

EVIDENCE BASED PRACTICES OUTCOMES AND COST BENEFITS WORKGROUP

Date: 5/25/05

Attendees:

Marion David, OMHAS, Facilitator; Erin Whitemore, Morrison Child and Family; Clifford Hartman, Linn County Mental Health; Jay Roberts, Cascadia Behavioral HealthCare; Teresa Posner, Verity/Multnomah County MHASD; Pamela Clark, OMHAS; Jay Harris, ABHA; Janet Walker, RRI

KEY DISCUSSION POINTS

There was confusion about what the group was supposed to be discussing at the meeting. The following concerns were raised.

1. Need for a mission statement and clarification of what role the group will play in
 - Refining the definition of an evidence-based practice. Is further refinement of the definition a possibility at this point in time? There are still concerns about the definition; e.g., it appears that treatments developed for people of color still do not qualify as level 3 practices in the absence of peer-reviewed published research. If the provider of a practice not supported by published research can demonstrate that the practice is having good outcomes, will the practice be accepted as level 3?
 - Defining the process for submitting a practice for consideration as an evidence-based practice; submitting practices for consideration as evidence-based practices; defining the process for reviewing a practice to determine if it is evidence-based; and reviewing practices to determine if they are evidence-based. The group needs to know who within and outside of OMHAS will be reviewing the practices. For example, will any members of this workgroup be reviewing practices? If the process for submitting and reviewing practices is already clearly defined, then the process needs to be shared with members of the group.
 - Delineating, refining or approving methods for measuring the fraction of treatment that is “evidence-based.” Delineating,

refining or approving methods for measuring the cost and/or cost effectiveness of treatment. Delineating, refining or approving methods for measuring treatment outcomes.

2. Asking providers to track what treatments are being provided and the fidelity of the treatments being provided, as well as to measure the cost of treatment and the outcomes of treatment, is asking too much.

Points made:

- The legislation requires us to track only three outcomes, at least two of which we can track using existing data sources. (It is not clear if we could track use of crisis/emergency services.) Given this, is it necessary for clinicians to track outcomes?
- One member of the group stated that, if we demonstrate an increase in use of evidence-based practices, we may be able to *assume* better outcomes (that is, we are pushing EBPs **because** we assume they yield better outcomes). If one accepts this argument, then again is it necessary for clinicians to track outcomes?
- Frequency and/or quality of training in the use of evidence-based practices, and frequency and/or quality of monitoring of adherence to evidence-based practices, could themselves be outcomes. If we choose process outcomes like these, we will support better practices and thereby support better treatment outcomes.
- It is probably not necessary to track every treatment provided to determine the cost of every treatment provided, or determine the outcome of every treatment episode. For example, we could evaluate a random sample of treatment episodes to determine what fraction is evidence-based and/or what fraction yields positive outcomes. As another example, we could select just two alternative treatments that are now being used for a given patient population, and compare those treatments on cost and benefits.

3. Other comments and requests:

- Have the data on the prevalence of evidence-based practices been updated since the end of March? At that time, only 22/38 counties were reporting their data.

- Do we have numbers for prevention services?
- We need to distribute materials electronically to the entire workgroup, preferably before meetings.
- Mike Morris has apparently been using the General Organizational Index to evaluate programs. We need to coordinate with him and determine if the GOI could be more widely implemented. Again, there is interest in using the organization's ability to do good QI as an outcome.
- We will determine if the Oregon Program Evaluators' Network could be of assistance.
- Providers don't always understand the concept of fidelity to treatment. It would be helpful if they could have some training around fidelity.
- How does or should this group interface with others inside and outside OMHAS?