

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

Site Visit Dates: November 2002 and March 2004

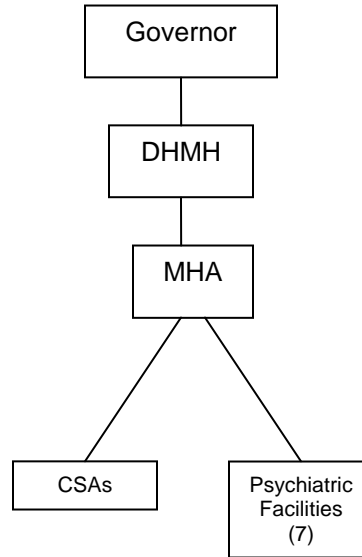
Overview in brief		
MH chief	Commissioner	
Placement of SMHA within State	Agency within a health department	
EBPs		
	Family Psychoeducation	Supported Employment
# sites using Implementation resource kits	2	3
# total sites	4	6
Statewide roll out planned??	no data	no data

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 Mental Hygiene Administration (MHA) is the State Mental Health Authority (SMHA) in Maryland. It is part of the Department of Health and Mental Hygiene (DHMH), a cabinet level secretariat. MHA is responsible for overseeing the delivery of public mental health services in the state. The SMHA operates seven state psychiatric hospitals and funds the majority of community mental health services through a Medicaid 1115 waiver.



Organization of the Maryland Mental Health System

Over the past decade, the SMHA has been transitioning from a centralized to a locally managed system of care for individuals of all ages with psychiatric disabilities. The present governance structure of public mental health services in Maryland reflects the transition from management by the SMHA to management at the local level through Core Services Agencies (CSA). All jurisdictions in Maryland now have CSAs which serve as agents of the SMHA at the local level. The CSAs are the focal point for the administration of the public mental health system (PMHS) in a defined jurisdiction. Most CSAs are not direct service providers.

Maryland has a large number of psychiatric rehabilitation organizations. The services provided within the system include limited case management services, as well as independent living skills, assistance with eligibility determination, and social recreation. Some of the rehabilitation service agencies are now adding outpatient clinics. A third group of providers are the Mobile Treatment Programs, which are similar to Assertive Community Treatment teams.

Evidence-Based Practices (EBPs)

In the EBP project Maryland is implementing the Supported Employment (SE) and the Family Psychoeducation (FPE) practices. Six sites were initially selected for SE, with three being part of the national demonstration project. Sites were recommended to the SMHA by CSAs through a Request For

EBP
Evidence-Based Practice

SE
Supported Employment

SMHA
State Mental Health Authority

CSA
Core Services Agency

Proposals (RFP) process. The SMHA selected sites with a mix of urban, suburban, and rural locations. For FPE, two sites were selected for initial implementation of the Implementation Resource Kit (IRK). The general selection criteria for FPE included the commitment level, philosophy about family involvement, and the capacity for self-appraisal of the candidate site. Additionally, selected sites had to have the capacity to involve ten families in FPE.

SMHA
State Mental Health
Authority

FPE
Family
Psychoeducation

Supported Employment had a history in Maryland. However, the sites using SE prior to the IRK project had low baseline fidelity scores. Sites applying to be included in the IRK project cited the \$20,000 start-up funds as an important factor in their decision to participate in the project.

SE
Supported Employment

IRK
Implementation
Resource Kit

A major SE issue for the SMHA was that some of the existing employment providers used an employment model that relied on agency-sponsored employment. Agency-sponsored employment is not consistent with the SE IRK design. Rather the SE EBP centers upon competitive employment. The SMHA has had to make clear that it will not reimburse for agency-sponsored employment.

EBP
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Practice

On the other hand, FPE neither had a history of existence, nor the infrastructure for implementation in Maryland. For these reasons, there was lag in the implementation for FPE.

Comments from family members about FPE include an acknowledgement that the National Alliance for the Mentally Ill's (NAMI) Family-To-Family (FTF) program and FPE are mutually supportive and that FTF is more illness oriented than FPE. However, FPE has been seen as more treatment and recovery oriented, with greater engagement of the clinical staff than FTF. In contrast, some consumers expressed disappointment about the lack of a recovery focus in the IRK. Consumers noted that one benefit of the FPE EBP tool was that it provided an opportunity to be with family members while not in conflict.

FTF
Family-to-Family

Leadership

In 2002, Maryland elected its first Republican Governor in 36 years. Under this administration, funding for mental health services was increased and a cabinet level department serving Maryland individuals with disabilities was created. The Secretary of Health & Mental Hygiene was appointed in April 2003 and is a veteran in Maryland's Health and Mental Hygiene department. A few months

after the new Secretary was appointed, he named the interim Director of the SMHA to be the Commissioner of the MHA.

SMHA
State Mental Health
Authority

Leadership from the Governor’s office, the Secretary’s office, and the Legislature is supportive of initiatives related to evidence-based practices and outcomes. While access to the broad array of mental health services has gone up by 50 percent in the last few years, questions still arise about whether services being provided are effective and worthwhile. Given the budget situation, proof of the utility of services is a prominent concern; hence, the emergence and support for EBPs and outcomes.

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Leadership within the SMHA appears to have stabilized with the appointment of the new Commissioner. A core of experienced, long-term senior managers within the agency has helped to maintain direction for the agency and has provided continuity to the initiatives underway. Maryland’s EBP initiative was originally supported by the prior mental health Commissioner to address quality of care at the practitioner level. Further, the prior Commissioner developed contracts with the University of Maryland (UM) to support initiatives related to training, evidence-based practices, and outcomes measures. The change in commissioners has not altered the focus on quality services at the practitioner level. In fact, recent communications by agency leadership have reiterated the commitment to evidence-based practices, recovery, and outcomes-based performance measures.

There are several ways in which the state has exhibited leadership to promote evidence-based practices. These include: (1) a commitment of resources to the initiative; (2) building partnerships with stakeholders, provider agencies, and other state agencies; (3) plans to modify regulations so that they are aligned with expectations consistent with EBP promulgation; and (4) judicious choice of “leaders” related to the specific EBPs that were part of the EBP IRK Project.

IRK
Implementation
Resource Kit

Additionally, stakeholders have been involved with the implementation of both evidence-based practices in Maryland. At the beginning of the EBP projects, the SMHA formed an Advisory Committee for each IRK. Each committee has SMHA, CSA, consumer, and provider representation. These committees meet on a regular basis, and often have representatives from other state agencies involved. One notable agency that has taken part in the committee meetings is the vocational rehabilitation agency, the Department of Rehabilitation Services (DORS). DORS has worked closely with the SMHA, CSA, and provider staff over the last year in

CSA
Core Services Agency

DORS
Department of
Rehabilitative Services

order to understand and participate in the SE EBP. This participation has created increased collaboration between the two agencies and has resulted in the co-location of counselors from DORS at some of the sites providing supported employment.

Financing

In 1998, through the implementation of the PMHS, the SMHA began to administer all State and federal funds related to mental health services, including Medicaid. Maryland Health Partners (MHP), a statewide administrative services organization (ASO), was hired to provide access, utilization management, claims processing, management information, and evaluation services. The principal goals of the MA 1115 Waiver were to increase access to services, increase consumer choice, and provide a one-tiered system of care with a combination of Medicaid and state funds.

The SMHA has been central to the initiation and implementation of EBPs through its funding and training activities. Both SE and FPE sites have received start up funds to help defray the costs of training and start up for the IRK. While these monies are not sufficient to cover all start up related costs, they are critical to ease the loss of revenue caused by staff involvement in training rather than billable service hours. All project sites continue to receive \$10,000 per year to assist with clinical time – i.e. team meeting reimbursement for therapist time, etc. However, due to budget constraints, administrative budget cuts were made to the Core Service Agencies. These cuts have resulted in CSA staff being less available to provide support and assistance for EBP and other programs.

The SMHA used Block Grant funds to establish two centers at the University of Maryland: a center for evidence-based practices and a center for evaluation and outcomes systems. A third center, funded by the SMHA with State general funds, was established to conduct training. These collaborative infrastructure additions have augmented the Administration’s ability to advance knowledge and expertise in the state by drawing on the academic expertise and professional experience of staff at the university. This relationship between UM and MHA is highly collaborative and mutually supportive.

Several significant changes to SE financing have taken place to facilitate the move toward the EBP model and competitive employment. First, reimbursement for SE services has increased and payment is now more consonant with EBP practice; however,

SE
Supported Employment

EBP
Evidence-Based Practice

DORS
Department of Rehabilitative Services

PMHS
Public Mental Health System

SMHA
State Mental Health Authority

FPE
Family Psychoeducation

IRK
Implementation Resource Kit

CSA
Core Services Agency

UM
University of Maryland

MHA
Mental Health Administration

obtaining reimbursement from all sources is burdensome and may not cover all SE costs. Second, the SMHA established a new payment method and went from fee-for-service payment to a case rate for all Psychiatric Rehabilitation Programs (which may include all SE programs). And third, the desired outcome for employment was redefined as competitive employment only. This allows MHA to reimburse solely for placement in a competitive job and not for agency sponsored placements, consistent with the IRK model of SE.

Initially MHA identified a billing code for FPE. However in February 2004, MHA identified a new service code only for outpatient mental health clinics that provide FPE. At the time of the March 2004 site visit, nearly 18 months after the initial visit, frustrations were beginning to surface regarding the fact that reimbursement issues for FPE services had not been resolved. The complicating factor was that most of the FPE participants have Medicare as their primary insurance, which does not provide reimbursement for these services. The SMHA is intervening directly to resolve this issue and is communicating more actively with the FPE sites.

The FPE providers were instructed to bill for FPE through the ASO. Despite the activation of the new FPE codes, FPE services provided without the consumer present are not on the approved billing list. Interestingly, the new Health Insurance Portability and Accountability Act (HIPAA) procedure code does not distinguish whether or not the service is with a consumer, while the former reimbursement code was able to discern this. Only FPE EBP programs in Maryland are allowed to use the FPE billing code.

Several of the site informants stated that the SMHA needs to continue to work to have “dollars line-up with what we want for consumers”. For example, one barrier for most agencies is that clinicians are not reimbursed for attending team meetings, but meetings are an integral part of the EBP model. Another barrier mentioned was that until EBPs pay for themselves, there will continue to be limited adoption regardless of the potential outcomes for clients.

Regulations

All hospitals and health-related institutions in Maryland must be licensed or approved by the Office of Health Care Quality (OHCQ). In addition to licensing, sites are provided technical assistance and reviews by the CSAs. But because of budget constraints in Maryland which resulted in staff reductions at the OHCQ, the CSAs

SE
Supported Employment

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IRK
Implementation Resource Kit

FPE
Family Psychoeducation

ASO
Administrative Services Organization

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CSA
Core Services Agencies

OHCQ
Office of Health Care Quality

have taken on a greater oversight role. This role is awkward for the CSAs, however, because they historically have played more of an advocacy role for the providers.

Prior to implementation of the EBP Project, Maryland had altered some regulations and processes to become more supportive of the SE EBP. They included SMHA vocational regulations defining supported employment as competitive employment. These changes apply not only to the EBP IRK sites, but to the entire state. Other important policy changes include the revision of the SE referral/authorization form, revision of the individual vocational plan form, and an agreement with DORS to streamline the eligibility process for SE.

The current SE program regulations are compatible with the EBP IRK but are not complete. To make the standards more consonant, the SMHA would have to go through a two year process to change the regulations. However, there is no plan to go through the official regulatory change process at this time.

No specific regulatory changes for FPE were discussed in Maryland.

Training

The SMHA's training program is coordinated by the University of Maryland. Historically, the training provided by the University of Maryland was conference based. Currently, about 4,000 people are trained each year through the extensive list of available conferences. The University has two new areas to support the EBP initiative: 1.) the Systems Evaluation Center (SEC) that includes full time implementation monitors who will develop fidelity scales and an outcomes measurement component and 2.) the Evidence Based Practice Center

After the IRK implementation began it became clear that the existing state training budget was insufficient for the EBP implementation. To address this issue, the SMHA has been discussing alternatives to the conference based training approach. They are seeking to reallocate training funds to a more effective EBP training model. Ideas about reallocation includes the pooling of funds to leverage the manner in which skills training is provided to be a more targeted approach, and the evaluation of web based and/or computer based training options.

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Rehabilitative Services

FPE
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The EBP sites received the full complement of IRK training from a former consultant and trainer from the University of Maryland. The training received universal praise. It was often remarked that it was the whole EBP implementation process (the on-going technical assistance, training by the consultant, leadership teams, etc.) not just the IRKs, that allowed success.

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If the SE EBP is to spread and be sustained, education and training must be targeted at multiple levels of the provider agencies (Chief Executive Officers, program managers, and staff) and key stakeholders (DORS, families). Champions must be created at multiple levels of the mental health system since EBPs are vulnerable to staff turnover, and could potentially lose momentum and support.

SE
Supported Employment

DORS
Department of
Rehabilitative Services

In addition to multiple level champions internal to the mental health system, consumers need to be educated on the benefits of EBPs as a way of increasing demand for them. Consumers also need instruction on the benefits of work to remove the fear of working. Consumer-to-consumer counseling was thought to be a promising idea to address these consumer education issues.

In contrast to the ready support SE had in Maryland, the SMHA had to enhance training to develop interest in the FPE EBP. Consequently, the SMHA performed additional training with the CSAs and providers to explain FPE. The providers believe that training is critical to enabling the FPE IRK to sustain itself after the project is over. Despite the general positive perception about training, feedback regarding the FPE IRK implementation included frustrations over provider agency staff turn-over and the drain on other agency staff and resources to maintain an adequate level of effort to sustain the IRK.

SMHA
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FPE
Family
Psychoeducation

CSA
Core Services
Agencies

A significant feature of the FPE rollout in Maryland was the selection of the trainer, who had a former affiliation with NAMI-Maryland. Her credibility and understanding of the nuances and distinctions between FPE and Family-to-Family services were critical to the success of the IRK implementation. She also played a critical role in facilitating the acceptance of FPE through understanding and empathy of the fears and misperceptions of family members. One advantage of this trainer was the opportunity to train staff how to engage family members more effectively.

NAMI
National Alliance for
the Mentally Ill

Overall, the hands-on knowledge and experience of the respective SE and FPE consultant/trainers were essential to the high degree of EBP implementation in Maryland. Both of these individuals were

able to command a high degree of credibility with all stakeholders. Additionally, these trainers were able to serve as a liaison between the SMHA and the CSAs to establish and reinforce the EBPs' as well as maintain the IRKs' momentum.

The state is taking steps to shape the post-EBP Project future. The University of Maryland has been asked to coordinate an EBP planning process for statewide EBP implementation beginning in the summer of 2004. Among the training-related areas to be discussed are:

- Should credentialing/certification of agencies or practitioners be pursued?
- Should credentialing lead to higher reimbursement rates?
- Should UM training money be used for conferences or skill training?
- Should all sites (staff, leadership teams) be brought together every 6 months?
- How should on-going skills training with the high turnover rate be addressed?

Quality Monitoring

There is currently no state-wide outcomes data system in Maryland. Maryland's data/Management Information System shifted to a financial and claims based system in 1998 when the state shifted to the ASO system. This claims based system results in a long lag in data collection due to the time that agencies have to submit their claims. However, Maryland is starting a pilot project, in collaboration with the University of Maryland Systems Evaluation Center, to collect data on five outcome measures: Living Situation, Employment, School/Work, Juvenile Justice & Criminal Justice Involvement, and symptoms. The pilot will provide information toward implementation of a strategic outcomes measurement system statewide. The adult measurement tool was in the process of being finalized at the time of the March 2004 visit. The tool is a questionnaire for adult mental health consumers with initial, ongoing, and discharge versions.

In addition to this data collection effort, outcomes questionnaires for the SE and FPE projects were developed. The FPE project has two questionnaires: one for family members and one for consumers. If the MHA decides to use all of the measurement tools, it is probable that each tool will be shortened. Provider feedback was solicited about ways to abbreviate the tools without much resolve. Presently, the SE and FPE outcome measurement tools are not in use.

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CSA
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IRK
Implementation
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UM
University of Maryland

ASO
Administrative Services
Organization

SE
Supported Employment

FPE
Family
Psychoeducation

MHA
Mental Health
Administration

Currently, fidelity reviews are done on the EBP sites according to the National Project standards every six months. However, at this time there is no plan in place for continuing these reviews after the project ends.

A major quality improvement mechanism seems to be the SMHA staff's work with the SE-EBP Advisory Board. In this forum, obstacles to implementation occurring in the field are discussed and are brought to the attention of the state for consideration. Since EBPs are a small part of the SMHA's responsibilities, the designated SMHA liaison staff act to keep the issue on the SMHA agenda. Additionally, close collaboration with the SE trainer keeps the SMHA up to date on other obstacles and barriers as they surface.

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