**IDEAS National Advisory Board Meeting (October 29 & 30, 2013)**

**Framework for Advisory Board Meeting Discussion (Hoagwood)**

1. **What we leave behind for the MH system after P30 funding ends:**

* **Tools for measurement of services** (e.g. quality indicators) and **implementation strategies** (e.g. toolkit for embedding FPAs) to assist in state rollouts of evidence-based practices (**adoption ‘interventions’**).

2. **IDEAS Center Accomplishments:**

**What we Know:**

1. FSS Evidence
2. Adoption Training and Tools (CTAC & EBTDC)
3. QI’s for Improved Tx

**Next Steps: Turn into Toolkit for ACOs:**

1. Increase Access

2. Reduce Expenses

3. Increase Quality

4. Improve Outcomes

* **Built strong evidence-base on family support model** (i.e. family support model (i.e. PEP), tools and methods for data collection and evaluation, and implementation strategies (i.e. ARC);
* **Developed and testing of quality indicators** for family support services, adolescent depression, prescribing practices (PSYCKES);
* **Special Journal Issues** (FSS, Coaching and Consultation, Mixed Methods);
* **Large-scale EBP training expertise** (EBTDC, CTAC).

**3. Where to invest Center time and energy?**

Ongoing studies include F2F, Adoption Study, QI measures work (adolescent depression, PSYCKES); newly-funded grants include Mobile Health for Behavioral Health (Chacko), Task-Shifting /MFGs into Child Welfare (Gopalan); RO1 resubmission, MFG for Youth w/DBD (McKay & Hoagwood).

**Priorities for IDEAS:**

* **contextualize** to be able to generalize;
* focus additional **QI work**: patient-centered outcomes, depressed mothers;
* quickly develop **interventions** for viable NYS clinics;
* focus on **functions** not institutions;
* conduct **external scan and partner** w/NSMHPD, NGA, LCSL, CMS Medicaid;
* **tools for MCOs** for early childhood (0-5) prevention programs

4. **Obtaining post-NIMH funding for IDEAS Center**

**a. State**. Expansion of CTAC work, partnerships w/*pediatric care* leaders (Tom Farley, Jim Talon) and Patient Centered Medical Homes (Sarah Scholle, NYS).

1. **Federal.** SAMHSA (Patton/Delaney), *MH TA Center* (partner w/ constituency group(s) for turnkey TA activities; explore *Primary Care TA* partnerships ([United Hospital Fund](http://www.uhfnyc.org/), [Primary Care Development Corporation](http://www.pcdc.org), Sherry Glied)
2. **Fee-for-Service Business Model.** Business model/service center for other States, to include toolbox of tools for functions and specialty care (e.g. foster care). Important to keep synergistic academic and state services connections.

**Summary of IDEAS Center Studies: Action Items**

**1. Clinic Technical Assistance Center (CTAC) and The Adoption Study**

* studies like these important for NYS (long-standing effort to improve adoption of EBPs, 2006-on) and all states investing EBP $.
* adoption dataset is **valuable** (e.g. adopter groups (low, medium, high and super-adopter) communicate meaningful adopter profiles, most important is super-adopters information, must include qualitative mixed methods collected in systematic way;
* CTAC efforts instilled more rational clinic decision-making process (even if not to adopt) by forcing benchmarking of financial data;
* created **academic learning laboratory and test environment** for implementation approaches (e.g. MAP and common elements approach).

**Action Items:**

* **Develop strategies & tools for clinics in new era of managed care plans:**
	+ for the 25% of clinics will be financially viable (tools to show ROI to managed care plans);
	+ for the 25% that ***may b***e financially viable (simulation tools to increase financial viability);
	+ for the 50% we know are not viable *(*use Palinkas social networking, help structure consortia to help them manage risk and still provide services to the population; or provide plans for orderly closure of clinics where partnerships not possible).
* **Quality Indicators (or ‘what would plans want?)**. Study other state efforts (MA, MI) efforts in this area (e.g. pay-for-performance), and focus on developing behavioral health measures because where there are measures, behavioral health care gets integrated (integration of care is really integration of risk; see also AHRQ published tools for measuring the integration of BH and primary care). Important lesson = successful organizations are based on the **PATIENT outcomes** (e.g. hand-washing, keep patients well) not ORGANIZATIONAL outcomes (e.g. clinic), and keeping organizations well (e.g. learning orgs, LCs).
* **Naturalistic Study**. Consider going back to OMH to propose cohort study (great data at NKI, Jim Robinson), with clinic as unit, as this transition occurs, to look at access to care (e.g. mystery shopper), quality of care (CTAC original purpose) for all clinics and follow BEAM participants through CARES QI, see who ‘dies,’; data available for propensity score matching, regional rollout, delayed start. Partner w/NYSDOH (Shah), new multi-payor database and NY Foundation for Mental Health.
1. **Family-to-Family Study (F2F).**
* ARC organizational training almost complete, recruiting families

**Action Items / Opportunities:**

* Waiver programs (F2F study there) may be health homes in New York State
* FPAs are para-professionals who are *more economical* than PhDs, counselors
* chance to energize family support movement;
* Consider plans for packaging, replicating and how to spread the use of this set of services.
1. **Development of Quality Indicators for Adolescent Depression**
* depression care pathway created (Lewandowski et al) by analyzing common elements; limited evidence in child lit for 8 of 11 of the care pathways;
* Studied care pathway in Bellevue (NYS), Kaiser (Colorado) and GroupHealth (Denver). Findings: 1) screening not routine; 2) pediatric screening rate is what you expect in pop 3) we don’t know what happened to kids (data behind firewall), and taking a newer sample to see if data is the same.

**Action Items / Opportunities:**

* Look at comparators (West Coast), is it possible to get at the context of these places (e.g. embedded clinician) and explore the role of the family (self-report and parent-report) in measurement and potential use of PCORI funding?
* Set up measures at **system** level (where money is going, Medicaid managed care), **not organizational level,** through organizations like APA, NCQA and partner with Mary Durham and Greg, need state Medicaid authorities (Foster, Medical Director of Medicaid) at the table.
1. **Foster Care and Psychotropic Drug Use (Bonnie Kerker)**
* this study part of larger ACF-funded project to insert trauma-focused interventions into clinics, concern re: high-rates of antipsychotic Rx use;
* limited data (Connections dataset) on psychotropic use among NYC children in foster care; 30% foster care, 13.5 welfare.

**Action Items / Opportunities:**

1. Re-focus future work from antipsychotic medications effect on placement disruption (will be too difficult to pick out effect) to providing State Medicaid directors with **tools to help them care for this very expensive population of children**. Instead, look at top two diagnoses (ADHD and adjustment disorders, maybe trauma, these capture 60%) and see what can we do there?
2. Partner with Ramesh/Laurel. Use common factors approach, focus on what they are not getting which is proven psychosocial treatments. Also, review Jewish Family Services study. See also NYC efforts to build to scale Project KEEP (Oregon Social Learning Center), using PMTO, training case-workers to deliver Project KEEP. What can you do to bring in low-cost behavioral interventions.
3. **PSYCKES (Molly Finnerty)**
* quality Indicators effort to measure use of psychotropic meds due to prescribing trends, clinical concerns (metabolic) and public policy concerns (safety and disparities in use, e.g. Medicaid, race).
* Quality improvement initiative found NYC better than rest of state.

**Action Items / Opportunities:**

* Focus on developing these **quality indicators** (develop additional measures for children; examine correlates for measures developed (e.g. analysis for psychosocial) characterize use of antipsychotics in children). Add *patient-reported outcomes* in order to be able to be integrated into larger health systems, and work on content.
* Figure out how to get **PSYCKES picked up by the managed care plans** (e.g. develop a clinic a tool to spit out data that says we are good at x or y so that the plan picks them up (see Barbara Stanley, safety planning application) so that system-wide changes can be made. Note also that PSYCKES can be used by Care Managers (i.e. Family Peer Advocates) to help guide care.

**Overall environmental Context for Conducting IDEAS studies:**

Existing and new IDEAS studies (study targets and outcomes) need to be modified to meet new healthcare system needs (ACA and healthcare exchanges). ACOs and health homes (all budgeted systems) they have high-powered financial incentives to cut corners, will need big time performance measures to keep them in line and from making shortcuts, insure quality care.

**BOTTOM LINE**: New environment (ACA & Exchanges) need QUALITY MEASURES – IOM, NIMH efforts in this area, $1 million to create behavioral care quality measures. Psychosocial measures largely ignored in quality measures; should include family-report measures.

**Action Items / Opportunities:**

* consider how IDEAS studies meet **needs of managed Medicaid and private plans for quality measures** and reducing costs (e.g. quality indicators FPA-provided services, reducing costs of care via use of FPAs);
* how IDEAS data or tools can assist regional accountable care organizations in providing better quality care (e.g**. quality indicators** for antipsychotic use, PSYCKES);
* add to existing CTAC or new study of the integration of primary & behavioral healthcare.
* Read Brookings Institution White Paper on ACA and Federalism

**Potential New IDEAS Studies in New Era of Healthcare (ACA and Exchanges)**

1. Tremendous opportunity for study of provision of MH services in:
	1. **New State Exchanges** (23) **vs. federally-run exchanges** (27) to study variations in: activist vs. passive systems, choice of benchmark, degree of competition, and level of outreach activities / navigation quality.

Issues to study: Selection issues (how they pick), total spending, navigator variation by state (in some cases coordinators for care and navigators overlap), and impact of parity in small grp and individual markets (cost, access,, and treatment patterns). Parents AND kids are now covered by services; a different way to look at contextualization; potential for comparative PCORI application looking at engagement (open access, EBP engagement and family peer advocates)

**b. New State Medicaid Expansions** (23) vs. non-expansions

Issues to Study: Not many kids picked up here; most pressing to study are COMPLEX FAMILIES (e.g. foster care; specialty service orgs will pop up to manage risk for these populations; new ACF contract out to develop foster care quality measures; study ‘churning’ problem, Medicaid is 30-40% cheaper per person than the basic health plan.

1. **Evaluating the ACA.** A significant amount of data will be available potentially to study: Kaiser Study in CA (cohort study); RWJF Internet Survey; state-based data in state healthcare marketplaces; rate review required by feds will produce data on rates and assumptions; reinsurance data going to be revealing; study of navigators (some FPAs?); states’ multi-payor databases (NY going live next month.)
2. **Effectiveness studies of Nurse Family Partnership,** funded under ACA. What are active ingredients? Can we do stepped care because of cost?
3. **How to serve special populations better under ACOs** (e.g. foster care); consider partnering with big cities / regional ACO, who are more connected to these populations.
4. **Develop and study interventions that link TANF and parenting** (e.g. PMT courses, 4R’s and 2S’s); see also CT study on TANF and tx for domestic violence, increased back-to-work); also, PMT intervention, delivered by FPA, for preemie population mothers (preemies 1/4 of hospital costs), make parents feel more efficacious (including contraception to prevent quick 2nd birth).
5. **Partner with urban ACOs (all in Medicaid-rich data environments) to help them treat kids with conduct disorder.** Epi studies show 40-45% of kids in low-income w/conduct disorder. Now, ACO responsible for these kids for long period (5 years).