

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

Site Visit Dates: October 2002 and March 2004

<b>Overview in brief</b>	
MH chief	Commissioner
Placement of SMHA within State	Division within an umbrella agency
<b>EBPs</b>	
	<b>Supported Employment</b>
# sites using Implementation resource kits	3
# total sites	3
Statewide roll out planned??	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.

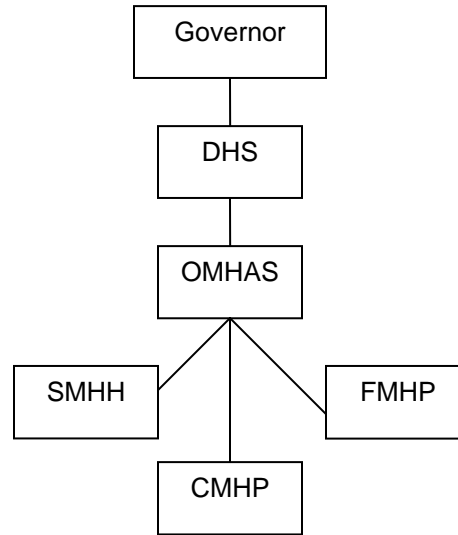
This report reflects the observations of the site visitors based on their synthesis of the views expressed by multiple individuals during the 1-2 days of each visit. Related facts from other documentary materials were also included to complete the longitudinal story of each site's implementation process. 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

Public mental health services are administered within Oregon’s Department of Human Services (DHS) by the Office of Mental Health and Addiction Services (OMHAS). OMHAS serves as the State Mental Health Authority. As the State Mental Health Authority, DHS has primary responsibility for two state mental health hospitals (SMHH), community mental health programs (CMHP), and forensic mental health programs (FMHP).

The State is required by statute to establish a contractual relationship with each county to assure the provision of community mental health services.

State funds are allocated to counties using a “block grant” approach. Oregon Health Plan (OHP) Mental Health Organization (MHO) contractors are required to establish linkages with non-OHP funded support services. These non-OHP services are contracted through Community Mental Health Programs.



**Organization of the Oregon Mental Health System**

## Evidence-Based Practices (EBPs)

In the EBP project Oregon is implementing the Supported Employment (SE) practice. OMHAS developed a Request for Applications (RFA) to solicit participation in the Implementation Resource Kit (IRK) project by community mental health programs. Selection criteria included geographical considerations, degree to which family and consumer advocates would be involved, existing fidelity ratings on SE (medium to low), and likelihood of success in utilizing training and consultation provided in the EBP process.

As Oregon moves forward on a statewide basis with EBP implementation efforts, several challenges and needs were identified. At the state level critical contingencies included: mechanisms for promoting general system-level programmatic principles related to EBP implementation (for example to achieve fidelity with the General Organizational Index (GOI)), the development of rules and regulations that support EBP implementation at the broad organizational level (vs.

**EBP**  
Evidence-Based  
Practice

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and Addiction Services

**SE**  
Supported Employment

implementation of specific EBPs), and instituting contracts and technical assistance initiatives so that the EBPs actually get implemented.

**EBP**  
Evidence-Based  
Practice

An important aspect of Oregon’s participation in the EBP project was the recognition of the system-level adaptation that was needed for sustained uptake. In this sense, the introduction of EBPs helped catalyze an understanding of the system-level and organizational transformation needs so that EBPs could be introduced more easily.

### **Leadership**

Since the beginning of the EBP IRK project there was a change in commissioner of the Office of Mental Health and Addiction Services. During this interval, the state continued to experience a financial crisis and, as a result, several programmatic cutbacks occurred. Fortunately, these cutbacks were less severe for mental health services than originally expected. The state had also passed legislation requiring that several state agencies, including OMHAS, dedicate an increasing proportion of state monies to “evidence-based programs” over the next several years. Within this context, the state continues to build on its historical emphasis on quality in the area of mental health services.

**IRK**  
Implementation  
Resource Kit

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and Addiction Services

During the EBP IRK project a new Commissioner was appointed to head the State Mental Health Authority (SMHA). This transition to the new Commissioner was smooth and seamless. From the perspective of EBP implementation, the new Commissioner was one of the champions of the EBP initiative. Despite this change at the top of the organization, the leadership team within OMHAS remained intact. Several of the people involved with EBP implementation remained at the agency. This provided both continuity and stability in implementation efforts. The leadership team at OMHAS has continued to have high credibility with the Oregon Legislature.

**IRK**  
Implementation  
Resource Kit

One unforeseen benefit of the EBP IRK project was the extent of the collaboration between the state mental health authority and the state vocational rehabilitation agency. This state-level collaboration also had a positive impact on facilitating coordination and collaboration at the local level. Initially, the roles of the two agencies needed to be better defined, but they worked together to address provider concerns and apprehensions, struggling with different problems at different sites.

The evidence-based nature of Supported Employment and the competitive employment outcomes produced in SE programs (versus employment in enclaves or sheltered work settings) helped enhance the credibility OMHAS in its relationship with Voc Rehab (VR). The mutual goals of both agencies were addressed through the EBP initiative, allowing for and creating a climate of collaboration for future initiatives.

**SE**  
Supported Employment

**OMHAS**  
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**EBP**  
Evidence-Based  
Practice

Local level leadership was also a contributing factor in moving forward with EBP implementation. Some of the original EBP efforts were instigated at the local level through foundation grants. Across sites, different approaches were adopted at the local level to move forward with EBP implementation. At some sites, introduction of EBPs became the basis for refining the quality assurance and quality improvement system. This improvement included the development of outcome measures and learning to “package” data differently for various groups.

### **Financing**

In 1989 the entire nation watched as Oregon developed an elaborate process for prioritizing health-related services for funding. Conditions and treatment pairs were ranked according to the state of medical technology, the effectiveness and cost of treatment, public values, and advice from medical specialist and ethicists. Since 1993 this prioritized list has served as the basis for a rationalized allocation of health, mental health, and chemical dependency services. Coverage for treatment is based on the prioritized list of integrated condition/treatment pairs as recommended by the state Legislative Assembly.

The Oregon Health Plan includes an expanded mental health benefit that covers all individuals eligible for the Oregon Health Plan. As of July 1, 2002, 82% of persons who are Medicaid-eligible receive their Medicaid mental health benefit through an at-risk managed care Mental Health Organization (MHO). Mental health services continue to be made available to persons ineligible for the Oregon Health Plan according to statutorily defined risk criteria. These services are paid for through a variety of mechanisms including grants, private insurance, and local funds.

Despite shortages associated with the state budget crisis, OMHAS is committed to promoting EBPs and has facilitated their implementation. Originally, a major impetus for evidence-based practices was a Mental Health Alignment Plan (issued in

January 2001) which provided a blueprint for the development of the mental health system emphasizing local control and flexibility in Oregon. Initially, the allocation of \$8 million to implement the plan was viewed as a major source of funding for broad dissemination and implementation of EBPs. Over time, however, this source of funding shrank considerably and eventually was projected to be unavailable.

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Practice

OMHAS has had an “opportunistic” approach to EBP implementation, capitalizing on opportunities such as the Johnson & Johnson grants to promote Supported Employment and participation in the National EBP Demonstration Project. A significant portion of Block Grant increases were allocated to EBP implementation and were used to support sites’ participation in the IRK project. The state and local sites funded start up costs and implementation through a combination of a state Real Choice Systems Change Grant, a Dartmouth University Psychiatric Research Center (PRC) grant, Johnson & Johnson monies, and Lilly monies.

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Resource Kit

Originally, Supported Employment was paid for solely by state general revenue funds. However, in October 2003 Supported Employment had its own code that could be billed under Medicaid. The collaboration with the vocational rehabilitation agency has also helped provide resources for Supported Employment. The VR agency has funded a vocational rehabilitation counselor at some sites.

**VR**  
Vocational  
Rehabilitation Agency

With budget constraints, the financing of EBPs in Oregon is somewhat dependent on what other services will not be funded. Day treatment and psychotherapy were identified as services not being used effectively, suggesting the possibility of diverting some of the resources currently used for day treatment to Supported Employment. Senate Bill 267 clearly provides an impetus for financing evidence-based practices, allowing for the shifting of dollars to more effective interventions. However, an issue of concern in Oregon relates to the definition of evidence-based practices. The concern is that of the unknown (and presumably negative) impact on practices that are considered effective, or “promising”, even though their evidentiary base is still developing or unfounded.

### **Regulations**

Senate Bill 267 was a bill passed in the 2003 Legislative Session. This bill created new provisions requiring that an increased

proportion of public funds be dedicated to evidence-based programs. For the biennium beginning July 1, 2005, legislation requires that at least 25 per cent of state monies spent on mental health and addictions be spent on evidence-based programs; for the biennium beginning July 1, 2007, the proportion would go up to 50 per cent; and then in the succeeding biennium, the expectation was that the proportion would go up to 75 percent. In the legislation, an “evidence-based program” means “a program that: (a) incorporates significant and relevant practices based on scientifically based research; and (b) is cost effective.” All state and federal funds are affected by this bill, including services provided through Medicaid.

In response to this legislation, OMHAS has proposed three levels of evidence-based practices and three levels of non-evidence-based practices. The EBP levels 1 through 3 meet the scientific rigor that defines an evidence-based service. The three non-EBP levels 4 through 6 seek to define practices that may develop into EBPs over time. These six levels are:

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<p><b>EBP</b> Evidence-Based Practice</p>
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- Level 1            A practice that is supported by scientifically sound randomized controlled studies that have shown consistently positive outcomes in both scientifically controlled and routine settings. (The practice is sufficiently documented through research to permit the assessment of fidelity.)
- Level 2            A practice that is supported by scientifically sound experimental studies that have demonstrated consistently positive outcomes either in scientifically controlled settings or routine care settings, but not in both. (The research could be either randomized controlled studies or rigorously conducted evaluations.) While fidelity can be assessed, the fidelity measurement tools may not have been formally developed or fully tested.
- Level 3            These are evidence-based practices that may have been modified or adapted for a population or setting that is different from which it was formally developed and documented.
- Levels 4 -6        These levels consist of non-evidence-based practices that have not been documented and/or replicated through scientifically sound research procedures but for which evidence is being developed through specification of procedures and monitoring of outcomes. These services fill a gap not covered by EBPs in the service delivery system.

To place a particular practice in the appropriate level, OMHAS has identified six attributes to consider: transparency, research, standardization, replication, presence of a fidelity scale, and meaningful outcomes.

A major challenge for the ascription to these levels and the assessment of cost-effectiveness is that, in many ways, the

requirements for evidence-based services exceed the current level of knowledge and science in mental health. Also, much of the research conducted related to EBPs has been conducted in community settings. How EBP programs are identified for services provided in hospital settings may prove more difficult.

**EBP**  
Evidence-Based  
Practice

## Training

Responsibility for training is shared between state and local authorities. At the state level, OMHAS has set aside approximately \$100,000 per year for training and has a director of training. The training element of OMHAS has a mission “to provide skills training to implement current, evidence-based and culturally competent prevention and treatment services.” Training was to occur through the eight regional training centers. However, the training office covers a large spectrum of activities, including computer training, HIPAA-related training, domestic violence, etc., so the evidence-based component is a small portion of the entire training plan.

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**HIPPA**  
Health Insurance  
Portability and  
Accountability Act

While OMHAS has a training office, its responsibilities are broad in terms of staff development so it has not had the capacity to support EBP implementation. Instead, a specific trainer was identified for Supported Employment. This person has supported EBP implementation through telephonic support, training sessions, and on-site visits. A major lesson derived from this experience was that EBP implementation requires ongoing consultation and support and cannot be based on a minimal number of training sessions.

With the increased emphasis on EBPs, the Association of Community Mental Health Programs is organizing provider training related to both Supported Employment and Assertive Community Treatment (ACT). The plan is to extend this training so that the six EBPs covered in the IRK project are addressed. The Association has created an educational company to develop and distribute materials related to evidence-based practices to providers.

**IRK**  
Implementation  
Resource Kit

Local authorities cited support from the state as critical to the advancement of EBPs, both in terms of support related to the clinical end of the practice as well as for administrative, infrastructure development related to data and outcomes. Specifically, the state trainer was described as maintaining regular, weekly contact and being open to ideas and working with local issues; similarly, other OMHAS staff were also described as responsive to local concerns and priorities.

Involvement with the EBP IRK project has had a positive impact in several unintended areas at the local level. One of the most important consequences was that within the context of budget shortfalls, layoffs, and sagging morale, the IRKs have provided a rallying focus and purpose for staff. As staff received more training and information, the IRKs were a source of both commitment and quality improvement.

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Evidence-Based  
Practice

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### **Quality Monitoring**

The OMHAS Quality Assurance and Certification Unit is responsible for certification and licensure of provider organizations that are deemed to be in compliance with Oregon Administrative Rules and state laws. Mental Health Organizations under contract with OMHAS are required to submit annual quality assurance plans and work plans that are reviewed and approved by the Quality Assurance Section. OMHAS also analyzes data from utilization reports, periodic reports from MHOs, and other outcome measures for use in quality improvement and monitoring activities.

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and Addiction Services

**MHO**  
Mental Health  
Organizations

A major finding for the EBP initiative in Oregon was that organizational development at the local level was critical for the implementing EBPs with fidelity. This includes addressing the key components of the GOI (including the implementation of outcomes measures), recruiting staff for the project, and getting the buy-in of clinicians. In some sites, the GOI was consciously integrated into ongoing quality assurance activities.

**GOI**  
General Organizational  
Index

Additionally, data reports were developed for various audiences using a combination of Medicaid data, enrollment/demographic information, and the monitoring of employment at both admission and discharge.

An important aspect of the quality improvement effort at the various implementation sites was the monitoring of outcomes related to Supported Employment. Agencies monitor the number of persons who were competitively employed as a result of EBP implementation, the number of persons actively seeking jobs, the number of persons moving from sheltered employment to Supported Employment, the number of hours worked each week, and the number of days a person had employment was also monitored.

Both the fidelity measures and the GOI were reported as making the job of the clinical supervisor easier. These instruments provided sound benchmarks and guidelines for

ongoing evaluations and for establishing goals. In some cases, the staff member selected as the Supported Employment specialist was considered to be the critical factor in achieving the documented outcomes. Both personnel quality and stability of staff (low turnover) were cited as critical aspects to achieving high levels of fidelity.