The Perfect Storm: Collision of the Business of Mental Health and the Implementation of Evidence-Based Practices

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Financing has been hypothesized to be an important driver of the implementation of evidence-based practices (EBPs), yet there has been little systematic investigation of financing as a factor in EBP implementation. This column presents findings from a qualitative study of the effects of financial factors on the implementation of EBPs in a large urban publicly funded mental health system. Interviews with 33 agency leaders and 16 policy makers identified financial distress in community mental health agencies, leading to concerns about complex and expensive implementation of EBPs. Stakeholders agreed that the cost of EBP implementation should be shared between the agencies and the system; however, the stakeholders did not agree on how EBPs should be financed.

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Changes in the financing of community mental health care have altered the organization and delivery of publicly funded services over the past 60 years (1,2). Medicaid reimbursement rates are often less than those in the private market place, and substantial cuts in state aid to behavioral health programs since the financial crisis of 2008 have increased concerns about behavioral health budgets (3). Concurrently, payers, policy makers, and advocates have encouraged community mental health programs to implement evidence-based practices (EBPs) (4,5), which may exacerbate these financial pressures because of the high cost of adopting and sustaining new practices (6). Implementation science frameworks posit funding as a key factor in implementation (7). A growing body of empirical literature supports the important role of funding in the implementation and sustainment of EBPs (8,9).

The City of Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) is a large publicly funded urban mental health system with more than 200 agencies providing mental health and substance abuse services. Over the past eight years, DBHIDS has supported implementation of several EBPs (cognitive therapy, trauma-focused cognitive-behavioral therapy, prolonged exposure, and dialectical behavior therapy) in selected agencies (10). DBHIDS pays for training and consultation and for internal employees to support each initiative, and in some cases DBHIDS reimburses for lost staff time and provides an enhanced reimbursement rate. These efforts provided a unique opportunity to study implementation in a mental health system that has financially supported a large implementation effort. Researchers have investigated other important constructs that are thought to affect implementation, such as organizational climate, culture, and attitudes (11), but there has been little empirical exploration of the role of funding in implementation of EBPs in community mental health care. This study used qualitative inquiry to understand this pivotal construct from the perspectives of both agency leaders and system policy makers.

ASSESSING EFFECTS OF FINANCIAL FACTORS IN EBP IMPLEMENTATION

Data came from 49 stakeholder interviews. Procedures were approved by the University of Pennsylvania and City of Philadelphia Institutional Review Boards. Thirty-three agency leaders from the 42 agencies (response rate of 79%) who participated in DBHIDS initiatives completed interviews. Sixteen policy makers (hereafter referred to as system leaders) from DBHIDS and Community Behavioral Health (CBH) were also invited to participate; all agreed. System leaders included senior leadership of DBHIDS and CBH, as well as internal coordinators dedicated to each EBP initiative. CBH is the nonprofit behavioral health managed care organization for Medicaid-enrolled Philadelphians.

We developed a semistructured open interview guide to collect information about participants' experiences with

TABLE 1. Agency leaders (N=33) and system leaders (N=16) endorsing themes related to the implementation of evidence-based practices (EBPs), and illustrative quotes

Theme	N	%	Quote
Agency leaders			
EBPs are expensive	26	79%	"Time is money."
EBPs are financially advantageous	19	58%	"We have a belief that if you provide this level of support, training, and care to clinicians then you are going to see less turnover and more stability, which would be less costs to recruitment." "It's an incredibly valuable marketing tool to be able to say we practice EBP."
The cost of EBPs should be shared between the agency and the system	17	52%	"It's my problem to juggle finances and find a way to get the money somewhere." "We've restructured to give the EBP the appropriate amount of time and resources."
Agency financial distress	13	39%	"[Policy maker] said she/he is pleased to be able to offer this initiative training but she/he really expects the agencies to sustain. And I heard what the audience said: 'How? We already do not have funding to support our basic program, let alone anything extra.'"
No EBPs without external funding	11	33%	"As great as it is to say that 14 out of 14 therapists are certified in [EBP], we'll be out of business at this rate if we don't get back to doing the things we need to do."
Financing suggestions	22	67%	"A 20% increase to our regular rate, then we start thinking about who else I can send to this training. Money gets people engaged." "Services should be funded. Trainings should be funded. Supervision should be funded. If policy makers are serious about having these [EBPs] and those who say 'the agency should go out and raise their own money and have bake sales.' It's not realistic."
System leaders			
EBPs are expensive for the agencies and for the system	15	94%	"Very costly." "Just as I think the providers would say they're not paid to do this, we're not funded to do this."
Financing suggestions	14	88%	"If they are unwilling to change their business model and clinical and operational flow, then there is only one viable pathway [for EBP implementation], and it is increased rates."

EBP initiatives, with a focus on factors that support or impede the implementation process, particularly the role of funding. Transcripts were analyzed in an iterative process based on a modified grounded theory approach (12).

Agency leaders agreed that implementing EBPs is costly and that the time commitment detracts from productivity (Table 1). Agency leaders noted the time and expense of additional supervision, consultation, note writing, training, technology, and session preparation time—and for some protocols, longer sessions required by the EBP than billing permits. Most agency leaders noted that EBPs are financially advantageous because they could yield increased revenue through increased patient referrals, engagement, and retention; enhanced reputation; and decreased employee turnover. About half the agency leaders believed that the cost of EBPs should be a shared responsibility between agencies and the public system and described internal financial restructuring and using external grants and endowment funds to accommodate these extra costs. Agency administrators, especially those overseeing outpatient services, acknowledged financial distress due to rising costs and decreased funding and reimbursement. A third of agency leaders reported that EBP implementation was fiscally impossible without external funding. Most agency leaders had suggestions for policy makers to support EBP implementation. Most of their suggestions involved enhancing reimbursement rates and other financial incentives (that is, pay for performance and preferred-provider designation).

EBP implementation was described by system leaders as a financial commitment for both the system and the agencies (Table 1). Even though system leaders acknowledged fiscal challenges of EBP implementation for the agencies, they unanimously advocated less for enhanced rates and financial incentives and more for financial and business planning at the agency level to accommodate the financial realities of EBP implementation.

DISCUSSION

This study was the first to systematically investigate from the perspective of multiple stakeholders how funding influences implementation of EBPs. Both agency and system leaders agreed that EBP implementation is costly, and most agreed that this cost should be shared. The stakeholders did not agree on how EBPs should be financed.

Increasing reimbursement rates is never simple. State Medicaid rates are often below private market rates, which constrains the system's ability to enhance rates (13). Payers have the difficult dilemma of determining what to pay for (for example, training, service delivery, or outcomes) and how to resolve fidelity, certification, and measurement issues. However, EBPs are by nature a set of easily definable interventions that can theoretically garner a higher reimbursement rate. The development of methods for value-based reimbursement (for example, pay for outcomes) and innovative financial structures

to provide financial incentives to promote EBPs is in its infancy in mental health care (14). More research is needed to identify and evaluate effective financial incentives (5). Nonetheless, the increasing policy emphasis on EBPs and excellence in health care delivery may be the single greatest future opportunity for enhanced reimbursement rates.

This exploration into the funding of EBP implementation uncovered questions about financing in public mental health care. The crumbling infrastructure in outpatient settings may endanger the implementation and sustainability of EBPs (13). The financial landscape has likely become even more constrained because of reductions in funding by state agencies. These community mental health programs may need to be more efficient than ever, particularly if they are to take on the additional cost of implementing EBPs. EBP implementation requires agency leaders to be proficient in effective business practices; however, many leaders do not have business backgrounds. Through the Business Efficiencies and Effectiveness Project (BEEP) Learning Collaborative (www.ctacny.com/beep-business-efficiences-and-effectiveness-project.html), New York State is attempting to improve fiscal effectiveness of organizations in concert with implementation efforts. There has also been promising work in Australia, where programs voluntarily share and discuss financial and service information in order to improve business practices (15). If the financing problem is in part a result of business inefficiencies, more work is needed to identify organizationally efficient mental health agencies and how to promote better business practices. Cross-academic collaborations with business schools along with community-academic partnerships would be particularly beneficial.

The context of Philadelphia is worthy of note. Philadelphia has a public system with a strong commitment to EBPs in both belief and dollars. Even though agencies did not pay for training, consultation, and other start-up costs, they reported significant financial burden related to productivity, billing, and sustainability. This has troubling implications for public systems that cannot afford significant investment in EBP implementation, as well as for community mental health programs that endeavor to adopt EBPs without financial backing.

Three study limitations should be mentioned. First, this sample represented one system, and results may not be generalizable to agencies outside Philadelphia. Second, interviewee responses were subject to recall bias. Third, the study did not include financial analysis of agency operations. Whether agencies are actually inefficient or inadequately funded is an empirical question that begs further scrutiny.

The study findings have important implications. Much has been written about the importance of funding in the EBP implementation process, but little empirical work has delved into why, from the perspectives of multiple stakeholders, financing is important and how the broader fiscal landscape influences the EBP implementation process. It is our hope that this investigation launches a systematic research agenda that leads to a richer understanding of the fiscal challenges coupled with the financial realities of implementing EBPs in mental health care.

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