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

Site Visit Dates: September 2002 and March 2004

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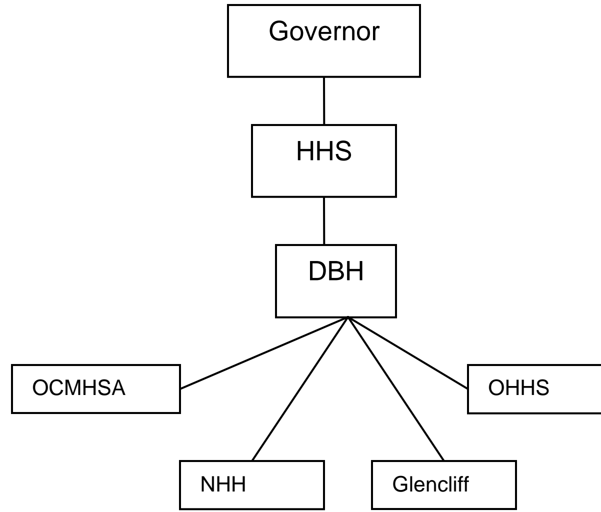
This report on implementing evidence-based practices has been synthesized from a series of site visit reports that were completed at two points in time--one early in the implementation process for each State and another 15-18 months later near the point of expected full implementation. The site visits 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 Division of Behavioral Health (DBH), which has primary responsibility for public mental health services, is part of a larger umbrella Health and Human Services (HHS) agency. The Director of the Division is directly accountable to the Commissioner of the Department of Health and Human Services (HHS). The Division of Behavioral Health includes several mental health units: the Office of Community Mental Health Services Administration (OCMHSA), the New Hampshire Hospital (NHH), the Glencliff Home for the Elderly, and the Office of Homeless and Housing Services (OHHS). The Division administers the state mental health system centrally.



Organization of the New Hampshire Mental Health System

The New Hampshire mental health delivery system consists of ten (10) regional community mental health centers (CMHCs) and numerous affiliated programs and facilities including an array of consumer-operated peer-support programs and three state-operated facilities. The community mental health agencies are private nonprofit organizations with annual performance contracts with the Division. Services for people living in a given region are planned, managed and delivered by the community mental health agency, which is designated under state law by the Director of the Division.

> **EBP**
> Evidence-Based Practice

> **CMHC**
> Community Mental Health Center

> **SMHA**
> State Mental Health Authority

Evidence-Based Practices (EBPs)

In the EBP project New Hampshire is implementing the Illness Management and Recovery (IMR) practice and the Family Psychoeducation (FPE) practice. Two sites implemented each of the practices, with one site implementing both (three total CMHCs participating). The sites were chosen based upon interest and mutual agreement with the State Mental Health Authority (SMHA) in a non-competitive process. The criteria the SMHA used for the

selection of the sites include the level of a CMHCs interest, the capacity to deliver the required services, a commitment to the project, and the role of consumers and families at each site.

CMHC
Community Mental Health Center

Initial training and consultation for the Implementation Resource Kit (IRK) sites was provided by Dartmouth University's Psychiatric Research Center (PRC), the leaders of the national demonstration project.

Leadership

New Hampshire has had a new Governor during the implementation of the EBP project. Also, the legislature now has conservative leadership in both houses. Unfortunately, the Division of Behavioral Health has devoted a significant portion of time over the last two years responding to legislative audits and reviews of the provider system. The New Hampshire Office of the Attorney General and Office of Inspector General are conducting reviews of services billed by several providers in the state. This review has necessitated a significant amount of staff resources from DBH.

EBP
Evidence-Based Practice

DBH
Division of Behavioral Health

At the time of the site visit, the SMHA commissioner was the Acting Division Director for Behavioral Health and reports directly to the commissioner of the Department of Health and Human Services. DBH has experienced significant instability in leadership over the past two years, with five different appointed or acting commissioners during this period. However, the current SMHA commissioner has been in the Acting role almost two years now, both under the prior administration and under this new one. In this two-year period, the SMHA Commissioner has experienced reporting to three different HHS Commissioners (one Acting and two Commissioners), two of which who had ideas about reorganizing the Department.

SMHA
State Mental Health Authority

HHS
Health and Human Services

With the department reorganization under the current Secretary of HHS, the Division lost the Deputy Director and Administrator of the Office of Policy and Planning to a newly created Bureau of Program Integrity. Despite all these changes, consistent leadership of the EBP implementation was provided largely through the state project leader and the consultant and trainer from Dartmouth PRC. At times, these champions have experienced the IRK sites as being less responsive to project oversight, fidelity measurement and training/supervision than they would like. Nevertheless, the Acting Director has instituted an EBP steering committee chaired by the Executive Director of one of the pilot sites. It is the intent of the Acting Director that EBPs will be rolled out to the entire mental

PRC
Psychiatric Research Center

IRK
Implementation Resource Kit

health system over the next three years. A grant application was made to Center for Medicaid Services (CMS) to help fund the implementation of IMR at CMHCs, the New Hampshire Hospital, and Peer Support Agencies.

IMR
Illness Management and Recovery

CMHC
Community Mental Health Center

PRC
Psychiatric Research Center

EBP
Evidence-Based Practice

A Steering Committee of the Chief Executive Officers (CEOs) of the sites, PRC, and Division leadership has been convened to provide leadership statewide about EBPs. This Steering Committee recognizes that New Hampshire's failure to provide statewide leadership from the beginning of this project has made expansion of EBPs difficult. They are committed to communicating that outcome-based, evidence-based practices are a new and important way of doing business.

Partly because of the recent organizational changes and changes within the state regarding mental health infrastructure at the state level, the provider agencies (i.e., CMHCs) formed an Association of Behavioral Health Centers and have become politically active, including hiring a lobbyist to work through the Governor's office on their issues. Given the vast amount of strain and stress in the mental health system, including the political changes, department reorganizations, budget cuts, and the increased lobbying and direct political activity from the CMHCs, there appears to be an eroding sense of authority in the SMHA relationship with the CMHCs. In fact, the Association requested that the Division eliminate some of its regulatory requirements.

SMHA
State Mental Health Authority

IRK
Implementation Resource Kit

The impact of the convergence of the timing for the EBP IRK implementation with the state's budget crisis and leadership changes was not foreseen. Due to the shifting SMHA priorities and the need to make realignments to the system of care and to the budget, there was initial limited commitment and resources dedicated to presenting the case for these EBPs and the EBP demonstration project, generally. Additionally, there was limited involvement of key stakeholders in the EBP implementation process -who could have assisted with creating the demand for the practices. Consequently, the EBP uptake has been slow, the fidelity has been minimal, and the perceptions about what the project is all about vary significantly between the state, the sites, and the Dartmouth PRC project team. At the time of the second site visit, however, there was increased recognition that the EBP initiative could be the basis of larger mental health system reform.

Because of these events, the Acting SMHA Director has demonstrated that EBP implementation is a top priority for the New Hampshire mental health system. He sees EBPs as a way to

improve the quality of care delivered to consumers and to regain credibility for the Division. In some senses the Acting Director is trying to regain the capacity the system as a whole has lost during the upheaval of the last couple of years.

Financing

DBH is the biggest division/budget within the HHS Department outside provider payments in Medicaid. While DBH has a large budget with HHS, the legislature has great control over the way money is spent, allocating funds down to the office line item. This limits flexibility to meet emerging needs. Medicaid is the major mechanism for funding mental health services in New Hampshire. There is a "bundled" rate for rehabilitation services, and a fee-for-service schedule for treatment services. Medicaid targets are used by the SMHA when contracting with CMHCs. Contracts are based on history, performance (including state hospital use), per client costs, and the like. Rates were set to incentivize in-community services and out-of-office services, but this has created some problems with documentation and has led to perceived over-billing. Now, DBH is revisiting the rates and is hoping to incentivize recovery as an outcome, thereby achieving graduation of consumers from the system.

DBH
Division of Behavioral Health

HHS
Health and Human Services

SMHA
State Mental Health Authority

CMHC
Community Mental Health Center

The SMHA prefers to bundle rehabilitation services and keep a fee-for-service mechanism for other services. DBH has a "Choice and Control" initiative that will allow a consumer to have a budget and a broker to determine a plan for services. The consumer could then spend the allocated money on the services they want. This initiative is being developed from a "Real Choices" federal grant, and is similar to Arkansas' "Independent Choices" program. Providers have expressed concern that this initiative will add costs (brokers and administrators) and will encourage undue competition in a time of limited resources. Families are concerned that consumers will not be able to make reasoned choices.

The Department developed a position paper that Family Psychoeducation and Illness Management and Recovery should be viewed as psychotherapeutic rehabilitation treatment practices that should be reimbursed by Medicaid. The argument that was made was that these services are within the services that may be covered under the federal Medicaid definition of rehabilitation services, that they qualified for Medicaid Federal Medical Assistance Percentage (FMAP) under the state plan, and that they were considered clinically effective, evidence-based treatment practices by the Substance Abuse and Mental Health Services Administration

(SAMHSA). Additionally, the Department argued that Medicaid requirements for “state wideness” and comparability were not compromised because these federal requirements for uniformity in the state plan do not prohibit treatment practice pilots that individual patients and providers may wish to participate in under the existing scope of Medicaid coverage.

The different codes that were proposed for billing FPE and IMR were under “therapy” or as Mental Illness Management Services (MIMS). The payments associated with each of these codes are based on the academic training of the provider, the location of treatment, and whether the treatment is provided on an individual or a group basis. Two issues with these billing strategies were raised: one was for billing IMR services provided outside an office setting – this situation was approved; the second was whether billing could take place if the family member received the service without the presence of the consumer. The decision was that the consumer needed to be present for billing purposes.

FPE
Family Psychoeducation

IMR
Illness Management and Recovery

To support the community mental health centers participation in the IRK project, the state provided each center with $6,000 for one practice and $10,000 for doing both FPE and IMR to cover some of the non-reimbursable costs associated with training and implementation. In retrospect, according to the center directors, this was not sufficient as an incentive, primarily because they were experiencing a loss of revenue in related areas.

IRK
Implementation Resource Kit

Regulations

No explicit regulation changes were made to facilitate the implementation of EBPs in this state.

EBP
Evidence-Based Practice

Training

The PRC provided staff training for the IRK teams. Coordinators from selected agencies volunteered for the project and then other staff were selected in order to meet capacity needs. The SMHA staff were the liaisons to the PRC and the three CMHCs implementing the EBPs. PRC completed the baseline assessments and implementation monitoring to measure the fidelity to the model.

PRC
Psychiatric Research Center

SMHA
State Mental Health Authority

As with other Community Mental Health programs across the country, there has been significant staff turnover at the sites. This turnover has caused the PRC consultant and trainer to train new staff doing the IRK practices, executive directors (ED), program

CMHC
Community Mental Health Center

directors, and clinical directors subsequent to the initial planned trainings. If the implementation of the IRKs is to be successful, it is clear that more consideration is needed in terms of training and in addressing turnover issues (which, from the perspective of EBP implementation, were also training issues).

IRK
Implementation Resource Kit

EBP
Evidence-Based Practice

Some important observations regarding successful implementation of IRKs centered on communication and recruitment issues. First, if the ED and clinical director in an agency or site did not communicate the mission critical nature of EBP implementation, line workers trying to implement the practice found the IRK difficult to execute successfully. A second observation is that the supervisors did not push line staff to recruit families to assist with the implementation of the IMR IRK, resulting in recruitment difficulty.

ED
Executive Director

IMR
Illness Management and Recovery

Further, given the productivity targets that front-line staff had to meet, EBP implementation efforts were an “add on” to existing work that were not necessarily counted in terms of achieving these required targets. This placed staff in a “no-win” situation; the implication being that there may, in fact, need to be an explicit incentive structure rather than an implicit penalty associated with EBP implementation for front-line staff.

Due to the need to reduce its budget, the SMHA training budget, with the exception of the contract with PRC, has been eliminated. In order to address this funding need, the state’s contract with the PRC will be more focused primarily on training for the two targeted practices to increase effectiveness and efficiency of the workforce more than for EBPs per se.

SMHA
State Mental Health Authority

PRC
Psychiatric Research Center

Quality Monitoring

The array of changes within the system has resulted in difficulty getting the two EBP practices implemented with fidelity to the models presented in the IRKs. New Hampshire had the lowest fidelity scores at six months of any of the participating states. One of the four sites had a significantly lower score than most other sites across the multiple states. Both state and site leadership were surprised by these scores. Local sites felt that they were being subject to undue criticism rather than getting support to move forward with adequate EBP implementation.

The National Alliance for the Mentally Ill (NAMI) New Hampshire director saw EBP implementation begin just as the state’s fiscal challenges forced the system to consider changes on multiple

levels and dedicate resources to other priorities. The relationship between consumers, providers, and the Division became strained and challenged during this period of time. The NAMI Director describes CMHCs as reluctant to see the value of a common indicator for their unique approaches to the delivery of services. CMHC's were still in the development phase of developing common indicators of performance, which were finally achieved to the success of all involved in that project. He suggested providing assistance to the CMHCs to stay engaged and do implementation, then measure fidelity or outcomes, but not both. As it was, fidelity was measured before CMHCs were truly engaged in the process and before they had fully implemented the practices. The CMHCs view the fidelity assessment as a test of the practice and not the implementation.

NAMI
National Alliance for the Mentally Ill

CMHC
Community Mental Health Center

From the SMHA perspective, accountability is a concept that is being developed, and because of competing demands on the CMHCs, EBP implementation is being integrated into this larger accountability initiative. Instead, the focus has shifted to accounting, financial, and compliance accountability issues. Despite this official shift in focus, the CMHCs see themselves as committed to quality improvement and indicate that they are constantly looking for new ways to deliver better care. EBP implementation is viewed as one mechanism to move this quality agenda forward.

SMHA
State Mental Health Authority

EBP
Evidence-Based Practice

The Division will customize IMR within the MIMS requirements. They are focusing on demonstrating the outcomes of what they do, rather than demonstrating fidelity to a model that has little meaning for the highly charged political environment in which the Division is currently operating.

IMR
Illness Management and Recovery

MIMS
Mental Illness Management Services

DBH has a key performance indicators project that has been in progress for several years. The Division is trying to utilize a Mental Health Systems Improvement Plan (MHSIP) to drive the indicators project to collect common data and have common performance indicators across the adult mental health system. Last year, DBH began using the key performance indicators to drive the budgeted Medicaid portion of the CMHC contracts.

DBH
Division of Behavioral Health