

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

Site Visit Dates: March 2003 and April 2004

Overview in brief		
MH chief	Commissioner	
Placement of SMHA within State	Cabinet level department	
EBPs		
	Integrated Dual Diagnosis Treatment	Illness Management and Recovery
# sites using Implementation resource kits	4	4
# total sites	23	8
Statewide roll out planned??	no data	no

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.

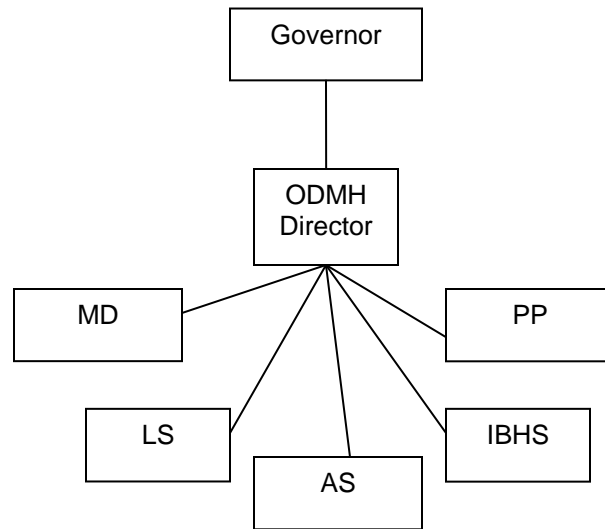
This report reflects the observations of the site visitors based on their synthesis of the views expressed by multiple individuals during the 1-2 days of each visit. Related facts from other documentary materials were also included to complete the longitudinal story of each site's implementation process. 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 Ohio State Department of Mental Health (ODMH) is an independent agency with direct accountability to the Governor's office. The department is organized into five divisions and the Director's Office (DO):

Medical Director (MD), Legal Services (LS), Administrative Services (AS), Integrated Behavioral Healthcare System (IBHS), and Programs and Policy (PP). In general, ODMH shapes the "overall statewide system of public mental health care through policy leadership, legislation, regulation and standard setting, the establishment of

fiscal incentives, monitoring and oversight, interagency coordination and the dissemination and application of research results". ODMH considers its main responsibilities to plan, develop, fund, approve, and monitor annual local county mental health plans. It provides services directly through state psychiatric hospitals and state operated outpatient programs.



Organization of the Ohio Mental Health System

Collectively, 50 local authorities oversee the non-profit organization (NPO) community mental health agencies (about 500) that deliver mental health and addiction services in communities. The local authorities are responsible for planning, funding, monitoring and evaluating the service systems within their geographical areas. Each geographic area covers between 32,000 and 1 million people and 1-5 county mental health systems. The authority boards develop and maintain a comprehensive community-based system of care through annual plans. Authorities also contract with an array of local service agencies for direct service delivery.

The state has organized seven Coordinating Centers of Excellence (CCOE) as an extension of itself, and considers the centers "agents" for translating policy into practice at the local and provider levels. Using a diffusion of innovations model for implementation, the CCOEs market Evidence Based-Practices, implement Evidence-Based Practices, and primarily provide training and evaluation and pilot support across the state to providers. The CCOEs include Substance Abuse/Mental Illness (SAMI), Center for Learning Excellence (CLEX), Ohio Medication Algorithm Project (OMAP), Center for Innovative Practices (CIP), Illness Management and Recovery (IMR), Criminal Justice, and Cluster Based Planning Alliance as foci for their efforts.

Evidence-Based Practices (EBPs)

In the EBP project Ohio is implementing the Integrated Dual Diagnosis Treatment (IDDT) and Illness Management and Recovery (IMR) practices. A total of 8 sites are implementing the Dual Diagnosis and IMR Implementation Resource Kits (IRK). Two CCOEs, one focused on co-occurring Substance Abuse and Mental Illness and the other focused on IMR, were responsible for selecting the sites -no calls for proposals were issued. Instead, each CCOE was asked to recommend 4 sites for the project, and the ODMH gave the final approval for participation. Criteria for selection included a mix of urban/rural sites, diverse representation across the state, and whether the agency was receptive to EBPs and the IRK Project requirements. The main incentive for providers to participate in the IRK project was the opportunity to receive state supported training. Currently, 19 non-IRK sites are implementing IDDT as part of an earlier SAMI initiative, and four non-IRK sites are implementing IMR.

A few of the dual diagnosis sites provided financial incentives for their clinicians participating in the IRK project. These incentives include a bonus/raise in pay if licensing/accreditation is maintained/obtained, and a productivity credit for participating in training. Sites did not have to be dually certified for Substance abuse and mental health to participate. Teams internal to sites for IDDT have been organized in several ways, including: redirection of efforts to dual diagnosis clients, recruitment of new teams, and recruitment of existing teams to begin the IRK.

State respondents perceive that the implementation of the IRK EBPs and other EBP activities have moved forward in ways they expected. Time was cited as the biggest facilitator associated with the state's progress. That is, now that all those involved in the IRK project and others involved in implementing non-IRK EBPs, have "gotten their feet on the ground, adjustments to the process are easier". The state will continue to support the implementation of EBPs, regardless of the uncertainty that exists about financial resources for future technical assistance and training. One expectation is that trainer monies (e.g. for Train the Trainer programs) may be raised from other CCOE supported activities.

ODMH thinks that the IRK process was necessary and useful but not sufficient to meet its goals for EBP training, dissemination, and roll out of services. The state had not expected the extent to which implementing both IRK and non-IRK EBPs would require significant overlapping and duplicative efforts and structures. The state thinks that the next two years are critical in determining how to encourage



the adoption of EBPs. This process will occur while simultaneously maintaining, or in many cases obtaining, accreditation, complying with ODMH Outcomes use/reporting and performance improvement rules, and functioning in an increasingly Medicaid-driven payment structure. ODMH will continue to work with the CCOEs as the main body to implement ODMH strategies for the IRK and non-IRK EBPs, and to roll out its Quality Agenda through multiple venues (e.g. newsletter, website).

ODMH does not expect to roll out IMR statewide in the way it might with other specific IRK practices. However, ODMH is encouraging and supports a number of recovery-oriented, illness/wellness self-management approaches. The IMR IRK at this point is seen as one tool in the arsenal, but not the only approach to recovery-oriented service approaches.

ODMH and providers alike have been surprised at how much upfront organizational readiness has been required to implement an IRK practice, especially IMR. IMR is seen as a paradigm shift affecting documentation, team structure, attitudes, and relations with consumers and among staff. However, some of the IMR sites see it as less difficult to implement than supported employment or IDDT.

Leadership

Ohio’s strong and stable leadership within the Department of Mental Health remains the major facilitator in implementing EBPs throughout the state. Since the initial state/local site visit in 2003, the most significant change in leadership at the state level has been the retirement of the Director of the Department of Alcohol and Drug Addiction Services (ODADAS). The new Director collaborates more directly with ODMH staff to implement state initiatives and to more directly address the service delivery challenges for persons with co-occurring mental health and substance abuse disorders (COD). This change has been creating a more open and synergistic approach to rolling out some of the state’s initiatives (e.g. Quality Agenda) and to addressing the needs of certain populations (e.g. COD) and providers across systems.

Like the ODMH Director, all key SMHA staff have remained in their positions and have continued to work on implementing and expanding EBPs and other initiatives throughout the state. Staff are very committed to integrating research into practice, to being innovative, and to proactively working with their provider communities and CCOEs. One additional SMHA staff person may

EBP
Evidence-Based Practice

ODMH
Ohio Department of Mental Health

CCOE
Coordinating Centers of Excellence

IRK
Implementation Resource Kit

IMR
Illness Management and Recovery

IDDT
Integrated Dual Diagnosis Treatment

COD
Co-occurring Mental Health and Substance Abuse Disorders

SMHA
State Mental Health Authority

be hired within the current fiscal year to assist with EBP implementation efforts in both outpatient and inpatient settings.

One state Committee, the ODADAS Advisory Committee, can be considered a new (indirect) champion for IDDT services. The Committee is addressing recommendations from a stakeholder’s group that evaluated the state’s alcohol and other drug treatment and prevention system. ODMH staff participate in the Committee and are working collaboratively on projects that address Medicaid, reimbursement, community planning, and improvement of service quality and efficiency.

Site level support has been constant despite some changes in leadership at the IDDT and IMR sites. Although several issues have arisen around implementation, the sites remain committed to the EBP project. Several site directors seem appreciative of the interest and time that the state has invested in helping them achieve fidelity to the IRK model and in addressing implementation issues in general.

The SMHA leadership is increasingly able to articulate that Ohio is encouraging rather than regulating science-based practices and a quality agenda that includes the use of EBPs. They discuss the differences between implementation of a practice, adoption of EBPs, and adaptation of a particular practice to make it work within each unique local context. SMHA leadership sees the CCOEs as a critical aspect of its ability to stimulate and support adoption and adaptation of EBPs. ODMH views adaptation as critical and that implementation of EBPs is an evolutionary process rather than a specific event or project. They convey the message of entrepreneurial change, not “making people do the right thing.”

Financing

Mental health and addiction services are mainly financed through the state’s Medicaid benefit and local board dollar matches. Currently, core mental health and addiction benefits covered by Medicaid are not being delivered by managed care organizations and this is not expected to change. County boards support about 90% of Community Mental Health Center (CMHC) and NPO financial needs through arrangements described in their annual mental health and addiction service spending plans. Boards are responsible for matching dollars and administering monies to contracted providers. All but five boards have taxing powers and are able to generate real estate taxes and local levy resources.

EBP
Evidence-Based Practice

ODADAS
Ohio Department of Alcohol and Drug Addiction Services

IDDT
Integrated Dual Diagnosis Treatment

ODMH
Ohio Department of Mental Health

IMR
Illness Management and Recovery

IRK
Implementation Resource Kit

SMHA
State Mental Health Authority

CCOE
Coordinating Centers of Excellence

NPO
Non-profit Organization

Each of the IMR and Dual Diagnosis sites received \$7,500 from ODMH to offset costs of staff training time and other start-up costs. This money was allocated to each site by ODMH after determining that funds from the IRK Project to offset costs -which had been anticipated -were not going to be available. The eight sites expect that the start-up monies from ODMH for the demonstration project and research will not be sustainable for future implementation start-ups. Therefore, the providers are aware that they need to actively begin searching for alternative funding mechanisms for dual diagnosis teams.

IMR
Illness Management
and Recovery

ODMH
Ohio Department of
Mental Health

IRK
Implementation
Resource Kit

CCOE
Coordinating Centers
of Excellence

After start-up, the need for funding for on-going training is a critical issue according to IMR sites and the IMR CCOE. With staff turnover and expansion of the staff who need to understand the materials, initial training, booster training, and training around fidelity measurement is on-going, not just a one-time concern or cost. This problem is exacerbated by ongoing trends such as the “Medicaidization” of funding (which results in reduced organizational slack resources), and staff turnover. These trends increase the complexity of training efforts.

EBPs continue to be billed and reimbursed like any other service. IDDT is billed largely through mental health billing codes. Individual and group community support program (CSP) Medicaid services clearly cover IMR now. However, support for staff time spent in training is an issue. Staff training needs to include initial and booster training, as well as training on fidelity scoring. But staff time to participate in training is generally not funded by Medicaid.

EBP
Evidence-Based
Practice

IDDT
Integrated Dual
Diagnosis Treatment

ODMH is in the process of suggesting funding mechanisms and certification changes that can make it easier to deliver dual diagnosis services. Medicaid reimbursement codes are used to bill separately for mental health and substance abuse services under ODMH arrangements. Currently there are two separate clinical systems/requirements and funding lines for dual diagnosis. No dual diagnosis codes exist for any type of billing. It is anticipated that dual diagnosis services will be paid for under mental health codes in the future. ODMH has not yet approached Medicaid about making it easier to bill for IMR services.

By statute, ODADAS runs a Governor’s Advisory Council that examines Medicaid issues. Medicaid, ODMH, and ODADAS are working together to deal with Medicaid and other financing issues. This working relationship between ODMH and Medicaid has facilitated addressing several issues including: a lawsuit about contracting brought by providers against ODMH, ODADAS, and the

ODADAS
Ohio Department of
Alcohol and Drug
Addiction Services

Association of the Boards, shifting from a retrospective to prospective rate system, and developing incentives.

Regulations

The state has been working on licensing and certification standards, not specific to EBPs. In September 2003 ODMH certification standards became effective, replacing program standards that had been in place for over 10 years. The overarching goals of regulatory reform were to: reduce the volume and complexity of prescriptive regulation (while increasing protections for vulnerable clients in the context of resource erosion), increase an orientation to outcomes accountability, require performance improvement efforts, and require private accreditation for most mainstream providers. The new Administrative Rules include documentation standards, rules for performance improvement, consumer outcomes and research, rules for the certification process, services standards, and agency policies. The new Rules represent the Department's regulatory approach to supporting quality improvement and outcomes. Together with EBPs, these approaches represent major components of ODMH's Clinical Quality Agenda.

EBP
Evidence-Based
Practice

ODMH
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Mental Health

The state has not yet developed, and at the current time does not intend to develop, regulatory strategies that are specific to EBPs. This lack of intent is related to the perceived limits in the science and incomplete experience with real-world use of EBPs. The steps that are being taken to improve services, outcomes measurement, quality, and accountability are being developed within a collaborative and holistic approach to mental health and substance abuse care generally, as well as a policy/management mindset that encourages learning and quality improvement in a very turbulent environment.

Training

ODMH invests much time, effort, and monies into the implementation of new and ongoing training and technical assistance across the state. Several efforts to keep providers trained in leading technologies include the CCOEs, state conferences, use of outside experts and university researchers, a residency and training program, internal research, and the implementation of a quality agenda. ODMH coordinates training and technical assistance efforts with ODADAS as needed.

CCOE
Coordinating Centers
of Excellence

ODADAS
Ohio Director of the
Department of Alcohol
and Drug Addiction
Services

The ODMH Internal Management Team for the IRK Project and the SAMI and IMR CCOE staffs meet to discuss organizational development issues, problem solving, and ODMH expectations of the implementation of the two EBPs. Staff turnover had led to much retraining, modified training, and the CCOEs bringing in additional trainers at times. IMR sites have requested additional training, but the IMR CCOE has not yet been able to accommodate this request. The CCOE does plan additional trainings in the future, including a train-the-trainer methodology.

The skill of the trainer has become an issue for both the CCOE and ODMH. They have determined that the trainer cannot be just a generalist skilled in training, but must also have clinical skills, especially for training those case managers who have less well-developed clinical skills themselves.

Organizational readiness and the maintenance required to implement the IRK EBPs (and EBPs in general) in the demonstration sites has been addressed by the CCOE trainers in start-up and in an ongoing fashion. IDDT agencies view CCOE training and ongoing technical assistance and monitoring critical to EBP success. At this time it is unclear which sources of funding will support future trainings and technical assistance for IRK sites after the project ends. However, sites think that it is critical that ongoing training is available to support the maintenance and success of EBPs. There does seem to be the expectation that CCOEs will continue to provide training in some fashion. All sites noted that more funding is needed to help them maintain EBPs and to perform certain start-up activities such as consumer outreach.

Quality Monitoring

Quality assurance/improvement guidelines exist at both the state and local levels. The state is re-evaluating its standards, objectives, measurement, definitions, expected results, and biannual approach to working with local boards within the Quality Assurance (QA) process. One of the changes that is being made is that the state is transitioning from a more open-ended, qualitative QA system, to one that is more quantitatively based. This transition has posed some challenges for providers and the state.

The IRK project uses the fidelity measurement processes that were developed for the national demonstration. The consultant/trainer for the IRK project trains and monitors the sites in this process. Each CCOE is responsible for consulting, training, and evaluating with fidelity in mind. The oversight and technical assistance

ODMH
Ohio Department of
Mental Health

IRK
Implementation
Resource Kit

SAMI
Substance Abuse and
Mental Illness, one of
the Coordinating
Centers of Excellence

IMR
Illness Management
and Recovery

CCOE
Coordinating Centers
of Excellence

EBP
Evidence-Based
Practice

IDDT
Integrated Dual
Diagnosis Treatment

QA
Quality Assurance

provided by the ODMH Evaluation Coordinator for the IRK project and other ODMH staff is designed to increase awareness of the Department's commitment to and support of EBP adoption within local systems.

The IMR IRK, unlike the other IRKs, is a compilation of practices and concepts that have been researched independently, not as a total package. Therefore, the connection between fidelity and outcomes is less clear in this IRK than with the other IRK practices, creating a need to test the fidelity-outcomes connection in IMR. Ohio will also assess fidelity for new IMR activities; but its format is not defined at this time.

ODMH's Quality Agenda, Balanced Scorecard activities, and ongoing EBP research efforts are all designed to create outcomes consistency throughout the state. These efforts will help agencies to achieve fidelity to whichever treatments and services they are implementing. The new Administrative Rules for certification represent the Department's regulatory approach to supporting quality improvement and outcomes. As a general practice, fidelity measures are being used as performance measures, and as part of the state's usual continuous quality improvement. ODMH views fidelity and outcomes as complementary, with both not necessarily needing to be achieved or achieved at the same time.

In 2003, ODMH implemented a standardized approach to measuring consumer outcomes. The Ohio Mental Health Consumer Outcomes System was mandated as part of a new set of certification standards. Although ODMH has led the development of the state-wide Mental Health Outcomes System, at this time it is not possible to track outcomes for IRK versus non-IRK service recipients. Reporting of consistent Outcomes System data will be mandatory as of September 2004 for all boards and providers. Further, the use of the data for treatment planning and performance improvement will be mandatory by September 2005.

ODMH has a history of integrating research and practice to improve mental health and substance abuse systems, and organizational and provider competencies. Ohio has experimented with a number of ways to improve quality, including the introduction and support of EBPs. ODMH is also making significant strides in understanding and incorporating learning from research about what it takes to implement such broad system changes to improve clinical care and outcomes, through its IDARP project. The IRK project is just one of many efforts ODMH is making to assure consumers receive the best care possible within available resources.

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