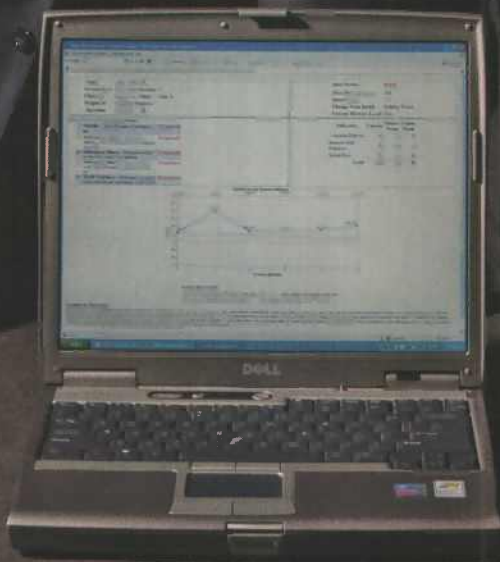
Utah has brought all stakeholders together in a consumer-focused outcomes measurement system

BY MICHAEL J. LAMBERT, PhD, AND GARY M. BURLINGAME, PhD

Administrators at Utah's Division of Substance Abuse and Mental Health (DSAMH) have implemented a bold initiative: managing all statewide mental health services on the basis of real-time outcomes of services provided by approximately 1,500 clinicians. Utah elected to implement a consumer-centered outcomes system repeatedly shown to improve outcomes and reduce treatment failures in six rigorous randomized clinical trials.¹⁻⁶

Mark Payne, DSAMH director, states that the division's primary goal is to improve care and access to services by pushing beyond the mere provision of evidence-based practices (i.e., laboratory clinical trials). In the division's view, using evidence-based practices or "best practices" for specific treatments is only one way to maximize patient benefit and, by itself, is inadequate for ensuring quality of care for the individual consumer. A critical and complementary procedure is to manage care by examining *practice-based evidence*.

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In short, practice-based evidence consists of real-time patient outcomes being delivered to clinicians immediately before treatment sessions and using outcome data on all patients to make decisions about effective interventions. DSAMH believes that a practitioner should know the consequences of behavioral healthcare for each individual receiving treatment. This belief is founded on solid evidence from clinical trials, in which feedback on individual patient progress *during* therapy improves the eventual outcome, produces more cost-effective treatment, and reduces waiting times for treatment. Progress data inform decisions to discontinue more expensive care when maximum benefit is reached (i.e., clinicians have more information to consider stepping up or stepping down care).

Using evidence from the real world and laboratory research, Utah partnered with a vendor of outcome measurements (OQ Measures, LLC) last year to implement a five-minute self-report outcome measurement across its entire care continuum (inpatient, outpatient, residential, etc.) and with all facilities contracting with the state, as well as state-run facilities. A significant advantage to this approach is the ability to monitor patients' progress regardless of the care setting.

When the partnership between the state and vendor began, two of the state's mental health centers already were having success with using the vendor's software package, which collects self-report assessments before each treatment session using a handheld PDA (figure) or computer kiosk, or paper survey. The software system provides real-time (five seconds from entry) reports to clinicians on a patient's "mental health vital signs," which are tracked based on three dimensions: adults' symptomatic distress, interpersonal relations, and functioning in daily activities. Adolescents and parents/guardians provide parallel information on age-normed questionnaires.

Most importantly, the scoring software applies empirically derived and tested algorithms that identify consumers whose treatment response is off-track for a positive outcome. The software system then alerts the clinician with an electronic or printed report that identifies clients who need

particular attention—i.e., cases at risk for treatment failure.

A similar procedure is used in primary care to monitor blood pressure. A high blood pressure reading may result in an initial prescription of diet and exercise. If that works, there's nothing more to be done. If blood pressure remains high,

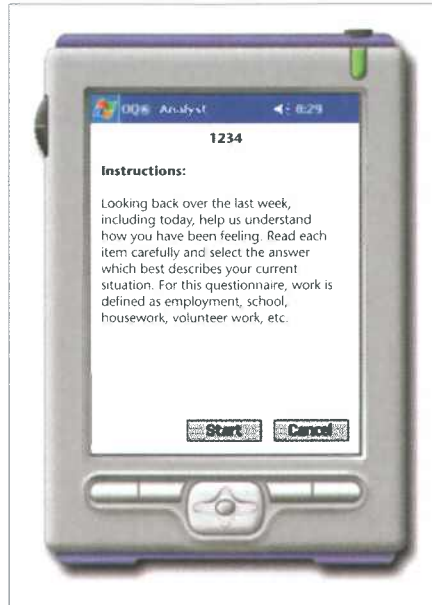


Figure.

the physician may intensify treatment by prescribing medication. Behavioral health organizations can systematically apply the same management procedures in mental health and substance abuse care. In Utah, when clients not on track for a positive outcome are identified (about 20%), the software provides additional assessments for problem solving, along with a decision tree and suggested interventions (clinical support tools) for such cases.

The most distinctive feature of DSAMH's system is its central focus on collecting data to provide clinicians with real-time, consumer-focused outcomes. Using real-time outcomes is in stark contrast with the typical practice of collecting and storing outcome data for quarterly or annual administrative reports. Nevertheless, the accumulated data can support subsequent practice research that examines which treatments or services are particularly effective, as well as support regular administrative reports. Thus, practice-based evidence ultimately drives

initiatives to improve service delivery by examining treatment center and regional variations in outcomes. The greatest advantage of this type of research is that it relies on what actually takes place in clinical practice.

A core principle of practice-based evidence is that all services are *assessed* to determine if they have their intended impact—improving patient well-being. Since *practice* is the core driver, it meets both practitioners' and managers' desires to provide quality services assessed in part by repeated consumer-based outcome assessments. However, practitioners' *adoption* of practice-based evidence in service delivery is crucial, as they strive to generate solutions to improve outcomes at the local level with individual clients. This is why each Utah clinician and administrator receives brief training in how to use the software system to improve their patients' clinical outcomes.

Practice-based measurement systems need to realistically fit into daily clinical practice to ensure continuous use. Adopting routine measurement systems requires using information technology systems. Practice-based evidence makes the individual client central because predicting the course of progress in treatment is based, in part, upon his/her initial mental health vital signs. More specifically, the DSAMH's practice-based evidence relies upon sophisticated statistical procedures applied to large clinical data sets drawn from practice research in Utah and insurance companies that cover more than 17.5 million lives across the nation. These statistical procedures produce a predicted trajectory of change for clients who enter treatment at varying levels of distress. These predicted trajectories are used for triage or for comparison against a client's actual progress, supporting clinical decisions *during* treatment. In short, predicted change trajectories provide a continuous reference or benchmark against which to evaluate an individual patient's progress. Using statistical information on expected treatment response parallels practitioners' use of tacit clinical information to guide them through successive clinical decision-making processes, supplying them with greater predictive accuracy.

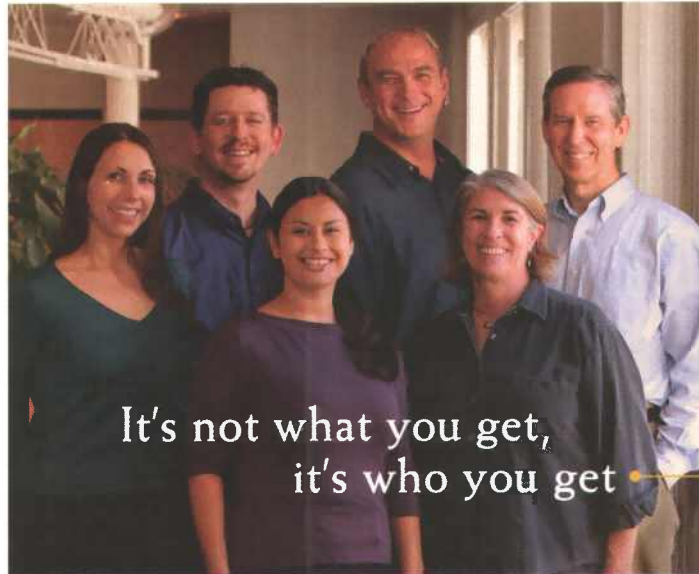
SAMPLE

At the organizational service level, the focus moves to groups or clusters of clients rather than individual clients. Thus, rather than providing feedback on the individual client, aggregate feedback data are provided to assist in quality of service delivery decisions on a macro level.

For instance, the Utah State Hospital had used aggregate outcome data to calculate the average level of symptom distress for patients at discharge using multiyear in-house data. The hospital now uses target scores derived from self- and practitioner-completed outcome assessments as one “trigger” for initiating discharge planning discussions with patients, inpatient treatment teams, and the referring community mental health centers. Outcome data with target scores now provide a hospital-wide metric that reduces unit or practitioner preferences (e.g., length of stay, medication, etc.) based on patient level of functioning—outcomes provide common mental health vital sign metrics. Since every center referring to the hospital now uses the same mental health vital signs, historical trends in outcome scores (symptom distress) assist in decision making between facilities and, of course, for continuous monitoring.

When aggregate outcome data are available, program and client characteristics can be examined as potential mediators or moderators of outcomes within a service setting. One component within any service that has received relatively sparse attention is the practitioner. Traditional treatment-focused research aims largely to make therapist contributions irrelevant. However, Okiishi et al, using a database on 71 practitioners, found considerable variation between average rates of clients’ change, with top therapists showing average rates of client recovery twice those of bottom-ranked therapists.⁷ The top therapists also had half as many patients whose condition deteriorated. None of the differences could be attributed to the use of specific types of psychotherapy. These and similar findings underscore the urgent need to address the issue of therapist effectiveness, which is wholly consistent with Utah’s new practice-based evidence approach. While it seems logical that some therapists are more effec-

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