STATE BEHAVIORAL HEALTH INNOVATIONS: DISSEMINATING PROMISING PRACTICES

Sylvia B. Perlman and Richard H. Dougherty
DMA Health Strategies

August 2006

ABSTRACT: According to reports issued by the President's New Freedom Commission on Mental Health and the Institute of Medicine, the delivery of mental health care in the United States requires radical improvement and reform. To help identify promising innovations in behavioral health care, the authors of this report interviewed experts in the field of mental health and substance abuse. Based on their suggestions, the authors selected and described 17 practices—all related to purchasing and quality improvement—being implemented by states in behavioral health care. Many of the projects result from the increasing demands placed on state agencies to meet needs with a reduced budget, leaving states with little choice but to increase efficiency and effectiveness. The innovations fall into six categories: enhancing consumer-centered care, criminal justice/mental health collaboration, system integration, the use of performance incentives, quality improvement, and other promising practices.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. This report and other Fund publications are available online at www.cmwf.org. To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts. Commonwealth Fund pub. no. 945.

CONTENTS

About the Authors iv

Acknowledgments v

Executive Summary vi

Background 1

Enhancing Consumer-Centered Care (New Jersey, Georgia, Florida) 2

Criminal Justice/Mental Health Collaboration (Ohio) 8

System Integration (New Jersey, New Mexico, Washington) 11

Using Performance Incentives (Delaware, Kentucky, Oregon) 17

Quality Improvement (Washington, Iowa, Oklahoma) 22

Other Significant Projects (Tennessee, Minnesota, California, Wyoming) 27

Discussion: Dissemination and Diffusion 32

Conclusion 34

Appendix A. Other Work on Innovations in Behavioral Health Care 36

Appendix B. Methodology 41

Appendix C. List of Expert Informants 43

Appendix D. Contact Information for Innovations 44

Notes 48

ABOUT THE AUTHORS

Sylvia B. Perlman, Ph.D., is a senior associate at DMA Health Strategies, a consulting firm focused on behavioral health systems. Her recent and current projects include a study of Massachusetts's first jail diversion program; writing a state substance abuse strategic plan for Massachusetts; consultation and major writing responsibility for proposals by public agencies and private organizations to public and private funders; developing a series of employer briefs summarizing the literature on treatment for substance use disorders for the Center for Substance Abuse Treatment; and playing a major role in the Children's Mental Health Benchmarking Project, funded primarily by the Annie E. Casey Foundation. She previously served as associate director and director of quality management for Mental Health and Substance Abuse Corporations of Massachusetts. Dr. Perlman received her A.B. from Smith College, magna cum laude, and her Ph.D. from Brandeis University. She currently serves on the board of Consumer Quality Initiatives, a consumer-directed organization; and as a member of the quality improvement committee of Jewish Family and Children's Service of Greater Boston. She has published articles on a variety of topics in numerous journals and has presented at many local and national conferences.

Richard H. Dougherty, Ph.D., is president of DMA Health Strategies and over the past 22 years has consulted with businesses and government agencies to implement strategies designed to manage health systems change and quality improvement. He currently leads two separate strategic planning and implementation projects for the Massachusetts Department of Mental Health and the Bureau of Substance Abuse Services; consults to the city of Philadelphia on a commission for children's behavioral health; facilitates the eight-county California Learning Collaborative for the California Institute of Mental Health, and oversees numerous other projects within the firm. He has written articles on self-directed services and quality improvement in mental health, worked on the Children's Mental Health Benchmarking Project, developed an RFP for San Diego County's Administrative Services Organization, and worked on a procurement project for the Massachusetts Medicaid carve-out and Massachusetts's Commonworks programs. Prior to forming DMA in 1987, Dr. Dougherty was a senior manager at BDO/Seidman, manager of finance and board member of National Mentor, Inc., and program manager for the Massachusetts Department of Social Services, in charge of residential procurement. He has an A.B. from Colgate University, an A.M. in social service administration from the University of Chicago, and a Ph.D. in applied social psychology from Boston University. He has recently been treasurer and a member of the board of the American College of Mental Health Administration and is on the board of several other national and community organizations.

ACKNOWLEDGMENTS

The authors are grateful to the leaders consulted during the initial stage of the project and are especially pleased to acknowledge the assistance from the managers of the innovations described in this report. All these individuals graciously took time out of their busy schedules to offer valuable information and thoughtful comments on specific projects within the context of the larger behavioral health care system. The authors also extend gratitude to Stephen Schoenbaum, executive vice president, and to Karen Adams, program officer, at The Commonwealth Fund. Their many helpful comments significantly improved the quality and utility of the report. Finally, they thank Jennifer Edwards, formerly a program officer at The Commonwealth Fund, who helped to develop the project into its final form.

Editorial support was provided by Deborah Lorber.

EXECUTIVE SUMMARY

Building on the foundation laid by the President's New Freedom Commission on Mental Health and the Institute of Medicine—calling for radical reform and improvement of the mental health and substance abuse systems of care—this report identifies 17 innovations in behavioral health care being implemented by states. By describing and disseminating these innovations—all related to purchasing and quality improvement of mental health and substance abuse care—the authors of this report hope to acknowledge the work of many leaders in the field while assisting states in the task of translating policy into effective practice.

To identify promising projects, the authors interviewed 21 experts in the field and surveyed the mental health and substance abuse directors in all 50 states. Their suggestions led to the 17 projects included in the report. [For a full description of the methodology, see Appendix B.] When requesting nominations, the authors asked for practices that:

- increase cost effectiveness;
- improve access;
- lead to improved clinical outcomes (although innovations in direct clinical care were not sought);
- enhance patient-centeredness;
- reduce disparities; or
- reduce fragmentation of care.

The projects reviewed are in various stages of implementation and evaluation. Some are worthy of review and consideration by other states although they have not yet accomplished all their goals. There are rarely perfect solutions to complex social problems, and other states and counties can learn from mistakes made in early innovations. This information can help the field move forward by informing state and county decision makers about their peers' efforts and the trends in the field, so that they, in turn, can more knowledgeably consider their own options in designing or modifying existing policies and programs.

The 17 innovations fall into the following six categories:

Enhancing consumer-centered care. Generally, individuals with mental illness receive care in a location, modality, and amount dictated by professionals. In consumer-centered care, services are more explicitly tailored to the needs of individuals, delivered in a way that is sensitive to their needs and allowing for greater control, in terms of the type of services received, location, and provider.

Criminal justice/mental health collaboration. Jails and prisons have become a de facto component of the nation's inpatient behavioral health system, housing more individuals with mental health and substance abuse needs than do psychiatric hospitals. Programs that utilize criminal justice diversion and reentry strategies can help to avoid unnecessary criminalization and extended incarceration of nonviolent adult and juvenile offenders with mental illnesses.

System integration. To combat issues of fragmentation, some states have initiated projects that provide for a coordinated system of care and a blended funding arrangement. Integrating service systems, however, is a massive undertaking, involving multiple players, agencies, legislative mandates, providers, structures, and funding sources.

Using performance incentives. Many states use contracting methods that either reimburse costs or set fixed prices. More recently, however, states have begun developing ways of using performance incentives. In human services, performance can be defined in relation to services performed by the contractor or to outcomes achieved by clients.

Quality improvement. While all the innovations are intended to improve quality, the projects in this section are explicitly intended to improve the way in which particular state agencies perform their own functions or encourage their contracted providers to perform. The ultimate goal is to improve the care clients receive, as well as their clinical and functional outcomes.

Other significant projects. Four innovations stood alone in their areas of concern, yet seemed worthy of mention by virtue of their apparently successful approaches to issues that challenge nearly all mental health and substance abuse agencies.

Highlights of the Case Studies

- In New Jersey, Consumer Connections recruits, trains, and supports consumers of mental health services to be providers of mental health services as volunteers, or as full or part-time paraprofessionals or professionals within the mental health and human service systems. These services are available at no charge to consumers of

mental health services in New Jersey. Since inception, the program has had 850 graduates. Of these, 65 percent to 70 percent are currently working in mental health care, substance abuse treatment, or other human service settings throughout the state.

- The Criminal Justice Coordinating Center of Excellence was initiated to develop programs throughout Ohio to help keep people with mental disorders out of jail and in treatment. Working with the National GAINS Center for Evidence-Based Programs in the Justice System, the program has developed a model to encourage communities to approach jail diversion systematically.

- The Washington Medicaid Integration Partnership is a comprehensive approach that blends funds for behavioral health, primary care, and long-term care services in a county-based system. The 5,000 adult Medicaid enrollees in the county have access to care coordinators, primary care providers, specialty care, and drug and alcohol services. By bringing all the services under one roof, the project planners hope to provide a "medical home" for clients where they will be cared for by a stable team of professionals they know and trust. In the long run, the project leaders believe that focusing on preventive care and services is likely to save money, as well as improve lives.

- For 2003 through 2005, the Kentucky Department for Mental Health and Mental Retardation Services designated 1 percent of total state general funds for use as performance incentives. This amount was increased to 10 percent for the fiscal year 2005–06. While the program has not yet been formally evaluated, preliminary internal review suggests that there has been improvement in the integrity of data collection and greater awareness of responsibility for using best practices and achieving quality outcomes.

- The Iowa Department of Public Health, Division of Behavioral Health and Professional Licensure, is working with the Network for the Improvement of Addiction Treatment (NIATx) to improve access and retention within the addiction treatment field. Using the NIATx model, Iowa has worked with local addiction service providers to decrease wait time to outpatient services. One agency reduced wait times by an average of 56 percent, while admissions increased by 186 percent. The state agency is now working to disseminate the NIATx principles to all addiction service providers in Iowa.

- The Creating Homes Initiative (CHI) partners the Tennessee Department of Mental Health and Developmental Disabilities with local communities to create permanent housing options for Tennesseans with mental illness and co-occurring

disorders. Using a grant from the Centers for Medicare and Medicaid Services, CHI has provided greater access to information and services about available housing options and reduced stigma surrounding mental illness through community education and social marketing efforts. By late 2005, CHI had successfully created 4,288 affordable, safe, permanent, quality housing options in consumers' chosen communities. Most importantly, the state reports a 95 percent reduction in the rate of re-hospitalization for consumers residing in CHI housing.

Many of the projects described in this report result in no small part from the demands placed on state agencies to meet an increased need for services with a reduced budget. Many states have little choice but to try to improve performance and increase efficiency and effectiveness. They have sought to accomplish these goals by adopting approaches from other parts of the health care system, like performance-based contracting, and projects from the private sector, like primary care integration and chronic disease management.

While careful reporting on the results of these efforts is crucial to the design of new initiatives, evaluations are often funded insufficiently or not at all. Yet, in the absence of competent studies, state policymakers cannot be sure which innovations are worthy of consideration. New models of evaluation are needed—ones that can document change and report on a set of standard and comparable measures.

By facilitating local efforts, sharing best practices, and reporting on the outcomes of innovations wherever possible, states can act as "incubators" of promising practices. Disseminating details about current innovations, including accomplishments and challenges, is one vital component of this approach.

Summary Table Describing Innovations

State	Project	Brief Description	MH	SA	Kids	Adults	Financial Support
Enhancing Consumer-Centered Care							
GA	Certified Peer Specialist project	Consumers complete extensive training program and work is then reimbursable by Medicaid.	✓			✓	GA Division of Mental Health, Developmental Disabilities and Addictive Diseases
NJ	Consumer Connections	Trains and supports consumer to fill mental health and human services jobs.	✓			✓	Mental Health Association of NJ operates program with funding from NJ Division of Mental Health Services
FL	Self-Directed Care	Each participant given control over resources to purchase mental health services.	✓			✓	Administered by NAMI of Collier County and funded by the Florida Dept. of Children and Families District 8.
Criminal Justice/Mental Health Collaboration							
OH	Criminal Justice Coordinating Center of Excellence	Collaborative model that seeks to encourage communities throughout the state to develop jail diversion programs.	✓			✓	Ohio DMH, based at Northeastern Ohio Universities College of Medicine
System Integration							
NJ	Division of Child Behavioral Health Services	Development of one comprehensive system of flexible, accessible community-based services with individualized service planning across child-serving systems; common screening and assessment tools and protocols; effective community-based crisis management.	✓		✓		One pool of state and federal child welfare, mental health, and Medicaid funds
NM	Behavioral Health Purchasing collaborative	Blended funding for mental health, criminal justice, child welfare, temporary assistance for needy families, and substance abuse.	✓	✓	✓	✓	All state and federal funding for behavioral health services
WA	Medicaid Integration Partnership	All funding in one county blended and health care, pharmacy, and mental health and substance abuse care managed by one managed care contractor. Plans to extend program throughout the state.	✓	✓	✓	✓	Medicaid funds.

State	Project	Brief Description	MH	SA	Kids	Adults	Financial Support
Using Performance Incentives							
OR	Implementation of Evidence-Based Practices	In response to state law requiring increasing amounts of state funds devoted to evidence-based practices, the Office of Mental Health and Addiction Services is restructuring the mental health and substance abuse delivery systems for adults and youth.	✓	✓		✓	Percentage of state funds used to treat people with substance abuse problems and mental illness must be grounded in evidence-based practices. These percentages will increase in future years.
DE	Performance-Based Contracting	Performance-based contracting that provides financial rewards to providers who are able to engage and retain clients in treatment.		✓		✓	State of Delaware
KY	Performance-Based Contracting for Mental Health	Kentucky's Department for Mental Health and Mental Retardation Services has engaged in extensive internal planning and process change to use performance-based contracting strategies.	✓		✓	✓	For 2003–2005, the department designated 1 percent of total state general funds for use as performance incentives. Increased to 10 percent for 2005–06.
Quality Improvement							
OK	Process Improvement in Substance Abuse Services	State Department of Mental Health and Substance Abuse Services uses quarterly reports with providers to promote a culture of performance improvement. Reports focus on six indicators that track identification of eligible persons and their initiation and engagement in treatment.		✓		✓	State Department of Mental Health and Substance Abuse Services and the Network for the Improvement of Addiction Treatment, funded by SAMHSA and the Robert Wood Johnson Foundation
IA	Process Improvement	Improve access and retention by identifying and reviewing licensing standards that present barriers to access and retention.		✓		✓	State of Iowa, with technical assistance from Network for the Improvement of Addiction Treatment, funded by SAMHSA and the Robert Wood Johnson Foundation
WA	Research and Data Analysis	The Research and Data Analysis Division of the state's Department of Social and Health Services produces reports used for quality improvement purposes and to document the effectiveness of services and the need for additional services.	✓	✓	✓	✓	Washington State Department of Social and Health Services

State	Project	Brief Description	MH	SA	Kids	Adults	Financial Support
Other							
CA	Proposition 63	Provides funds to expand services and programs for mentally ill children and adults; requires the state to develop mental health service programs on prevention, early intervention, education and training.	✓		✓	✓	1 percent tax on taxable personal income above $1 million to fund expanded health services for mentally ill children, adults, seniors. Passed in November 2004.
MN	Minnesota Mental Health Action Group	Broad-based coalition of mental health providers, hospitals, health plans, consumer advocacy organizations, and the state Departments of Human Services and Health developed a "road map" for system changes.	✓		✓	✓	Numerous health plans, insurers, and hospitals.
WY	Healthy Together	Disease management program that includes all Medicaid members, with additional services for those with chronic ailments, including mental disorders.	✓	✓	✓	✓	Wyoming Medicaid
TN	Creating Homes Initiative	Provides a consumer-directed, accessible housing resource system for Tennesseans diagnosed with mental illness or co-occurring disorders; works to reduce stigma.	✓			✓	Varied sources: federal, state, public, private, traditional, non-traditional

STATE BEHAVIORAL HEALTH INNOVATIONS: DISSEMINATING PROMISING PRACTICES

BACKGROUND

The Federal Action Agenda

In July 2003, the President's New Freedom Commission on Mental Health released its final report, *Achieving the Promise: Transforming Mental Health Care in America.*[1] The report concluded that "to improve access to quality care and services, the Commission recommends fundamentally transforming how mental health care is delivered in America."[2] That is, the report emphasized that reform is not enough, transformation is essential. The Substance Abuse and Mental Health Services Administration responded to the report in several ways. Most notably, it developed an action agenda, published in July 2005, and awarded five-year Mental Health Transformation State Incentive Grants (MHT SIGs) to seven states in September 2005.

The agenda—the *Federal Action Agenda: First Steps*[3]—states five principles, each associated with a series of steps aimed at transforming the mental health system. These principles are:[4]

- Focus on the desired outcomes of mental health care to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation.
- Focus on community-level models of care that effectively coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services.
- Focus on those policies that maximize the utility of existing resources by increasing cost-effectiveness and reducing unnecessary and burdensome regulatory barriers.
- Consider how mental health research findings can be used most effectively to influence the delivery of services.
- Follow the principles of federalism, and ensure that [the Commission's] recommendations promote innovation, flexibility, and accountability at all levels of government and respect the constitutional role of the states and Indian tribes.

This report describes 17 specific innovations, representing creative and effective efforts being implemented by states in behavioral health. Each of the innovations responds

to at least one—and often more than one—of these principles. Of the seven states that were awarded MHT SIGs totaling $92.5 million over five years, four are cited in this report: Ohio, Oklahoma, Washington, and New Mexico.

The Institute of Medicine

In November 2005, the Institute of Medicine (IOM) released its report, *Improving the Quality of Health Care for Mental and Substance-Use Conditions*.[5] Written by an IOM committee charged with exploring the implications of the *Crossing the Quality Chasm*[6] report for the field of mental health and addictive disorders, the report offers a set of nine recommendations aimed at improving care for mental health and substance-use conditions. These include the following:

- Health care purchasers should use tools for reducing selection-related incentives, i.e., attempts to limit the coverage and quality of mental health and substance abuse care; Congress and state legislatures should enact parity for coverage of mental health and substance abuse care treatment; all purchasers should use quality measures in procurement and accountability processes; state and local governments should increase the use of funding mechanisms that link some funds to measures of quality.
- Federal and state agencies and private foundations should create health services research strategies and innovative approaches that address treatment effectiveness and quality improvement in usual settings of care delivery. In addition, funders should develop new research and demonstration funding models that encourage local innovation.

This paper addresses issues at the juncture of these two recommendations, with a goal of offering state and local purchasers and other stakeholders information on some of the best innovations in purchasing, financing, and quality improvement.

ENHANCING CONSUMER-CENTERED CARE (NEW JERSEY, GEORGIA, FLORIDA)

The behavioral health field is increasingly recognizing that consumer-directed services contribute to successful recovery. Typically, individuals with mental illnesses receive care from professionals who dictate the location, modality, and amount of care. In consumer-centered care, the service recipient or "consumer" has greater control, in terms of the type of services received, location, and provider. Both the New Freedom Commission on Mental Health and the recent IOM report focus on consumer- (or "patient-") centered care and contain specific recommendations on how to provide it.[7] The success of the

programs in New Jersey, Georgia, and Florida will be of interest to
the many states trying to follow these recommendations. One project allows consumers to control resources to purchase care while the other two focus on employment and peer support.

New Jersey: Consumer Connections

Summary. The Consumer Connections program was in the forefront of the movement encouraging consumers as providers in New Jersey when it began operation in 1997. Consumer Connections recruits, trains, and supports consumers of mental health services to be providers of mental health services as volunteers, or as full or part-time paraprofessionals or professionals within the mental health and human service systems. Services are available at no charge to consumers of mental health services in New Jersey.

Consumer Connections provides networking information to help connect job-seekers and employers; develops opportunities for consumers to participate as service providers; provides basic training in mental health issues, personal development, communication skills, and job skills; offers training, evaluation, and support for those entering work assignments; and coordinates with other employment, training, and educational programs to expand opportunities for consumers.

The program has three components: the Employment Opportunity Bank, Consumer Provider Training, and the Consumer Support Network. The Employment Opportunity Bank includes a listing of employment opportunities for consumer providers in New Jersey; general consumer provider employment opportunity Web sites; career planning Web sites; and a job search workshop. Employment services are available on the Web site, by calling a toll-free number, and in-person by appointment. The workforce development coordinator discusses available job opportunities with potential applicants and helps to arrange and prepare for interviews.

Next year Consumer Connections is hoping to open a Workforce Development Center to provide consumers with a place to use the program's computers, Internet access, and other technology for individual job searches, career development, and job readiness testing and employment preparation. The goal is to create more flexible and comprehensive support services both before and during employment.

The core component of the program—Consumer Provider Training—is an intensive 90-hour training that takes place two days per week over the course of nearly two months. It is offered twice each year, once in the northern part of the state and once

in the southern region. The training gives participants new skills, as well as the information and resources they need to take the first step toward employment. Because of its length and intensity, the training creates cohesion and support among group members.

The core training curriculum was recently revised and enhanced. An individual who completes the training, as well as 2,000 hours in the field, is eligible for certification as a Community Mental Health Associate (CMHA). An additional 36-hour program offers training in co-occurring disorders (i.e., concurrent mental illness and substance abuse). The CMHA certification helps consumers become eligible for entry-level residential, case management, and peer advocate positions. In 2005 there were a total of 65 graduates from the core and co-occurring disorders trainings.[8]

Throughout the year, Consumer Connections offers more specialized trainings to graduates of its core program. During the summer of 2005, a three-day training was offered to consumers working in psychiatric emergency screening centers.

The final piece of the program, Consumer Support Network, provides ongoing support and training to individuals employed within the mental health system. Services include pre- and post-employment workshops, peer supervision groups, and individual support through face-to-face and telephone contact.[9]

Funding and administration. Consumer Connections is funded by the Mental Health Association in New Jersey (MHANJ) and the New Jersey Department of Human Service's Division of Mental Health Services (DMHS).

Results. Each Consumer Connections class enrolls no more than 25 individuals, with about 90 percent typically completing the program. Training participants receive evaluation forms after each training session, and since 1997 programs have consistently rated in the very good to excellent range. Since its inception, the program has had 850 graduates. Of these, 65 percent to 70 percent are currently working in mental health care, substance abuse treatment, or other human service settings throughout the state. Although services offered by individuals with the CMHA certification are not billable to third party payers in New Jersey, programs look to Consumer Connections graduates to fill non-clinical positions because the training is known to provide a comprehensive overview of the mental health and substance abuse service systems. Graduates work in residential programs and self-help centers, as case managers and as consumer advocates.

Using both informal and formal feedback, MHANJ modified the Consumer Connections program, for example, increasing the number of core curriculum days from 11 to 15. Focus groups of agency providers and conversations with staff of DMHS have led to other changes. For example, certain advanced training topics have been added to the curriculum, including training for individuals interested in working in psychiatric emergency screening centers.

The Consumer Provider Association in New Jersey (CPANJ) was founded in 2001, with technical assistance and financial support from MHANJ and a Substance Abuse and Mental Health Services Administration consumer networking grant. The goal of this organization was to further expand employment opportunities for consumer providers in New Jersey. In 2005, CPANJ had a paid membership of 150 consumers. It holds regional support meetings and has lobbied for increased salaries and advancement opportunities for consumer providers. New Jersey's consumer providers have become an effective and important part of the mental health advocacy network in presenting consumer issues at legislative hearings and in individual meetings with legislators and the Governor.

Georgia: Certified Peer Specialists

Summary. Since December 2001, a total of 285 current and former mental health consumers have completed training and examination in Georgia to become certified peer specialists (CPSs). They have been prepared to assist consumers in directing their own recovery and in building skills, setting goals, solving problems, and establishing and sustaining mutual self-help groups. These peer support services are reimbursable under Georgia's implementation of the Medicaid Rehabilitation Option.

Certification requires that each CPS complete a rigorous nine-day training program, and pass written and oral examinations on the structure of the Georgia mental health system, clients' rights, cultural competency, confidentiality, and record-keeping. Candidates are selected to take part in the training based on their ability to meet the guidelines. Employment status is also a criteria, and candidates are considered in the following priority order: 1) consumers who are currently employed by public or private providers of Medicaid billable services; 2) consumers who have distinguished themselves as peer leaders and are being sponsored by Medicaid providers for possible hire; and 3) consumers who work within peer services that do not bill Medicaid and those seeking certification to improve their marketability. The project conducts training at least twice per year and holds quarterly continuing education seminars and workshops for those already certified to learn emerging best practices in mental health recovery.

Funding and administration. A portion of the Georgia CPS Project is funded through a grant from the Center for Mental Health Services, a constituent agency of SAMHSA. The project is a part of the Consumer Relations and Recovery Section (known as the consumer affairs office in other states) of the State Division of Mental Health, Developmental Disabilities and Addictive Diseases in Georgia's Department of Human Resources. Eligibility to receive services from a CPS is clearly defined within the state's Medicaid guidelines.[10] The guidelines include, for example, admission and continuing stay criteria for clients, as well as clinical exclusions; required program components; and staffing and clinical operations requirements. Peer specialists may operate within a variety of programmatic contexts (e.g., within a freestanding peer support center or an existing clinical service provider) but must not be operated in isolation from the other programs within the facility or organization with which it is affiliated. Each program is required to have a Peer Supports Organizational Plan that spells out its service philosophy, staffing pattern, involvement of consumer staff in clinical team meetings, and other essential details.

Results. Two years after implementation, Georgia indicated its confidence in the CPS model by raising the reimbursement rate from 45 percent to 55 percent of the traditional day treatment model. In 2004, Georgia billed approximately $6 million in peer support services to Medicaid under the Rehabilitation Option. As the distribution of services moves from heavy dependence on a traditional day treatment model to greater reliance on the new peer support model, services are delivered at lower cost to the state and federal government.

The CPS workforce currently includes more than 200 individuals who support more than 2,500 consumers in a given year. CPS classes have approximately 31 enrollees. Of these, on average, one enrollee drops out. Seventy-five percent of CPS candidates pass the exam the first time they take it; 98 percent pass by their second try. The project's data suggest that involvement in the project has a positive impact on the consumer's own recovery and sense of empowerment.

Data from the Treatment Request and Integrated Georgia Reporting System, which providers complete as part of Medicaid service authorization, were analyzed to compare recovery outcomes for consumers who were enrolled in peer support services with those who were not. Those included in the analysis were identified as "seriously and persistently mentally ill," with diagnoses of schizophrenia, bipolar disorder, and major depression. The review compared 160 consumers who received peer support services in fiscal 2003 with 488 consumers who had been enrolled in traditional day treatment

services in fiscal 2002. Consumers receiving peer support services showed improvement in each of the following areas: current symptoms and behaviors; skill deficits; and available resources and needs. In each, the impact was small, but positive. Those enrolled in peer support services showed a greater level of improvement in all three areas than did those receiving day treatment services.[11]

Georgia has been working with other states, notably South Carolina and Hawaii, on their development of peer specialist programs.

Florida: Self-Directed Care

Summary. A recent paper on self-directed care for individuals with psychiatric disabilities states:

> Self-direction is a philosophy designed to help persons with special needs build a meaningful life with effective opportunities to develop and reach valued life goals. Self-direction provides a framework for the organization of service delivery systems to support the recovery of people with mental illnesses at any stage in the process of change by accommodating a wide range of goals and preferences. Self-direction is built on the five principles of freedom, authority, support, responsibility, and confirmation. . . .[12]

The movement for "self-directed care" originated in the 1960s among individuals with physical disabilities and by the 1990s had significantly shaped the system of care for those with developmental disabilities. Individuals with psychiatric disabilities have more recently begun to adapt the concept for themselves.

In the Florida self-directed care (FloridaSDC) model, public funding follows the participant rather than the provider, with individuals making decisions regarding their own services to the greatest extent possible. That is, instead of the state directly contracting with a public community mental health provider, the participant receives control of a portion of the public resources he or she needs to access mental health services. Existing providers do deliver residential, inpatient, and crisis stabilization services through the traditional delivery system.[13]

The FloridaSDC program encourages individuals to live independent lives, with the ultimate goal of giving each participant the opportunity to recover from the adverse effects of mental illness and return to work in the community. This model differs from the insurance models that are emerging in the private sector because it does not rely on the

use of copayments or high deductibles to create incentives for the efficient self-management of funds

Funding and administration. The FloridaSDC program is administered by the National Alliance of Mental Illness of Collier County and funded by District 8 of the Florida Department of Children and Families. The program began in Jacksonville, and a similar, but more family-directed system has been implemented in Hillsborough County for more than 500 families of children with emotional disturbances in the child welfare system. The latter program uses an administrative services contractor to help families manage their mental health spending accounts, develop a network of providers of wraparound services, and coordinate funding with treatment plans and county case management staff. Small, pilot programs have begun to spring up in other states, including Oregon, Minnesota, and Texas, as well.

Results. The program is too new to have information on outcomes. Recovery is being measured in a number of ways. Individuals define productivity for themselves, with "productive days in the community" constituting one recovery measure. In addition, participants complete structured self-reports about the achievement of personal recovery goals and objectives. Standard objective measures, including input from spouses or partners and life coaches, are also used to evaluate individual outcomes. FloridaSDC is just completing its first seven-month contract, and is negotiating a three-year contract. The program currently has 56 people actively engaged, with 37 fully enrolled and using their SDC funds. The rest are working on their first plans or the initial application. Florida SDC and the other self-directed care programs across the country face the next major challenge—expanding to include a much larger portion of the eligible population.

CRIMINAL JUSTICE/MENTAL HEALTH COLLABORATION (OHIO)

Jails and prisons have become a significant de facto component of the nation's inpatient behavioral health system, housing more individuals with mental health and substance abuse needs on any given day than do psychiatric hospitals. The National GAINS Center, which collects and disseminates information about services for individuals with mental health and substance abuse disorders who come into contact with the justice system, estimates that approximately 800,000 people with serious mental illness are admitted to U.S. jails every year, and that nearly three-quarters of those individuals (72%) also have co-occurring substance use disorders.[14] As of 1998, there were only 261,903 inpatient psychiatric beds in the United States.[15]

As a result, the New Freedom Commission recommends widely adopting adult criminal justice and juvenile justice diversion and reentry strategies to avoid the unnecessary criminalization and extended incarceration of nonviolent adult and juvenile offenders with mental illnesses.[16] These strategies include intervening to prevent the incarceration of nonviolent offenders who have mental illness (i.e., diversion), and assisting individuals with mental illness to effect a successful transition back into the community following incarceration (i.e., reentry).

Ohio has responded to the problem of the criminalization of the mentally ill by developing the Criminal Justice Coordinating Center of Excellence.

Ohio: Criminal Justice Coordinating Center of Excellence

Summary. Ohio's public mental health system includes the Ohio Department of Mental Health (ODMH), state hospitals, 50 county and multi-county boards, and more than 500 community mental health agencies. The boards do not provide direct care. Rather, they act as local mental health authorities—funding, planning, monitoring, and purchasing services. This decentralized approach, which emphasizes local management and control and generates strong citizen involvement and local financial support for mental health services, also poses a leadership challenge for the state's mental health department in its efforts to transform the state's services. Ohio was one of seven states to receive a five-year state infrastructure transformation grant from SAMHSA.

One method of transformation is the creation of coordinating centers of excellence (CCOEs) and networks, each focused on disseminating best practices in a specific area. There are currently 10 CCOEs and two networks providing technical assistance and consultation to county boards, providers, consumers, and advocates. The goal is to systematically disseminate and encourage the implementation of evidenced-based practices throughout Ohio's community mental health system. Each CCOE is housed within a university or other contracting organization and has an ODMH staff liaison. The use of CCOEs, coupled with strong data systems and financial and regulatory practices, has enabled the state to lead the county boards to significant changes in practice and quality.

The goal of the Criminal Justice CCOE (CJ/CCOE) is to develop programs throughout Ohio that will help keep people with mental disorders out of jail and in treatment.[17] Working with the National GAINS Center for Evidence-Based Programs in the Justice System, the CJ/CCOE has developed a model to encourage communities to approach jail diversion systematically, at multiple levels. This model proposes that there are a number of "points of interception" or opportunities where an intervention can be made

to keep individuals with mental illness from entering or going deeper into the criminal justice system. The model has four levels.

There are different strategies at each level to provide assessment and treatment services for consumers. The first level involves providing best clinical practices in accessible mental health systems. In other words, by providing high quality care to those who need it, people with mental illnesses will be maintained in the community and will be far less likely to enter into the criminal justice system. The specific clinical practices include, for example, assertive community treatment and integrated mental health and substance abuse treatment. The next level is pre-arrest diversion, involving a partnership between law enforcement and emergency services such as a crisis intervention team. Post-arrest interventions may occur in initial detention at hearings or during commitment. Finally, interventions may also take place upon reentry into the community from jails, state prisons, or forensic hospitalizations. These interventions primarily include facilitating links to needed benefits and treatment services. The CJ/CCOE is involved in training staff and in encouraging and assisting development of local programs throughout the state.

Communities that form effective collaborations between the mental health and criminal justice professions typically choose to establish mental health courts or crisis intervention teams (CITs). The most visible of these efforts have been the CITs.

The Ohio program receives technical assistance from a national CIT effort and the CJ/CCOE in turn provides consultation to the Council of State Governments and the Bureau of Justice Assistance on police–mental health issues.

Funding and administration. The CJ/CCOE is housed at Northeastern Ohio Universities College of Medicine and receives funding from the ODMH.

Results. As of April 2006, 1,695 CIT officers have been trained in 46 Ohio counties. This includes law enforcement officers from 141 police departments, 35 county sheriff departments, and 14 colleges and universities. Twenty-six counties perform their own CIT training. As a result of the training and development work done by the CCOE, all major urban Ohio counties except one currently have CITs in place. The one remaining county is planning its first CIT class for the summer of 2006. There are 27 mental health courts and nine state funded diversion programs currently operating, with nine additional programs in development. Ohio currently has more mental health or specialty courts than any other state.

The CCOE's Web site allows sharing of information across the state regarding both the development of specific types of programs (e.g., CITs and jail diversion programs) and also regarding the general theory and practice of mental health/criminal justice programming. Papers on a variety of topics, including evaluations of the implementation of some programs, are available on the Web site.

SYSTEM INTEGRATION (NEW JERSEY, NEW MEXICO, WASHINGTON)

Virtually every study of mental health concludes, as did the New Freedom Commission, that "the mental health delivery system is fragmented and in disarray."[18] In response, the Federal Action Agenda suggests that a transformed mental health system rely on multiple sources of financing with the flexibility to pay for effective mental health treatments and services and a coordinated system of care.[19] Although widely recommended, integrating service systems is a massive undertaking, and one that must be approached carefully. State agencies responsible for health care, mental health care, substance abuse care, education, child welfare, and corrections all play roles in meeting the needs of those with mental and substance-use disorders. But each agency has its own legislative mandate, cadre of specifically trained professionals, structure, organization, and funding sources, and often its own provider system—making the recommended integration enormously challenging. Furthermore, Medicaid's complex regulations and unique federal/state funding formula impose additional constraints while offering potential opportunities. Finally, state mental health systems have traditionally expended significant proportions of their budgets on institutional care, a situation that has been changing over the past generation. There has also been a focus on medical issues, rather than recovery—an orientation that is only beginning to change.

New Jersey: Division of Child Behavioral Health Services

Summary. The New Jersey Division of Child Behavioral Health Services (DCBHS) initiative, formerly known as the Partnership for Children, is the most mature of the three initiatives described in this section. Although, as discussed below, it experienced some growing pains and criticisms,[20] other states can learn from its experiences, including the challenges it continues to face.

DCBHS serves children and adolescents with emotional and behavioral health needs, and their families, across three previously uncoordinated child-serving systems, the Division of Medical Assistance and Health Services (the state's Medicaid agency), the Division of Youth and Family Services (the child welfare agency), and the Division of Mental Health Services (the mental health authority). DCBHS is charged with reforming these service systems to improve outcomes for children, adolescents, and their families.

ValueOptions, a for-profit company, serves as the contracted system administrator (CSA), performing utilization management, monitoring, and outcome tracking functions. The CSA is intended to be the single point of contact regarding a child and family's plan of care. County-based care management organizations (CMOs) coordinate care for youth with multi-system or complex needs and their families. The DCBHS effort incorporates changes to the Medicaid program, such as use of the Early and Periodic Screening, Diagnosis and Treatment program and of the Rehabilitation Option to encourage screening and serving children with behavioral health needs and their families.[21]

Following a standardized assessment process, a care coordinator from the CSA makes an initial determination regarding the level of care a child needs. If the child does not need complex care, the care coordinator makes a direct referral to a service provider; if multi-system or complex care is required, the child and family are referred to a CMO. If the child and family need a moderate level of face-to-face case management, they are referred to youth case management.

Family support organizations managed by family members of children with emotional and behavioral disturbances have also been created within the DCBHS structure; they provide individual representatives to help families negotiate the new integrated system and to advocate on their behalf. Mobile response services, which respond within one hour from the time of phone contact to the CSA, provide crisis intervention services to help maintain children within their home environments and to avoid unnecessary psychiatric hospitalizations and changes in living arrangements.

The Behavioral Research and Training Institute, a nonprofit, interdisciplinary research, training, and consulting service of University Behavioral HealthCare of the University of Medicine and Dentistry of New Jersey, is providing a comprehensive training and technical assistance program for DCBHS. The effort includes direct support for all aspects of preparation, start-up, implementation, ongoing development, and evaluation of components of the system of care.[22]

Funding and administration. DCBHS is a constituent agency of New Jersey's Department of Human Services and was created during fiscal year 2001. In its first year, DCBHS pooled approximately $167 million across three agencies by restructuring the publicly funded systems that serve troubled children. New funds of $39 million were included in DCBHS in its first year and over $100 million were added over the following four years.

Results. The purpose of this initiative is not to save money, but to improve care. Therefore, none of the organizations involved has a financial incentive to limit the provision of services, a situation that contrasts significantly with earlier managed care initiatives. However, budget shortfalls and disruptions in state administration apparently took a toll on the program. As it was developing, the program was unable to meet its original targets. In addition, there were complaints that coordination with the education and juvenile justice systems was inadequate.[23] DCBHS has been working to respond to these concerns, and, as evidenced by current data presented below, seems to be realizing its goals.

As of February 3, 2006, 30,920 children were being served or had received a service within the past year. This compares favorably with the agency's projections that it would be serving 30,000 children annually by fiscal year 2006. In the CMOs—the highest level of care—2,150 children were receiving services, with an expectation that the system will be serving 2,820 by June 2007. Also as of February 3, 2006, there were 4,533 children active in youth case management, with an average length of stay of four to six months. As of February 2006, the mobile response services reported that it had served 7,400 children. A total of 2,331 families were actively receiving peer support from family service organizations.

The combination of mobile response and other services has begun to have the desired impact on the children and families the system serves, maintaining children in the community and keeping them out of hospitals. One of the most significant outcomes of the DCBHS effort was the closing, on December 31, 2005, of the 40-bed state hospital that served children. In addition, New Jersey has eliminated the phenomenon of children languishing in juvenile detention centers awaiting services. Youth case managers working in 15 courts now complete standardized assessments even before adjudication and begin to arrange care at the earliest possible time. As of September 30, 2005, there were no children in detention awaiting services.

DCBHS is working with the Department of Education to review the CMO practice model. The two agencies are using qualitative processes to ensure that the goals and methods of the educational system are woven into service planning. DCBHS has also brought in outside experts to assist in evaluation and planning. They have contracted with the Louis de la Parte Florida Mental Health Institute at the University of South Florida to assess the entire system of care.

New Mexico: Behavioral Health Purchasing Collaborative

Summary. The combination of constrained budgets and the growing demand for improved coordination of services led New Mexico to seek to develop a more effective and efficient behavioral health care delivery system. In September 2003, New Mexico's governor directed all agencies involved in the delivery, funding, or oversight of behavioral health care services to work collaboratively to create a single statewide behavioral health service delivery system. House Bill 271, which created the Interagency Behavioral Health Purchasing Collaborative ("the Collaborative"), was signed into law by the governor on March 3, 2004.

The Collaborative, which was effective on May 19, 2004, includes 17 representatives from 15 different state agencies, as well as a representative from the governor's office.[24] It has been mandated to:

- inventory all expenditures for mental health and substance abuse services;
- create a single behavioral health care and services delivery system that promotes mental health; emphasizes prevention, early intervention, resiliency, recovery, and rehabilitation; manages funds efficiently, and ensures availability of services throughout the state;
- pay special attention to regional, cultural, and other local issues, and seek and consider suggestions of Native Americans;
- contract with a single, statewide services purchasing entity;
- monitor service capacities and utilization to achieve desired performance outcomes;
- make decisions regarding funds, interdepartmental staff, grant writing, and grant management;
- plan comprehensively and meet state and federal requirements; and
- oversee systems of care and the administration of those systems.[25]

To achieve these goals, cross-agency work groups have been created, comprising a "virtual department" across agencies rather than a reorganization of those agencies. These groups have created common service definitions; developed evaluation plans and local collaboratives; negotiated system performance indicators and customer outcomes; begun workforce development; and initiated telehealth approaches in rural areas.[26] Plans for the next few years include increased use of evidence-based practices; augmenting workforce

development activities; improving the system's efficiency; streamlining systems for providers and customers; and improving outcomes focused on recovery and resilience.

Funding and administration. The Collaborative will bring together agencies with the use of approximately $350 million in state and federal funds, with another $50 million to $100 million anticipated by fiscal year 2009. The Secretaries of the Human Services and Health Departments co-chair the Collaborative; in addition, there is a full-time behavioral health czar and chief executive officer appointed by the governor. In April 2005, the Collaborative selected ValueOptions to help manage the initiative.[27] The state's contracts with ValueOptions will incorporate many of the performance measures discussed below.

Results. Given the magnitude of the New Mexico innovation, and the fact that it is still in a very early stage, results are not yet available. The Collaborative is, however, involved in a variety of evaluation efforts. The Collaborative itself is a component of the governor's performance and accountability system, which measures agency performance and outcomes against key program goals. The system includes four tasks related to behavioral health: reduce suicide among youth and high-risk individuals; improve access, quality, and value of mental health and substance abuse services; provide enhanced services for high-risk and high-need individuals; and increase rural, frontier, and border access to behavioral health services. A total of 25 performance measures are associated with the four tasks. Each will be evaluated using baseline statistics, data from fiscal year 2005, and specified targets for 2006 and 2007. The performance measures include a full range of behavioral health outcomes related to employment, education, housing, addictions, involvement with the juvenile and adult corrections systems, coordination of care, consumer satisfaction, access to care, and improvement in clinical outcomes. One challenge the Collaborative faces is that data from prior years do not cover the same broader population now being served.

The Collaborative will work with experts in economic analysis of behavioral health data to help determine the costs and benefits of its restructuring work. In addition, it is working with numerous advisers and funders, including the Robert Wood Johnson Foundation, the National Institute of Mental Health, and the MacArthur Foundation's Network on Mental Health Policy Research, in order to effectively evaluate aspects of the initiative. For example, the MacArthur Foundation's Network on Mental Health Policy Research is assisting with a process evaluation; the Robert Wood Johnson Foundation is supporting a study that is mapping funds and evaluating cost impacts; and the National Institute of Mental Health has funded an ambitious multi-year study to look at the impact of the Collaborative on safety-net providers.

There is considerable interest in and excitement about New Mexico's initiative among national and state leaders in behavioral health, and especially among those concerned about fragmentation.

Washington: Medicaid Integration Partnership

Summary. The Washington Medicaid Integration Partnership (WMIP) is a comprehensive approach that blends funds for behavioral health, primary care, and long-term care services in a county-based system. According to the state's Web site, the leaders of this project are overcoming decades of organizational habits, federal regulations, community skepticism, and cultural differences to integrate services in an effort to make the lives of clients easier and healthier.[28]

Molina Healthcare of Washington, the state's largest Medicaid health plan, has been contracted by the Washington Department of Social and Health Services to ensure that the 5,000 adult Medicaid enrollees in Snohomish County each have access to care coordinators, primary care providers, specialty care, and drug and alcohol services. Clients' care coordinators will ensure that individuals get services when they need them, without having to navigate separate systems. Individuals with asthma, diabetes, and heart disease are enrolled in disease management programs. As the project matures, long-term care will be integrated into the system.

The project planners believe that bringing all the services under one roof will provide a "medical home" for clients where they will be cared for by a stable team of professionals they know and trust. The system will focus on preventive care and services to keep people healthier. In the long run, the project leaders believe this will be likely to save money as well as improve lives.[29] The project builds on the state's research demonstrating that increased access to mental health and chemical dependency treatment can lower medical costs and reduce the risk of death among aged, blind, or disabled clients.[30]

Project team members have met with local government representatives as well as providers since early in 2005. Informational sessions and enrollment began in November 2005. These efforts—to integrate behavioral and physical health funding at the county level—are a significant innovation, particularly for states that have county-based behavioral health systems. Observers and researchers within and outside the state will pay special attention to the experience consumers have in care and how the service integration affects their lives. Other county behavioral health systems in Washington will be closely watching the project to observe its results, especially because of concerns that the needs of people

with serious mental illnesses and addictions may be overlooked by a system that primarily focuses on physical health care services.

Funding and administration. This project involves combining the funding for primary care and behavioral health services in Snohomish County under a single managed care organization, Molina Healthcare of Washington. The funds are derived from federal, state, and county sources. The project began providing care for clients in January 2005 and as of November 2005, 1,927 individuals were enrolled. In August 2005, the Center for Health Care Strategies announced the award of a $50,000 grant to the WMIP. If the pilot efforts in Snohomish County proceed well, plans will be developed to expand the effort statewide.

Results. Oversight and evaluation of the WMIP involves federal, state, and county government agencies, and ultimately the state legislature, as it considers potential expansion of the model. Although outcome data are not yet available, the project is being evaluated by independent researchers and watched closely by advocates and other county behavioral health administrators. Some of these individuals note that blending funds does not by itself lead to the effective integration of care; rather, the integration must occur at the provider level and in day-to-day practice. The project builds upon promising research from Washington (discussed in the innovation on Washington's data and research on page 23) that demonstrates that increased access to mental health and chemical dependency services can lower medical costs. If the current contractor is successful in addressing the behavioral health needs, as well as the physical health and long term-care needs, of consumers, the model is likely to have a significant impact on county-based behavioral health systems in Washington and elsewhere.

USING PERFORMANCE INCENTIVES (DELAWARE, KENTUCKY, OREGON)

Many states use contracting methods that either reimburse costs or set fixed prices with mental health and substance abuse (and other human service) providers, both public and private. More recently, however, states have begun developing ways of using performance incentives. Performance-based contracting techniques, which provide for payment to contractors as they accomplish predetermined results, have existed for some time, but have typically been associated with public works efforts such as highway maintenance and solid waste management. In human services, performance can be defined in relation to services performed by the contractor or to outcomes achieved by clients.[31]

Delaware: Performance-Based Contracting for Substance Abuse Services—Concurrent Recovery Monitoring

Summary. Delaware's Division of Substance Abuse and Mental Health (DSAMH) has worked for many years to introduce evidence-based practices into substance abuse treatment programs. After dissemination and training efforts produced few results, DSAMH shifted gears and implemented a comprehensive two-indicator performance monitoring/contracting system that links program payments to achievement of goals related to access, engagement, and active participation in treatment. Evidence-based practices were proposed as an approach to help providers meet their performance goals. This was one of the first statewide efforts in the substance abuse field to apply performance incentives to contracts. More recently, DSAMH has implemented performance-based contracting with evidence-based indicators (e.g. engagement, measured by the percentage of consumers who continue treatment) to influence day-to-day management and clinical practices within the state's substance abuse treatment programs. Providers receive additional funds in their contracts if they meet individually negotiated targets for improved rates of engagement. Adopting evidence-based practices and changes in scheduling and other business processes have been extremely useful in helping Delaware providers meet these targets.

In addition, DSAMH, in collaboration with the Treatment Research Institute, a not-for-profit organization engaged in policy research and dissemination, is currently in the process of implementing concurrent recovery monitoring (CRM) in the statewide, publicly funded outpatient treatment system. The CRM project extends DSAMH's previous performance-based contracts into a more comprehensive outcome evaluation at the both the patient and program levels. CRM accomplishes two closely related tasks. It captures the traditional evidence-based outcome measures of recovery and, by collecting measures at regularly repeated intervals, monitors and guides patient change.

The researchers compare the approach they are using in CRM to the approach physicians use in the treatment of hypertension,[32] with blood pressure readings used to evaluate patient status. The clinician can collect and interpret the information and use it immediately to adjust treatment. CRM enables patients to inform the clinician directly about progress during the course of treatment. The information is then used simultaneously to evaluate patients' status and support clinical decision-making. Periodically, throughout the course of care (at two weeks and then at least monthly), a counselor asks the client key questions regarding alcohol and drug use, crime, employment, utilization of health care, and participation in services. A breath, urine, or other biological specimen is collected to verify the client's report. The process can be

completed in less than 10 minutes and provides data that can be used not only at the level of the individual client but also in aggregate form to measure program accountability and effectiveness.

CRM measures can be objectively validated through physical specimens or administrative databases and represent important goals for clients, programs, and the state. DSAMH's goal is to document ongoing recovery status within and across treatment sites. In doing so, it expects to improve management and clinical practice, implementation of evidence-based practices, and client outcomes. Coupled with the existing performance incentives, CRM will place an increased focus on outcomes and permit new aggregate outcome measures to be developed. Future efforts will likely include additional measures from the CRM and related processes in the performance contracts.[33]

Funding and administration. The program is operated by DSAMH using state and federal funds.

Results. With funding from the National Institute on Drug Abuse, the Treatment Research Institute is evaluating the programs' current data collection activities, selecting outcome indicators from the established research literature, and pilot testing the collection and reporting of these measures in four of the state's publicly funded adult outpatient substance abuse treatment programs. The researchers will then use feedback from the pilot testing to modify the CRM procedures and implement them in all 11 of the state's contracted outpatient programs. They will also monitor the impact of the new CRM procedures on the programs and their patients.

Kentucky: Performance-Based Contracting for Mental Health

Summary. During fiscal years 2003 through 2005, the Kentucky Department for Mental Health and Mental Retardation Services (KDMHMRS) designated 1 percent of total state general funds for use as performance incentives. For state fiscal year 2005–06 this amount was increased to 10 percent. The performance-based contracting (PBC) initiative entailed extensive revisions to all agency processes, including planning across all divisions to blend the experience of contract personnel, accountants, program administrators, and licensed clinicians. At the same time, the PBC initiatives shifted the focus from activities and processes to intended results, with the state agency using the incentives to encourage achievement of goals.

Kentucky's PBC initiatives include best-practices training for all mental health and mental retardation (MH/MR) regional board employees, as well as the board members

themselves; quality improvement initiatives based on consumer outcomes; and supported employment for individuals with mental retardation, developmental disabilities, and/or mental illness. In each area, the department has defined a rationale, requirements, indicators, and documentation to be submitted, and has established clear outcome incentives. Incentives define what proportion of the total available amount each program receives according to how well that program has succeeded at achieving specific targets.[34]

For example, to ensure identification of clients with mental health diagnoses in substance abuse treatment centers, a screening tool is administered to all clients. To meet this goal, every regional MH/MR board is required to complete four steps: 1) identify an initial screening tool; 2) train staff to use the tool; 3) administer the tool to all clients with a completed psychosocial evaluation; and 4) include documentation in each client's medical record. DMHMRS provides an electronic format for reporting, and screening data must be submitted within 30 days of the end of each quarter. Incentives are paid as follows: for 95 percent compliance, the full 1 percent available is paid; for 85 percent compliance, 3/4 of 1 percent is paid; for 75 percent compliance, 1/2 of 1 percent is paid. No incentive is paid for compliance below 75 percent. There are similar requirements and incentives specified for training in best practices; quality improvement (for which the incentive totals 3 percent of state general funds); development and submission of referral, assessment, and admission processes and plans for crisis stabilization units; administration of a Brief Psychiatric Rating scale at admission and discharge for all adults and children admitted to crises stabilization programs; training of at least half of staff in supported employment; and increase in the number of employed clients.[35]

Funding and administration. As noted above, funding for performance incentives comes from the state's general fund. The program is administered by the agency; the effort has required involvement of all divisions.

Results. Cost savings resulting from the initiative will be determined when it is evaluated in the last quarter of fiscal year 2006. Preliminary internal review suggests, however, that it has already achieved a number of positive outcomes, including:

- improvement in the integrity of data collection, as correctible errors are eliminated;
- greater awareness of responsibility for using best practices and achieving quality outcomes; and
- positive feedback and support from the regional boards.[36]

KDMHMRS intends to use feedback from the centers to improve the outcome incentives for fiscal year 2007. It will also be adding outcome incentives to most other contracted services, including direct care staffing in MH/MR facilities and management and operation of state owned facilities and group homes for clients with mental illness, mental retardation, or developmental disabilities.[37]

Oregon: Implementation of Evidence-Based Practices

Summary. In 2003, the Oregon Legislative Assembly passed Senate Bill 267, a controversial measure requiring increased proportions of state funds be allocated to evidence-based practices (EBPs). The law applies to five state agencies, one of which is the Department of Human Services, Office of Mental Health and Addiction Services (OMHAS). Each agency must spend 25 percent of public funds on EBPs in 2005, 50 percent in 2007, and 75 percent in 2009 and thereafter. SB 267 defines an EBP as "a program that: a) incorporates significant and relevant practices based on scientifically based research; and b) is cost effective."[38] In response to this legislative mandate, OMHAS is significantly restructuring the mental health and substance abuse delivery systems for adults and youth.

This shift constitutes a major upheaval for both the mental health and addiction treatment systems. Although the legislation requires a specified proportion of funds to support EBPs, the agency has proceeded on the assumption that all its clinical and prevention services are subject to the requirements of the legislation. In its planning effort, OMHAS has included a focus on lifelong recovery for individuals with mental illness or substance abuse disorders. It has also engaged in extensive collaboration with internal and external stakeholders.

As part of an effort to meet the requirements of SB 267, OMHAS used broad community input to develop an operational definition of EBPs.[39] This definition includes "an evidence continuum with six levels ranging from multiple randomized studies in controlled and usual care settings to no evidence that supports the efficacy or effectiveness of the practice."[40] The first three levels of this continuum are considered EBPs that meet the OMHAS standard.

Funding and administration. Oregon has a complex and diverse prevention and treatment service delivery system, with clinical services funded at the state, regional, and county levels.[41] Thus, the process for implementing the requirements of SB 267 involves a large number and a wide variety of stakeholders in numerous workgroups and advisory committees. OMHAS is requiring that contractors demonstrate use of EBPs and is reviewing its contracts to determine what revisions are needed.

Results. As part of its planning process, OMHAS surveyed its community mental health programs (CMHPs) and contractors to determine how much funding was being spent on EBPs at the initiation of the project. (CMHPs, in turn, contract with private nonprofit providers, with virtually all community treatment services provided through contracts or subcontracts with county or private nonprofit providers.) The survey indicated that, as of February 2005, 56 percent of funds used by CMHPs for substance abuse services supported EBPs. Taking fidelity into account (i.e., accounting for the fact that not all practices designated as EBPs are offered with total fidelity to the processes specified in the original research), 49 percent of the funds supported EBPs. The same survey showed that approximately 33 percent of funds used by CMHPs for mental health treatment services supported EBPs; accounting for fidelity, only 11 percent of the funds support EBPs. This is the first effort in the country to determine the scope of EBP implementation throughout an entire state system.

The findings suggest that the targets, particularly those set for 2009 and thereafter, may be difficult to achieve and may ultimately need to be changed. But the urgency of the challenge has forced action by state administrators, providers, and other stakeholders to dramatically restructure their system.

Oregon's innovation has proven to be quite controversial. Providers and some advocates have argued that requiring 75 percent of services to be evidence-based is unnecessarily restrictive and does not leave enough room for agencies to purchase newer but promising practices. However, the law has forced the state agency to confront the gap between current practice and evidence; creative approaches have emerged as a result. In future years, the standards may need to be relaxed because the state may not be able to afford to maintain them.

QUALITY IMPROVEMENT (WASHINGTON, IOWA, OKLAHOMA)

All the innovations described in this report are intended to improve quality in some way. Those described in this section, however, are explicitly intended to improve the way in which particular state agencies perform their own functions or encourage their contracted providers to perform. The ultimate goal is to improve the care clients receive, and thereby their clinical and functional outcomes.

The Washington innovation represents the work of a research division, within a large umbrella human services agency, in reporting and analyzing data that can be used to support policymaking. Both the Iowa and the Oklahoma innovations are aimed at achieving goals specified by the Washington Circle, a multidisciplinary group with

extensive experience in alcohol and other drug disorders, managed care, and performance management. The Washington Circle's work begins from the premise that there is a need to promote quality and accountability in the delivery and management of alcohol and other drug services. The organization believes this is best accomplished by adopting a process of care model and defining a set of measures for each domain within that model.[42]

Washington: Research and Data Analysis

Summary. The Research and Data Analysis (RDA) Division of Washington's Department of Social and Health Services (DSHS) produces funded research reports that analyze the services that DSHS provides in terms of need, demand, use, supply, risk, cost, and outcomes. RDA produces analyses that are used for quality improvement purposes and to document the effectiveness of existing services and the need for additional services. RDA's audience includes the managers of the umbrella agency and its divisions, the governor's office, the legislature, other local, state and federal agencies, and the general public.

Research reports published within the past 10 years are available on the DSHS Web site, organized by author, title, date, and geography. RDA extracts and matches client-level data on services and costs from all programs and databases within the umbrella agency. It has been conducting these activities since 1990—at first episodically and, since 1999, continuously. As the database has matured, it has become possible to look at clients across years and examine issues related to the costs of serving and also, of not serving, clients. That is, it may be possible to identify a client population "in need" of a specific kind of service but not receiving it.[43]

RDA also uses its research methods to improve the quality of its own performance. During the summer of 2004, RDA conducted a Web-based survey of its internal and state-level external (e.g., state legislature) customers. The survey led the division to redesign its Web site, provide better information about its own services to DSHS customers, and improve its geographical information and analysis.[44]

Funding and administration. RDA serves as a central resource within a very large, umbrella human services agency that includes both the Division of Alcohol and Substance Abuse (DASA) and Medical Assistance (the state's Medicaid agency), among others. RDA projects are funded by state dollars, federal dollars (currently including SAMHSA and the National Institutes of Health), and foundations. Each project is sponsored by a DSHS program or by the agency's central administration to answer a particular question, although getting any given question answered may be contingent on funding. That is, RDA can only engage in studies for which it receives funding. RDA writes proposals with

or for other programs, or a program may write a proposal and subcontract with RDA subsequently. Sometimes, other agencies use their own program budgets to pay RDA.

Results. As an objective internal resource that is able to produce high quality, unbiased data analyses, RDA has had some significant achievements. For example, in a relatively simple analysis some years ago, RDA found that aged and disabled clients were underserved with regard to alcohol and drug treatment, but that the subsequent medical costs of those who did get treatment declined in comparison to similar clients who needed but did not receive it. When RDA presented this information to DASA and Medical Assistance, the two agencies agreed to support a joint investigation to demonstrate whether savings would be realized if access to alcohol and drug services was improved. The resulting paper, combined with other work, led to a more extensive treatment gap initiative.[45]

DASA has used RDA research extensively to examine cross-system utilization and costs of people who abuse alcohol and other drugs. This work has helped legislators and others recognize that treating substance use would lead to significant cost offsets in the emergency room and in the treatment of other medical conditions. The efforts of stakeholders, in combination with these research results, recently led to an infusion of $67 million in new funds into the substance abuse system.

The use of data and research findings to guide public policy is, of course, not new. Indeed, as the Director of RDA says, the technical issues the agency deals with present less significant problems than do the policies and practices that have arisen over time within the contexts of the various organizational units. Those organizational contexts and relationships ease or impede the flow of data surrounding the many policy questions.[46]

Iowa: Process Improvement

Summary. The Iowa Department of Public Health, Division of Behavioral Health and Professional Licensure, is one of five state agencies that is participating in the Network for the Improvement of Addiction Treatment (NIATx) State Pilot Project, a collaborative project aimed at improving access and retention within the addiction treatment field. (For a more detailed description of NIATx, see Appendix A.) Research has shown that access to treatment and retention in treatment are the greatest predictors of successful recovery. Using the NIATx model, Iowa has worked with local addiction service providers to decrease wait time to services in the outpatient level of care (as measured by time from initial contact to treatment).

One key strategy—recommended by NIATx and used in the Iowa project—is the "walk-through," an exercise in which staff members walk through the treatment processes just as clients do. Iowa state agency and managed care staff conducted walk-throughs at a number of local provider agencies, and found them to be powerful change motivators. Process improvements to shorten wait times that local staff had long sought were realized quickly after the walk-through documented their value. These improvements included: reducing paperwork, decreasing the length of the intake session, allowing a reduction in the number of individual sessions, and increasing the flexibility of counselors' scheduling.

Funding and administration. Iowa has received training, support, and technical assistance from NIATx, with nearly all of the funding for the project coming from the state itself.

Results. Treatment agencies used common "before-and-after" measures to document the outcomes of the procedural changes they implemented. At one agency, the average "before" wait time for an initial evaluation was six days. After the changes, the average was reduced to 1.3 days. Another agency found that wait times were reduced by an average of 56 percent, while admissions increased by 186 percent. The state agency is now working to disseminate the NIATx principles to all addiction service providers in Iowa.

As a result of the NIATx project, the state is identifying and reviewing admission and documentation requirements in licensing standards that present barriers to access and retention. The state is also pilot testing the elimination of continuing care review requirements, thereby giving intake personnel more time to conduct intakes, and is considering modifying its incentive formula to facilitate use of process improvement techniques.

Oklahoma: Process Improvement in Substance Abuse Services

Summary. More than two years ago, Oklahoma's Department of Mental Health and Substance Abuse Services (DMHSAS) initiated a system to measure and improve the performance of state-funded substance abuse treatment agencies.[47] At approximately the same time, the state began quality improvement work with NIATx. (For a more detailed description of NIATx, see Appendix A.) DMHSAS uses a quarterly regional performance management report to track mental health and substance abuse indicators, including six indicators that track identification of eligible persons and their initiation and engagement in substance abuse treatment. These indicators are: identification, initiation into outpatient services, initiation following detoxification services, engagement in outpatient services, engagement following detoxification services, and engagement following residential treatment. These measures are consistent with measures developed by the Washington

Circle Group. They have been adopted by the National Committee for Quality Assurance (NCQA) for its Health Plan Employer Data and Information Set (HEDIS).[48] The quarterly reports appear on the agency's Web site to give feedback to providers, service recipients, departmental administrators, and other stakeholders. Key indicators of performance are reported for all substance abuse treatment providers that DMHSAS funds in whole or in part.[49]

The state agency analyzes these data following each reporting cycle and uses the analyses with service providers for quality improvement. Each quarter, the data are presented for the past seven quarters and the present one, demonstrating trends over time as well as comparisons across the eight regions in the state. Presentation of the data leads naturally to an effort to explain regional differences and promotes a culture of performance improvement. Providers interpret their own outcomes and propose corrective actions; subsequent reports evaluate the impact of the improvements implemented. According to Steven Davis, Ph.D., the director of the department's Decision Support Services, "A planned expansion of Medicaid substance abuse services will include a performance and outcomes monitoring system that integrates DMHSAS and Medicaid data."[50]

Funding and administration. SAMHSA has funded technical assistance for the past several years to help DMHSAS develop its performance management reports. In addition, after one private treatment provider in Oklahoma applied for and received a NIATx grant from the Robert Wood Johnson Foundation, DMHSAS was invited to apply for a grant and received funding, as well. Since that grant ended in May 2006, DMHSAS is looking for additional opportunities for support that will enable it to continue and expand its work.

Results. Over the past two years, the rate of identification of persons meeting DMHSAS eligibility criteria and receiving services during each quarter has steadily increased from 6.7 percent to 9 percent, initiation following a first outpatient service has remained relatively constant at 75 percent, and engagement in outpatient treatment ranged from 60 percent to 66.4 percent.[51] Through its work with NIATx, the state has changed eligibility determination procedures at participating provider agencies and dramatically reduced the time to first appointment for individuals requesting state-funded services. The state's focus on the use of data for quality improvement and improved access to care has had a dramatic impact on the service system and garnered significant national attention.

OTHER SIGNIFICANT PROJECTS (TENNESSEE, MINNESOTA, CALIFORNIA, WYOMING)

In addition to the projects that fit into discrete categories, the survey process identified four innovations that stood alone in their areas of concern, yet seemed worthy of mention—by virtue of their apparently successful approaches to issues that challenge nearly all mental health and substance abuse agencies. This group includes Tennessee's initiative to expand housing opportunities for individuals with mental illness; Minnesota's public/private partnership that is helping to transform the state's mental heath system; California's "tax on millionaires" that expands resources for mental health services; and Wyoming's health management program.

Tennessee: Creating Homes Initiative

Summary. Because, according to the New Freedom Commission, "the lack of decent, safe, affordable, and integrated housing is one of the most significant barriers to full participation in community life for people with serious mental illness,"[52] ensuring permanent housing for mental health consumers has been a focus in Tennessee. The Creating Homes Initiative (CHI) partners the Tennessee Department of Mental Health and Developmental Disabilities with local communities to create permanent housing options for Tennesseans with mental illness and co-occurring disorders. CHI, operated by the department's Office of Recovery Services, has used a Real Choice Systems Change grant from the Centers for Medicare and Medicaid Services to facilitate a systemic change in the way stakeholders access information about available housing options, housing support services, and housing development; and to reduce stigma surrounding mental illness and combat "not in my backyard" attitudes in Tennessee through community education and social marketing efforts. To accomplish these goals, project staff have developed a comprehensive housing information Web site,[53] are conducting a longitudinal evaluation of the effects of stable housing on the recovery process, are producing a television campaign to reduce stigma, and hosted three Housing Academies across the state between November 2004 and November 2005. These were two and one-half day conferences offered at no charge to consumers, family members, advocates, providers, policymakers, and housing developers, in which all aspects of housing for individuals with mental illness were discussed. Speakers discussed, for example, legal issues, discrimination, advocacy, financial literacy, and home ownership, and presented examples of successful housing programs within the state.

Funding and administration. The annual allocation for the Office of Recovery Services is $2,500,000. These resources have been leveraged with other sources of funding, including federal, state, public, private, traditional, and nontraditional sources, to approximately

$101 million. Partnering with local communities has also increased cost effectiveness by encouraging the involvement of local faith groups, concerned citizens, and advocates.

Results. CHI established an initial goal of helping to find appropriate permanent housing options for at least 2,005 persons by the year 2005; the initiative achieved that goal by 2002. By late 2005, the CHI had successfully created 4,288 affordable, safe, permanent, quality housing options in consumers' chosen communities. The housing options range along a continuum from home ownership to independent congregate living without onsite staff to group housing with 24-hour supervised staff. Most importantly, the state reports a 95 percent reduction in the rate of re-hospitalization for consumers who are residing in CHI housing.[54]

Minnesota: Minnesota Mental Health Action Group

Summary. The Minnesota Mental Health Action Group (MMHAG) is a broad-based coalition of mental health providers, hospitals, health plans, consumer advocacy organizations, local government agencies and officials, and the Minnesota Departments of Human Services and Health. These groups joined forces to begin the process of transforming Minnesota's mental health system.[55] MMHAG functions to establish links among those working on mental health system reform, to help coordinate their activities to achieve common objectives, and to fill gaps where no progress is being made. Hundreds of people and organizations have been involved in MMHAG since its formation was announced at the 2003 fall conference of the Minnesota Community Mental Health Centers.

Funding and administration. MMHAG is co-chaired by the commissioner of the state's Department of Human Services and the former board chair of the Citizens League of Minnesota, and staffed by a consulting firm and the Citizens League. MMHAG's steering committee, which includes representatives of major hospitals, professional associations, public officials, mental health and social service agencies, and insurers, as well as consumer and family advocates, has spearheaded and coordinated the effort. Each individual on the steering committee is a leader in his or her own sphere. MMHAG has been funded by Minnesota's hospitals and health plans. These organizations also contributed significant in-kind support and participated in action teams, work groups, and the steering committee.

A Web site was created to facilitate communication among all participating groups and individuals. To date, activities include:

- comparing reports, recommendations, and proposals of prior task forces and commissions, and identifying and prioritizing goals and strategies that are commonly identified, and that have broad support.
- identifying and establishing links with existing leaders and groups working on priority areas, and establishing new task forces for areas without organized efforts under way.
- convening work groups to develop reform recommendations on topics including quality measurement, behavioral health benefits in insurance plans, financing and payment systems, screening and early intervention, and mental health in schools.
- developing a coordinated plan and timeline for achieving mental health system reforms in each priority area and following up to ensure progress is made.
- serving as change agents to bring about desired reforms by organizing and leading work groups to mobilize action around the specific priorities.
- acting collectively to overcome barriers and seek needed public policy changes.[56]

Results. One outcome has been communication and cooperation among groups with a past history of tension and conflict, such as consumer advocacy groups and the health plan companies.

The project moved swiftly to realize its goals. MMHAG began in the fall of 2003. By April 2005, Minnesota's governor had issued a directive to the Department of Human Services to design a mental health system consistent with MMHAG's vision, principles, and desired outcomes. In June 2005, MMHAG published *Road Map for Mental Health System Reform in Minnesota,*[57] which comprehensively describes the group's vision and guiding principles, as well as its approach to issues including financing, accountability, access, employment, screening, and mental health in schools. MMHAG also developed a model set of mental health benefits; both the state and private health plans have taken action to modify benefits based on these recommendations.

In February 2006, the governor announced a major legislative initiative to implement the recommendations of MMHAG, including $50 million in new state funding and major changes to the way the state pays for and delivers mental health services. The state legislature passed some key components of the governor's initiative during the 2006 legislative season. (For detailed information on the fate of this initiative, see the state's Web site.) Upon enactment of reforms, MMHAG is expected to shift to a monitoring mode to watch over implementation.

California: Proposition 63

Summary. In November 2004, the voters of California passed Proposition 63, which asked, "Should a 1 percent tax on taxable personal income above $1 million to fund expanded health services for mentally ill children, adults, and seniors be established?" The Proposition became law on January 1, 2005, and is known as the Mental Health Services Act (MHSA). It provides funds to counties to expand services and develop programs and integrated service plans for mentally ill children and adults; requires the state to develop mental health service programs on prevention, early intervention, education, and training; creates a commission to approve certain county programs and expenditures; and prohibits the state from decreasing funding for mental health services below current levels.[58]

Funding and administration. According to the state's Department of Mental Health (DMH), MHSA was projected to generate approximately $254 million in fiscal year 2004–05, $683 million in 2005–06 and increasing amounts thereafter. Much of the funding will be provided to county mental health agencies to fund programs consistent with the goals of the initiative.[59] An extensive stakeholder process, state-wide and county by county, is being employed to inform state and county implementation efforts. The process includes quarterly general stakeholder meetings; special topic workgroup sessions; client and family member meetings; statewide conference calls; and posting of critical information on the DMH Web site. The many elements of the MHSA are designed to work together to lead to a transformed mental health system that is consumer and family driven, recovery- and resilience-oriented, and culturally competent.[60]

Each county was required to submit a funding request to DMH by March 15, 2005, in order to receive MHSA funding to develop a local community program planning process. DMH is working in partnership with counties and stakeholders to ensure a broad, effective community planning process in each county. DMH staff will continue to provide technical assistance and monitor the planning processes.

To provide for an orderly implementation of the MHSA, DMH has planned for sequential phases of development for each of its six components. The components, all of which must be woven into an integrated plan at the local level and a comprehensive strategy at the state level, are: community program planning; community services and supports; capital facilities and information technology; education and training programs; prevention and early intervention programs; and innovative programs.

Results. One of the major successes of the MHSA process over the past year has been the extensive involvement of stakeholders and the transparency of the process. Over 3,300

participants have taken part in workgroups and conference calls, and more than 49,000 people have been involved at the county level. The passage of Proposition 63, in other words, has led not just to an infusion of new money into the system, but also to an extensive planning process within each county and at the state level.

Two quarterly stakeholder meetings took place in October 2005, in Sacramento and in Los Angeles, to review the status of the MHSA; a total of 155 individuals attended these two sessions. Speakers gave high marks to the governor, the legislature, DMH, county mental health directors, county supervisors, and the MHSA oversight and accountability commission for managing the process smoothly. Rusty Selix, executive director of the California Council of Community Mental Health Agencies, who had been a prime proponent of the proposition, said that "on a scale of 1 to 10, the process rates an 11."[61]

Wyoming: Medicaid/APS Healthy Together Health Management Program

Summary. State Medicaid programs are increasingly implementing disease management (DM) programs as part of their primary care case management initiatives. These programs target consumers with certain health conditions and provide educational materials, care coordination, and specialized services to assist consumers in achieving access to services and self-care. Only a few states, including Wyoming, Colorado, Georgia, and Florida, have included clients with behavioral health conditions among their target groups.

By providing education, support, and coordination of health care, APS's health management program, Healthy Together, has increased both the appropriate utilization of services by clients and the quality of care offered by providers. The program reinforces the need for each individual to find a "medical home" or primary care provider and offers support and education to help clients take more responsibility for their own care.[62] APS calls its program "health management," rather than "disease management," and offers services to its entire Medicaid plan membership, not just those with specific ailments.

The Healthy Together medical director works closely with physicians' offices to explain the program and its potential benefits in increasing patient compliance with treatment and follow-up care plans. The program identifies Medicaid patients through claims data, outreach, and other health risk appraisal activities to determine the appropriate level of care. Case managers and health coaches support physicians' treatment plans and work with patients, finding them resources as needed (including transportation to office visits, food, and clothing). Each head of household receives the *Healthwise* self-care handbook, which offers guidance on medical conditions, advice about home care, and access to a 24/7 call center.

The more than 8,000 EqualityCare clients who have been diagnosed with chronic illnesses (including depression, as well as congestive heart failure and diabetes) have nurse health coaches who phone them regularly to answer questions about their illnesses and to ensure they are following the treatment regimes prescribed by their providers and that they are receiving the services and resources they need to mitigate complications and maintain their quality of life. For many individuals with physical health conditions, depression and substance abuse are significant co-morbid conditions.

Funding and administration. APS Healthcare provides services to over 55,000 Medicaid recipients in Wyoming's Equality Care (Medicaid) program, which falls within the Office of Health Care Financing in the state's Department of Health.

Results. From 2004 to 2005, the number of people covered by EqualityCare increased, but the program realized overall cost avoidance of approximately 9.1 percent, or more than $15.5 million in state and federal costs, in the first six months of 2005 after implementation of the health management program. The program also demonstrated an 11 percent decrease in emergency room visits. In October 2005, Healthy Together received an award from the Disease Management Association of America as Best Government Disease Management Program for demonstrating excellence in the design, development, implementation, and operation of a DM program resulting in favorable outcomes.[63]

Although depression is the only behavioral health condition on which it currently focuses, the Healthy Together program is an example of the emerging use of innovative DM approaches within Medicaid that help consumers manage their chronic behavioral health conditions and recovery. Medicaid pays for a significant proportion of all behavioral health care throughout the country, and the DM model holds promise for schizophrenia, bipolar disorder, and other conditions, including depression. Thus, this project represents a potentially growing trend in Medicaid. As more behavioral health conditions are included, such efforts will have a significant impact on states' behavioral health care delivery systems. DM approaches can also help state mental health and substance abuse authorities reframe and redesign the services they provide.

DISCUSSION: DISSEMINATION AND DIFFUSION

Where do states find their innovative ideas, and how do those ideas spread? The IOM report, *Improving the Quality of Health Care for Mental and Substance-Use Conditions,* summarizes key findings of a study by Greenhalgh et al. regarding diffusion of service innovations.[64] According to Greenhalgh, innovations are "diffused" (defined as "unplanned, informal, decentralized" spread) and "disseminated" (spread that is "planned,

formal, often centralized”). The current report represents one critical piece of dissemination strategy—encouraging the spread of innovations by informing states about one another’s efforts.

For a variety of reasons, the factors affecting the adoption of innovations are far more complex in government than in business. Public policymakers answer to myriad stakeholders. The process of change is often politically driven by elected officials who may pick up on some issues or ideas, but not others. Choices may depend on personal interests or on what officials or staff members believe may attract the attention of voters. Advocacy organizations, foundations, and think tanks, both at the national and state levels, may also disseminate innovative ideas. These activities may result in a broad range of recommendations, sometimes competing from both sides of the aisle. Finally, the unique characteristics of each state’s financing and organization have a major impact on the types of innovations adopted and how well they work.

These issues all come into play in the field of behavioral health services, an arena with a particularly complex, interconnected structure. Services may be publicly operated, privately contracted, or both. Often, mental health and substance abuse services are organized and delivered through separate systems. County agencies may also be involved with the delivery of services. And, finally, Medicaid funds may be administered by a separate agency or be under the control of the behavioral health authority.

The result is often that even when an innovation has the same name, like “disease management,” its structure and operation may differ significantly from state to state. Because the influences on each state are unique, based on its particular structure and funding, each of the states highlighted in this report has fit its innovation into its own structure, resulting in programs that may be difficult to replicate exactly.

Because of its great diversity and endemic fragmentation, the behavioral health field is moving in various directions simultaneously. Thus, this study has identified many different types of innovations, ranging from person-centered care to system integration, all aimed at improving purchasing practices and quality. These innovation reflect influences from various sources—IOM, the Institute for Healthcare Improvement, and the National Governor’s Association, among others. State leaders seeking strategies to improve their systems must seek advice and information from these sources and select the innovations most appropriate to their states, adapting as necessary.

As a result of the significant variation among states in the organization and financing of behavioral health care, as well as the programs that are unique to each state, there is a compelling need to be quite purposive about the diffusion and dissemination process.

The involvement of independent, trusted organizations is critical to dissemination in behavioral health. The National Association of State Mental Health Program Directors, the National Association of State Alcohol and Drug Abuse Directors, as well as their Medicaid counterpart, the National Association of State Medicaid Directors of the American Public Human Services Association, have often filled this role for state officials, as has SAMHSA. Their regular meetings and conferences play a vital role in disseminating new ideas. However, in an era of tight budgets, these activities are often the first to be eliminated. Furthermore, these organizations rarely have the resources to conduct the kind of systematic review of innovations reflected in this report. States need assistance in adopting, managing, and evaluating innovations that have proven successful elsewhere and are relevant to their own systems.

The federal government has an important role to play in encouraging the adoption of specific approaches, particularly ones that federally funded research has found effective. This "science-to-service" function can help states transform their behavioral health systems and achieve the goals called for by the New Freedom Commission, the Federal Action Agenda, and the IOM. State and federal officials need decision support in the form of more timely and relevant data. This report is but one step in the journey.

CONCLUSION

This report focuses on practices in state behavioral health purchasing and quality improvement that leading experts have identified as exemplary and innovative. While the review focused exclusively on states' innovations, such practices are also being adopted at the county and provider levels, within tribal organizations, and in managed care organizations. Best practices from all these areas merit ongoing attention; disseminating innovations will help each state's behavioral health system become a high-performing one.

Some of the innovations identified already demonstrate strong track records while others are classified as "promising." Some are fairly controversial (e.g., Oregon's required implementation of best practices), while others have been widely applauded and imitated (e.g., Georgia's certified peer specialist program). Some reflect almost exclusively the work of one government agency (e.g., Kentucky's performance-based contracting), while others involve extensive interagency collaborations (e.g., the system integration efforts in New Mexico and New Jersey).

Many of the projects result in no small part from the demands placed on state agencies to meet an increased need for services with a reduced budget. Many states have little choice but to try to improve performance and increase efficiency and effectiveness. They have sought to accomplish these goals by adopting approaches from other parts of the health care system, like performance-based contracting, and projects from the private sector, like primary care integration and chronic disease management. Careful reporting on the results of these efforts is crucial to the design of new initiatives in other states.

The dearth of practice-based evidence—studies or data addressing the successes and challenges of many of these state innovations—is striking. Too often, evaluations of policy innovations are funded insufficiently or not at all. The time required to plan and implement a study, collect and analyze process and outcome data, and publish results is likely to be three or more years, and the cost can be significant. Often, key program features have changed by the time evaluations are complete and available to the public. And state administrators are more focused on implementing programs and fixing problems, believing they do not have time for evaluations. Yet, in the absence of competent studies, state policymakers cannot be sure which innovations are worthy of consideration. New models of evaluation are needed—ones that can document change, report on a set of standard and comparable measures across sites, and that are accessible, and ultimately valuable, to management.

Across the country, states are trying to respond to the challenges laid out by the Federal Action Agenda and the IOM. Each state mental health and substance abuse agency is approaching issues in its own way, trying to make its system more consumer-centered, collaborating with other state agencies, and improving performance and the quality of the services it purchases. Such dramatic change cannot and will not be accomplished by a top-down, federal approach; instead the federal and state governments must act as "incubators," facilitating local efforts, sharing best practices, and reporting on the outcomes of innovations wherever possible. Methods must be developed for states to share knowledge—with a wide audience and with minimal bureaucratic hurdles—about what each initiative has accomplished. This "incubator" method is consistent with SAMHSA's Transformation Grants to seven states; 43 others require the encouragement to incubate new ideas as well. Disseminating details about current innovations, including accomplishments and challenges, is one vital component of this state-by-state approach.

APPENDIX A. OTHER WORK ON INNOVATIONS IN BEHAVIORAL HEALTH CARE

FEDERAL EFFORTS

The New Freedom Commission on Mental Health

The most widely disseminated recent work on innovation in mental health is the final report of the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*.[65] Published in July 2003, this report not only sets goals and recommendations, but also describes a dozen "model programs," ranging from screening programs to information systems, and from clinical systems to nonclinical programs like supported employment. There is little doubt that all of the projects described in the Commission's report are worthy of widespread dissemination and, where appropriate and feasible, replication. Some are relatively new, while others have been in operation for well over a decade and are already being implemented in many locales. Because the Commission's report has been widely distributed over the past three years, the model programs described are now well known in the field and are not included in this report.

National Registry of Evidence-Based Programs and Practices

SAMHSA's Web site offers the National Registry of Evidence-Based Programs and Practices (NREPP), a compendium of "promising" programs (i.e., ones that are scientifically defensible), "effective" programs (i.e., ones that are well implemented, well evaluated, and produce a consistent, positive pattern of results), and "model" programs (i.e., those that are not only well implemented and well evaluated, but those with developers that have coordinated and agreed with SAMHSA to provide materials, training, and technical assistance for nationwide implementation).[66] NREPP was initially developed by the Center for Substance Abuse Prevention in the late 1990s and listed substance abuse prevention programs. Several years later, it was expanded to include dual disorder (i.e., mental and substance use disorder) programs and, in 2003, the Center for Mental Health Services began to consider including mental health promotion, prevention, and treatment programs for inclusion. SAMHSA is currently determining how to revise NREPP.

NREPP provides a valuable service by reviewing and evaluating substance abuse prevention and treatment programs according to formal criteria, and then disseminating information on its Web site about programs that meet those criteria. NREPP, however, is geared to use by providers. It does not include purchaser activities.

ORGANIZATIONS

National Association of State Mental Health Program Directors

The National Association of State Mental Health Program Directors (NASMHPD), which represents state mental health commissioners and directors and their agencies, offers consultation, training, and technical assistance to help its constituents identify and respond to critical policy issues. NASMHPD operates under a cooperative agreement with the National Governors Association. Together with the NASMHPD Research Institute, Inc. (NRI), a partner organization, it informs its constituents of the latest in mental health research in administration and service delivery.[67]

In 2002, the NRI Center for Mental Health Quality and Accountability was established, to focus on sharing information about implementation of evidence-based practices and on expanding their use. Funding comes from SAMHSA's Center for Mental Health Services. The NRI Web site offers suggestions for program development in specific areas (e.g., cultural competence, mental health/school/family collaboration) and reports on current state activities related to evidence-based practices. It also describes the technical assistance activities NRI has offered to states. The Center has recently completed site visits to a number of states that are implementing systemic changes, and plans to publish a document to help other states better understand these changes.

National Association of State Alcohol/Drug Abuse Directors

The National Association of State Alcohol/Drug Abuse Directors (NASADAD) is a private, nonprofit organization originally incorporated in 1971 to serve state drug agency directors; it expanded in 1978 to include state alcoholism agency directors. NASADAD's purpose is to foster and support the development of effective alcohol and drug abuse prevention and treatment programs throughout every state. It promotes training within the substance abuse field as well as cross-training in other systems; provides technical assistance to its membership; promotes the establishment of national standards for quality assurance, outcomes, and performance; helps shape public policy positions that advance the provision of effective prevention and treatment services and increase funding for same; and works to maintain a stable base of funding.[68] NASADAD contributes its expertise to many research and other projects, and its staff is extremely well informed about best practices and innovations.

National Academy for State Health Policy

The National Academy for State Health Policy (NASHP) is a nonprofit, nonpartisan organization dedicated to helping states achieve excellence in health policy and practice. NASHP currently focuses most of its efforts in five areas of health care reform: access for

the uninsured, family and community health, the health care marketplace, long-term and chronic care, and managed care and purchasing strategies. While some of its programs touch on behavioral health care issues (notably the Assuring Better Child Health and Development initiative), mental health and substance abuse are not core areas for NASHP.[69] NASHP is working on a project to collect and present information on initiatives each state is undertaking relative to the goals of The Commonwealth Fund's Commission on a High Performance Health System. Their team will produce a report and a Web-based tool allowing easy access to this information by topic and by state.

FOUNDATIONS

Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation (RWJF) is the nation's largest philanthropy devoted exclusively to the goal of improving the health and health care of all Americans. Working toward that goal, it currently pursues four key program areas: assuring that all Americans have access to quality health care at reasonable cost; improving the quality of care and support for people with chronic health conditions; promoting healthy communities and lifestyles; and reducing the personal, social, and economic harm caused by substance abuse—tobacco, alcohol, and illicit drugs. Given the size of RWJF and the sheer volume of funds it distributes (grants and contracts worth more than $3 billion over the past decade), some of its work touches on behavioral health innovations. The most relevant efforts are the foundation's Resources for Recovery program and the Network for the Improvement of Addiction Treatment (NIATx).

- Resources for Recovery was established in 2002 to expand access to and resources for alcohol and drug treatment services by helping states develop strategies to enhance treatment outcomes, support administrative efficiencies, and explore diversified funding options. Originally intended to conclude in June 2005, it was extended for a fourth year. Resources for Recovery has provided technical assistance and other resources to 15 states, and planning and analysis grants to five of those states. The project is currently being evaluated.

- The Network for the Improvement of Addiction Treatment (NIATx) is a partnership among RWJF's Paths to Recovery program, the Center for Substance Abuse Treatment's Strengthening Treatment Access and Retention program, and independent addiction treatment organizations in 25 states. NIATx is working with its member organizations, and the field at large, to make organizational changes that impact four goals: reducing wait times, reducing no-show rates, increasing continuation, and increasing admissions. The decision to focus on these

four goals is based largely on research of the Washington Circle, a multi-disciplinary group of providers, researchers, managed care representatives, and public policymakers.

The purpose of NIATx is to help treatment projects identify and improve the work practices, policies, and processes that can enhance their ability to get patients into treatment and keep them long enough to make a meaningful difference. To accomplish this, NIATx provides information and training to the field, funds treatment programs to design and implement improvement strategies, and shares with the field the successes and challenges these programs experience.

In addition, NIATx funds a state pilot project that aims to: identify how states can exercise leadership roles to improve treatment quality; use demonstrated process improvement methods to design and test how states and other payers can work together with providers to improve access and retention in addiction treatment; and document and disseminate innovative practices used by states and payers in collaboration with treatment providers to improve quality performance.

States can have a profound impact on addiction treatment performance. By leveraging their role as major purchasers of addiction treatment services, states can spread practices that improve access and retention as well as guide performance improvement. This initiative is helping states improve the performance of their provider networks. The design of the state pilot project aims to: 1) develop an infrastructure to support process improvement at the state and treatment provider level; 2) give single state agencies (SSAs) the opportunity to test the use of process improvement techniques on a small scale; and 3) use what is learned to develop a strategic plan to improve access and retention statewide. In each pilot state, the SSA director and a designated state team change leader work in partnership with managed behavioral health organizations, state provider associations, NIATx treatment providers, and other stakeholders to develop provider learning networks and pilot the implementation of improvements to increase client access and retention.

This report cites state NIATx projects in Iowa and Oklahoma.

Center for Health Care Strategies

The work of the Center for Health Care Strategies (CHCS) focuses largely on purchasers, both public and private. While the organization was originally geared toward providing

funding to identify and demonstrate best practices in Medicaid managed care, the core of CHCS's work currently is to encourage states, health plans, and consumer groups, through technical assistance and training, to engage in quality improvement activities. The goal is to improve services for beneficiaries, reduce racial and ethnic health disparities, and increase community options for people with disabilities. Although CHCS does not focus exclusively on behavioral health, it has several current relevant initiatives:

- Best Clinical and Administrative Practices Initiative: Improving Managed Care Quality for Adolescents with Serious Behavioral Health Disorders.[70] A group of nine managed care organizations, both public and commercial, integrated health maintenance organizations, and managed behavioral health organizations, is working on this project with support from the Annie E. Casey Foundation. Each entity is working on its own project. For example, the goal of King County (Washington) Mental Health Plan's pilot project is to reduce the number of youths hospitalized by refining hospital alternatives and educating the community about alternatives to inpatient care. Community Health Choice, an HMO in the Houston area, aims to educate non-psychiatrist physicians who prescribe anti-depressants for adolescents about appropriate assessment and referral.

- CHCS recently announced that it is awarding up to $100,000 to each of five states to fund the development of models for integrating the financing, delivery, and administration of primary, acute, long-term care, chronic, and behavioral health services for adults who are dually eligible for Medicaid and Medicare, as well as those who receive services solely through Medicaid.[71] Four of the five states that are receiving these competitively awarded funds are cited in this report. Washington is specifically cited for its Medicaid Integration Project, which is currently operational in one county and expected to expand to others.

- Finally, CHCS is working with the Technical Assistance Collaborative, within the Robert Wood Johnson Foundation's Resources for Recovery project, in an effort to help states develop and implement financing strategies that can expand substance abuse treatment services without increasing expenditures. In February 2006, CHCS hosted a meeting that was attended by state substance abuse directors and representatives of state substance abuse trade associations from each state. The goal of the meeting was for states to be able to share their experiences in implementing system changes.

APPENDIX B. METHODOLOGY

Survey of State Mental Health and Substance Abuse Directors

During October and November 2005, staff of DMA Health Strategies (DMA) sent e-mail messages to all state directors of mental health and of substance abuse, requesting that they submit nominations of innovative programs in the areas of purchasing or quality improvement that they were familiar with, either in their own states or in other states. About two weeks after sending the initial e-mails, DMA staff members sent follow-up messages and enabled respondents to submit nominations using a Web-based research tool. This tool, which informants found at http://www.surveymonkey.com/, enabled respondents easily to complete a brief form on the Web. Since the survey is now closed, it is no longer possible to provide a link to the actual instrument used. These two methods yielded relatively few responses.

Telephone Interviews with Experts

Personal or telephone interviews were conducted with 21 experts in the field between October 24th and November 15th. (See Appendix C for a list of expert informants.) From these sources, DMA received several dozen nominations of innovative practices and, in some cases, states where the entire mental health or substance abuse program appeared to offer promising examples of innovation. Many experts offered sizable lists of ideas for consideration. Because the goal for the interviews was to maximize the number of ideas generated, DMA staff members did not seek many specifics on the innovations at that point. Primarily, the information sought was the name of an individual involved with the project, contact information if available, and enough additional detail to allow for further research.

Types of Innovations Sought

When requesting nominations, DMA Health further defined and limited the type of innovation sought by asking for purchasing and quality improvement practices that:

- increase cost effectiveness;
- improve access;
- lead to improved clinical outcomes (although not in direct clinical care);
- enhance patient-centeredness;
- reduce disparities; and/or
- reduce fragmentation of care.

Selecting Innovations for Inclusion

DMA staff identified the ideas mentioned by several different experts, and also those that met the following criteria:

- the innovation was either being implemented at the state level or had significant state involvement through funding or policymaking;
- the innovation was being implemented and some data were available to suggest the extent to which it was achieving its goals;
- the innovation was new enough that it had not previously been extensively documented in the peer-reviewed literature; and
- the innovation would be of interest to other states, and receptive to replication.

Because the DMA team deliberately sought new, promising innovations, rather than those documented in the peer-reviewed literature, they found relatively little hard data on outcomes. Project managers were asked provide whatever qualitative or quantitative data they could; most were able to offer some evaluative information or evaluation plans. The outcomes of certain innovations are somewhat elusive, and yet their efforts appeared to be sufficiently compelling to warrant inclusion.

There was a certain amount of subjectivity in the nomination and selection of practices. DMA staff sought to minimize this bias by incorporating the views of leaders at the federal and state levels, and of advocates as well as consumer and provider organizations. Innovations selected were mentioned by several people or illustrated emerging trends in the field. Different types of projects were sought for inclusion, touching on both substance abuse and mental health services. While attempts to balance the number of innovations in mental health and substance abuse, and those serving children and adults, may not have been completely successful, the examples in one area are often applicable to others.

Confirming Descriptions

DMA staff used an iterative process to select and describe the innovations, initially seeking enough information to decide whether to include a project, and then seeking further detail for preparation of the report. Each step required considerable research on the Web, as well as telephone calls to individuals involved in operating or supervising the innovations. Once project descriptions were drafted, each was sent to the appropriate contact person for review. Notably, there were very few corrections; virtually every contact person felt that the drafted description captured the essence of the project. In several instances, however, the contact person offered additional detail that was helpful to a thorough understanding of the innovation.

APPENDIX C. LIST OF EXPERT INFORMANTS

Name	Organization
Neal Adams, M.D.	California Department of Mental Health
Kamala D. Allen, MHS	Center for Health Care Strategies
Mary Armstrong	University of South Florida
Gary M. Blau, Ph.D.	SAMHSA/Center for Mental Health Services/ Child, Adolescent and Family Branch
Jennifer Bright	National Mental Health Association
Victor Capoccia, Ph.D.	The Robert Wood Johnson Foundation
Doreen Cavanaugh, Ph.D.	Georgetown University, Health Policy Institute; Washington Circle
Mady Chalk, Ph.D.	Treatment Research Institute
Shannon CrossBear	Federation of Families for Children's Mental Health; Children's Outcomes Roundtable
Allen Daniels	Alliance Behavioral Health; Member of the IOM Behavioral Health Committee
King Davis, Ph.D.	Hogg Foundation for Mental Health
Lewis E. Gallant, Ph.D.	National Association of State Alcohol/Drug Abuse Directors
Vijay Ganju	National Association of State Mental Health Program Directors Research Institute
Michael Hogan, Ph.D.	Ohio Department of Mental Health; New Freedom Commission on Mental Health
Connie Horgan	Brandeis University; Washington Circle
Larke N. Huang, Ph.D.	American Institutes for Research; New Freedom Commission on Mental Health
Peter S. Jensen, M.D.	Columbia University, Center for Advancement of Children's Mental Health
Neva Kaye	National Academy for State Health Policy
Patrick McCarthy, Ph.D.	The Annie E. Casey Foundation
Todd Molfenter	Center for Health Systems Research & Analysis, University of Wisconsin–Madison
Sheila A. Pires, MPA	Human Service Collaborative
A. Kathryn Power, M.Ed.	Center for Mental Health Services, SAMHSA
Linda Rosenberg, MSW, CSW	National Council for Community Behavioral Healthcare

APPENDIX D. CONTACT INFORMATION FOR INNOVATIONS

ENHANCING PATIENT-CENTERED CARE

Georgia's Certified Peer Specialist Program

Contact person: Beth Filson, Project Manager
Contact information: 2 Peachtree Street, NW, Suite 23-444, Atlanta, GA 30303
emfilson@dhr.state.ga.us
Phone number: 404-657-3383
Web site: http://www.gacps.org/Home.html

New Jersey's Consumer Connections Program

Contact person: Bob Kley
Contact information: 88 Pompton Avenue, Verona, NJ 07044
rkley@mhanj.org
Phone number: 800-367-8850
Web site: http://www.mhanj.org/ProgramsServices/prog_serv2.htm

Florida's Self-Directed Care Program (FloridaSDC)

Contact person: David Sarchet, Program Coordinator
Contact information: Florida Self-Directed Care Program
5020 Tamiami Trail North, Suite 110
Naples FL 34103
sarchet@comcast.net
Phone number: 239-649-0807
Web site: http://flsdc.org/about.htm

CRIMINAL JUSTICE/MENTAL HEALTH COLLABORATION

Ohio's Criminal Justice Coordinating Center of Excellence (CJ/CCOE)

Contact person: Jo Ann Harris, Administrative Director
Contact information: NEOUCOM, P.O. Box 95, Rootstown, OH 44272
jharris@neoucom.edu
Phone number: 330-325-6162
Web site: http://www.neoucom.edu/CJCCOE/about.html

SYSTEM INTEGRATION

New Jersey's Division of Child Behavioral Health Services (DCBHS)

Contact person:	Julie Caliwan, Director of Policy, Planning & Quality Assurance
Contact information:	50 East State Street, PO Box 700, Trenton, NJ 08625
	Julie.caliwan@dhs.state.nj.us
Phone number:	609-292-7807
Web site:	http://www.state.nj.us/humanservices/dcbhs/

New Mexico's Behavioral Health Purchasing Collaborative

Contact person:	Pamela Hyde, Secretary, Human Services Department
Contact information:	2009 S. Pacheco, P.O. Box 2348, Santa Fe, NM 87504
	pam.hyde@state.nm.us
Phone number:	505-827-7750
Web site:	http://www.state.nm.us/hsd/bhdwg/history.html

Washington's Medicaid Integration Project

Contact person:	Alice Lind, Department of Social and Health Services
	Health and Recovery Services Administration
	Medical Assistance, Coordinated Care Section Administration
Contact information:	lindar@dshs.wa.gov
Phone number:	360-725-1629
Web site:	http://fortress.wa.gov/dshs/maa/mip/

USING PERFORMANCE INCENTIVES

Delaware's Performance-Based Contracting for Substance Abuse: Concurrent Recovery Monitoring (CRM)

Contact person:	Jack Kemp, Director of Alcohol and Drug Services
Contact information:	1901 N. DuPont Highway, Main Bldg., New Castle, DE 19720
	jack.kemp@state.de.us
Phone number:	302-255-9399
Web site:	http://www.dhss.delaware.gov/dhss/dsamh/index.html

Kentucky's Performance-Based Contracting for Mental Health

Contact person:	Kathy Burke
Contact information:	100 Fair Oaks Lane, 4E-A, Frankfort, KY 40621 Kathy.Burke@ky.gov
Phone number:	502-564-4860
Web site:	http://mhmr.ky.gov/kdmhmrs/perfbasedoutcomes.asp

Oregon's Required Implementation of Evidence-Based Practices

Contact person:	Robert Miller, Manager, Evidence-Based Practices
Contact information:	Mental Health and Addiction Services 500 Summer Street NE E86, Salem, OR 97301 bob.miller@state.or.us
Phone number:	503-945-6185
Web site:	http://www.oregon.gov/DHS/mentalhealth/ebp/main.shtml#history

QUALITY IMPROVEMENT

Washington's Use of Data

Contact person:	Elizabeth Kohlenberg, Ph.D., Director
Contact information:	Department of Social and Health Services, Research and Data Analysis Division (RDA), 14th & Jefferson St. PO Box 45204, Olympia, WA 98504-5204 kohleer@dshs.wa.gov
Phone number:	360-902-0707
Web site:	http://www1.dshs.wa.gov/rda/rc/bygeography.shtm#washington

Iowa's Process Improvement Project

Contact person:	Janet Zwick, Deputy Director, Director of Behavioral Health and Professional Licensure
Contact information:	321 E. 12th Street, Des Moines, IA 50319 jzwick@idph.state.ia.us
Phone number:	515-281-4417
Web site:	http://www.idph.state.ia.us/bhpl/default.asp

Oklahoma's Process Improvement in Substance Abuse Services

Contact person:	Steve Davis, Ph.D., Director, Decision Support Services, ODMHSAS
Contact information:	P.O. Box 3277, Oklahoma City, OK 73152-3277 sdavis@odmhsas.org
Phone number:	405-522-3813
Web site:	http://www.odmhsas.org/eda/statisticsother.htm

OTHER SIGNIFICANT PROJECTS

Tennessee's Creating Homes Initiative (CHI)

Contact person:	Marie Williams
Contact information:	Cordell Hull Building, 3rd Floor 425 Fifth Avenue N, Nashville, TN 37243 marie.williams@state.tn.us
Phone number:	615-253-3049
Web site:	http://www.housingwithinreach.org/

Minnesota Mental Health Action Group

Contact person:	Michael Scandrett
Contact information:	Halleland Health Consulting, c/o Citizens League 708 S. 3rd St., Suite 500, Minneapolis, MN 55415; mscandrett@halleland.com
Phone number:	651-293-0575
Web site:	http://www.citizensleague.net/mentalhealth/index.html

California's Proposition 63

Contact person:	Stephen W. Mayberg, Ph.D., Director, CA DMH
Contact information:	1600 Ninth Street, Room 151, Sacramento, CA 95814 stephen.mayberg@dmh.ca.gov
Phone number:	916-654-2309
Web site:	http://www.dmh.cahwnet.gov/MHSA/default.asp

Wyoming's Medicaid/APS Healthy Together Health Management Program

Contact person:	Teri Green, Medical Policy Coordinator
Contact information:	Wyoming Department of Health, 401 Hathaway Bldg. Cheyenne, WY 82002 Tgreen1@state.wy.us
Phone number:	307-777-7908;
Web site:	http://wdh.state.wy.us/medicaid/healthmgmt.asp

NOTES

[1] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, Md.: 2003. http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html.

[2] Ibid., p. 4.

[3] Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *Transforming Mental Health Care in America. Federal Action Agenda: First Steps.* DHHS Pub. No. SMA-05-4060. Rockville, Md.: 2005.

[4] Ibid., p. iii.

[5] Institute of Medicine, *Improving the Quality of Health Care for Mental and Substance-Use Conditions.* Washington, D.C.: National Academies Press, 2005. http://www.nap.edu/books/0309100445/html/.

[6] Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, D.C.: National Academies Press, 2001. http://www.nap.edu/books/0309072808/html/.

[7] Goal Two of the New Freedom Commission on Mental Health is: "Mental health care is consumer and family driven," and within this larger goal Recommendation 2.2 is: "Involve consumers and families fully in orienting the mental health system toward recovery." Similarly, Recommendation Three of *Improving the Quality of Health Care for Mental and Substance-Use Conditions,* the report of the Institute of Medicine's Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, says that, "To promote patient-centered care, all parties involved in health care for M/SU [mental and substance use] conditions should support the decision-making abilities and preferences of persons with M/SU problems and illnesses; coercion should be avoided whenever possible."

[8] Personal communication with staff of Consumer Connections program. Feb. 1–2, 2006.

[9] http://www.mhanj.org/ProgramsServices/ConsumerConnections/3-supp/ConsumerSupportNetwork2.htm, accessed Dec. 27, 2005.

[10] See http://www.gacps.org/files/peer_supports_guidelines2_03.doc, accessed Jan. 23, 2006.

[11] Based on information received from the Georgia CPS Project, Feb. 1, 2006.

[12] J. Cook, S. Terrell, and J. Jonikas, *Promoting Self-Determination for Individuals with Psychiatric Disabilities Through Self-Directed Services: A Look at Federal, State, and Public Systems as Sources of Cash-Outs and Other Fiscal Expansion Opportunities,* Mar. 2004. http://media.shs.net/ken/pdf/selfdet.pdf.

[13] http://flsdc.org/about.htm, accessed Dec. 27, 2005.

[14] http://www.gainsctr.com/html/tapa/jail%20diversion/background.asp, accessed Dec. 28, 2005.

[15] http://pn.psychiatryonline.org/cgi/content/full/36/15/9, accessed Dec. 28, 2005.

[16] *Achieving the Promise,* op. cit., pp. 43–44.

[17] CJ/CCOE Web site: http://www.neoucom.edu/CJCCOE/about.html, accessed Dec. 28, 2005.

[18] *Achieving the Promise,* op. cit., p. 3 (quoting from the Commission's own *Interim Report*).

[19] *Transforming Mental Health Care in America,* op. cit. p. 58.

[20] For example, see *Treating Troubled Children: Lessons Learned from New Jersey's Partnership for Children,* Association for Children of New Jersey, May 2004. http://www.njparentscaucus.org/admin.pdf. Accessed Dec. 13, 2005.

[21] http://www.state.nj.us/humanservices/dcbhs/archives.htm, accessed Dec. 13, 2005.

[22] http://ubhc.umdnj.edu/brti/partners4children.htm, accessed Dec. 13, 2005.

[23] http://ubhc.umdnj.edu/brti/partners4children.htm, accessed Dec. 13, 2005.

[24] The agencies in the NM Purchasing Collaborative include: Aging and Long-Term Services Department; Administrative Office of the Courts; Children, Youth and Families Department; Corrections Department, Department of Finance and Administration; Department of Health; Department of Labor; Department of Transportation; Developmental Disabilities Planning Council; Division of Vocational Rehabilitation; Governor's Commission on Disability; Governor's Health Policy Coordinator; Health Policy Commission; Human Services Department; Indian Affairs Department; Mortgage Finance Authority; Public Education Department (two representatives, one from the Division of Vocational Rehabilitation); and the State Public Defender's Office.

[25] New Mexico Behavioral Health Purchasing Collaborative Executive Summary, http://www.state.nm.us/hsd/bhdwg/pdf/PurchCollExecSum.pdf, accessed Dec. 28, 2005.

[26] http://www.state.nm.us/hsd/bhdwg/pdf/PurchCollExecSum.pdf, accessed Dec. 28, 2005.

[27] "New Mexico's Behavioral Health Collaborative Selects ValueOptions as Statewide Entity," http://www.valueoptions.com/news/releases/release040105.htm.

[28] http://www1.dshs.wa.gov/WorkingTogether/wmip.html, accessed Dec. 28, 2005.

[29] Ibid.

[30] "Pilot Project of Molina Healthcare of Washington and Washington State Receive CHCS Grant," http://phx.corporate-ir.net/phoenix.zhtml?c=137837&p=irol-newsArticle&ID=750339&highlight.

[31] Evelyn Bandoh, "Outsourcing the Delivery of Human Services," Welfare Information Network, *Issue Notes,* vol. 7, no. 12, Oct. 2003. http://www.financeproject.org/Publications/outsourcinghumanservicesIN.htm.

[32] Information provided via e-mail by A. Thomas McLellan, Chief Executive Officer, Treatment Research Institute, June 28, 2006.

[33] Summarized from http://www.tresearch.org/tx_systems/de_r21.htm, accessed Dec. 28, 2005.

[34] Drawn from Nomination form submitted by Kentucky Department for Mental Health and Mental Retardation Services.

[35] http://mhmr.ky.gov/kdmhmrs/perfbasedoutcomes.asp, accessed Dec. 28, 2005.

[36] E-mail correspondence with Kathy L. Burke, KDMHMRS.

[37] Ibid.

[38] Implementation of Evidence-Based Practices (EBP) in Oregon, Revised June 6, 2005. http://www.oregon.gov/DHS/mentalhealth/ebp/factsheet.pdf.

[39] http://www.oregon.gov/DHS/mentalhealth/ebp/main.shtml#history.

[40] Implementation of Evidence-Based Practices (EBP) in Oregon, op. cit.

[41] http://www.oregon.gov/DHS/mentalhealth/ebp/ebp-reprtjud.pdf, accessed Dec. 28, 2005.

[42] http://www.washingtoncircle.org/, accessed Dec. 27, 2005.

[43] E-mail from Elizabeth Kohlenberg, Jan. 19, 2006.

[44]"What Do RDA Customers Want? Summary" at http://www1.dshs.wa.gov/rda/research/11/123.shtm, accessed Dec. 27, 2005.

[45] Ibid.

[46] E-mail from Elizabeth Kohlenberg, Ph.D., Director of RDA. Jan. 20, 2006.

[47] S. Davis et al., "State Agency Measurement System Development: Oklahoma's Experience," presented at American Public Health Association Annual Meeting, Dec. 13, 2005. http://apha.confex.com/apha/133am/techprogram/paper_120917.htm, accessed Dec. 27, 2005.

[48] D. W. Garnick, M. T. Lee, M. Chalk et al., "Establishing the Feasibility of Performance Measures for Alcohol and Other Drugs." *Journal of Substance Abuse Treatment* 23:375-385 (2002).

[49] http://www.odmhsas.org/eda/statisticsother.htm, accessed Dec. 27, 2005.

[50] S. Davis et al., op. cit.

[51] Ibid.

[52] *Achieving the Promise,* op. cit., p. 30.

[53] http://www.housingwithinreach.org; accessed Dec. 28, 2005.

[54] Drawn from material included in Nomination submitted by Tennessee Department of Mental Health and Developmental Disabilities and from http://www.housingwithinreach.org/index.asp, accessed Dec. 28, 2005.

[55] http://www.citizensleague.net/mentalhealth/blogimages/MMHAG%20Road%20Map%20for%20Mental%20Health%20System%20Reform%20in%20Minnesota.doc, p. 4. Accessed Dec. 15, 2005.

[56] http://www.citizensleague.net/mentalhealth/html/about_mhag.html, accessed Dec. 15, 2005.

[57] http://www.citizensleague.net/mentalhealth/blogimages/MMHAG%20Road% 20Map%20for%20Mental% 20Health%20System%20Reform%20in%20Minnesota.doc, accessed Dec. 15, 2005.

[58] http://www.smartvoter.org/2004/11/02/ca/state/prop/63/, accessed Dec. 28, 2005.

[59] http://www.dmh.cahwnet.gov/MHSA/default.asp, accessed Dec. 28, 2005.

[60] DMH, MHSA, Stakeholder Input Process, General Stakeholders Meeting #4, Meeting Summary, p. 3. http://www.dmh.cahwnet.gov/MHSA/docs/GenStkhldrMtgSumm10-25-26-05.pdf.

[61] Ibid.

[62] "Wyoming Medicaid Program avoids $15 million in costs; Emergency Room visits made by Medicaid clients in Health Management program drop 11%," Press Release, Oct. 10, 2005.

[63] "APS' Wyoming Health Management Program Awarded Best Government DM Program by Disease Management Association of America," Press Release, Oct. 19, 2005, http://www.apshealthcare.com/newsroom/archive/2005/october19_2005.htm, accessed Dec. 28, 2005.

[64] Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., and Kyriakidou, O. 2004. "Diffusion of Innovations in Service Organizations: Systematic Review and Recommendations," *Milbank Quarterly,* 82, 4: 581–629.

[65] DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

[66] SAMHSA's National Registry of Evidence-based Programs and Practices, at http://modelprograms.samhsa.gov/template.cfm?page=nreppover; accessed Nov. 22, 2005.

[67] From the NASMHPD Web site, http://www.nasmhpd.org/index.cfm; accessed Nov. 22, 2005.

[68] Adapted from the NASADAD Web site: http://www.nasadad.org/index.php?doc_id=2, accessed Dec. 28, 2005.

[69] NASHP staff were extremely gracious and knowledgeable when we contacted them, especially regarding Medicaid innovations and children's mental health systems.

[70] http://www.chcs.org/info-url_nocat4252/info-url_nocat.htm; accessed Nov. 28, 2005.

[71] CHCS Press Release, Dec. 8, 2005, "Five States Awarded Grants to Improve Integrated Health Care for Medicaid/Medicare Consumers," http://www.chcs.org/info-url3969/info-url_show.htm?doc_id=326796. Accessed Jan. 3, 2006.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.cmwf.org.

Using Clinical Evidence to Manage Pharmacy Benefits: Experiences of Six States (Mar. 2006). David Bergman, Jack Hoadley, Neva Kaye, Jeffrey Crowley, and Martha Hostetter. The authors of this issue brief provide an overview of how six state Medicaid agencies are managing their pharmacy benefit.

Can Medicaid Do More with Less? (Mar. 2006). Alan Weil, National Academy for State Health Policy. Prepared for the Commonwealth Fund/Alliance for Health Reform 2006 Bipartisan Congressional Health Policy Conference, this report notes that Medicaid enrollees—who have extremely limited incomes—cannot absorb increases in out-of-pocket health costs as readily as the working population.

Designing Maine's DirigoChoice Benefit Plan (Dec. 2005). Jill Rosenthal and Cynthia Pernice, National Academy for State Health Policy. This report examines the challenges Maine faced in crafting the DirigoChoice benefit design, the benefit structure for 2005, and various administration and enrollment issues.

Federal Aid to State High-Risk Pools: Promoting Health Insurance Coverage or Providing Fiscal Relief? (Nov. 2005). Karen Pollitz and Eliza Bangit, Georgetown University Health Policy Institute. The authors of this article find that most states receiving matching funds for state high-risk pools have not used them to make coverage more affordable or accessible.

Issues Related to State and Employer Innovations in Insurance Coverage (July 2005). Erin C. Strumpf. This issue brief—prepared for the 2005 Commonwealth Fund/John F. Kennedy School of Government Bipartisan Congressional Health Policy Conference—reports that successful strategies to increase rates of insurance coverage require both flexibility to tailor approaches that best serve their residents and employees and basic protections to ensure that new programs do not leave vulnerable groups behind.

Impact of Changes to Premiums, Cost-Sharing, and Benefits on Adult Medicaid Beneficiaries: Results from an Ongoing Study of the Oregon Health Plan (July 2005). Bill J. Wright, Matthew J. Carlson, Jeanene Smith, and Tina Edlund. In 2003, Oregon raised premiums, required copays for the first time, and imposed a six-month lockout for individuals missing premium payments. This study reports that nearly two-thirds of surveyed individuals lost their coverage after the initial premium and cost-sharing increases, many directly resulting from increased costs.