

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

Site Visit Dates: March 2003 and March 2004

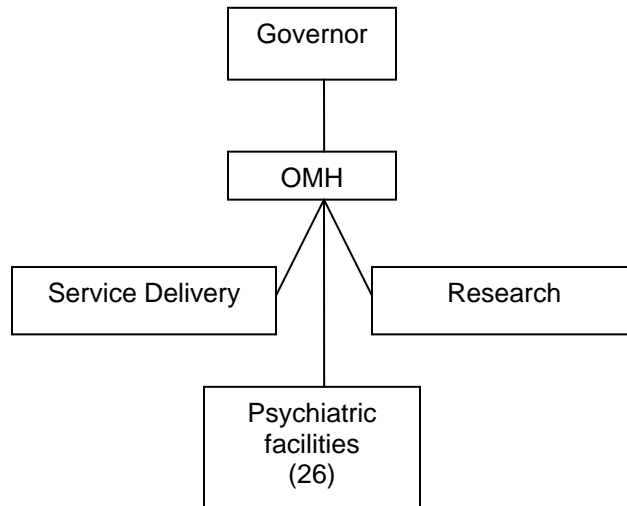
Overview in brief		
MH chief	Commissioner	
Placement of SMHA within State	Cabinet level	
EBPs		
	Assertive Community Treatment	Illness Management and Recovery
# sites using Implementation resource kits	5	4
# total sites	64	9
Statewide roll out planned??	in progress	in progress

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 Office of Mental Health (OMH) in New York State (NYS) is a cabinet level office in which the Commissioner of Mental Health reports directly to the Governor. OMH has an Adult Services Division that deals with the delivery of services to clients. The state office also has two research-oriented centers that focus on basic and clinical research and the Center for Information Technology and Evaluation Research (CITER), which focuses on evaluation research. New York State maintains 26 state psychiatric facilities, works with 62 local governmental units, and oversees approximately 2,500 mental health programs.



Organization of the New York Mental Health System

The local providers and county authorities play a large role in the NYS system. While each county is organized differently, they all have the same statutory responsibilities for planning, directing, and overseeing their local mental health service systems. Counties are also responsible for case management assignment and housing services. Some counties have chosen to be purely administrative entities, while others actually provide some services to clients directly. Despite their different governance structures, the state has tried to engage counties as partners for change within the system. Counties are given autonomy and discretion for deciding their service repertoires within state funding regulations, but are also constrained by accountability mechanisms set up by the state’s central office.

Evidence-Based Practices (EBPs)

In the EBP project New York State is implementing the Assertive Community Treatment (ACT) and Illness Management and Recovery (IMR) (called Wellness Self-Management in NYS) practices. The initial implementation of ACT and participation in the national demonstration project at the site level in New York was done on a voluntary basis. All five ACT Implementation Resource Kit (IRK) sites are all located in a corridor from New York City to Albany in order to facilitate access to the sites from the Albany staff. Additionally, these sites were selected because of their readiness for ACT team implementation at the beginning of the national demonstration project. Four sites were selected for IMR

EBP
Evidence-Based Practice

NYS
New York State

ACT
Assertive Community Treatment

IMR
Illness Management and Recovery

implementation, including one forensic psychiatric center in a prison. These sites were selected through provider interest and discussion with the Adult Services team at OMH.

OMH
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The models of both ACT and IMR being implemented in New York State are commensurate with the Dartmouth IRK projects, but have been slightly modified to fit the New York context. Although changes were made to the training packets, the New York team received approval from the national demonstration staff. The demonstration staff ensured the modified content and approach was consistent with the larger IRK project and would not affect fidelity measures. OMH is also trying to add a strong recovery and wellness philosophy to the ACT training that is not included in the IRKs. Although this focus is not explicitly addressed in the IRKs, it is not contradictory to its focus, either.

ACT
Assertive Community Treatment

IMR
Illness Management and Recovery

IRK
Implementation Resource Kit

Throughout the implementation initiative, OMH has worked to build meaningful partnerships with stakeholders, giving them a clear role in supporting the implementation of EBPs. In some cases this involves redirecting contracts held by peer or family advocacy agencies to support the EBP initiatives. One outcome of this partnership was a series of focus groups conducted with over 400 stakeholders statewide. These focus groups resulted in a white paper on consumers' views and priorities related to EBPs and the "10 rules" outlined in the Institute of Medicine's *Quality Chasm* report. Stakeholders have remained fairly supportive of EBPs in NYS.

EBP
Evidence-Based Practice

NYS
New York State

OMH has been implementing its "Winds of Change" marketing campaign aimed at organizational culture change throughout the process of the EBP demonstration. The agency hopes that this ongoing campaign and the supporting information included with the campaign will create a culture of change among providers to accept and implement EBPs after the demonstration project has ended. As such, NYS has remained committed to implementing all of the EBPs within the state. OMH is using ACT as a platform for all of the other EBPs, and has started to add in other EBPs including IMR and Integrated Dual Diagnosis Treatment (IDDT) to ACT in certain sites.

Leadership

OMH is an executive level agency within New York State government, with representation in the Governor's cabinet. Under the Governor's leadership during his three terms in office, New York's public mental health system has experienced a decade of

quality improvement and enhanced mental health services. A key piece of legislation during this decade was the enactment of Kendra's Law in 1999. This new law served to infuse the state mental health system with \$200 million annually for service quality improvement and further the quality improvement agenda being implemented in New York. Further, a cumulative \$1.4 billion has been redirected from unneeded bed capacity in State psychiatric centers, and reinvested in high-quality, recovery-oriented services based in the community, where 99 percent of all New Yorkers receive mental health care.

OMH has a high level of agency commitment and energy for moving EBPs forward, starting at the highest levels of the agency. The Commissioner, appointed in 2004, was a key part of the leadership team under the previous Commissioner, and in particular she was a champion and leader for the state's EBP initiatives. The Commissioner is committed to EBP implementation statewide and has tasked all relevant divisions to support EBP implementation efforts. This agency-wide support has been consistent from the early stages of the EBP project.

Some providers are working to take ownership of the IRK projects. These providers see the IRK project as an on-going process of learning and creativity while staying true to the principles of each practice. The state views its role as trying to model individualized approaches to system development, just as it takes an individualized approach to consumers. OMH sees the IRKs as "a roadmap, not a script." Despite these individualized efforts and the overall positive perspective on the IRK project, some agencies have reported that the IRKs are intimidating to some clinicians, while other clinicians have expressed concerns that the IRK material and processes have been "dumbed down".

Financing

As in most states, Medicaid matching funds are a major driver for mental health services in New York. OMH is in the process of implementing a new licensed and Medicaid-funded comprehensive rehabilitation program called Personalized Recovery Oriented Services (PROS). Under PROS a monthly tiered Medicaid case payment will replace deficit funding for a wide range of rehabilitation, psychosocial, and vocational support services. The first PROS license is expected to be issued in the summer of 2005.

ACT was initially deficit financed within New York. In the earliest stages of implementation only those locations that had financial

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EBP
Evidence-Based
Practice

IRK
Implementation
Resource Kit

PROS
Personalized Recovery
Oriented Services

ACT
Assertive Community
Treatment

slack or could be financially forward-looking participated. During the major expansion of ACT services beginning in State Fiscal Year 2001-2002, new teams were provided with “bridge funding” to pay for ACT team functioning until licensure and billing was approved. The state has provided money for initial training and computers, and maintained an ongoing ACT training budget, some of which is dedicated to training on other EBPs within ACT teams, including IMR.

ACT
Assertive Community
Treatment

EBP
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Illness Management
and Recovery

The ACT teams are reimbursed monthly on a case payment basis with two Medicaid rates: one for full billing and one for partial billing based on client contact requirements. The state bills Medicaid for ACT under the rehabilitation option. The cost of an ACT slot is about \$10,000 per year –which is comparable to costs in other states. However, the state has encountered some issues with the current ACT Medicaid formula and is recalculating its rate to provide more competitive salaries, especially for physicians and nurses.

OMH
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IMR services can be billed as group or individual psychotherapy, or as part of a day rate in a Continuing Day Treatment or Rehab program. OMH has sent a letter to all licensed providers to explain how to bill Medicaid for IMR services. IMR is seen as a central component of the new PROS comprehensive rehabilitation program being implemented within the state

PROS
Personalized Recovery
Oriented Services

Regulations

In general, agencies are not licensed or certified for EBPs. Rather they provide EBPs based upon the skills of the teams/individuals within the agency that provide the services.

The State of New York spent considerable time developing certification and licensing procedures for its ACT teams. ACT has been designed as a stand alone, licensed and certified service in New York State. Any agency wishing to develop a licensed ACT program must submit a Prior Approval Review (PAR) application outlining how they plan to meet the licensing and certification standards in the State. The PAR application becomes an opportunity for OMH staff to educate agencies about what is required to develop and sustain a high fidelity ACT program. Once the PAR is approved, programs receive a temporary operating license, and can begin to enroll clients and bill Medicaid. At 6 months teams have their first certification visit. Based on this 6-month review, teams are certified for a defined period of time. The certification team comes back prior to the end of the certification

PAR
Prior Approval Review

period to assess the team again, focusing on any deficiencies that may have been found in the prior review. It is expected that programs will be certified for increasingly long periods of time, similar to intervals seen with other state licensed programs (1-3 years depending upon performance).

OMH is still finalizing scores for individual items and overall scores on the ACT Certification Manual, including the identification of critical items where a good performance is required for renewal of certification. In general OMH prefers a technical assistance and quality improvement approach to a more punitive approach for reviews. In their quality improvement approach, poor performers are asked to develop corrective plans of action and have increased frequency of certification visits. The agency would like to create a continuum of review for authorization, instead of revoking certification.

ACT teams must be certified to receive Medicaid funding for its services. Fidelity measures, including all of the Dartmouth Assertive Community Treatment Scale (DACTS) items and select items from each of the other EBP fidelity scales, are built into the certification for ACT. A similar approach is planned for the PROS certification instrument, with one or two items taken from each of the EBP fidelity scales. PROS will offer an array of rehabilitation and recovery focused services funded by Medicaid for providers willing to move to that certification process.

Training

OMH has set aside monies for continuing ACT training activities for new teams as they are created. Training money is provided for individual ACT teams and for the centralized training support entity for EBPs.

Education and training has emerged as an important factor for successful EBP implementation. The IRK model for training, which involves an intensive training for a few days, followed by onsite supervision and consultation for 12 months, appears to be an effective method for supporting implementation. OMH is looking into alternatives that will allow for broader penetration of training. It also is working also to help programs develop the capacity to train and supervise new staff, rather than relying solely on external training and supervision.

ACT IRK sites received training according to the national protocol. The content of the initial ACT training was modified slightly from the

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ACT
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IRK
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Resource Kit

national IRK: a section on recovery was added and reworded to increase the emphasis on recovery; a section on cultural competence was added; and a “shadowing” experience for trainees to go on site with a high fidelity team was incorporated. After the initial training, IRK sites received 12 months of ongoing supervision and consultation. ACT team members are also receiving training in additional EBPs, modeled after the IRK curriculum. One difference about the training for these additional EBP components is that there is no onsite supervision for the other EBPs. Instead, trainees come together as a group for follow-up training and supervision. To date, IMR and IDDT trainings have taken place for ACT teams. As OMH continues to license new ACT teams, the agency is considering covering the training material in the initial intensive training module over a longer period of time to address issues of staff turn over.

The IMR IRK sites also were trained according to national protocol with some revisions. The consultants and trainers felt a particularly important addition to their training was a quarterly meeting of program leaders across sites to allow program leaders to learn from each other. Training in Illness Management and Recovery is being viewed by OMH as a core competency that all practitioners should have. OMH is working to help providers develop a more holistic approach to the treatment of mental illness. The training also emphasizes other components crucial to consumer recovery, such as housing and vocational services.

Training and turnover among ACT team members is an issue within the state. There needs to be realistic recruitment of ACT staffers so that they understand the pressures of working with this population and so that they do not get overwhelmed and leave the position after they have gone through training.

In the ACT and IMR IRK sites, the ongoing monthly supervision for 12 months following the initial training was felt to be crucial to the success of the project. One ACT site and all IMR sites asked to continue the consultant beyond the 12-month point. A survey of program leaders at non-IRK sites indicated that their ACT teams also found ongoing access to a consultant helpful.

OMH uses every opportunity it has to promote “knowledge-based practice.” The agency forms partnerships to explore solutions from different and important perspectives in an attempt to build “learning communities.” The goal of this effort is to increase the use of science in day-to-day treatment, to increase the availability of knowledge-based practices, and to increase the willingness of system participants to look at and use data to improve the quality of

IRK
Implementation
Resource Kit

ACT
Assertive Community
Treatment

EBP
Evidence-Based
Practice

IMR
Illness Management
and Recovery

IDDT
Integrated Dual
Diagnosis Treatment

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services. OMH respondents indicated that although there is a willingness by system participants to look at data and supporting information pertaining to performance, awareness building is a necessary but not sufficient element of garnering support for EBPs.

OMH
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EBP
Evidence-Based Practice

NYS
New York State

CAIRS
Child and Adult Integrated Reporting System

Quality Monitoring

NYS uses both primary and secondary data analysis for outcomes monitoring. OMH uses secondary data such as service utilization (Medicaid) and criminal justice status (from the State Dept. of Criminal Justice Services) to develop system performance measures. The primary data is collected through the Child and Adult Integrated Reporting System (CAIRS), a newly implemented computerized tracking system for adult and child client populations. CAIRS is a web-based application that allows data entered at the program to be retrieved by the program and by OMH at the client, program, county, region, or state level. Extracts of the database can be used to conduct ad hoc analyses on clients served in different programs. CAIRS represents a shift regarding the value and use of data within the NYS mental health system. Although there is currently no financial incentive to use the system and no sanction for not doing so, the individual and program comparison reports available through CAIRS are helping to encourage some providers to use the system.

OMH is encouraging the use of data for quality improvement throughout the state's mental health system as one part of the move toward knowledge-based practices. The development of the new CAIRS data system is one example of this, and the use of data in the state's Statewide Comprehensive Plan for Mental Health Services is another. OMH has also begun including data on fidelity measurement and individual client-based data from the new information system in the certification review process for ACT.

ACT
Assertive Community Treatment

Quality management of ACT teams is handled mainly through the licensure standards and adherence to the DACTS model. Outcomes for ACT clients are required for teams at baseline, and at six months. The outcomes are based on a variety of quality of life and clinical variables, consistent with the outcomes sought for seriously mentally ill individuals as a whole. Thus, the emphasis for the certification process and ACT teams is on continuous quality improvement and technical assistance.

DACTS
Dartmouth Assertive Community Treatment Scale

Although programs are not required to assess their own fidelity, they are required to conduct Quality Improvement assessments on program processes and outcomes. One IMR site is expecting to do

IMR
Illness Management and Recovery

its own internal evaluation and outcome study. The state's program committee and client representation committee is interested in also looking at the outcomes and qualitative results associated with IMR.

<p>IMR Illness Management and Recovery</p>
