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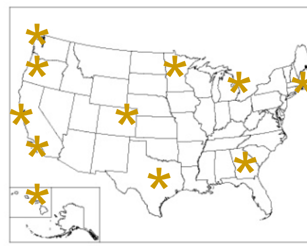

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# Should mental health interventions be locally grown or factory farmed?

Greg Simon – Group Health Research Institute

Supported by NIMH cooperative agreement U19 MH092201

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# My original title was really a lament:

Why can’t EBPs be less like broccoli…

and more like crack?

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# Then I saw this:

Article

## Practice-Based Versus Telemedicine-Based Collaborative Care for Depression in Rural Federally Qualified Health Centers: A Pragmatic Randomized Comparative Effectiveness Trial

John C. Fortney, Ph.D.

Jeffrey M. Pyne, M.D.

Sip B. Mouden, M.S., C.R.C.

Dinesh Mittal, M.D.

Teresa J. Hudson, Pharm.D.

Gary W. Schroeder, Ph.D.

David K. Williams, Ph.D.

**Objective:** Practice-based collaborative care is a complex evidence-based practice that is difficult to implement in smaller primary care practices that lack on-site mental health staff. Telemedicine-based collaborative care virtually co-locates and integrates mental health providers into primary care settings. The objective of this multisite randomized pragmatic comparative effectiveness trial was to compare the outcomes of patients assigned to practice-based and telemedicine-based collaborative care.

**Method:** From 2007 to 2009, patients at federally qualified health centers serving

manager and a pharmacist by telephone, and a psychologist and a psychiatrist via videoconferencing. The primary clinical outcome measures were treatment response, remission, and change in depression severity.

**Results:** Significant group main effects were observed for both response (odds ratio=7.74, 95% CI=3.94–15.20) and remission (odds ratio=12.69, 95% CI=4.81–33.46), and a significant overall group-by-time interaction effect was observed for depression severity on the Hopkins Symptom Checklist, with greater reductions in

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# Fortney trial of local vs. central collaborative care

- Rural primary clinics (FQHCs) without on-site mental health specialists
- Adult patients beginning or continuing depression treatment
- Randomly assigned to two models of collaborative care
  - Local care manager (telephonic or in-person)
  - Centralized telephonic care management

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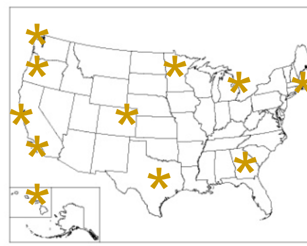

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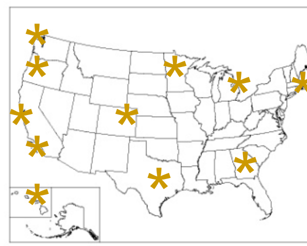
# Big win for centralized delivery model:

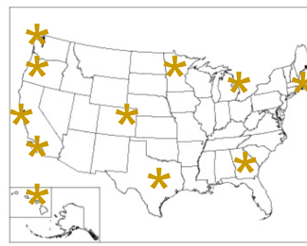
- More care manager contacts
- Greater fidelity to intervention content
- Significantly higher proportion of patients:
  - “Very satisfied” with treatment (74% vs. 62%)
  - Significant improvement in symptoms (53% vs. 21%)
  - Remission of depression (31% vs. 11%)





# Alternative models for delivering mental health treatments:

- Locally grown (Craft paradigm)
  - Distributed production
  - Quality through individual skill and motivation
- Factory farmed (Industrial paradigm)
  - Centralized production and delivery over distance
  - Quality through standard processes





# We make these decisions every day

- Things I like local and handmade:
  - Artisan bread
  - Sweet corn
- Things I like from a big factory:
  - Automobile brakes
  - Airplanes

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# 2 key questions regarding interventions:

- Does it travel well - or does quality degrade with distance?
- Is local variation the source of quality - or the enemy of it?

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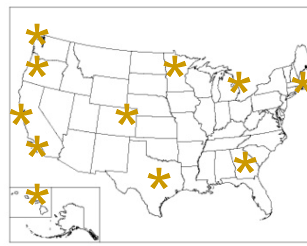

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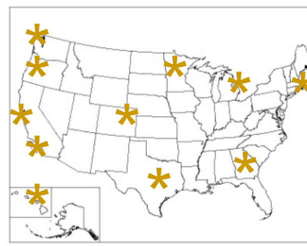
# General evidence supporting tele-mental health interventions

- Psychiatric assessment by video conference
- Telephone outreach and care management
- Telephone CBT for depression





# Specific evidence regarding distance delivery: Mohr trial of in-person vs. telephone CBT

- Primary care patients initiating psychotherapy for depression
- Randomly assigned to in-person or telephone CBT (same therapists, highly structured protocol)
- Findings:
  - Moderately better adherence with telephone treatment
  - No difference in clinical outcomes at end of treatment
  - Moderately better outcomes 6 mos later with in-person treatment

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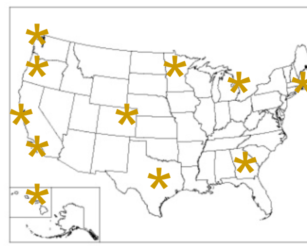

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# General evidence supporting centrally produced mental health interventions:

- Telephone care management and CBT for depression
- Recent CODIACS trial of depression treatment in ischemic heart disease

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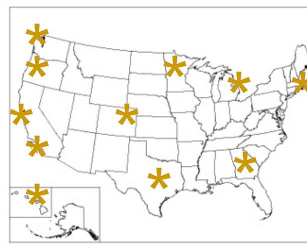

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# Specific evidence regarding centralized production:

Fortney trial is only head-to-head comparison

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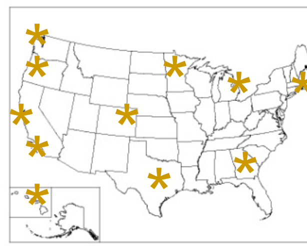

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# Our key questions (applied to depression treatment):

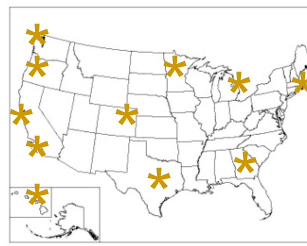
- Does it travel well - or does quality degrade with distance? – Distance delivery does work. But - fidelity being equal - effectiveness may decline slightly with distance.
- Is local variation the source of quality - or the enemy of it? – Quality and fidelity much are higher with centralized production.

**Caveat: Based on the limited information we have so far**

# What does this mean for implementation of EBPs?

- The usual model: Please try it. It's good for you. Pretty please! I'll make it fly around like a plane!

- The new model: We have an alternative!





# Or:

The best cure for a picky eater

Is a hungry little brother.

# Washington HB 1448

**It is the intent of the legislature to recognize the application of telemedicine as a reimbursable service by which an individual receives medical services from a health care provider without face-to-face contact with the provider.**

**It is also the intent of the legislature to reduce the compliance requirements on hospitals when granting privileges or associations to telemedicine physicians.**

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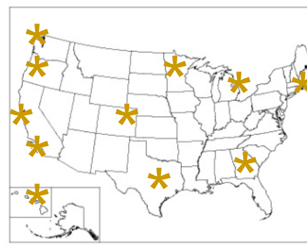
# State coverage for telemedicine services

MA
RI
CT
NJ
DE
MD

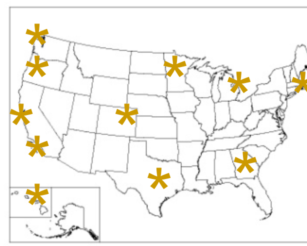
- Medicaid and Private Insurance Coverage for Telehealth
- Medicaid Coverage for Telehealth
- Private Insurance Coverage for Telehealth
- No Required Coverage for Telehealth





# What's an EBP champion / implementation researcher to do?

- Referee the competition – Propose head-to-head comparisons of centrally-produced vs. locally sourced treatments
- Be the competition - Start your own EBP factory farm and take over the world!

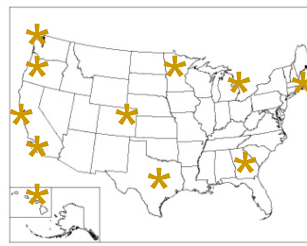




# If that's not enough of an abomination…

Centrally delivered interventions open the door to several provocative questions:

- Should we be quicker to declare failure and switch providers?
- Does it really matter to talk to the same therapist every time?





# If people say…

- That's unethical!
- That's not legal!
- That's too dangerous to even let people try it!

Then things are progressing just as expected.