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COMMENTARY

Big Studies, Simple Lessons

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Abstract

Goldman describes how service systems research examines the impact of economic and organizational strategies designed to promote particular service combinations (such as continuity of care) and inhibit others (such as preferentially serving only those individuals who are the easiest to treat). The recurring theme from the large services research initiatives is that the content of care, as well as the organization and financing of care, matters. This theme is distinct from what these large services research projects were designed to assess, which speaks both to the unexpected benefits from these massive studies and the need for more efficient tools to examine the interrelationships among the organization, financing and content of care.

In his commentary, 'Organizing mental health services: an evidence-based approach', Howard Goldman reminds us, with a breadth of perspective few others can share, that, when it comes to improving health status, it all matters: the quality of the clinical care, the organization of services and the fiscal incentives and disincentives at play. We ignore any one at our peril.

Because of the diversity of players involved, interventions to improve the quality of health care are enormously variable, ranging from providing training and supervision to clinicians to enhance their treatment skills to enacting legislation to adjust fiscal incentives via changes in payment structures. Yet each of these interventions must play out within the context of the others. Goldman describes how service systems research examines the impact of economic and organizational strategies designed to promote particular service combinations (such as continuity of care) and inhibit others (such as preferentially serving only those individuals who are the easiest to treat). We can change system structures, and the interaction among these entities, and have no discernable impact on client outcomes. The service-system interventions in the Robert Wood Johnson Foundation Program on Chronic Mental Illness (RWJ/PCMI) were successful in demonstrating improved continuity of care; however they resulted in no discernable change in clinical outcomes, at least within the time frame studied. So, we are reminded that these structural characteristics of a system are necessary but not sufficient characteristics to promote good care. The care loci and the relationships among them create a context that has an enormous impact upon the quality of the care received, but the context is not the care itself. An unskilled clinician in a poorly organized system is as ineffective as an unskilled clinician in a well organized system. Similarly, skilled clinicians in chaotic non-systems of care are doomed to have limited impact. One can work in a well funded, multi-disciplinary mobile crisis team, but, unless there are other supportive services available with which clients can become engaged once the crisis of the moment is resolved, one's long-term clinical impact will be sorely constrained. The quality of the clinical care matters. The array of services matters. The financial arrangements knitting together the service array matters. And the challenge for services researchers is to provide information for policy makers to use to advance each of these domains and to understand their interplay, and to provide this information within a time frame that allows administrative decisions to be informed by research findings. Policy will be made; our challenge as services researchers is to mount studies which can be useful to policymakers.

Each of the large studies reviewed by Goldman generated a clean take-home message of direct policy relevance. Interestingly, each of these messages is other than what the study was designed/reviewed/funded to do. The message from RWJ/PCMI is 'The quality of the clinical care matters'. The message from the Fort Bragg demonstration is 'Monitor the intervention so that you know what they were'. The message from the Schizophrenia PORT is 'Research findings are not making it into practice'. The message from the ACCESS project is 'Absent incentives to the contrary, systems will change whether you pay them to or not'. At this point in time, these messages can seem like penetrating glimpses into the obvious or like hard-won realizations. True, it did not take such massive studies to demonstrate these points, but big studies capture attention and speak loudly. We now have echoes in our ears that make sure that we do not assume that case management is happening because the sign on the door says 'case management' nor that increased communication between agencies influences communications between clients and clinicians. And, if we

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learn faster from unanticipated results than from predictable accomplishments, then each of these large studies will be very useful indeed. System integration (alone) did not change the quality of care received by an individual. Funding a new service did not mean that people received that service. Demonstrating that family therapy improved outcomes for people with schizophrenia did not make clinicians do more family therapy. These are hard-won lessons to incorporate into our planning and policy making.

Fortunately, as research technologies evolve, we have new tools to examine system components, the interaction among these components, the quality of the clinical care provided, and the interplay among these domains. And, increasingly, we can do so very efficiently for entire populations as compliments to the labor-intensive samples of years past. For example, data systems that allow patient-level merging of data on service utilization, medication and provider characteristics let us generate reports to monitor proxies for the quality of care received and to examine the impact on one level of changing rules at another level. Consider the case of monitoring the quality of treatment for people with schizophrenia. If we draw from the research literature that medication is a necessary but not sufficient component of care and that ongoing relationships with service providers help maximize recovery, then we can use such data warehouses to identify programs with service patterns which suggest adherence to such guidelines (e.g., by identifying systems/programs/practitioners with high rates of kept appointments with the same psychiatrist over long time periods versus those where a patient sees a different psychiatrist at each visit). Similarly, the rate of medication refills can provide a proxy for whether the medication being prescribed is acceptable to the patient. We can examine what we know about the relative effectiveness of various antipsychotic medications and look at their respective market shares to make inferences about the quality of care (programs that treat people with schizophrenia but that have no such individuals taking clozapine or most on conventional agents raise flags of concern). The emergence of such information systems allows us to operationalize treatment algorithms and monitor adherence from the perspective of the system, agency, clinician and patient. Moreover, we will look to large services research projects such as the Texas Medication Algorithm Project to tell us the correlation between adherence to medication algorithms and client-level outcomes. And, when the surprises and bruises from that project are in, we will have our next take-home message from the humbling experience of undertaking massive interventions to change practice in ways that improve client outcomes.

Goldman opens his paper by describing how policy makers have to proceed with their business absent a clear set of evidence-based decision rules. Surely, policy makers have rules: stay out of the newspapers; stay within budget; pay only for what someone else won't pay for. Data-based decision rules are what are in short supply. Even those data-based rules mentioned above deriving from large services-research studies often are inferences from the results of the studies rather than 'cleaner' data from smaller, more tightly controlled and less generalizable experimental studies. And some questions are bound to have different answers depending upon the context within which care is delivered. Make-versus-buy decisions may well have different answers depending on the local setting. A challenge for services research is identifying what generalizes across widely differing systems. The recurring theme from the large services research initiatives is that the content of care, as well as the organization and financing of care, matters. Each domain is critical to the effective organization of mental health services.

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