

Implementing Evidence-Based Practices in Indiana: A State Mental Health Authority Perspective

Site Visit Dates: December 2002 and March 2004

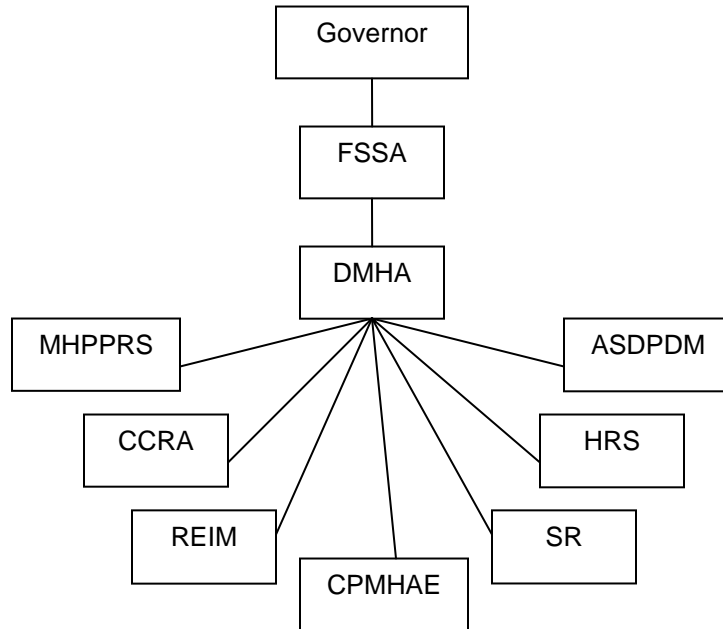
Overview in brief		
MH chief	Director	
Placement of SMHA within State	Division within an umbrella agency	
EBPs		
	Assertive Community Treatment	Integrated Dual Diagnosis Treatment
# sites using Implementation resource kits	8	6
# total sites	15	6
Statewide roll out planned??	potentially	no plans

This report on implementing evidence-based practices has been synthesized from a series of site visit reports that were completed at two points in time--one early in the implementation process for each State and another 15-18 months later near the point of expected full implementation. The site visits were conducted by 2-4 person teams composed of members of the MacArthur Foundation Network on Mental Health Policy Research. These visits were conducted with the cooperation of the individual States and the National Association of State Mental Health Program Directors (NASMHPD) and its Research Institute.

This report reflects the observations of the site visitors based on their synthesis of the views expressed by multiple individuals during the 1-2 days of each visit. Related facts from other documentary materials were also included to complete the longitudinal story of each site's implementation process. Every effort has been made to be accurate in this summary, but there may still be some remaining inaccuracies or differences of opinion about what actually was stated and the interpretations derived. Admittedly, the observations in this summary are based in part on the opinions of informants who spoke with us more than factual information. However, we believe that the perceptions of the informants reflect the multifaceted context in which EBPs are being implemented in each State. Each report has been reviewed by all of the site visitors and by officials of the respective State mental health authorities.

Background

The Indiana Division of Mental Health and Addiction is housed within an umbrella agency, Family and Social Services Administration (FSSA). Within the FSSA, Indiana has a single Division that integrates mental health and substance abuse services, the Division of Mental Health and Addiction (DMHA). All CMHCs in Indiana provide mental health and addiction services. The Division of Mental Health and Addiction has seven main internal components. These offices are organized around financial and treatment services to create clear lines of authority and responsibility within the organization. The seven components are:



Organization of the Indiana Mental Health System

mental health policy, planning, and regional services (MHPPRS), certification, contracts and resource allocation (CCRA), revenue enhancement and information management/reporting (REIM), addiction services, drug prevention, and disaster management (ASDPDM), hospitals and regional centers (HRS), communications, public mental health and addiction education (CPMHAE), and support resources (SR).

The state mental health system in Indiana is organized by catchment areas around the state in 92 counties. There are 30 community mental health centers (CMHCs) that provide services to the counties. The state interacts directly with CMHCs. There are no local mental health authorities at the county or city/town levels in the state. Inpatient care is provided at the direction of the CMHC that own or operates the inpatient bed, which is certified by the Department of Health.

State psychiatric hospital inpatient beds are allocated and controlled by the state's mental health department. Beds are allocated to CMHCs from a central department. Allocation serves a gatekeeper function since the community centers must limit their inpatient days by the number of beds that are available within their allowance.

Evidence-Based Practices (EBPs)

In the EBP Implementation Resource Kit (IRK) project Indiana is implementing the Assertive Community Treatment (ACT) and Integrated Dual Diagnosis (IDDT) practices. The ACT demonstration sites were selected for geographic balancing within the state. Teams were selected strategically, in that the teams were located in CMHCs with good relationships with Medicaid, filed reports in a timely manner, and appeared to be able to get certified for ACT quickly. Geographic mix, but not urban/rural mix was a concern with site selection. Teams were located in northern, central, and southern Indiana.

The IDDT sites were selected by the state through a Request for Proposals (RFP) process. Criteria for site selection included geographic balance (north, south, central parts of the state), urban/rural mix, and accessibility to other centers in their area. Initially, six IDDT sites were selected.

Indiana added eight more ACT sites to the IRK demonstration in December of 2002 and an additional four sites in early 2004, so their total has increased to 15 teams from the initial 3 at the beginning of the national demonstration project. All of the early implementing 11 teams have received the same training through the Technical Assistance Center. Six sites are implementing IDDT with two new start-ups in 2004.

There is an expectation that each of the CMHCs will want at least one ACT team. However, there is no clear plan for either EBP after the demonstration ends or for the statewide roll out of the current practices. Both the state hospitals and forensics departments in Indiana are advocating ACT for their service appropriate client populations. The state seems supportive of the ACT Technical Assistance Center's intentions to continue its implementation monitoring after the IRK project ends, and moving toward becoming a more general EBP Technical Assistance Center.

Some site Chief Executive Officers (CEOs) perceive that maintaining EBPs over the long-term will require building more infrastructure at the state level such as interagency partnerships, some legislative action, advocacy support, and monies for training. Advocates noted that in five years they would like the state to have achieved more statewide community togetherness and sensitivity to "what the needs of persons with mental illness and addictions are".

EBP
Evidence-Based
Practice

ACT
Assertive Community
Treatment

CMHC
Community Mental
Health Center

IDDT
Integrated Dual
Diagnosis Treatment

IRK
Implementation
Resource Kit

Leadership

There have been significant changes in the Indiana leadership, both generally and within the EBP leadership in the DMHA, the Division of Mental Health and Addiction. These changes, overall, have not seemed to affect the EBP demonstration project in Indiana or its implementation to a great extent. The project seems to have enough support within the stable DMHA staff and the sites so that it has taken on an institutionalized implementation and perspective.

The governor's office, the FSSA Secretary, and the DMHA director have all turned over several times since the commencement of the national EBP initiative. At the gubernatorial level, there was a death; at the FSSA secretarial level, there was at least one turnover; and the DMHA directorship has gone through a retirement and several interim directors since 2001. In addition, the DMHA's Deputy Director for Transitional Services, and EBP champion, also left the Division.

In February 2003 a new Director of DMHA was appointed. The new Director immediately set three priorities: 1. improving care and access to mental health services for children and families; 2. employment (supported employment processes); and 3. driving recovery outcomes and performance. The third priority is very much tied to the implementation of EBPs throughout the state. The third priority is also a goal to leverage performance partnership grants by determining the best use of state funds and the most effective or promising treatments for clients. The new Director's priorities also fit well within the national agenda set by the President's New Freedom Commission.

Despite the turbulent environment of the state executive leadership and within the leadership of FSSA and the Division, the key DMHA staff were fairly consistent. Some staff have moved to different positions within the agency due to reassignment and/or promotion, but the key players are mostly still present. One key turnover in DMHA was the resignation of the Deputy Director because he was the internal EBP champion in the DMHA. However, another individual that has been key to the IRK project has remained with the Division and has become a second champion for the project.

Financing

Payment for mental health services in Indiana is administered through a combination of DMHA's Hoosier Assurance Plan and Indiana's Medicaid program. The DMHA pays for mental health and addiction services through quasi-managed care contracts with

EBP
Evidence-Based
Practice

DMHA
Division of Mental
Health and Addictions

FSSA
Family and Social
Services

IRK
Implementation
Resource Kit

the CMHCs. DMHA makes a risk-adjusted payment for services based upon an individual's chronicity and acuity through the Hoosier Assurance Plan, up to a CMHC's total allocation amount. The state has set a higher adjusted case rate for dual diagnosis to compensate for the difficulties in measuring functioning for this population, the lack of adequate data for this group, and to incentivize providers to properly bill for these diagnoses.

CMHC
Community Mental
Health Center

DMHA
Division of Mental
Health and Addictions

The 15 ACT teams received \$333,000 from the state for start up costs. The state also funded the ACT Technical Assistance Center, training, and fidelity measurement efforts. The ability to continue funding at this level of commitment was considered not to be feasible in the long term. However, the State can pursue Medicaid administrative dollars for certain ACT Technical Assistance Center services. Unfortunately until a Medicaid bundled rate is approved for ACT services (the state has been in a process of getting approval for this change), they can not pursue that option. But given existing demands in the Division, pursuit of this funding stream is not a priority and will remain a future possibility.

ACT
Assertive Community
Treatment

One of the major streams of mental health and addiction funding within the state is the Hoosier Assurance Plan. But unfortunately these funds are difficult for CMHC directors to predict from year to year. The difficulty stems from the dollars being comparatively based on each provider's client load and acuity mix, as well as the current amount of money available in a competitive environment. At the time of the first site visit, DMHA had set-aside \$5 million in Hoosier Assurance Plan dollars for dual diagnosis clients (not specifically for IDDT services). But in 2003, this set-aside for IDDT clients could not be continued.

IDDT
Integrated Dual
Diagnosis Treatment

No separate funding mechanism has been established for IDDT at this time. However, several potential strategies are being discussed to improve coverage for dual diagnosis services such as expanding ACT financing to IDDT and considering a higher reimbursement rate for IDDT.

Currently, the state is not paying for the billable time forfeited by the training modules, except for the ACT Start-up costs. The site directors find it difficult to support a team that is not producing billable hours. This is the case with IMR, ACT, and IDDT; although it is less of a problem for ACT since the providers have a separate funding stream for the ACT teams. IDDT sites are committed to dealing with the impact on productivity during the IRK project.

IMR
Illness Management
and Recovery

IRK
Implementation
Resource Kit

One consistent observation by several EBP site directors was that the state does not have an effective mental health service financing model for rural providers. Rural providers have higher costs due to transportation and lower client density, but the state financing methodology does not pay higher rates to accommodate this difference.

EBP
Evidence-Based Practice

Regulations

The state has put into place certification standards for ACT teams. These standards were based loosely upon the Dartmouth Assertive Community Treatment Scale (DACTS) fidelity instrument, but were changed into a yes/no format. While the DACTS questions were not directly put into the certification procedures, the certification standards are linked to high fidelity scores within the DACTS (such as the standards at 4 and 5 levels of fidelity). The ACT Technical Assistance Center played a large role in assisting DMHA to develop Indiana's standards.

ACT
Assertive Community Treatment

DACTS
Dartmouth Assertive Community Treatment Scale

DMHA
Division of Mental Health and Addictions

Fidelity measures are not a part of the regulatory process in Indiana at this time. The fidelity measurement is done through the Technical Assistance Center. This approach was taken so that the fidelity measures were not seen as part of the state's punitive efforts, but rather as a genuine quality improvement mechanism.

The ACT teams have now incorporated Supported Employment as a necessary part of their teams. The DMHA promulgated ACT certification rules in 2003 that require the incorporation of supported employment.

No specific regulatory changes were discussed for IDDT.

IDDT
Integrated Dual Diagnosis Treatment

Training

The ACT Technical Assistance Center of Indiana does the training for the EBP sites, follow-up training programs within the state, and maintains partnerships within the state with other agencies and advocates. Trainings have been completed for all but one EBP site. As part of training follow-up, the Technical Assistance Center runs monthly conference calls for the existing teams to aid in team development and to answer questions.

The training is based upon the EBP IRKs, and almost all sites have completed training. However, since turnover is a problem, training timing and frequency is an issue. The ACT Technical Assistance Center provides regional meetings, monthly telephone conferences,

IRK
Implementation Resource Kit

fulfillment of special requests for information, a list serve, fidelity assessment, booster trainings (twice a year in the north and central parts of the state), and internal trainers as part of their training mission.

There are both internal and external trainers within the EBP sites. The ACT Technical Assistance Center hired one of the EBP trainers from Ohio to assist them in planning and implementing a “train the trainer” program. The “train the trainer” program helps develop trainers within the agency so that they can address agency training needs over and above the external training provided. IDDT sites expressed a preference for an “internal trainer” option instead of solely depending on a trainer from the Technical Assistance Center.

The impact of the ACT training seems to be viewed as favorable. Yet, the initial trainings are not perceived to be as important as the follow-up trainings and meetings. The follow-ups make it possible for clinicians to ask questions about real situations that may not have been thought of when the initial training first took place. Teams seem to be very good at structuring their teams, but not in the clinical aspects of ACT at team formation. Additionally, the SE component of the ACT teams in Indiana still needs a bit more development and understanding by the clinicians.

The IDDT sites also have been pleased with the training they have received. In addition to training, the IDDT sites have had access to extra resources and supports to make organizational transitions to implement IDDT and to deal with the impact of organizational transitions on productivity. Recent trainings have highlighted the issue of staff retention as a priority, and questions of sustainability of EBPs and the IRK initiative if the high rate of staff turnover continues.

The ACT Technical Assistance Center has been supported by DMHA from its inception. The State of Indiana initially had a grant from the Robert Wood Johnson Foundation to fund the ACT Technical Assistance Center. However, after that grant ended, the state funded the Center to continue to provide the training and assistance to the ACT teams in the state. Thus far, there has been a sufficient amount of funding for training in Indiana.

Quality Monitoring

The quality assurance measures in the state are based upon manuals and DMHA Rules that were developed within Indiana.

EBP
Evidence-Based
Practice

ACT
Assertive Community
Treatment

IDDT
Integrated Dual
Diagnosis Treatment

SE
Supported Employment

IRK
Implementation
Resource Kit

DMHA
Division of Mental
Health and Addictions

The DMHA Rules address standards for specific types of programs, and the manual explains standards for providers regarding what is expected, criteria for enrollment in services, and service descriptions. The manual is used in conjunction with data systems. The data systems mainly contain three types of data: encounters and service –actual receipt of services and which center provided them; revenue for each client –private pay insurance or Medicaid; and reassessment data. It is possible to determine the mix and type of services delivered by each provider, where the services were provided, and to make comparisons to overall service need across providers within the state. The existing information systems in the state are undergoing changes to allow for better coding of ACT and IDDT services that are certified by the state. These changes will enable the clear tracking of EBP clients and services.

DMHA
Division of Mental
Health and Addictions

ACT
Assertive Community
Treatment

IDDT
Integrated Dual
Diagnosis Treatment

The state does not use fidelity measures officially in its formal process of assessing ACT teams, IDDT services, or any other services. Individual providers are able to provide either fidelity or outcomes measures for the services they deliver. Despite this emphasis on outcomes and not fidelity, ACT certification standards are tied to the DACTS.

EBP
Evidence-Based
Practice

DACTS
Dartmouth Assertive
Community Treatment
Scale

The Technical Assistance Center uses a modified DACTS fidelity monitoring program to help ACT teams improve and problem solve. The ACT Technical Assistance Center has a systematic way of conducting fidelity visits and giving feedback reports to the implementing sites. The fidelity measurements are used in an informal way within the state; it is used to give ACT teams feedback for quality improvement/information.

The focus within Indiana’s DMHA is on outcomes, rather than fidelity. Client outcomes are a pervasive priority for all of the Division’s programs. However, state respondents noted that measuring fidelity and outcomes has been difficult since no official quality assurance process or procedures are associated with the IRKs. The state’s research dollars also continue to steadily decrease, which has significantly impacted its ability to measure outcomes on a variety of levels.

IRK
Implementation
Resource Kit

Currently, the ACT Technical Assistance Center is piloting the COMP software system that was developed in Kansas. This software could potentially make monitoring and tracking easier within the state if it is adopted. COMP is expected to be used in all ACT and IDDT teams. The compliance with the software system has been very good in the ACT teams during the trial period. All DMHA contracted providers are required to submit data to the

DMHA's Community Services Data System. However, the decision to adopt the COMP software statewide has not yet been made.

IDDT sites noted that COMP could be a good vehicle to solve the lack of state measures for IDDT. They hoped that the state would promote this software package more strongly because it (the state) does not have a solid data infrastructure to support its agenda. The IRK has not been a catalyst to start-up measurement processes in the sites. However, sites have distinct views about the differences between outcomes and fidelity measures, and the values of each. All sites are concerned about cost effectiveness of EBP and IRK implementation.

DMHA
Division of Mental
Health and Addictions

IDDT
Integrated Dual
Diagnosis Treatment

IRK
Implementation
Resource Kit

EBP
Evidence-Based
Practice