

ISCTM 2010 National Mental Health Research-to-Policy Forum:
The Role of CER in Future Mental Health Policy Decision Making

Session 2:

**Relating the Science of CER to
Mental Health Policy and Clinical Care**

Sir Michael Rawlins, MD

Chairman, National Institute of Health &
Clinical Excellence (NICE)

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Joe Parks, MD

Medical Director, Missouri Department of Mental Health;
President, Medical Directors Council, National Association of
State Mental Health Program Directors (NASMHPD)

My Background

- Medical Director and former Division Director Comprehensive Psychiatric Services
 - Operate hospitals, contract for outpatient
 - 4500 employees, 500 contractors
 - \$369 million treats 74,000 patients per year
- Consultant to MoHealthNet (Missouri Medicaid)
- President NASMHPD Medical Director's Council
- Practicing Psychiatrist

National Association of State Mental Health Program Directors (NASMHPD)

- Membership is the Commissioners/Directors of state mental health agencies all 50 states, 4 territories, and the District of Columbia who are responsible for the provision of mental health services to citizens utilizing the public system of care.
- Represents the \$23 billion public mental health service delivery system serving 6.1 million people annually.
- NASMHPD Medical Directors Council identifies emerging clinical and provides policy guidance to national mental health leadership

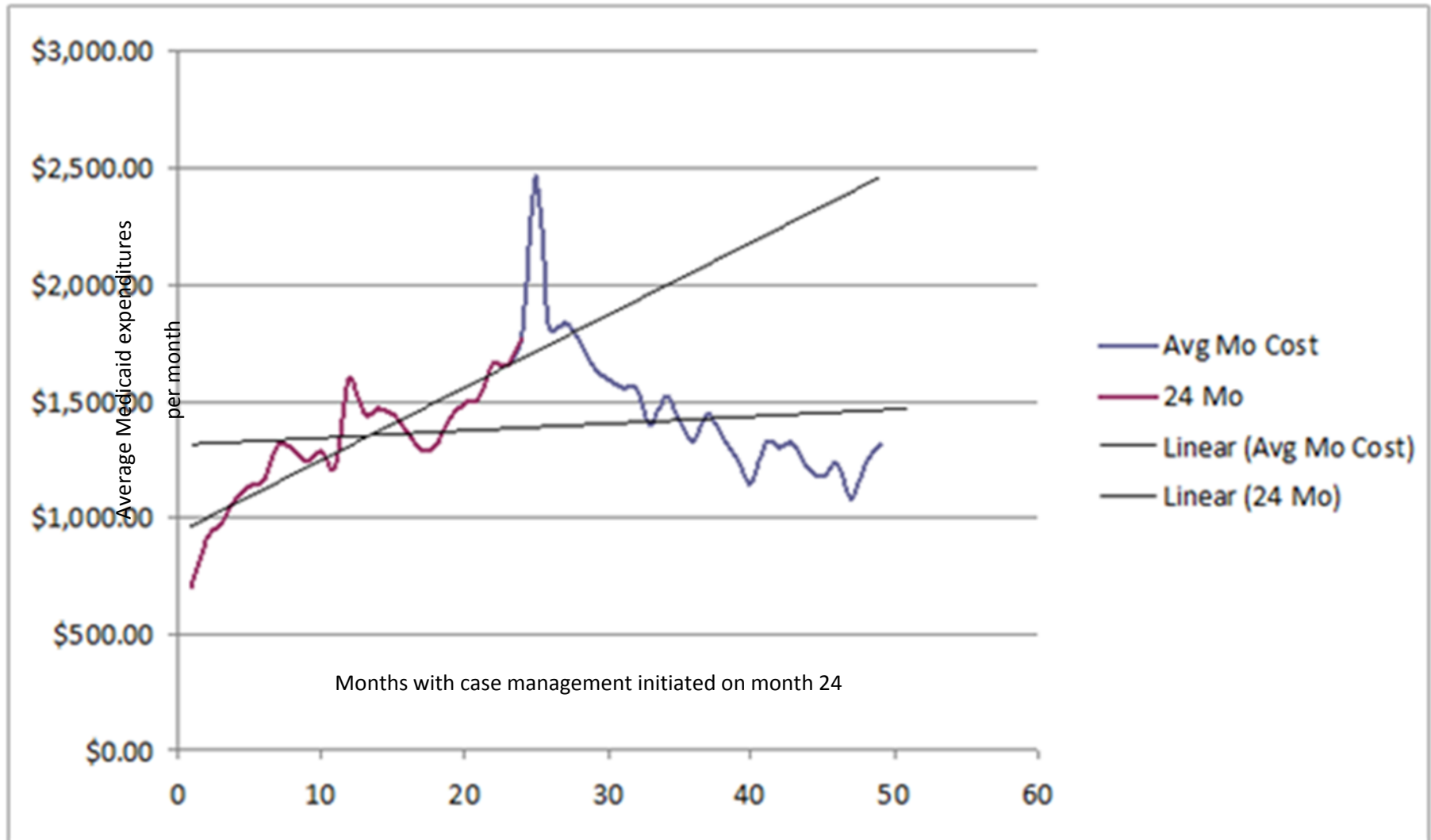
What I Need CER for

- General Operational Needs
 - Funding specific programs/services
 - Choosing target populations
 - Rate setting
 - Designing benefit packages
 - Methodology that uses data I have and/or minimal standard data set suitable for many different analyses
- Most Helpful Focus Areas
 - High-volume standard services
 - Services as delivered in the average care setting

CER Needed for Better Management

- Who should be served specialty mental health system instead of primary care?
- Treatment planning – any value added?
- Children's System of Care – any value added?
- Mental Health community support/case management (not ACT)
- How many choices have to be on a PDL

Total HealthCare Utilization Per User Per Month Pre and Post Community Mental Health Case Management



Atypical Choices for Initial Access in States Using a PDL

- All Seven 7 States
- Six Choices 7 States
- Five Choices 5 States
- Four Choices 5 States
- Three Choices 1 State
- Less than 3 Choices - None

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Karl Broich, MD

Deputy Head, Federal Institute for Drugs and Medical Devices,
Germany (Bundesinstitut für Arzneimittel und Medizinprodukte)

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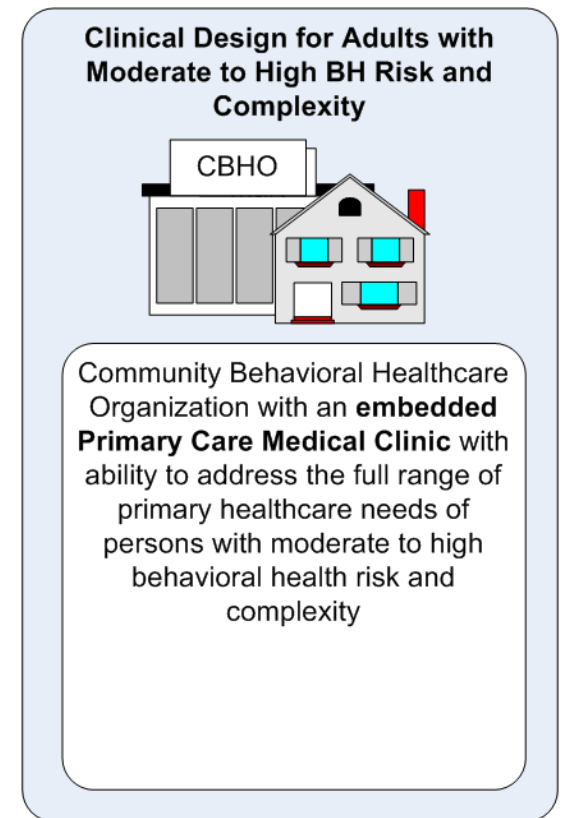
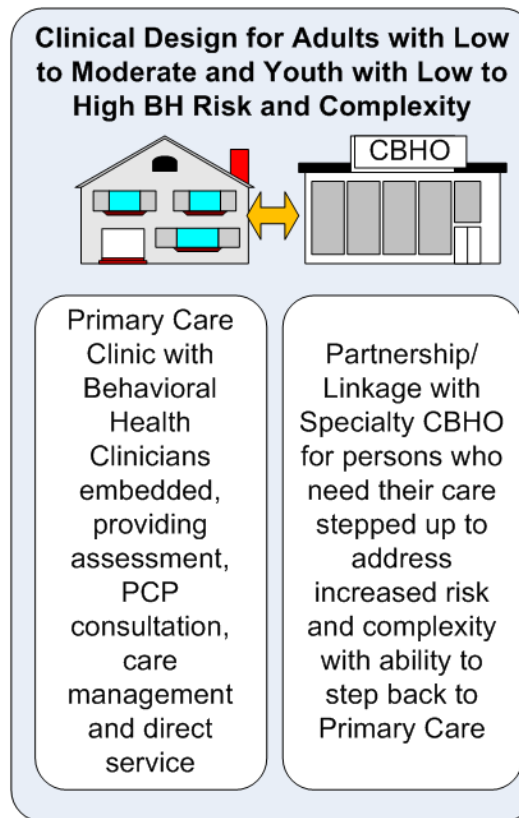
Dale Jarvis, CPA
MCPP Healthcare Consulting, Inc.

My Background

- Managing Consultant at MCPP Healthcare Consulting, a Seattle-based consulting firm, and a member of the National Council for Community Behavioral Healthcare's Consulting Services
- 23 years experience consulting with over 300 community-based behavioral healthcare providers, Medicaid mental health plans, and state and local governments

Context for CER in Community-Based Systems

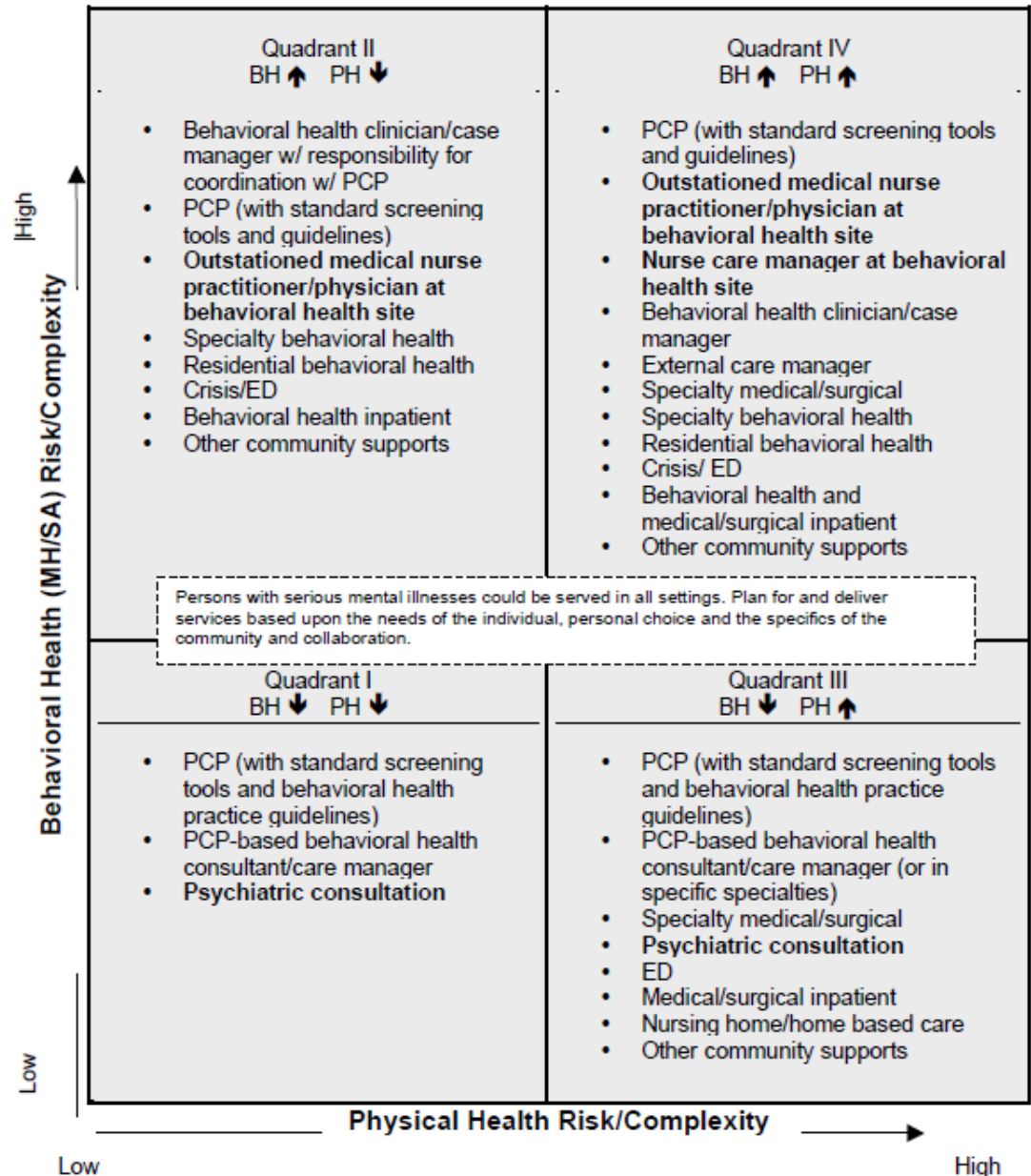
- The behavioral healthcare delivery system is on the cusp of a major transformation as integration of primary care, mental health and substance use accelerates
- We are expecting widespread use of bi-directional care: BH in PC and PC in BH
- With both systems implementing evidence-based clinical designs
- This changes the landscape of where and how evidence will be used



Context for CER in Community-Based Systems

- The 4-Quadrant Model is a framework for describing the populations, model elements, and clinical roles for providing BH in PC and PC in BH

The Four Quadrant Clinical Integration Model

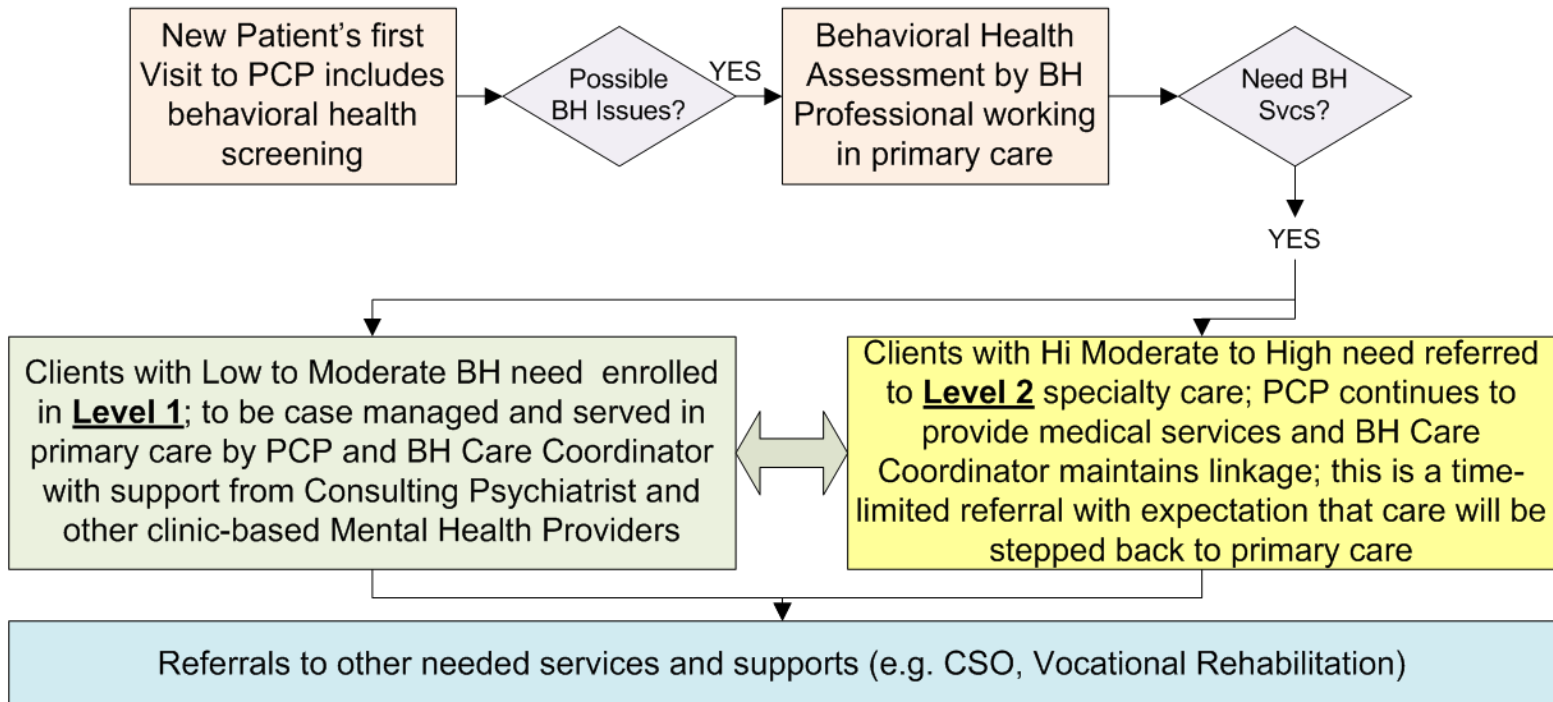


Context for CER in Community-Based Systems

- Example of an emerging BH in Primary Care model

Person Centered Healthcare Home Clinical Design based on IMPACT Model

- Systematic outcomes tracking (e.g., PHQ-9 for depression, GAD-7 for anxiety)
- Treatment adjustment as needed including stepped care (e.g. up to specialty BH) (based on clinical outcomes, evidence-based algorithm; in consultation with team psychiatrist)
- Relapse prevention



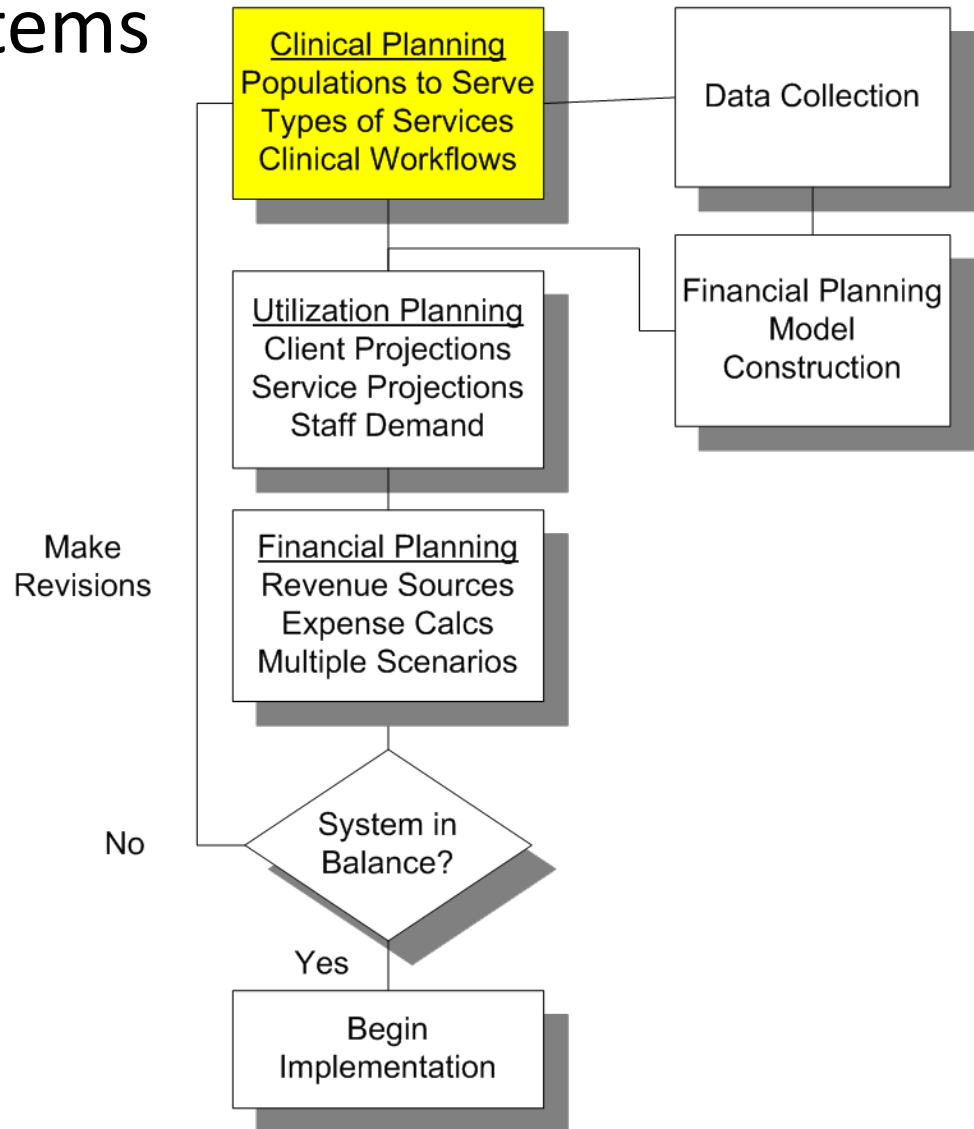
The IPI Continuum: A Collaborative MH/SU/Primary Care Continuum for the Safety Net Population

	Mild MH/SU Complexity	Moderate MH/SU Complexity	Serious MH/SU Complexity	Severe MH/SU Complexity
Optimal MH/SU services for each MH/SU level, for all ages (children, youth, adults, older adults) [Note: varying resources may not permit availability of all services within each level in every community, but all four levels of care should be available]	- Screening and assessment of commonly presenting MH/SU - Care management as needed - Self management goal setting (for MH/SU and physical health conditions) education, activation	- Care management/registry tracking of those receiving services - Self management goal setting (for MH/SU and physical health conditions) education, activation and relapse planning	- Care management/registry tracking of those receiving services - Assessment and monitoring of key health indicators¹ - Self management goal setting (for MH/SU and physical health conditions) education, activation and relapse planning	 - Care management/registry tracking of those receiving services - Assessment and monitoring of key health indicators¹⁸ - Self management goal setting (for MH/SU and physical health conditions) education, activation and relapse planning/Wellness Management and Recovery
	- Brief problem-oriented counseling/therapy - Prescribing “Watchful waiting” - Stepped care (changes in the types and intensity of services, medications) within this level or to another level	- Brief treatment of MH conditions, crisis plan - Prescribing - Pain Clinic - Psychiatric consultation for care manager/PCP - Stepped care (changes in the types and intensity of services, medications) within this level or to another level	- Risk assessment and crisis plan - Person-centered treatment plan - Treatment of MH disorders using evidence-based practices - Prescribing - Psychiatric consultation for care manager/PCP - Stepped care (changes in the types and intensity of services, medications, crisis and inpatient services) within this level or to another level	- Risk assessment and crisis plan - Person-centered treatment plan - Intensive Case Management Team/Assertive Community Treatment² - Family Psychoeducation - Medication Management - Supported Education - Supported Employment - Supported Housing/Housing First - Consumer-Operated Service Programs - Children’s Services - Stepped care within this level or to another level
Examples of evidence-based/ effective MH/SU	- IMPACT³ - Cognitive Behavioral Therapy - Motivational Interviewing - Screening, Brief Intervention, Referral and Treatment (SBIRT)⁴	- IMPACT²¹ - Cognitive Behavioral Therapy - Motivational Interviewing - Screening, Brief Intervention, Referral and Treatment (SBIRT)²²	- IMPACT²¹ - Cognitive Behavioral Therapy - Motivational Interviewing - Dialectical Behavioral Therapy - Functional Family Therapy	- See SAMHSA Evidence-Based Practices KITS available or in development¹⁹ [listed above] - Cognitive Behavioral Therapy - Motivational Interviewing - Dialectical Behavioral Therapy

CER Needs in Community-Based Systems

Program Design

- States, regions, and communities are redesigning their clinical, financial and management infrastructures to support bi-directional care
- They are doing so with limited evidence about clinical structures that work best for different populations:
 - Youth, adults, older adults
 - Persons with mild, moderate, serious and severe disorders
 - MH only, SU only, Co-occurring

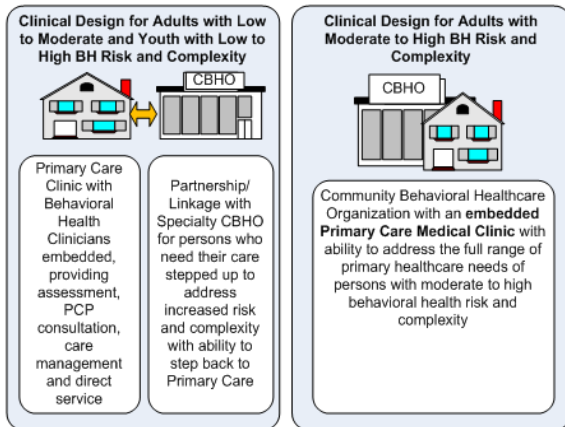


CER Needs in Community-Based Systems

Treatment Interventions



- Primary care clinic leadership need additional guidance to support treating a broader array of BH conditions in primary care
- Specialty MH/SU leadership need additional guidance to:
 - Support PCPs through the roles of BH Consultants in PC
 - Manage the stepped care transitions (up and down)
 - Better serve serious/severe in specialty care
- Severe funding limitations, large capacity/ demand gaps, and the absence of financial incentives have reduced the ability of both types of organizations to maintain/create the infrastructure to support CER research and translate theory into practice on a timely basis



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H. Stephen Leff, PhD

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