

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

Site Visit Dates: October 2002 and April 2004

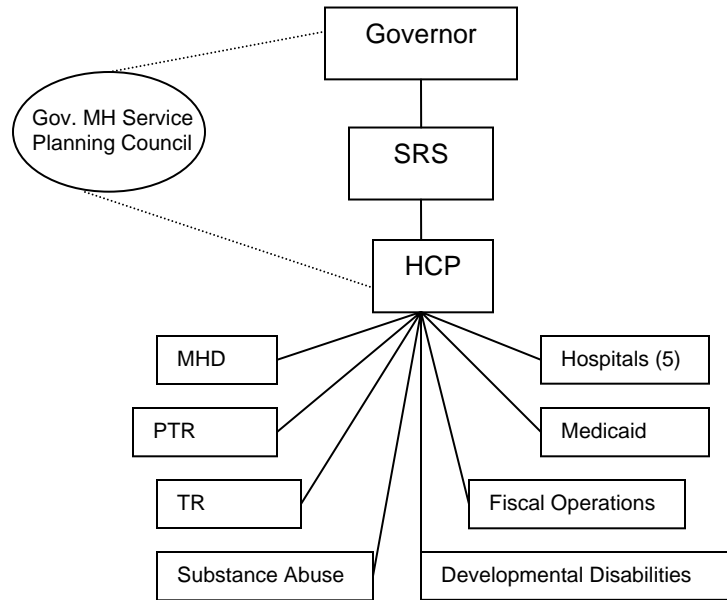
Overview in brief		
MH chief	Director	
Placement of SMHA within State	Sub division within an umbrella agency	
EBPs		
	Integrated Dual Diagnosis Treatment	Supported Employment
# sites using Implementation resource kits	3	9
# total sites	no data	no data
Statewide roll out planned??	3 or 4 additional only	yes

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 state public mental health system is organized under the Health Care Policy (HCP) division of the umbrella agency, Social and Rehabilitation Services (SRS). The Mental Health division (MHD) is the single state agency with responsibility for mental health services. HCP management includes the directors of state mental health, substance abuse, fiscal operations, Medicaid, developmental disabilities, TR, PTR and 5 hospital administrators who report directly to the head of the HCP. The head of HCP reports to the SRS Secretary.



Organization of the Kansas Mental Health System

The MHD works closely with the Governors Mental Health Services Planning Council to develop goals and plans for mental health services. Division activities are guided by a 5-year strategic plan and annual block grant plans for mental health and substance abuse services. The responsibilities of MHD are to oversee all public mental health services throughout Kansas' 105 counties, achieve accountability and performance (including quality assessment), license/certify all Community Mental Health Centers (CMHCs), and plan and provide staff training.

The delivery system in Kansas is organized around 27 community mental health centers in its 105 counties. Each CMHC is a county-based service authority and provider; there are no county mental health boards or local mental health authorities. Community programs are licensed by the MHD, with similar processes and standards for mental health and substance abuse providers and services. Service providers are certified within a CMHC.

There are three state psychiatric hospitals and 12 nursing facilities for mental health across the state. Inpatient hospital days are allocated to both state psychiatric facilities and local inpatient beds. Local inpatient beds are reserved for Medicaid and indigent care.

Evidence-Based Practices (EBPs)

In the EBP project Kansas is implementing the Integrated Dual Diagnosis Treatment (IDDT) practice and the Supported Employment (SE) practice. Sites for the EBP demonstration project were selected by a small group of individuals involved in the mental health system in Kansas, including the agency director and the main state trainer from the University of Kansas. The group chose the sites based on a number of criteria. The criteria included geographical area (rural/urban mix), agency factors such as stability, resources, and leadership, and existing client outcomes (for supported employment). Initially, two sites were selected for IDDT and three sites for SE.

EBP
Evidence-Based
Practice

IDDT
Integrated Dual
Diagnosis Treatment

SE
Supported
Employment

As of the second site visit there were a total of 12 EBP Implementation Resource Kit (IRK) sites in Kansas. IDDT was being implemented in 3 sites and SE was being implemented in 9 sites. The state had recently reinstated plans to expand IDDT to 3 or 4 additional sites. Since the early stages of the EBP demonstration project one IDDT site was replaced, so there was some initial turnover within the demonstration.

At the beginning of the demonstration project, all centers that were implementing the Dual Diagnosis and SE practices were working with their existing resources and had reorganized time so that staff could be trained in the EBP methods. In addition to their own funds, the national demonstration project provided some limited resources for the implementation kick offs.

Initial implementation required some reorganization within the participating agencies. Responsibilities at the CMHCs needed to be shifted (among both staff and administration), new staff hired, and Institutional Review Board issues resolved.

CMHC
Community Mental
Health Center

Expectations about what MHD will do after the IRK Project ends are still evolving. The state Department of Mental Health has committed to rolling out 6 EBP and emerging practice philosophies and goals in its strategic plan. This effort is driven by the New Freedom Commission report. However, MHD is not sure which resources will be set aside for new start up funds or technical assistance, or how agencies will financially support transitional activities to sustain EBPs or implement additional non-IRK EBPs. Additionally, the state has not set up any formal mechanism for requiring individual CMHCs to adopt EBPs, and is still in need of an “engagement process” to encourage agencies to adopt these practices voluntarily.

MHD
Mental Health
Division

IRK
Implementation
Resource Kit

Leadership

EBP champions in the state of Kansas are both internal and external to the SMHA. The Department of Mental Health is the primary champion and leader for EBP activities. The Department of Substance Abuse is now working more closely in this effort since IDDT IRK activities began in 2003. Secondary champions include the CMHCs site directors, and the key trainers in the state—KU, Wichita State, Addictions Technical Center and the National Alliance for the Mentally Ill (NAMI).

There have been several key leadership changeovers within Kansas during the time of the EBP demonstration project. At the time of the initial site visit the Department of Mental Health leadership was in transition with an Acting Director appointed to oversee the department and to work with the newly appointed state Director of Substance Abuse. In September 2003 the new state Mental Health Director was announced. He replaced the Acting Mental Health Director who held the position for 14 months.

The new Director is committed to a number of priorities that are consistent with the EBP project and with plans and initiatives that the state had already been putting into motion. He is very supportive of activities that will help make Kansas a state that functions with EBPs and recovery oriented principles as its base. There was a delay in implementing and expanding IDDT to new sites prior to the new Mental Health Director's arrival and shortly thereafter. However, regardless of the delay in fully implementing IDDT activities, and the new Mental Health Director's needing time to learn about the demonstration project, the project is moving forward at this time. IDDT site directors perceive that the change in state leadership represents an opportunity for some bottom up innovation in developing policies and programming rather than an obstacle to ongoing initiatives.

Despite the mental health chief changeover, there has been a great amount of stability within the Kansas mental health system. First, the former Acting Director of mental health remains with the department, serving in the position of Assistant Director and adds continuity to the system. Most key staff in MHD have remained in their positions, and site leadership for EBPs has been constant. In general, the site directors are very enthusiastic and supportive of all EBP efforts in the state. However, the Executive Director of Kansas NAMI and the state Consumer Affairs Officer agreed that more needs to be done to involve consumers and families in the

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CMHC
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KU
University of Kansas

MHD
Mental Health
Division

NAMI
National Alliance for
the Mentally Ill

EBP and other state projects, and to develop more systematic ways to reach consensus on EBP implementation.

EBP
Evidence-Based Practice

The Governor's office also experienced change during the EBP demonstration project. The office switched from republican to democratic leadership in 2003. The new governor has mandated that Kansas will "have one united government throughout the state" and that state departments will collaborate, integrate, and evaluate their efforts. The governor formed several teams to develop plans to implement this mandate, one of which was a mental health and substance abuse team. Consistent with this new emphasis on "one united government", the leadership within the Mental Health Department intends to use the President's New Freedom Commission Report to increase visibility of mental health issues in the legislature, and to speak with the governor about how to create better working relationships in this area. The changes that the Governor is making are seemingly complementary and consistent with MHD's plans and activities.

MHD
Mental Health Division

A constant source of support and leadership within the state mental health system has been from the University of Kansas. KU has provided extensive training and workshops for decades for clinicians and practitioners in the state. This leadership has continued through the EBP project, and will into the foreseeable future. In fact, KU has been a strong leader and supporter of EBPs in Kansas from the earliest talk of implementation.

KU
University of Kansas

SRS
Social and Rehabilitation Services Department

Financing

Mental health and substance abuse services are funded through a variety of mechanisms, including Medicaid, SRS and department monies, block grants and other federal grant sources, fee-for-service, state revenues, grants, Kansas' Medicaid Buy-In program, the Vocational Rehab Option, and research monies from efforts like the EBP Project. Several years ago, the SMHA capped the Medicaid match at 20% and is also pushing CMHCs to take more financial responsibility for services. In light of its strategic goals, the state agency is providing incentives for certain services, such as evidence-based practices. The MHD allocates monies to county-based services. CMHCs are financed through a county mil-levy, SMHA grants and contracts, and financing reforms. At this time, there is no managed care in Kansas' mental health system.

SMHA
State Mental Health Authority

CMHC
Community Mental Health Center

SE
Supported Employment

IRK
Implementation Resource Kit

At the inception of the EBP Project, Johnson & Johnson provided a one-time start up fund for SE IRK sites in Kansas, and the state provided the same funding for the IDDT IRK sites. Each site was

IDDT
Integrated Dual Diagnosis Treatment

allotted approximately \$9,000. Sites were allowed to apply these funds to training and other transitional activities needed to implement the EBPs. The state is continuing to offer CMHCs the start up funds for new EBPs but it is unclear how sustainable these funds are over the long term.

EBP
Evidence-Based Practice

Sites are responsible for funding the IRKs on their own. Medicaid and the Medicaid Rehab Option are the main sources of reimbursement for mental health, substance abuse, and IRK services. SRS staff estimate Medicaid caseloads to attempt to control expenditures; nonetheless, the state is still on a “Medicaid growth curve” and needs to address this over time. There is some expectation that recommendations made in the President’s New Freedom Commission Report will help to more explicitly connect Medicaid funding with EBP efforts. Approximately \$65 million is currently being spent on Federal Financial Participation contracts.

CMHC
Community Mental Health Center

IRK
Implementation Resource Kit

SRS
Social and Rehabilitation Services Department

Stable funding mechanisms at the state level have been established for supportive employment. The SE EBP was originally paid by Medicaid as a targeted case management service through the Voc Rehab Option. However, under this system there was some confusion among providers about the billing process for supported employment.

SE
Supported Employment

There will be a fairly significant policy change in the way SE is being funded within the state beginning in January 2005. The Vocational Rehabilitation (VR) services within the state moved to a fee-for-service payment system that pays for performance. Payment will be contingent on each milestone achieved by clients. This approach is a fee-for-service, non-capped Medicaid billing system with the state voc rehab agency.

IDDT services are billed through mental health Medicaid codes without any auditing problems. Mental health diagnosis is billed as the primary diagnosis and substance abuse is billed as the secondary diagnosis. Attempts were made to shift budgetary allocations in ways that made it possible to better balance the distribution of funds between mental health and substance abuse. However, given the current budgetary climate in Kansas, this reallocation was deemed infeasible.

IDDT
Integrated Dual Diagnosis Treatment

A few concerns were raised about funding streams that pertain to EBP implementation. First, Medicare only covers therapy and medication management services so it is not a good stream of funding for IDDT or SE, generally. To remedy this issue, complementary funding mechanisms, such as county tax funds, are

being explored as potential sources of EBP funds. However, CMHC directors are concerned non-traditional state appropriations that could be applied to EBP services may be diluted by appropriations to other public and private non-profit and faith-based organizations. Second, the state Mental Health Director expressed concern about the financial feasibility of maintaining a high technical assistance level and fidelity assessment in future iterations of the EBP roll out. The SMHA expressed a desire to find a way to do these activities in a manner that would continue to be effective, but less expensive.

EBP
Evidence-Based Practice

CMHC
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SMHA
State Mental Health Authority

Regulations

The state is considering developing regulations or Memorandums of Understanding (MOUs) that can help to clarify some of the financing for EBPs (especially IDDT). These new regulations would also strive to better link Quality Enhancement (QE) and training activities to performance indicators and outcomes of strategic planning goals.

IDDT
Integrated Dual Diagnosis Treatment

Further, the state department of mental health and substance abuse is thinking about a licensure proposal where substance abuse providers may also provide mental health services through a dual licensing and certification mechanism for the delivery of IDDT services. Currently, mental health and substance abuse licensing and certification are granted through different processes. An integrated treatment planning method would need to be developed that would make it possible to note that either a mental health or substance abuse disorder is a primary diagnosis. If this new flexible method is put into place, existing funding penalties associated with integrated treatment planning would need to be eliminated.

On a parallel track, the state Substance Abuse Director is working with mental health staff to create a treatment plan tool that includes both mental health and substance abuse domains that is consistent with licensure review. Guidelines are also being developed for auditors to use consistent mental health and substance abuse language when evaluating sites.

Training

The main sources of training in the state are KU, Wichita State University, and the Mid-America Technology Transfer Center (MATTC); and the main sources of funding for training are MHD (training budget line), Johnson & Johnson (start up funds only), provider organizations themselves, and some counties. The

KU
University of Kansas

MHD
Mental Health Division

state's historical relationship with universities, namely KU and Wichita State University, has been a major factor in delivering and maintaining intensive and ongoing training activities for the whole state.

KU
University of Kansas

Training activities range from informational workshops to 5-day intensive courses for providers. While KU, Wichita State University, and the MATTC provide different educational and training experiences, KU continues to have primary responsibility for training and monitoring at EBP IRK sites. However, curriculum development, systems change infrastructure strategies, and dissemination of lessons learned from working with providers have been done through both KU and MATTC.

MATTC
Mid-America
Technology Transfer
Center

EBP
Evidence-Based
Practice

IRK
Implementation
Resource Kit

After some initial delay, all IRK sites completed their initial staff and organizational trainings. Overall, the trainings have been received positively with no special issues. Respondents thought that KU's training was one of the key pieces in being able to deliver quality services. Consumer involvement in training varied by IRK site and EBP, however. All sites request and require ongoing technical assistance and ongoing training to keep the IRK and other EBP efforts on track.

While the trainings for SE have rolled ahead smoothly, several issues have arisen related to the trainings for IDDT. Most important, the training for IDDT is geared to CMHCs and mental health workers, but overlooks training substance abuse providers to deliver mental health services. A Substance Abuse Department workforce survey identified that substance abuse providers are in need of more IDDT training. Despite this recent finding, the IRK materials are perceived to focus on mental health workers and training continues to largely focus on CMHCs.

SE
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Directors have made it clear to the state that training and technical assistance from KU is essential to maintaining the IRK and other EBP efforts. However, it is unclear whether resources will be available from the state for KU and other organizations to provide ongoing training and technical assistance for EBPs. If ongoing assistance is not provided, sites would be able to continue some of the current services set in motion by the IRK project, but would not be able to expand EBP efforts.

Quality Monitoring

The IRK sites and KU use the fidelity measurement process that was developed for the demonstration project. Mental Health

Department Field Staff, part of the state’s QE office, are responsible for determining whether CMHCs are implementing policies well and according to standards and licensure. In general, the QE office plays a broader role than simply evaluating adherence to licensure. Instead, approximately every 90 days Field Staff assess strengths and weaknesses of current implementation, treatment plan, and billing issues for the IRK sites. Field Staff also address how fidelity scales, outcome measurement, the state’s Performance Implementation Plan, and Client Status Reports work together and how CMHCs are or are not benefiting from these processes. Despite this focus on fidelity by the QE office and the state, fidelity measures are not built into contracts with the state - contracts are based primarily on outcome targets.

QE
Quality
Enhancement

CMHC
Community Mental
Health Center

IRK
Implementation
Resource Kit

There are some residual concerns about fidelity measurement among the sites. One site reported that their center was not sure how effective measuring fidelity will be, how much effort it is going to really take to assess how well fidelity is being implemented, whether some of the structural components of the scales are sufficient to measure “good” outcomes, and that different levels of evidence are associated with the various scale items. Further, at least one SE site thought that the baseline assessments and fidelity scales were disruptive and that it has been difficult to include consumers and family members in the monitoring process. Both IDDT and SE site directors are concerned about how inconsistencies in the state’s QE/Medicaid audit process, and long delays in receiving feedback, is affecting their service delivery and reimbursement in general, and maintaining fidelity in the IRK project in particular.

SE
Supported
Employment

IDDT
Integrated Dual
Diagnosis Treatment

While fidelity is perceived to be critical to sustaining EBPs, state and CMHC respondents indicated that clearer expectations related to fidelity, outcomes, and accountability need to be defined. Sites value fidelity reviews largely because the reviews help to maintain the connections between training, technical support, and supervision. Sites were not receptive to the idea that a “stripped down” fidelity measure could be created to help address sustainability. That is, they thought that fidelity measures, as is, were appropriate and should be maintained. However, they did recognize the fact that “practical” methods may need to be developed to help achieve fidelity in the future. Sites were not sure how sustainable fidelity measures will be after the IRK project ends.

EBP
Evidence-Based
Practice

The state continues to manage its AIMS database as the central mechanism to monitor service delivery and quality. Beginning in late 2004, unique identifiers for IRK and non-IRK sites will be

incorporated into the database and will be defined to fit EBP groups for SE and IDDT. The state is developing strategies to create stronger linkages between practice and outcomes by developing a system to integrate billing, outcomes, substance abuse, mental health, and state hospital data.

Outcome measures continue to be used as part of the state's usual QE and contracting processes. Efforts are ongoing to determine which outcomes are most meaningful and useful to improve systems, assist in the implementation of EBPs, and help to elevate mental health, substance abuse, and SE issues in the legislature. The MHD strategic plan outlines various goals for EBPs that indicate general outcome targets for the state and CMHCs, but at this time there are no specific outcomes for IDDT, or for other IRK EBPs.

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