



Center for Mental Health Services

Substance Abuse and Mental Health Services Administration

# Transformation Transfer Initiative

Fiscal Year 2008, 2009,  
2010 & 2011 Projects

Overview

**NASMHPD**

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Center for Mental Health Services

Substance Abuse and Mental Health Services Administration

**It is with pride that I congratulate the Transformation Transfer Initiative (TTI) Awardees of Fiscal Years 2008, 2009, 2010 and 2011, representing 37 States and 46 projects. The effort and leadership of each State in providing models of *transformation in action*, guiding state and local systems to be more consumer-driven and recovery-oriented, continues to be exemplary. By targeting flexible “tipping point” resources to behavioral health communities, the TTI initiatives have shown clear evidence of success through the years, as well as sustainable, positive impact on state behavioral health systems. TTI supports efforts that work with the present reality of limited resources to show what can be accomplished to achieve important goals in more effective ways. Each of the initiatives embodies a spirit of expertise, resourcefulness and innovation to address significant behavioral health needs that demand creative responses, unique to each state.**

**SAMHSA/CMHS will continue to support efforts such as the TTI that leverages positive system change in states and local communities coming together, sharing ideas and facilitating peer-to-peer technical assistance to accomplish measurable goals. We are proud to have partnered in these successful projects and offer heartfelt Congratulations! Together we are transforming behavioral health care in America!**

**Paolo del Vecchio  
Acting Director  
Center for Mental Health  
Services  
July 15, 2012**

# Introduction

*“Never in the history of America have we known so much about mental health and how to enable people with mental illnesses to live, work, learn, and participate fully in the community. Recovery from mental illnesses is now a realistic hope. Yet, much of what we know is not accessible to the people who need it the most. Today, we are on the threshold of achieving the promise of transforming mental health care in America. Government – Federal, State, and local – and thousands of organizations in the private sector are joining together to transform the mental health service delivery system across the Nation.”*

This vision statement, put forth in the Substance Abuse and Mental Health Services Administration (SAMHSA) report *Transforming Mental Health Care in America - Federal Action Agenda: First Steps*, describes very clearly the reality of today’s public mental health system and calls attention to the opportunities we have, by working together, to improve the lives of Americans with mental illness and substance use disorders. Changing systems with bureaucratic infrastructures to be recovery and outcome-oriented, however, takes investment, hard work and the ability to bring the right players to the table. States, as the largest payers of mental health services, are in a key position to lead and influence systems change with all stakeholders.

In 2007 SAMHSA’s Center for Mental Health Services (CMHS) created the Transformation Transfer Initiative (TTI) to assist in this essential transformative work. It sought to provide – on a competitive basis – funding awards to states, the District of Columbia, and all territories, that had not had the opportunity to participate in the Mental Health Transformation State Incentive Grant (T-SIG) program. Under the first year of the TTI (FY2008), CMHS awarded grants of \$105,000 each to ten states and the Commonwealth of Puerto Rico. Under the second year of the TTI (FY2009), CMHS awarded grants of \$221,000 each to eleven states. Under the third year of the TTI (FY2010), CMHS awarded grants of \$221,000 each to nine states; four states from FY08 received an award of \$110,500. Under the fourth year of the TTI (FY2011), CMHS awarded grants of \$221,000 each to eight states; four states from FY08 received an award of \$110,500. All forty-seven projects sought to identify and adopt transformation initiatives and activities that were implemented either through new initiatives or expansion of initiatives already underway, all rooted in quality systems change. Some states elected to advance multiple projects.

This important project has given these states the opportunity to increase efforts in transforming their state behavioral health delivery system to be more consumer and family driven and to break down the silos of state government that impede recovery and resiliency. These states also used their funding to leverage private and public resources to make current initiatives richer and more effective, and in many cases to provide the tipping point to transformation success.

This overview document highlights some of the successful outcomes for all thirty-five projects. If you would like more specific detail, in-state contact information is provided on each project page. Also feel free to contact NASMHPD’s TTI Project Director with questions as well at:

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# Alabama



## **FY2008 TTI PROJECT:**

*Coordination of public mental health and primary care through one large Adult Psychiatric Conference followed by regional roundtable discussions between family practice physicians and mental health clinicians to develop regional plans of action.*

## **KEY OUTCOMES:**

- A statewide “Psychiatric Institute” focusing on the integration of physical and behavioral health was held on April 11-13, 2008 in Orange Beach, Alabama with over 150 participants including psychiatrists, primary care physicians, nurse practitioners, and policy makers from four partnering state agencies.
- Responding to the evaluation, 85% of attending primary care physicians said they would like to attend again next year if offered and 95% indicated that the training was relevant to their practice/work.
- The statewide conference was followed by 10 regional roundtables to create local partnerships between primary care physicians and mental health professionals.
- Approximately 187 people attended the roundtables throughout the state. This total includes 27 physicians, 26 primary care providers, 56 community mental health center representatives, 25 representatives from advocate groups, and 10 consumers.
- Responding to the roundtable evaluation, 95% of physicians said that the roundtable was worth their time and that they met someone from the local area that they did not know.
- The Alabama Primary Health Care Association was a co-sponsor of these meetings and was pivotal in the planning and execution of regional roundtables, they also included a mental health track at their annual statewide conference.
- Leveraged resources from a Bristol-Myers Squibb Foundation grant to the Alabama “blackbelt” region to improve the overall health of these twelve very poor and rural counties in Alabama.

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# Alabama



## FY2010 TTI PROJECT:

*Improve collaboration with primary care providers through: 1) local planning grants to support collaboration between Community Mental Health Centers (CMHCs) and Federally Qualified Health Centers (FQHCs), 2) convening expert panels to address barriers and challenges to collaboration from the physician's perspective, and 3) a joint meeting between pediatricians and public mental health center psychiatrists to address improved collaboration.*

## KEY OUTCOMES:

- A survey was developed with the input of the Department of Mental Health Medical Director, Richard Powers, MD, and the Alabama Medicaid Agency Medical Director, Robert Moon, MD. The Alabama Primary Health Care Association created the survey instrument and sent it to CMHCs (12 responses), Hospital Emergency Departments (6 responses), and FQHCs (8 responses) for completion by their respective medical staff. There were positive responses to the concept of integration while primary care physicians were more positive about the use of telemedicine.
- Two expert panels were convened with the first on February 22, 2010, in Birmingham and the second on March 22, 2010, in Evergreen. Primary care physicians in hospitals, Public Health, and FQHCs were represented as were public sector psychiatrists. Dr. Moon and Dr. Powers attended and presented at both sessions. At each meeting, the results of the survey were shared along with the findings from the regional roundtable meetings supported by the first Transformation Transfer Initiative grant in 2008. The common messages from all of these sources was the need for more effective communication and working relationships between primary and mental health providers with integration being a well-received concept, the potential benefits of telemedicine, the need for more primary care physicians and psychiatrists, and the need for more on-going continuing education between psychiatrists and primary care physicians.
- Planning for funding six local planning grants began in December, 2009. The purpose of the grants was to support in-depth local planning that would result in a plan for improved collaboration and would also position the local coalition to apply for the next round of Substance Abuse and Mental Health Services Primary and Behavioral Healthcare Integration grants. A draft Request for Proposals (RFP) that was circulated to national experts contributed significantly to the knowledge base for the individuals participating and their respective agencies. Through the expert panels, individual practitioners both gained knowledge and developed an appreciation for the challenges facing their counterparts in primary and mental health care and shared their knowledge to inform the planning process for integrated services. The Child and Adolescent Psychiatric Institute provided a forum for pediatricians and psychiatrists to learn about best practices and to inform state agencies about their respective concerns when attempting to access each other's services. One of the predominant themes from the six local planning grant reports was an improved mutual understanding of the regulatory and fiscal parameters within which CMHCs and FQHCs operate.

- State-level Interagency relationships were expanded and strengthened beyond the scope of the specific activities supported by the grant. The Department of Mental Health (DMH) and the Medicaid Agency have a long-standing strong working relationship. The direct involvement of key Medicaid staff in the activities supported by the grant is a reflection of their commitment to improving collaboration between primary and mental health care. Dr. Moon from Medicaid was directly involved in planning and implementing the grant.
- Through Dr. Moon's leadership, Medicaid established regular monthly meetings with DMH to address parity and implementation of the Affordable Care Act. These meetings also involve representatives from the Substance Abuse Services Division, the Department of Public Health, the Department of Human Resources, and the Department of Youth Services. Medicaid also issued an RFP for three medical home pilot projects based on the work done in North Carolina. As a result of the Department's ongoing dialogue with Dr. Moon and other key staff, Medicaid required that the local mental health center be on the Board of Directors for the medical home pilot projects. Medicaid will take the lead on submitting an application for Health Homes for Enrollees with Chronic Conditions. Discussion is underway regarding a possible application for Medicaid Emergency Psychiatric Demonstration grant. Medicaid is seeking clarification on some of the regulatory language before committing to an application. The regular meetings with Medicaid have also provided a forum to discuss the Department's plans for a 1915(i) state plan amendment.
- One of the issues identified by the expert panels and the local grantees is how to support interagency collaboration through billing practices. The Department and Medicaid developed a joint policy statement clarifying billing through FQHCs for mental health services and promoting the concept of Interagency collaboration between FQHCs and CMHCs to effectively use the Medicaid Rehab Option.
- The Alabama Primary Health Care Association (APHCA) has been an active partner in grant implementation and in promoting improved collaboration between FQHCs and CMHCs. The APHCA annual conference included a track on integration of mental health and primary care. The local planning grants supported and enhanced collaborative efforts between CMHCs and FQHCs.
- The following quotations from mental health center executive directors reflect the influence of this grant:
 

*"I just returned from an excellent meeting with the CEO of the local FQHC and we have finally started a good dialogue about how we may be able to work together in the future. There apparently were some issues between our organizations 30 years ago that led him to keep his distance but I think we are on track to mending those fences ... which will ultimately enhance the lives of those we mutually serve. Thanks for keeping the issue of integrated care before us!"*

*" .. just wanted to say thank you for getting the issues of FQHC's and CMHC's on our radar screen. I appreciate you bringing it to the council and encouraging us to go to the Primary Health Care conference. I know I still have a lot to learn. But, I was able to shoot off an email even while we were in Mobile to the folks in our area who might be involved in applying for an FQ. Turns out the timing was perfect because they are applying and will now include us in the loop. I had a great and reassuring conversation with East Alabama Medical Center yesterday who assured me they want us involved and have no intention of creating a duplicate "mini-mental health center" inside the FQ without us. I would have never even known to ask if you hadn't kept it in front of us."*
- In summary, the modest amount of funding provided through this TTI grant supported concrete steps to enhance interagency collaboration to the goal of better integrating primary and mental health care. Improved knowledge contributed to improved interagency relationships which extended well beyond the specific agencies and individuals involved in grant Implementation.

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# Alaska



## FY2010 TTI PROJECT:

*The Alaska Psychiatric Institute's (API) Telebehavioral Health Open Access Clinic commenced January 2010 with the goal of providing immediate access to psychiatric, psychological, and behavioral health services for Alaskans living in rural and remote-rural locations throughout the state.*

## KEY OUTCOMES:

- As a result of our growth under SAMHSA's TTI grant, API's Telebehavioral Health program currently provides services to approximately 22 locations across Alaska. Of these, two are urban, five are rural, and 15 are remote-rural (off the road system and accessible only by airplane or boat). Based solely on our present contracted sites, the total population of Alaskans who have direct access to our psychiatric and psychological services is approximately 28,000. In addition, the Open Access Clinic is capable of providing these services statewide, filling a much needed gap in service access in Alaska because video-conferencing capability exists in most areas of the state. The growth of the program over the past year is indicative of the service needs of rural and remote-rural Alaska and suggests that the program is an overwhelming success. The program proved so viable that continued growth is expected over the next year and beyond.
- The goal of the Open Access Clinic was to provide same-day access to psychiatric and behavioral health assessment and treatment to rural and remote-rural Alaskans. This goal has been met; immediate state-wide access to psychiatric and psychological services has been available and widely accessed during the past year. The Open Access clinic consisted of two differing service models. The first model involved immediate access to services for sites that were already served by API's telebehavioral health program. The result was more rapid access to recurrent appointments and a dramatically increased ability to provide program services for emergent cases. The second model involved same day access to program services for sites that did not have an existing relationship with API's telebehavioral health program, via the use of a one-page fee-for-service agreement. As a result of this second model, providers and their patients (typically from small clinics) were able to immediately access psychiatric and behavioral health services on an as-needed, one-time basis. Providers indicated that they were quite pleased with the option of as-needed access. SAMHSA's TTI grant allowed us to develop and maintain a full time equivalent psychiatric provider as the program grew.
- During this start-up period we performed 494 psychiatric encounters that included 165 individual patients. Of 165 patients, 77 were males and 88 females.

- We provided highly skilled adult and child psychiatry that encompassed evidenced based and best practices. Services including psychiatric evaluations and treatment. We were able to provide child psychiatry through a VTC link to Children’s Hospital in Seattle, with a University of Washington faculty child psychiatrist; adult psychiatry with in-house psychiatrists including an addictions specialist and an advanced nurse practitioner. In referring to the telebehavioral health program a mental health clinician from a remote village stated, “This is by far away the very best service that we have been able to provide for our clients.” Another provider stated “The quick time frame to connect with you guys is wonderful”.
- We learned that the ability of the psychiatric provider to be tolerant, patient, and flexible was the most critical factor in the success of our program. For example, rural Alaska has a shortage of medical and behavioral health providers and often the existing behavioral health clinicians are inexperienced. Couple this with clients presenting with some of the most severe behavioral health and substance abuse problems in the country. For example, the clients we served described a history of multiple psychological traumas and reported multiple village suicides that included relatives and friends. Village cluster suicides are a tragic reality in rural Alaska. In light of these factors, it became clear to us that it was unreasonable to expect rural providers to fax a completed mental health assessment, the patient’s relevant medical records or a listing of the patient’s prescriptions prior to the appointment given the lack of personnel and the time they devote to day-to-day crises. We learned that our providers must understand that the patient may be late or connectivity problems could delay the appointment. Significant cultural differences exist that must be acknowledged and respected. For example, village culture is not fast paced, timely, or pressured thus our providers could not expect patients to always be on time for appointments.
- We were attentive to metabolic problems, especially for patients taking medications that cause weight gain and metabolic syndrome. Our psychiatrists ordered tests and referred patients to their medical providers to monitor the problems. We encouraged partner sites to purchase a scale and a blood pressure cuff so we could monitor BMI.
- We provided licensure supervision, consultation, and a safe avenue for remote providers to share their challenges and secondary trauma experiences. According to one mental health clinician “You guys have been my anchor”.
- Over the past year, API has increasingly utilized the Open Access infrastructure to conduct a number of live discharge planning sessions throughout Alaska. These sessions allowed hospitalized patients and their API providers to connect with family members and service providers from the patient’s home community or new setting (e.g., residential treatment facility or long-term assisted living facility) for continuity of care, service linkage, and daily living arrangements. All parties involved routinely cite live discharge planning as a successful and valued tool in transitioning hospitalized individuals back into their home communities or to new care settings. For example, partner-site patients participated in live discharge planning and attended their follow-up appointment back at home.

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# Arizona



## **FY2010 TTI PROJECT:**

*Implemented a peer-based whole health program in the two largest metropolitan areas in Arizona, Maricopa and Pima Counties, to transform the behavioral health system into one that applies a holistic approach to health to increase longevity and quality of life, increase coordination of care between primary care and behavioral health, and increase participation in recovery through medical autonomy.*

## **KEY OUTCOMES:**

### **Pima County: Health and Wellness Center - Camp Wellness**

The goal of Camp Wellness is to improve the health of persons with Serious Mental Illnesses (SMI) through 8 weeks of intensive health related education, skills training and peer support. Camp Wellness was founded through various partnerships, such as with the University of Arizona and several health & fitness centers. Camp Wellness is a place where individuals with an SMI can have a health assessment; develop health goals; increase health literacy; learn about diet and exercise; work with a mentor to learn how to shop and eat healthy; participate in relaxation classes and smoking cessation groups/classes; and learn proper use of fitness equipment and develop an exercise regimen.

### **Maricopa County: "For the Health of it" program**

In Maricopa County, a peer-based whole health program was developed with the goal to improve whole health in the behavioral health consumer. Once trained, peer and family support staff provide an array of interventions and supports within each of the outpatient clinics, including but not limited to diet education and fitness activities; empowering individuals when communicating with their Primary Care Physicians; stress reduction groups and activities; sleep hygiene groups; and diabetes and oral health education. This program was designed to put the participant in the lead role of their individual Whole Health Plan.

### **Outcomes and Achievements:**

#### **Pima County: Health and Wellness Center - Camp Wellness**

TTI funds were used to open Camp Wellness and successfully complete camps – including evaluation practices. Significant improvements were observed in the quality of life and health outcomes, including in the six minute walk test, the waist circumference and weight loss measurements. Analysis of the program's impact beyond the initial eight week intervention and the participant's maintenance of learned healthy practices will be conducted in the fall of 2011.

An important component of this program is to ensure that students apply what they learn and maintain their lifestyle changes. This has been accomplished through the work by the grant-funded Health Mentor, who works primarily with Camp alumni to ensure they maintain healthy lifestyles beyond their participation in the 8-week program. The Health Mentor continues to meet alumni at all local branches of the YMCA, and works with alumni who have had their Y passes revoked (due to lack of use) by offering them the chance to develop an individualized plan of supported physical activity to earn their pass back.

Another achievement is a stable pipeline of students. This has been achieved primarily through a TTI grant funded position which conducts marketing and promotional activities for Camp Wellness including presentations at service

providers' staff meetings, recruitment tables at providers' lobbies and distribution of posters and educational materials at providers' facilities. Having a position devoted to marketing dramatically increased referrals and resulted in increased enrollment and participation.

A video and website were developed to promote Camp Wellness and offer educational and informational resources to Camp students. Both video and website are vital components of recruitment presentations to service providers' staff and members. Camp marketing materials include the website address so members and providers can quickly download applications, learn more about the program and staff, etc.

#### **Maricopa County: "For the Health of it" program**

TTI funds were used to develop infrastructure for this program including training of Peer and Family Health Mentors, development of training materials for future mentors, design of supporting materials for program participants, and establishing evaluation and data collection.

Seventy-five peers were trained in whole health peer support by Larry Fricks and Ike Powell from Appalachian Consulting Group. This training has paid many dividends in terms of improved health outcomes. Based on Peer Support Whole Health developed by the Appalachian Consulting Group and the Georgia Mental Health Consumer Network, the Peer Support Whole Health Journal – "For the Health of It!" was designed and printed for use at all participating clinics. This is a 42 page journal for members to track their progress as they participate. It currently helps participants to: take ownership of their individual Whole Health Plan; develop and maintain efforts in reaching their goal(s); and document measurable results of the program.

The existing "Passport to Care" was redesigned and printed for use in this program and is being used at all participating clinics. This is a tool that looks like an actual passport and fits in your back pocket, is a ten-page "how to guide" for members, their families, and peers to start a dialogue with his or her medical doctor. It also contains information to access medical insurance and information about medications.

Data reporting and analysis tools were designed to ensure accurate and consistent measurement of outcomes among all participating clinics. At the clinic level, data collection takes place once a week during Whole Health group sessions. The collection method encompasses six measurable outcomes: Weight; Body Mass Index; Blood Pressure; Smoking Cessation; Increased Walking Distance; and Improved Sleep. The completed data sheets are submitted to the TTI Data Analyst on a monthly basis and entered into the Whole Health Database for tracking and reporting.

The most rewarding achievement is the positive impact in our members. From April 2010 to March 2011, there were a total of 659 encounters at 13 clinics with a total of 131 participants. Approximately 25 of these individuals reduced their high blood pressure to within normal range while participating in the program.

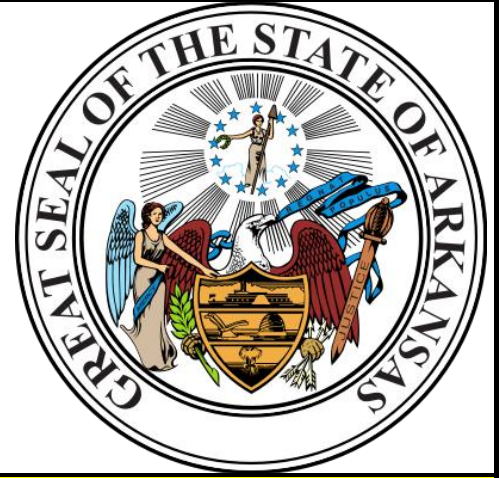
#### **Remarks:**

Learning from the past year has enabled Arizona to make improvements and explore ways to develop practices for integrated care in Arizona. A blueprint for implementing the Maricopa Whole Health Initiative has been in discussion and 14 essential elements identified for this integration model. Camp Wellness is gaining recognition outside Arizona as a model for integrated care. All of the TTI grant-funded positions mentioned above have been essential in improving recruitment, retention, community integration for students and alumni of Camp Wellness and establishing evaluation practices at both programs. Going forward, these positions will be retained and funded by the contractors and partners. Arizona also has the infrastructure in place for billing and encountering health promotion, peer support, skills training and transportation services so that they are reimbursable through Medicaid. The programs continue to create new partnerships, including one with the Arizona Smokers' Helpline (ASHLine). In addition, with oral health being a key component of each project, the State of Arizona has signed a MOU with the Arizona School of Dentistry to place whole health peer specialists at the school and its clinic to assist and educate Dental Students.

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# Arkansas



## **FY2010 TTI PROJECT:**

*Consumer empowerment through the creation/strengthening of a statewide consumer network.*

## **KEY OUTCOMES:**

The flexibility of this grant to tailor it to the specific needs of the State has made this an extremely effective grant. With the funds provided, Arkansas has made significant progress toward transforming its mental health system. The work initiated through the grant will continue even after the grant ends through state and private funding – such as through combining several funding streams to bring a second round of leadership training and train-the-trainer programs to the State. A second consumer conference is now in the planning stages, and private fund raising activities are underway. The tracking of local consumer councils through the Division of Behavioral Health Services contracts and annual reporting requirement will assure continued efforts and attention. Possible changes in Medicaid to fund peer supports will provide even more momentum for system changes toward recovery.

## **Outcomes Accomplished:**

### **1. An active consumer council in each of the State's fourteen Community Mental Health Centers and three Specialty Clinics**

Consumer councils now currently exist, or are in the formation stage, in all of the CMHCs and Specialty Clinics. Consumer council representatives are in contact with Division of Behavioral Health staff and Mental Health Council staff regarding the continual evolution of these councils. DBHS has modified CMHC and specialty clinic contracts to require them to report annually on their consumer councils including average attendance, meeting schedule, method of selection of consumer council leaders, communication pathways to and from the Center's Board of Directors, and policy changes based on consumer input.

### **2. First statewide Consumer Conference**

A statewide consumer conference was held November 9<sup>th</sup> – 10<sup>th</sup> in the capital city of Little Rock. Approximately 200 people attended. All CMHCs and two of the three specialty clinics were in attendance. Melinda Davis spoke on the formation of the Advocacy Initiative Network of Maine. Dr. Dan Fisher spoke of his recovery journey and its impact on his current professional and personal life. David Granirer provided a lively comedy show "Stand Up For Mental Health". Local speakers presented on the history of

the consumer movement in Arkansas, legislative advocacy, voice and choice, growing and nourishing your network, psychiatric advanced directives, trauma-informed care, and collaborative planning. Time was allotted for regional contacts and planning for next steps.

**3. At least one regional meeting in the five regions of the State to include representatives from behavioral and physical health, rehabilitation, higher education, local policymakers, and other entities as appropriate**

Six regional meetings were held; five regions were initially planned but transportation issues for one larger CMHC necessitated a sixth meeting. Each regional meeting had a different mix of community partners, including social security, community colleges, physical health agencies, rehabilitation agencies, department of human services, advocacy staff, department of corrections, area agency on aging, prosecuting attorney's office staff – victim witness program, and housing authority. Consumers were able to meet and talk with other consumers and community partners. Next steps discussed included future regional meetings.

**4. A strong foundation of recovery principles and commitment by consumers and providers leading to concrete steps toward a recovery-based behavioral health system**

Recovery concepts were discussed at each venue. Consumers, providers and community partners are much more knowledgeable about recovery. This process must continue so that all consumers and providers are not only aware of, but are providing and participating in recovery-focused activities and treatment. DHS has established a "Recovery Oriented System of Care" Committee made up of numerous divisions including Behavioral Health, Medicaid, Developmental Disabilities, Aging and Adult Services. This committee is expanding on some of the lessons learned through the consumer movement.

**5. A strong state-wide consumer voice**

The consumer voice in Arkansas has gained significant strength over the past year. The TTI grant has provided the foundation for significant "grass roots" advocacy by behavioral health consumers. The Mental Health Council of Arkansas coordinated a "Hill Day" for behavioral health to highlight relevant issues during the recent legislative session. 191 consumers participated, including at a House committee meeting and were recognized by the Chair as special guests. This grass roots participation in the legislative process served to empower the consumers and helped them to realize the true voice they have in the process.

**6. Evaluation surveys from each regional meeting to determine service gaps or areas for growth and coordination**

Evaluation surveys were obtained from participants in all of the regional meetings. Information obtained from these surveys, and other consumer groups, has served as a guide for current recommendations on the development of a 1915(i) state plan amendment to offer services noted as lacking such as supported employment and peer support services.

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# Colorado



## **FY2009 TTI PROJECT:**

*Assistance to the Governor's Behavioral Health Cabinet in facilitating the integration of Colorado's public behavioral health system. This project will establish a planning and implementation process for this transformation that includes the Behavioral Health Cabinet (Corrections, Medicaid, Human Services, Employment, Local Affairs, Public Health, and Public Safety), and a Behavioral Health Transformation Council comprised of departmental staff,, consumers and stakeholders.*

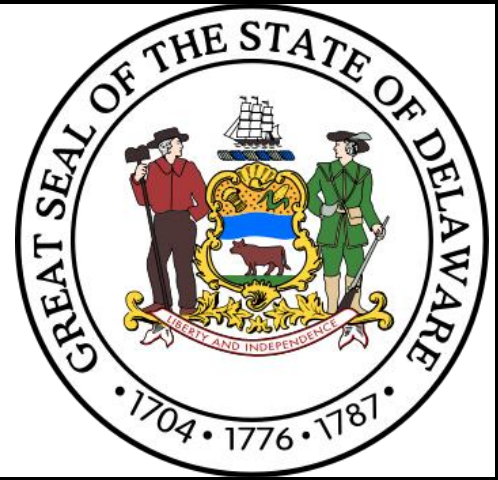
## **KEY OUTCOMES:**

- Over 75 regional forums conducted in cities across the state and via videoconferencing, to solicit input to the planning and implementation process, were attended by more than 550 Coloradans. The following groups were involved in the planning and participation of these forums: (1) Consumers, (2) Parent/Caregivers, (3) Adult Family Members, (4) Youth, (5) BH Providers, (6) Law Enforcement / Adult Corrections, (7) Juvenile Justice / Child Welfare / Schools, (8) Primary Care / Public Health, (9) Community / Business / Advocacy Leaders.
- A statewide Behavioral Health Transformation Council was developed to inform and advise the Governor's Behavioral Health Cabinet. Membership includes over twenty-five entities representing Consumers and Families, Providers, Advocacy, State Agencies, and non-behavioral health stakeholders. This group is developing specific implementation plans in four key areas: under 21/prevention; criminal justice; continuity of care; and sustainability.
- Legislation is being drafted for the next legislative session to codify the TTI work and outcomes. In addition, an Executive Order from the Governor as well as a Chief Justice Directive from the Judicial Branch are being considered to model collective leadership concerning behavioral health issues among the three branches of government.
- Input from the Governor's Behavioral Health Cabinet, which meets bimonthly, has contributed towards the protection of the Division of Behavioral Health's budget (Mental Health and Substance Abuse) despite overall cuts to state agencies totaling \$1.4 billion.
- Work continues on developing a plan to secure funding, staff, and other supports necessary to sustain the planning and implementation process established by the Behavioral Health Cabinet.

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# Delaware



## FY2011 TTI PROJECT:

### *Paving New Ground: Creating a Recovery-Oriented System*

#### KEY OUTCOMES:

1. Provide support and direction to the “budding” Delaware state consumer network
  - Hired network executive director in March, 2012.
  - The group has developed goals and objectives in the framework of a strategic plan.
  - The state-wide consumer group is now incorporated. It is working on becoming a 501 (c) 3 non-profit organization. The Director of the Office of Consumer Affairs continues to attend each monthly meeting. A sub-committee met with Steve Dettwyler, Director of Community Services, and communicated their proposal for funding priorities, many of which are part of Delaware’s agreement with United States Department of Justice (USDOJ).
  - The peers Delaware hired under the trauma grant started to attend the meetings.
  - One member presented a letter to the governor about the list of consumers compiled by law enforcement to identify consumers who have been involuntarily civilly committed. As a result the commitment law is being rewritten to a 24 hour standard.
2. Build on the initial integration of the employed Peer Specialists at the state hospital to provide hospital onsite services as well as Bridge Peer services that follow individuals upon their discharge from the hospital to assist them in their re-entry, as well as to identify gaps in services.
  - These initial Peer Specialists have been hired and funded with existing, sustainable funds. With the complement of the TTI funds, the Peer Specialists will be able to further leverage their efforts.
  - Continued work on a community re-integration services program, which works with hospitals on re-integration into the community.
  - ACT teams revised so that they are truer to the ACT model. Delaware hopes to have 8 teams following the revision. Teams are also adding performance measures to ensure faithfulness.
  - Peer specialist training held June, 2012. 20 consumers, to be hired as peer specialists and who are volunteering at our consumer run peer center, attended. These individuals will become either peer support specialists in the hospital, bridge peer specialists in the hospital and community, and trauma peer specialists in the community. Stipends created to sustain them until Delaware’s H/R system can get them hired.
  - New inpatient peer specialists will be hired over time, and more bridge peer specialists will be hired immediately. Because of the demand for bridge peer specialists we know we need more soon. They work with

*The TTI award was instrumental for both improving the state system and for showing the recovery orientation demanded by the DOJ investigation.*



individuals in our system as they transition from one level of care to another. Most of the demand is for hospital patients that are being discharged to the community, supported by the Olmstead decision. The agreement with the USDOJ will result in many more peer specialists in our system. Delaware is working on a data system to help track and evaluate this program. The Bridge Peer Program currently has 7 bridge peers and 1 team leader. They are getting more and more referrals and consequently are going to increase the size of the staff. The U.S.D.O.J. is staying informed about workload and staffing to insure that Delaware will be able to discharge hospital clients and give each discharged person a peer specialist to help them integrate into the community.

3. Supported statewide conference, named: "Living out Loud: the Magic of Transformation". The conference was held on 9/9/11. Close to 350 consumers attended.

4. Developed and implemented performance measures for all DSAMH community contracts that clearly delineate the expectation for all providers, state or private, to employ consumers in key roles. This included meeting with the director of our quality performance and contract monitoring office to discuss how Delaware can make sure that peer specialists are treated as professionals. Have now hired 8 trauma peer specialists to work in clinics. They are state employees and will do work relevant to the related trauma grant. There are plans to hire 8 more who will work in case management agencies. Several other agencies have hired peer specialists on their own.

5. Delineated and implemented the expectation of Peer inclusion through the DSAMH licensing and certification Department. This includes embedding and distributing licensing and certification standards in all DSAMH programs, and monitoring that agencies follow these standards. One such example is meeting with all clinics so that they understand and implement standards regarding peer specialists, job responsibilities, and the need for clinical supervision.

6. Trained DSAMH staff on the importance of integrating Peers in all services DSAMH provides and eventually incorporate these understandings/expectations into their respective job descriptions. This goal was accomplished by specific trainings by Peers and senior DSAMH leaders conjointly and included the development of curriculum training and fully revised policies, procedures, and forms where necessary. Training was done in two half-day segments.

7. Created a Peer Run Art Resource Center Program called the *Creative Vision Factory*. The Art Program has been a long-term goal of the Division. TTI funds helped pay for a director for the Art Program and create an advisory board. Delaware will support the continue to contract with the director once this grant award ends.

## **SUMMARY**

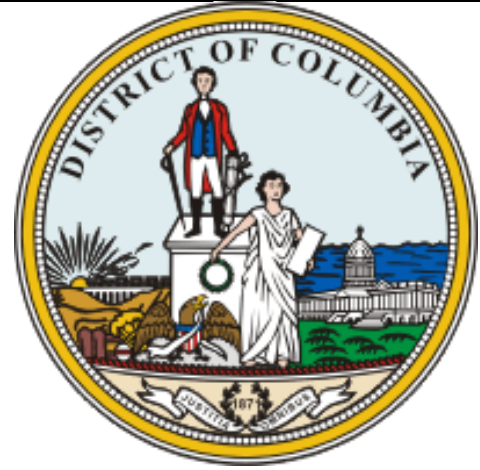
Delaware now has more than fifteen peer specialists working in three unique programs: the inpatient peer support specialists, the bridge peer program and trauma peer specialists. Delaware also has plans to hire up to eighteen more peer specialists. Delaware has combined funding from TTI and Trauma grants to meet the training needs and stipends to support the peer programs. Eventually through a combination of hiring state and private peer specialists, Delaware will have peer specialists in all of community and inpatient programs/agencies.

Statewide Delaware now has an Art Center, as well as several consumer resource centers run by consumers and funded by either the state or local outpatient agency. Delaware has a state-wide consumer network meeting monthly; our vision for that group is that it will become independent, involved in advocacy and running some programs such as the consumer satisfaction survey.

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# District of Columbia



## **FY 2010 TTI PROJECT:**

*Improve access to primary health care for individuals with chronic mental illness by expanding an existing project to co-locate primary health care practitioners with community mental health providers and also by incorporating peer specialists as "health navigators" to help consumers to take advantage of primary health care services.*

## **KEY OUTCOMES:**

### **Activities:**

- DMH originally planned to contract directly with two mental health clinics to expand the scope of the Chronic Care in Mental Health (CCI MH) project that was funded through a grant from the District's Department of Health (DOH). The DOH CCI MH project is managed by George Washington University School of Public Health (GWU) in collaboration with the Washington Hospital Center Diabetes Education Program (WHC). The focus of the CCI MH project is to develop models for how to best provide primary care to persons with diabetes and severe mental illness. WHC provides the nurse practitioners and the diabetes education, while GWU focuses on the project coordination and research aspects of the project.
- Although several mental health providers expressed interest in participating, only one submitted a proposal in response to the RFP and subsequently withdrew the proposal when they were unable to establish partnerships with a healthcare network to provide the physical health services. As a result, DMH worked with DOH to use the funds to expand the CCI MH program, with some funds going to GWU via a modification of the existing DOH grant agreement and the remainder going directly to WHC via sub-grant from DMH. The project expanded to include the mental health programs operated by Anchor Mental Health and the Trinity Square clinic which is affiliated with WHC.
- DMH also worked with GWU and WHC to develop and present a grand rounds style of training for psychiatrists and nursing personnel at each clinic site (four sites) and Saint Elizabeth's Hospital. Training was conducted on November 30, 2010 and December 1, 2010. Andrew Kolbasovsky, PsyD, MBA, who has implemented integrated care models in New York and published on the subject of integrating behavioral health and primary care, was the speaker. CEUs were offered for psychiatrists, nurses, social workers, licensed professional counselors and psychologists for the grand rounds presentation at Saint Elizabeth's Hospital. The training was well attended by program staff and also hospital staff. Suggestions for future training and activities that resulted from this training are described below.

**Lessons Learned:**

- Many mental health consumers in the District are "linked" to primary care services, although the collaboration between the mental health clinic and the primary care clinic is not consistent.
- One model does not work for every community-based provider in the District. The level of readiness among the District providers has varied widely. For example, one of the original sites (from the DOH Chronic Care Initiative grant) dropped out of the project in September because they felt the burdens of participating and referring consumers for the nurse practitioner to see were too great. However, the other original site has asked to expand the number of peer specialists working on the initiative (from two to three).
- Medicare reimburses for diabetes education, however, the District's Medicaid program does not. DMH will be working with the Department of Health Care Finance (DHCF) to try to address this issue.
- The District's Medicaid program does not reimburse nurse practitioners to draw blood for purposes of CLIA waived testing at off-site locations, such as mental health clinics. Instead, phlebotomists are used (which is actually more costly). DMH will be working with DHCF to try to address this issue.
- Training about physical health - diabetes education is needed for front-line staff.
- Peer specialists have been a great addition to the team and have been particularly helpful in coordinating and linking consumers to the diabetes education and wellness training conducted at the clinics.

**Future Plans:**

- Continue the project through the end of FY 2011 and evaluate progress in obtaining Medicaid reimbursement for diabetes education and blood draws by nurse practitioners.
- Complete implementation of peer specialist program by DMH which will facilitate Medicaid billing by peers participating in the CCI MH project.
- Offer Health Administration Responsibility Project (HARP) training for peer specialists.
- Offer additional training to frontline staff regarding management of physical health conditions and diabetes education.

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# Florida



## **FY2008 TTI PROJECT:**

*Development of Recovery and Resiliency Task Forces in Florida's six regions.*

### **KEY OUTCOMES:**

- Development of a recovery and resiliency task force in all six regions.
- Twelve two-day recovery and resiliency trainings (two in each region) with over 500 consumers attending.
- A recovery and resiliency task force meeting in each region.
- A statewide advanced leadership training for 34 consumer leaders across Florida.
- Two Certified Peer Specialist Trainings producing fifty new Peer Support Specialists.
- A statewide Certified Peer Specialist Train-the-Trainer three-day training for fourteen participants, including one person from each region.
- A statewide peer support sustainability conference is being planned.

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# Florida



## **FY2010 TTI PROJECT:**

*2059 participants attended six regional seminars on Trauma-Informed Care (TIC) throughout Florida.*

## **KEY OUTCOMES:**

Six regional seminars were held in Tallahassee, Jacksonville, Tampa, Orlando, Miami, and Boca Raton (one seminar in each of the Department's six administrative regions). Seminar participants included a broad range of stakeholders in Florida's mental health system, including mental health consumers, family members, advocates, executive and clinical staff of mental health provider agencies, other mental health professionals, staff of other social service and advocacy organizations, Department staff, and staff of other state agencies. A total of 2059 participants attended the six seminars.

The first day of each day-and-a half seminar featured presentations provided mostly by staff of the National Center for Trauma-Informed Care (NCTIC): Tonier Cain, Dr. Joan Gillece, David Washington, and Dr. Tim Tunner. Additional presentations were provided by Dr. Shairi Turner, Deputy Secretary of the Florida Department of Health (DOH). These presentations covered the profound psychological and biological impact of traumatic experience and concrete strategies for implementing trauma-informed care. The seminar agenda was developed by the Department in consultation with NCTIC staff.

The second day of each seminar (a half-day), served as the initial meeting of local trauma informed care strategic planning workgroups. These groups include diverse mental health stakeholders and have begun meeting regularly since the seminars. These workgroups have been tasked with authoring strategic plans to implement trauma-informed care for their respective local areas. These plans will be reviewed by the circuit, regional, and central offices of the Department as a basis for potential policy changes and new, trauma-related initiatives.

The Department contracted with the Florida Peer Network (FPN) for outreach, participant registration, event planning, travel reimbursement processing, and related services. Headed by a mental health consumer and advocate, Executive Director Rose Delaney, FPN is the only statewide mental health advocacy organization in Florida that is controlled by mental health consumers. (FPN's bylaws require its board to include at least 51 % mental health consumers.) Placing a consumer-controlled entity in this key role emphasized the importance of consumer empowerment in trauma-informed care, and lent credibility to the outreach effort toward consumers, family members, and advocates.

A total of 2,059 participants attended the six regional seminars. Mental health and substance abuse providers were 27.4% (565) of the participants. This category includes executive and clinical staff of provider organizations, as well as clinicians in private practice.

Department of Children and Families staff were 11.2% (231) of the participants. This includes central office, regional, and circuit staff, as well as staff of state mental health treatment facilities. Department of Juvenile Justice staff were 26.8% (551) of the participants. Other government agency personnel were 2.4% (49) of the participants. State agencies represented included the Department of Health, the Department of Elder Affairs (DOEA), and the Agency for Health Care Administration).

Staff of Community Based Care providers (CBCs), which provide child protective services under contract with the Department, were 11.6% (238) of the participants. Judicial and criminal justice system personnel were 2.6% (54) of the participants. This includes judges, magistrates, law enforcement officers, and the staff of courts and of the offices of state attorneys and public defenders. Department of Education and school personnel were 0.9% (19) of the participants.

Staff of other private social service and advocacy organizations were 12% (247) of the participants. This includes mental health advocacy groups, children's advocacy groups, domestic violence shelters, assisted living facilities, and many other types of organizations.

New local strategic planning workgroups were launched at the seminars, collectively covering the entirety of the state. Each workgroup is responsible for creating a strategic plan for its own local area. Having benefited from the assistance of department and consumer facilitators at their initial meetings, these workgroups have now selected their own leaders and have begun meeting regularly (monthly, in most cases). Though twenty-two workgroups were originally planned, several groups consolidated with others in their area, yielding a final count of seventeen.

These workgroups include a diverse array of stakeholders in the mental health system, including consumers, advocates, professionals, and the executive staff of provider agencies. Each workgroup is intended to be highly autonomous and responsive to the needs of the local community. The workgroups have been encouraged, where appropriate, to merge with other, related workgroups, task forces, or similar groups. Workgroups are keeping minutes of their meetings and sharing these with the Department. All strategic plans were completed by March 1, 2011.

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# Georgia



## **FY2009 TTI PROJECT:**

*Integrating whole health concepts into Georgia's Peer workforce with the development of peer support whole health services.*

## **KEY OUTCOMES:**

- Conducted Peer Support Whole Health Pilot Project Training (PSHW), in conjunction with Appalachian Consulting Group, on January 28 and 29, 2009 in Macon, Georgia. There were 33 training participants, including 18 Consumer Participants from the two Pilot Sites, 12 Certified Peer Specialists, and 3 APS Healthcare Employees.
- Eight Week Peer Specialist Whole Health (PSWH) training and programming occurred at two Peer Center Pilot Sites. The Training included consumer participants setting whole health goals, inclusion of these goals in their Individual Service/Recovery Plans and beginning work toward attainment of whole health goals.
- Worked with Wendy Tiegreen, DMHDDAD Medicaid Coordinator and key staff of APS Healthcare (DMHDDAD's external review organization), to conduct an audit of the progress notes charted on participants in the 8 week PSWH pilot study, as well as the detailed audit report, which is to discuss characteristics of notes that do or do not pass Medicaid criteria. This is a huge first step in Whole Health Peer Support being Medicaid billable in Georgia.
- Some of the critical points recognized within the audit findings include:
  - Whole health must be integrated into the entire behavioral health system.
  - Assessment forms must include information related to whole health.
  - Clinicians must be trained to integrate whole health goals into treatment service planning.
  - The pursuit of whole health and wellness should be incorporated into Behavioral Health care in a manner similar to employment, housing and meaningful community life.
- Five Regional (PSWH) Mental Health Provider meetings (with over 150 provider attending):
  - Region 1 – July 7, 2009 – Rome, GA
  - Region 2 – July 8, 2009 – Athens, GA
  - Region 3 – July 14, 2009- Atlanta, GA – The Carter Center
  - Region 4 – July 21, 2009 – Cordele, GA

Region 5 – July 23, 2009 – Savannah, GA

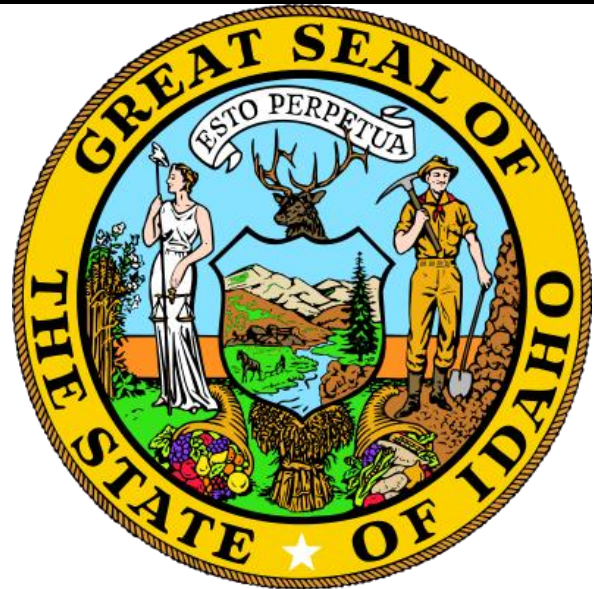
- Over 10% of Georgia's CPSs (63) participated in a total of three two-day PSWH training of trainers.
  - Conducted PSWH CPS Training at Callaway Gardens on May 27 and 28, 2009. Twenty CPSs and two older adults from the Fuqua Center on Late Life Depression completed the two-day training.
  - Conducted a TTI PSWH CPS Trainers Training at Simpsonwood on June 18 and 19; 19 CPSs and three older adults from the Fuqua Center on Late Life Depression completed the two-day training.
  - Conducted the TTI PSWH CPS Trainers Training at Epworth by the Sea on August 13 and 14, 2009; 19 CPSs and 2 older adults from the Fuqua Center on Late Life Depression completed the two- day training.
  
- Held the 18<sup>th</sup> Annual Georgia Mental Health Consumer Network Conference on August 18, 19 and 20, 2009 at Epworth by the Sea on St. Simon's Island, GA. Five hundred twenty-one consumers of mental health services attended, including the participants of the PSWH Pilot Project, who were provided scholarships. Included tasks were the preparation and distribution of Wellness Packs to all conference participants. For the first time in 16 years conference attendees voted affordable healthcare as one of the top five things needed for recovery from mental illness. Peer Support Whole Health services are a timely, person-centered and cost-effective component of affordable whole healthcare.
  
- Working closely with the TTI Whole Health Peer Support Projects in New Jersey and Michigan.
  
- Larry Fricks published an article in the National Council Newsletter highlighting Georgia's TTI Project.

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# Idaho



## 2011 TTI PROJECT:

*Creation of a data warehouse to collect and process data from multiple state systems*

## KEY OUTCOMES:

### INTRODUCTION:

Idaho's Transformation Transfer Initiative (TTI) project was centered around the development of a data warehouse built on a universal platform that allows multiple data system feeds. The vision is that at the end of the TTI project all State Behavioral Health Authority health records will be included in a single data-mart. This will allow for reporting across systems within the Division of Behavioral Health for the first time ever. Additionally, it will provide a springboard for providers, both public and private, to participate in the warehouse and the system-wide reporting structure.

### BACKGROUND:

Idaho had already laid some of the groundwork before the TTI funding. A little more than a year ago, there was no reliable data system for the state-run community mental health clinics. Apart from a legacy billing system, data was collected manually on individual spreadsheets maintained in each of the state's seven administrative regions. On the inpatient side, the two state-run psychiatric hospitals operated stand-alone legacy systems that were no longer supported by the vendor.

*Absent this project, Idaho would remain an ad-hoc data state, with no dashboards or other statewide data assessments.*

With appropriations from the state legislature, DBH had begun working to standardize and make improvements to its data. Beginning in 2007, Idaho's two state psychiatric hospitals began the implementation of the Veterans Health Information Systems and Technology Architecture (VistA) Application. Both hospitals are now using modules of VistA and the implementation is nearing completion.

The Division modified the Web Infrastructure for Treatment Services (WITS) system for use in an adult outpatient mental health setting, and the state-run Regional Mental Health Centers began using WITS in October 2009 as both an electronic health records and clinical practice management system. The Division will also convert its children's mental health program to the WITS system from an existing legacy system over the next few months.

On the Substance Use Disorders (SUDS) side, the Division partnered with the Office of Drug Policy to connect WITS to a web-based version of the uniform assessment (the Global Appraisal of Individual Needs or GAIN-I) for use by all of the state's contracted network of substance abuse treatment providers. SUDS network providers use WITS to enter client encounter data and the network manager provides payment data from the network manager's

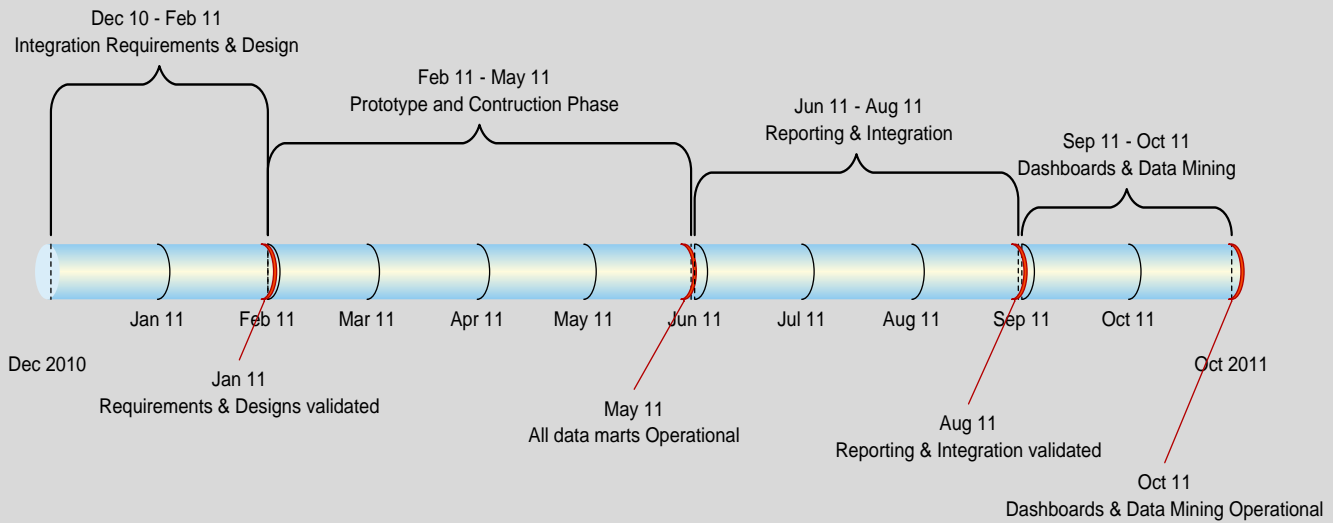
legacy system.

Data from the above systems were not integrated. The manual compilation of data from these disparate systems inhibited the timely access to useful information. DBH began work to construct the Behavioral Health Integrated Data Warehouse (BHIDW). The warehouse is based on the HL7 format, which is being used nationwide with current data communication and health data networks and exchanges. Adopting this industry standard allowed DBH to import data from all source systems and provide for unambiguous data communication among programs, divisions, and agencies. The focus has been on storage of clean, transformed, and cataloged data that will be made available to managers, administrators, and other business professionals for data mining, online analytical processing, and decision support.

### PROJECT PROGRESS:

The effort necessary to meet the projected timelines was short for an Information Technology project. The reality is that this project involved the development of four data warehouses into a single data-mart. In addition, the data systems used by the CMH program and the SUD historically contain all the necessary data for longitudinal reporting and therefore were necessarily included in the data warehouse. This model, in concept, allows queries across each of the warehouses/data sets.

The project was initiated with the development of a project team comprised of subject matter experts, management, information technology, programmers, and enterprise warehouse staff. The project team developed a project plan and associated timeline for milestones. See timeline below.



The development of the warehouse itself required additional work with vendors to provide regular, consistent transfers of data to a secure site. Those vendors include the Substance Abuse management services contractor, the WITS provider, and the VistA provider. It was also necessary to include Idaho's Child Welfare agency as they own the system FOCUS system, which was the former case management information system for the CMH program.

The data warehouse has been completed, including all four information system's individual marts. The data is currently being uploaded at least every two weeks or so if the host system has the capacity.

### PROJECT GOALS:

1. Focus on indicators that provide the most useful clinical and operational data possible within the scope of the data currently available within DBH.
2. Implement "dashboards" that will graphically present key performance indicators to senior management on demand. In some ways this is the primary goal of the project.
3. Identify, develop and build reports that measure service outcomes, trends, exceptions, and performance versus goals.
4. Provide a common data model for all data of interest regardless of the source (e.g. WITS, VistA, outside agency),

making it easier to report and analyze information than it would be if multiple systems were used to retrieve information.

5. Identify and resolve inconsistencies in data prior to loading data into the warehouse that simplifies reporting and analysis.
6. Complete the construction of the BHIDW composed of several data marts so it incorporates and integrates data from vendor-hosted and in-house information systems including (but not limited to) SUDS Program, Business Psychology Associates, Adult Mental Health Program, Children's Mental Health Program, State Hospital South, and State Hospital North. This process can also be used to incorporate appropriate data from other agencies (Medicaid MMIS, Department of Labor, Corrections, Juvenile Corrections, Tax Commission, Division of Financial Management, etc).

#### **OUTCOMES TO DATE:**

- Data dashboards for each program are available, are provided to senior leadership monthly, and are also posted on DBH's website for public viewing. Thus far managers have found the dashboards to be very helpful, but are also uncomfortable that the Commissioner and the public can view as well, especially when certain indicators (such as time spent with consumers, or direct client contact data) are abysmal.
- Data from these dashboards has already led to the appropriation of new funding for a fulltime FTE.
- There has been a resultant increase in trust in state leadership from key legislators.
- Data testing remains ongoing yet very time consuming.
- Meets the State's need for reliable, consolidated, unique and integrated analysis and reporting of its data at different levels of aggregation.
- Paves the way for other states that are interested in streamlining parallel data processes and disparate data sources and extracting outcomes and management data.
- Foundation for analyzing data from multiple sources to assess the efficacy of multi-agency services.
- Provides the necessary data to the State Mental Health Planning Council, consumers and family members to facilitate their monitoring the state MH system.
- Provides a foundation for implementation of Health Care Reform; especially the efficiencies achieved through comprehensive electronic health records.

#### **SUMMARY**

The TTI project in Idaho assisted with the initial development of a multiple system data warehouse. The project team is still working on the hard coding of the newly created data dashboard. All in the DBH system now have the ability to feed the dashboard on a routine basis and it will soon be published to the external website and the internal SharePoint team site for the Division staff and management to utilize consistently. The TTI project moved Idaho forward dramatically in our ability to process and provide meaningful data.

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# Illinois



## FY2008 TTI PROJECT:

*Create a co-occurring strategic plan and develop a criminal justice workgroup with regional sessions to develop regional system mapping to identify service gaps and barriers.*

## KEY OUTCOMES:

- Development of a statewide criminal justice transformation workgroup and five regional criminal justice transformation workgroups.
- Development of a statewide criminal justice transformation advisory council. This advisory council's first meeting began the planning process for five regional workshops to begin a regional mapping process. It was attended by executives of three partnering agencies (Substance Abuse, Corrections, Mental Health), the Cook County State's Attorney's Office, the Illinois Sheriff's Association, the Chicago Police Department, Illinois NAMI, Illinois MHA, four CMHC's, University of Illinois, Illinois Criminal Justice Information Authority, Corporation for Supportive Housing, an Appellate Judge, and **five Chief Judges from across the state**.
- The Illinois Judges Council, as an official partner of this project, authored and sent out the invitations for the five regional workshops to boost attendance.
- The five regional workshops, responsible for the regional mapping process and action plan, met over the summer. These workshops produced the following:
  - Identification of the interception points within the criminal justice system where individuals with mental illness and co-morbid substance use disorders can be provided with services and interventions;
  - Description of the service delivery process that supports the recovery of individuals with mental illness and co-morbid substance use problems intercepted in the criminal justice system;
  - Identification of best practices and promising initiatives that address the needs of individuals with mental illness and co-morbid substance use problems;
  - Identification of gaps in service and barriers to service delivery;
  - Development of work plans for each of the five regions; and
  - A statewide mapping report and three-year integration plan is expected by late fall.

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# Illinois



## FY2010 TTI PROJECTS:

*1) Implementation of a statewide mental health justice and advisory group; 2) Piloting an integrated mental health court database; 3) Implementation of a mental health and justice consumer conference.*

## KEY OUTCOMES:

### *Statewide Mental Health and Justice Advisory Group Strategic Planning:*

- Completed TTI strategic planning process and identified priority initiatives for MHJ transformation for the next two years.
- Completed Strategic Planning Report.
- Completed Medicaid application training for 150 provider staff and DMH social work staff working with justice involved consumers.
- Expanded JDL to Macon County, with four more counties targeted for expansions in the next year (Kane, Mclean, Sangamon, and Vermillion).
- Identified start-up support for an Illinois Mental Health and Justice Center of Excellence.
- **Issues/Concerns/Sustainability:** Sustaining MHJ actions and initiatives after the final expenditure of TTI award funds. The Illinois Criminal Justice Information Authority will provide funding for two years for a Mental Health and Justice Center of Excellence COE. This will allow time to identify and pursue other funding mechanisms to sustain the initiative.

### *Integrated Database Pilots:*

- Completed the process of piloting the Integrated Mental Health Court Database. Data was collected on 463 past and current participants at both pilot sites in Cook and Winnebago County. The chief pilot finding was that effectively capturing comprehensive participant data is impacted by the cohesiveness of the Mental Health Court Team in providing and sharing information. The pilot in Winnebago County showed more effective results in this respect as the data entry person has more efficient access to participant information. Both sites showed that the database is an effective tool for capturing information in a uniform but flexible manner.
- **Issues/Concerns/Sustainability:** Both sites will continue to use the Integrated Database. The database will be made available to other jurisdictions with mental health court programs through

continued involvement with the Mental Health Court Association and other activities involving the judiciary. The database will be provided to any mental health court at no charge.

***Mental Health and Justice Consumer Conference:***

- Tonier Cain, nationally recognized consumer expert on Trauma and Recovery provided keynote address at the DMH Region III and IV recovery conference.
- Tonier Cain, nationally recognized consumer expert on Trauma and Recovery provided keynote address at the Mental Health Court Association and Mental Health and Justice Statewide Conference in DuPage Illinois.
- Identified priority consumer recommendations for TTI strategic plan. Highest priority was identified as expanding peer to peer support services in Illinois.
- The TTI consumer consultant, Mrs. Frances Priester, provided peer to peer support to 21 recovery specialists and their supervisors working with local jails and court systems in their community in Macon, McLean, and Sangamon counties.
- ***Issues/Concern/Sustainability:*** Funding and resources are needed to expand MHJ peer to peer support initiatives. Any remaining TTI funds will be used to train additional peer to peer support staff in Illinois counties and regions.
- ***Overall Transformation Impact of Focus Area Outcomes***  
The Transformation Transfer Initiative has been instrumental in facilitating regional and statewide collaboration on Mental Health and Justice Issues in Illinois. Most noteworthy in the collaboration was the involvement of judiciary in providing leadership for regional and statewide planning. Despite an ongoing severe state budget crisis and continual cutbacks in mental health services in the community, the TTI partners and stakeholders continue to forge ahead with planning, problem solving, and initiative development. Although the TTI process identified more issues and service needs than it could ever fix in our current economic climate, it did raise the level of awareness of the needs of justice involved consumers. Also as important to transformation was the initiation of strategies through the TTI process that could become system wide approaches such as peer to peer support, and the development of a Mental Health and Justice Center of Excellence that can continue to support regional and statewide initiatives with consultation, training, technical assistance, and information dissemination.

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# Indiana



## FY2010 TTI PROJECT:

*Increased and improved recovery based care at the community level by (i) providing community mental health centers (CMHCs) and state operated psychiatric hospitals needed training for transformation initiatives and align them to a recovery-based philosophy and model clinical care and (ii) a media campaign designed to increase recovery awareness.*

## KEY OUTCOMES:

- Thirty-four training and technical assistance recovery/transformation activities were funded by TTI.
- Approximately 3,000 participants involved.
- Training breakdown included sessions on:
  - 135 people were trained on recovery based care
  - 329 people received MRO manual training
  - 187 individuals were trained on assessing and treating individuals with co-occurring disorders
  - 3 webinars, with 1383 participants, were held on prior approval processes
  - 303 people were trained on new performance expectations for recovery outcomes
  - Three peer webinars were held on (i) using peers to engage reluctant clients; (ii) role of the certified recovery specialist; and (iii) how to integrate certified recovery specialists into a clinical team
  - 123 people watched a webinar on states of change and person-centered treatment planning
  - 8 videoconferences are being held for providers who are struggling to implement recovery based care
- Regional training presentation subjects included:
  - Recovery based care - all levels of provider staff, consumers and families
  - MRO manual training - all levels of provider staff
  - Education and discussion regarding the transformation initiatives and recovery based care - consumers/families and community stakeholders
  - Assessing and treating individuals with co-occurring disorders - staff from DMHA funded providers, consumers and families
  - Prior Approval system processes (Expectations/utilization) - all levels of provider staff
  - Recovery Outcomes: new performance expectations - all levels of provider staff (webinar)
- Seven Regional Town Hall meetings were conducted with 294 individuals participating including

consumers, persons in recovery, family members, providers, policy makers and advocates.

- A statewide media campaign, conducted in partnership with Mental health America, assisted in the creation of various products and a speakers bureau.
- SAMHSA's "What a Difference a Friend Makes" PSA was aired 646 times across the state.
- "What a Difference a Friend Makes" Community Tool Kit was developed for distribution to various organizations across Indiana. Organizations receiving this toolkit include:

Lions' Clubs	NASW Indiana
Future Farmers of America	Indiana Psychiatric Society
Rotary Clubs	American Psychiatric Nurses Association
Junior League	Indiana
American Legion	Charitable News
Public Broadcasting	DBSA
PTA	Key Consumer Organization
Indiana Psychological Association	NAMI Indiana
- 2,889 brochures and "What a Difference a Friend Makes" materials were distributed.
- DMHA conducted surveys to assess readiness of behavioral health providers to implement recovery oriented care. Surveys were completed in March/April 2009 and February 2011 (pre/post TTI). Of the providers who completed both the Pre/Post Provider Readiness Assessment, over 2/3 indicated they had made overall improvement in implementation of recovery oriented principles for consumer services. This improvement was found in all three domains:
  - Recovery
  - Person-Centered Planning
  - Recovery Support Services
- Three surveys were used to assess needs and gaps. Information gleaned from the surveys was used to guide decision making for TTI funded training/TA topics.
- Other activities supported by the TTI funds include:
  - Development and maintenance of a FAQ
  - Development and maintenance of a training website to facilitate registration, share information, and host presentations/materials
- Numerous presentations were developed and delivered to various community stakeholders:
  - Consumer/family groups
  - Legislative groups
  - Behavioral health providers

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# Iowa



## FY2008 TTI PROJECTS:

1. *Development of emergency mental health crisis services through Iowa's CMHCs; and*
2. *Improvement of their children's mental health system through CAFAS training.*

## KEY OUTCOMES:

### *Development of emergency mental health crisis services through Iowa's CMHCs*

- Development of an Acute Mental Health Systems Task Force.
- This project was instrumental in helping the state of Iowa in dealing with the horrific tornadoes and flooding in 2008. This successful assistance received significant attention at the Iowa legislature and secured the department \$1.5 million in new funds to continue to develop Emergency Mental Health services.
- Also in response to the natural disasters, TTI funds were used to provide Mental Health First Aid (MHFA) instructor training to 22 professionals who will train other professionals to use Mental Health First Aid across the state.
- With work from Mark Engelhardt of the University of South Florida, the Task Force developed new state standards for Emergency Mental Health (EMH) services, a statewide implementation plan for statewide delivery of EMH services, plus safety net services in acute mental health care.

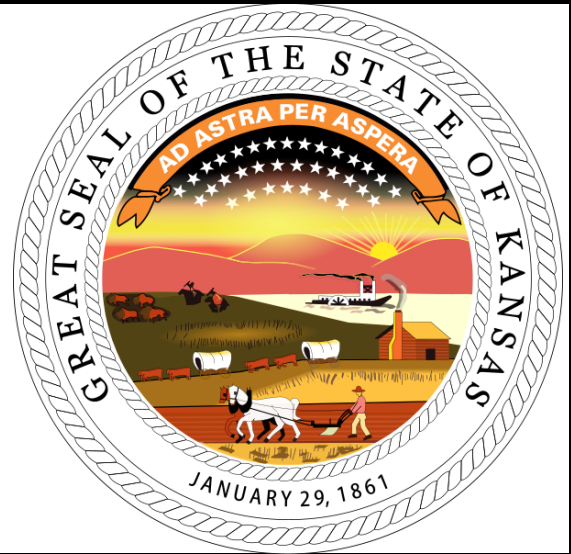
### *Improvement of their children's mental health system through CAFAS training*

- Dr. Kay Hodges, of the University of Michigan and the originator of the CAFAS ("Child & Adolescent Functional Assessment Scale") training, performed 'train the trainer' training to 39 mental health professionals from 34 CMHCs across Iowa to use the CAFAS and PECFAS ("Preschool and Early Childhood Functional Assessment Scale") assessment scales.
- Many Community Mental Health Centers purchased CAFAS software and licenses to enable computerized scoring of the CAFAS.
- The SMHA was also able to leverage the TTI grant to obtain \$500,000 of new funding from the Iowa Legislature to continue this training program beginning January 1, 2009.

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# Kansas



## 2011 TTI PROJECT:

*Whole health initiative to improve health and wellness and coordination of physical and mental health treatment for persons with severe and persistent mental illness*

## KEY OUTCOMES:

The Kansas Department of Social and Rehabilitation Services (SRS) contracted with three agencies: Kansas Health Solutions (KHS), The Association of Community Mental Health Centers in Kansas (ACMHCK), and Breakthrough Club of Sedgwick County, a vocational and social program for person with mental illness. Through collaborating with these three agencies, Kansas planned to achieve the following goals:

- Improve health and wellness and coordination of physical and mental health treatment;
- Provide training and technical assistance to mental health treatment providers and peer support organizers; and
- Advance existing efforts in the development of an effective behavioral health home and care coordination model to inform policy decisions in Kansas.

In order to achieve these goals, SRS committed to the following tasks:

- Improving the coordination of physical and mental health care by building upon the existing efforts of KHS to develop an effective care coordination model in Kansas;
- Partnering with Breakthrough Club of Sedgwick County to provide training and technical assistance to community mental health centers and consumer run organizations to incorporate health and wellness activities;
- Collaborating with The Association of Community Mental Health Centers of Kansas' to research efforts to identify effective and efficient behavior health home services that can be included as part of the Kansas State Medicaid Plan for health homes;
- Partnering with Wichita State University (WSU) to ensure the coordination of physical and mental health care is delivered by trained practitioners. WSU to develop and implement an on-line training for practitioners; and
- Developing standards and guidelines in consultation with providers, consumers, and advocates. These standards and guidelines will serve as a framework for the coordination of physical and mental health treatment and provide a springboard for developing a Medicaid state plan.

*Federal money had increased system preparedness re: whole health; has also increased managed care relations, acceptance and information exchanges.*

### Kansas Health Solutions

The first big event was held on January 27, 2011. KHS sponsored a Primary Care Integration pilot meeting in Wichita. Presenters included representatives from the Cherokee Health Systems. Feedback from participants was

very good. This was an opportunity for representatives from the integrated care pilots around Kansas to meet face to face and hear from Cherokee what success they had accomplished with integrating health care with mental health.

In collaboration with the Kansas Association for the Medically Underserved (KAMU), KHS has conducted monthly status meetings on the statewide primary care integrated pilot project. There are ten pilot sites around the state that involve CMHCs partnering with local health care providers and/or community health care clinics. KHS has developed a data system to track clients participating in the pilots. One of the tools used to track progress is the SF-12. Early data gleaned from the SF-12 indicated an 8% reduction or an average of \$37 a month less in medical expenditures per person.

KHS organized another statewide integrated health care symposium held September 27, 2011 in Wichita. This all day, professionally facilitated symposium included guest speakers from Missouri's Health Home initiative. Over 100 physical and behavioral health care providers, consumers and pilot participants attended.

#### **Breakthrough Club of Sedgwick County**

Breakthrough Club of Sedgwick County developed a 12 week program to encourage fitness and healthy eating called The H.E.A.L. Project. The H.E.A.L. project involves educating Breakthrough Club members on how to live a healthier life. The TTI funding was used to conduct eleven Train the Trainer sessions on the H.E.A.L. Project model. Members of Consumer Run Organizations and Community Mental Health staff were trained on the various aspects of the project and implemented a similar program upon the return to their home communities. Feedback has been very positive and the overall evaluation score from the participants was 4.74 out of 5. The participants walked away with specific plans and goals for their communities. Breakthrough Club has developed a manual for this training and shared it with NASMPHD.

#### **Association of Community Mental Health Centers of Kansas**

The ACMHCK has been conducting research, attending conferences, and participating in webinars on best practices currently being utilized for health homes. ACMHCK provided a final report to SRS with recommendations that can be included in the Kansas state Medicaid plan for health homes. Due to the TTI grant, CMHCs are also working towards this goal.

SRS expanded its agreement with ACMHCK and provided an orientation training to all 26 CMHC on how to integrate physical and mental health care. Because most of the effort to educate mental health providers on care integration has been focused on the targeted case managers, this training provided an opportunity for all CMHC staff – direct service and administrative staff to learn more about this exciting initiative taking off in Kansas.

#### **Wichita State University**

Wichita State University, a leveraged resource for the TTI grant, developed a Kansas specific Coordination of Care on-line training. The training went "live" on June 15, 2011. This training is required for all community mental health center targeted case managers to complete within 60 days of hire. From the time period of June 15-August 31, 2011, seven hundred thirty seven individuals completed the course. The feedback on this training has been very positive. The Wichita State curriculum has also been instrumental in the creation of a statewide train-the-trainer curriculum.

*In retrospect, the TTI grant was the catalyst to better health and wellness collaboration statewide.*

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# Kentucky



## **FY2008 TTI PROJECTS:**

- 1. Peer Support Initiative with State Medicaid Office; and*
- 2. Development of a Plan to Support High Fidelity Implementation of Wraparound.*

## **KEY OUTCOMES:**

### *Peer Support Initiative with State Medicaid Office*

- A Peer Support MOU with State Medicaid Office – as a result of which two pilot sites for Medicaid Peer Reimbursement have been established, with ability to bill soon.
- Development of a Peer Support Services Steering Team including consumers, family members, peer specialists, and representatives from the University of Kentucky, CMHCs, and state mental health, substance abuse and Medicaid agencies.
- Development of recovery curriculum for consumers, family members and clinical staff of the fourteen regional MHMR Boards.
- A statewide Recovery Forum which launched the recovery curriculum and attended by 82 consumers, as well as family members, clinicians, rehabilitation providers, educators, policy makers, and executive staff.
- Two statewide peer support trainings resulting in fifty additional trained peer specialists, giving Kentucky 155 total peer specialists.
- Three technical assistance teams were formed from members of the TTI Steering Team to support implementation of peer support services on a statewide basis.

### *Development of a Plan to Support High Fidelity Implementation of Wraparound*

- Creation of State Wraparound Implementation Fidelity Team (the “SWIFT”).
- Development of Implementation Plan for Wraparound using NIRN Implementation Drivers Framework.
- Development of cross-agency training curriculum for core components of wraparound facilitation.
- Development of training curriculum for coaches of wraparound facilitators, including mechanisms for fidelity monitoring.
- Assistance, participation, and expertise of Kentucky’s statewide children’s interagency council, which encompasses eleven other state agencies.

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# Kentucky



## 2011 TTI PROJECT:

- 1) *Service enhancement with the co-occurring providers through NIATx and mini-grants; and 2) facilitate the establishment of Double Trouble in Recovery groups*

## KEY OUTCOMES:

Originally Kentucky was going to focus on two major efforts to further promote the integration of mental health and substance abuse services:

1. Utilizing a Steering Committee the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) planned to hold a series of regional forums to educate stakeholders on the impact of PPACA and to help guide “next steps” in furthering the integration of services.
2. Facilitate the establishment of Double Trouble in Recovery groups in a small number of Kentucky’s CMHC regions dependent on developing local interest. Double Trouble in Recovery groups are peer-to-peer groups that focus on people who have co-occurring mental health and substance use disorders.

There was a need to change #1 above due to a change in Kentucky’s mechanism on how it manages its Medicaid benefits. Kentucky promulgated an RFP for managed care contracts during this time and it was determined that having regional forums could jeopardize the procurement process by inadvertently providing erroneous or selective information. Consequently, the forums were cancelled and the TTI project, with permission from NASMHPD, focused more intensely on service enhancement with the co-occurring providers.

**NIATx and mini-grants.** This focus took the form of continuing DBHDID’s project that reviewed and assessed the CMHC’s capability to serve individuals with co-occurring disabilities by using the DDCAT/DDMHT instrument (Dual Diagnosis Capability in Addiction Treatment/Dual Diagnosis Capability

*It cannot be emphasized enough that the way these funds have been distributed to the state is key to having a successful impact on service delivery for Kentucky. The flexibility of these funds allowed Kentucky to moderate the original plan, accrue the funds, modify contracts and continue with this part of the project in a fully planned and effective manner.*

in Mental Health Treatment). The TTI funds were used to award a series of \$6000 mini-grants to providers that submitted an application to the Director's Office that identified a change leader, a set of objectives to improve measures in at least three dimensions on the instrument, and a set of rapid-cycle initiatives showing their progress. This process improvement project is using the NIATx format, which this Division has supported and used on targeted areas successfully in the past.

Ultimately, 11 of 14 CMHC's accepted the mini-grants. Acceptance of the mini-grant means that a provider will be evaluated under the NIATx model – a process improvement model originally designed to improve access, retention and penetration rates with substance abuse services. By referencing the scores from the Dual Diagnosis Capability instruments the CMHCs used the mini-grant funds and the process improvement process to target improvements in services. Projects to improve scores were suggested by CMHCs, and ideas were cross-shared on monthly conference calls.

On May 1<sup>st</sup>, all CMHCs met to present their finished projects. Thereafter additional improvement projects will be self-funded by providers, who are generally excited by the results and improvements and have really "taken the bull by the horns." All 11 participating CMHCs are expected to continue their participation in the self-funded portion of the project.

### **Double Trouble in Recovery.**

Double Trouble in Recovery is a Twelve Step program for men and women to share their experiences, strengths and hopes with each other so that they may solve their common problems while helping others to recover from their particular addiction(s) and manage their mental disorder. The program is designed to meet the needs of the dually diagnosed, and is clearly for those having addictive substance problems as well as having been diagnosed with psychiatric disorders. Groups like Double Trouble in Recovery are incredibly important for people with co-occurring disorders as many substance abuse only support groups, such as Alcoholics Anonymous, can frown upon certain mental health medications. For example, anti-depressants are the drug of choice for some people in substance abuse programs and are sometimes perceived as an excuse or enabling. But in the mental health world, these drugs are frequently a critical part of a person's care.

Peers took much of the lead in Kentucky, and the first group was started in Lexington. As news spread about the group the project spread statewide. Originally Kentucky hoped to establish three groups, but five have been established and plans are underway to start two more. As with all peer based groups, there will be an evolutionary maturation of groups and the individuals in them.

Kentucky also sent two staff to the training in South Carolina to facilitate the start-up of the Double Trouble in Recovery programs. They have identified training material for these groups, and these have been purchased and distributed to a large number of professionals and peer mentors who have been identified as individuals with an interest in DTR. Since these are peer-to-peer groups and DBHDID cannot pay the facilitators directly, TTI resources have been used to provide training and logistical support for that training.

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# Louisiana



## **FY2009 TTI PROJECT:**

*Provide training, through the Early Childhood Supports and Services (ECSS) program, for public and private sector clinicians in specific EBPs in order to achieve improved clinical and functional outcomes in preschool children (birth through five years).*

## **KEY OUTCOMES:**

- Louisiana's ECSS program was included in the "Roadmap to Economic Success" document that early childhood advocates will be supporting for additional funding during this upcoming legislative session for sustaining the work done under the TTI.
- Partnered with Tulane University to write and test the training manual and curriculum.
- OMH's dialogue with its Medicaid office was successful in efforts to getting approval to bill for the PCIT (Parent-Child Interactive Treatment) component of the ECSS protocol; PCIT is an evidence-based treatment model; ECSS is anticipating approval to begin billing by July 1, 2010. This will greatly enhance Louisiana's ability to sustain and expand the program statewide.
- OMH leveraged an additional \$1 million in TANF funds, for ECSS Program, effective this fiscal year.
- Initial Training and Booster Training is on track for December 2009 for child clinicians working in state mental health clinics and network partners working in other state/private agencies. The training is free to qualified clinicians statewide and will be followed by booster sessions over three months. This training will be provided by Tulane Department of Child Psychiatry.

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# Maine



## FY2010 TTI PROJECT:

*The Office of Adult Mental Health Services worked with a group of consumers and providers to develop and implement a system of measures (in the form of a toolkit) focused on individual outcomes and recovery. The selected toolkit includes four measurement instruments: the OQ®, the Recovery Assessment Scale (RAS), the Data Infrastructure Grant Survey, and the LOCUS. The TTI grant also assisted Maine to define “recovery”, create a draft of “Recovery Guidelines for Mental Health”, develop a recovery-focused clinical training module for the administration of the toolkit, test Maine’s assumptions about whether the toolkit works to measure both individual and system outcomes, and create a training model for the implementation of the toolkit with providers and consumers.*

## KEY OUTCOMES:

- Maine established a work plan, hired two consumer groups to gather input for the recovery guidelines and develop recovery training as well as a consultant to produce a draft document incorporating all the feedback. Contracts were completed with the three pilot sites: Kennebec Behavioral Services, Common Ties, and CSI.
- OAMHS used the work from Connecticut as a basis for developing recovery guidelines for Maine. OAMHS conducted seven webinars based on each domain and included questions posted on the web for discussion as well as a power point for each webinar, collected input online, in written format and through discussion, and contracted with the Consumer Council of Maine to conduct a survey and focus groups. A final draft of the document will be circulated in the Summer of 2011.
- Maine created a Pilot Advisory Group that included representatives (consumers and staff) from each pilot site. Performed onsite training for one of the tools at each of the pilot agencies and used feedback from each training to improve the content.
- The recovery training effort was completed by June 2011. OAMHS contracted with a consumer group to develop the component based on the draft guidelines.
- OAMHS created a website on its main page and named it Recovery for Me. This site can be found at: <http://www.maine.gov/dhhs/mh/recovery/>.
- The pilots are just beginning to implement the RAS. Maine did, however, create focus groups that both discussed and took the RAS and are doing a community survey to gather input to norm the data.
- Maine has undertaken a pioneering effort to wed common measures associated with the recovery movement with well-recognized measures of outcome. More specifically, Maine partnered with the developers of the OQ®-45.2—the only system of outcome assessment recognized in SAMHSA’s National Registry of Evidence-based Programs and Practices—to simultaneously measure outcome and consumer recovery on two instruments: Corrigan’s Recovery Assessment Scale (RAS) and the NAMI Recovery Indicators (NRI).
- Maine is interested in not only tracking its services with respect to effectiveness on well-established



outcome measures of symptomatic improvement but also adding the voice of the consumer from a recovery perspective. In other words, to what extent are we adding value in the consumer's life by reducing troublesome symptoms **and** increasing the quality of their life on key dimensions of recovery? For this reason, Maine has been working to explore the relationship between recovery and outcomes with a psychometric examination. Data collection for this effort includes the use of consumer focused groups, a community collection of RAS data from residents of Maine and a collection of RAS and OQ Measures data by consumers receiving mental health services.

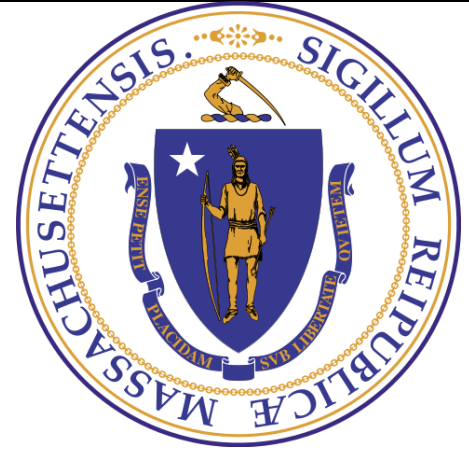
### **Lessons Learned:**

- Electronically self administered tools using a laptop or net book are the way to go but this takes a tremendous investment of resources and close communication between technical and program people. The stakeholders (pilot site administrators, clinical supervisors, direct service staff, technical staff, consumers, and the state staff) must all receive steady support, communication, and training. With the assistance of the pilot agencies, good technical support was essential in assuring that the clinical tools were accessible to community integration workers in the field.
- A slow start with two case managers from each of the pilot sites as initial implementers was a great idea! Maine learned along the way and corrected its vision as needed. Maine has moved from 6 case managers to 60 over the course of the project and will be implementing another rollout this summer. Pilots may make more sense as a way to create system change than the full scale infrastructure changes that we have tried in the past. At the state level, we can have a new governor and a new commissioner every 4 years so large scale change can get caught up in the political structure. In addition, agencies are in great flux with mergers and potential Medicaid changes so asking a whole system to focus on change is very difficult.
- Using the recovery work from Connecticut was extremely helpful and efficient as Maine went about creating Recovery Guidelines. OAMHS tried a new model for gathering input through the use of webinars. This worked well in that OAMHS provided material ahead of time as a sort of study guide and then participants were free to use the questions to think about their input. It was still a long process...webinars over seven months...and was hard to maintain enthusiasm for the process over that long a time period. Maine did have some technical glitches but we did get more comfortable with the process, as did participants.
- The theory of the project was to equally involve consumers, providers, and state staff in the development of the recovery guidelines. In reality, many consumers and providers expressed skepticism about the actual implementation of the guidelines and were reluctant to spend time in the discussion or implementing items. OAMHS is mindful of the need for the Office to model the guidelines or explain why not.
- The Recovery Guidelines provide a discussion basis with other parts of the Department, especially as we look at Medicaid policy and a variety managed care initiatives.

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# Massachusetts



## FY2010 TTI PROJECTS:

*(1) a statewide training effort on person-centered planning; and (2) initiation of a program for a shared decision-making model to foster the reduction in the use of psychiatric medications.*

## KEY OUTCOMES:

### Person Centered Planning

Massachusetts set the stage for the TTI grant through prior work such as the CMS Person Centered Planning (PCP) Implementation Grant. Upon receipt of the TTI grant, a PCP training team was convened and plans for the creation of a state-wide person-centered planning training curriculum and schedule of training sessions began. The team developed both an overview and a PCP facilitator training curriculum. The goal was to ensure that all individuals who are responsible for developing plans of care with DMH clients would be trained. The team worked with each of the state's geographic "Areas" to determine the manner, schedule and attendees for the trainings in each Area. Over the course of the grant, the training process and schedule and target audience has been continually modified based on the input from those trained, the Area staff and the training needs. DMH also determined that the curriculum designed for the community should be modified for the staff in DMH's inpatient facilities and DMH utilized the grant to begin to develop a modified curriculum and approach for these settings. *A hallmark of this project at all stages was the inclusion of peers in all aspects of its execution.*

Three presentations, offered across all six DMH Areas, were developed to implement the training:

- 1) An Overview of Person-Centered Planning – This was offered to the greatest number of staff as a basic introduction to PCP. Administrators, program evaluators, supervisors and all direct care staff including peer support staff were encouraged to attend.
- 2) PCP Facilitator Training – This training was offered to staff who were going to work directly with individuals in the development, documentation and implementation of treatment plans.
- 3) PCP Documentation Training – This session was designed to train staff to document the resultant treatment plans in such a way that would be true to the person-centered process and goals and preferences, etc. while still meeting the agency's requirements for licensing and billing.

Input was sought to ensure that these trainings built on current knowledge about PCP and matched local needs. They also gave the trainings a context and identified point people to ensure that the targeted staff attended. This insured that this initiative would be given due attention and not get lost in information overload.

The initial trainings are being followed up by post-TTI opportunities for consultation and technical assistance. These are not meant to reproduce the initial training, and would only be available to staff who were actively engaged in using PCP. The majority of the consultations have not yet taken place, although all are scheduled. As with the training, each area has chosen to take a slightly different path for the consultations - varying in number, participants, and focus.

The last component of the initiative is to develop a process to assist the DMH inpatient settings to shift to a more person-centered process for care planning in the inpatient setting and in planning for discharges. Beginning with

presentations to hospital leadership the PCP team has begun to assist inpatient leadership to form an applicable curriculum and a training plan. As with the other trainings, the hospitals plans are varied in their approach to bringing PCP to their facilities, some choosing to expose all staff to PCP principles, and others choosing to begin with specific units only. This work will also continue post-TTI.

Thus far, 20 training sessions were conducted in the community and 650 staff representing both state staff and vendor staff have been trained. This does not include the planned hospital trainings.

### **Shared Decision Making Medication Reduction (SDMMR)**

SDMMR helps people to simplify, reduce, or eliminate their behavioral health medications. SDMMR partners with CommonGround©, an internet-based system that interfaces with an SDMMR-*employed* Peer Support Specialist trained in its use. CommonGround© enables people to arrive at their appointments prepared and ready to articulate and achieve recovery goals. Shared Decision Making (SDM) is defined as an interactive process in which providers and clients simultaneously participate in the decision-making process and negotiate a treatment plan to implement. SDM recognizes that both providers and clients have important knowledge to contribute to the decision making process.

CommonGround©, is a web-based application that helps people prepare to meet with their psychiatrists and arrive in the office ready to discuss the things that are important to *them*. When a client goes for a medication appointment, there are many issues that need to be discussed. However, the appointment is short, often only 15-20 minutes. It can be hard for a client to organize his/her thoughts, answer questions, ask their own questions, speak about concerns and make decisions in that brief period of time. CommonGround© helps the client prepare before their appointment, so that during the appointment he/she is ready to work with their doctor to collaboratively identify the best solutions/decisions for that person's treatment and recovery.

A Decision Support Center is located in the out-patient clinic that employs peer support specialist services as well as computer kiosks with CommonGround© software. The client can visit the Decision Support Center anytime - access is not restricted to appointment times with or without Peer Support Specialists assistance. The client sits at a computer station and logs into a secure, personal account to access the program. The CommonGround© program provides many tools for support – however, those critical to Shared Decision Making are: The Power Statement; Personal Medicine; Health Report; Information Treatment; and the Library.

Two clinics (one withdrew due to financial issues) with the CommonGround© program were chosen as the original sites for launching the SDMMR program. The approach built upon the CommonGround©, program by adding the medication reduction option to the recovery goals. These sites were selected because there was already buy-in and an investment in shared-decision-making tools. The plan was limited to two sites due to cost ambiguity and what would and would not be Medicaid-reimbursable at the outset.

Clients voluntarily participated when they were clinically and environmentally stable. Certain clients were excluded due to factors such as pregnancy, recent suicide attempts and pending criminal charges.

Due to implementation hurdles, evaluation data is not yet available (full data is only available for 8 clients). The program, however, will continue into the future using TTI and other funding. Hurdles included:

- Clinicians were reluctant to participate, despite training on SDMMR.
- Originally being limited to one insurance carrier (the pilot site now takes all forms of insurance).
- Delays in obtaining administrative (needed to compile evaluation materials) and billing support.
- Initial difficulties in obtaining volunteer clients, especially females and minorities.

Regardless of these difficulties, the SDMMR manual and other products have been finished and are available for use by DMH and other states.

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# Michigan



## **FY2009 TTI PROJECT:**

*Integration of physical and mental health care in selected Community Mental Health Services Programs (CMHSPs) by providing a comprehensive peer-led whole health initiative.*

## **KEY OUTCOMES:**

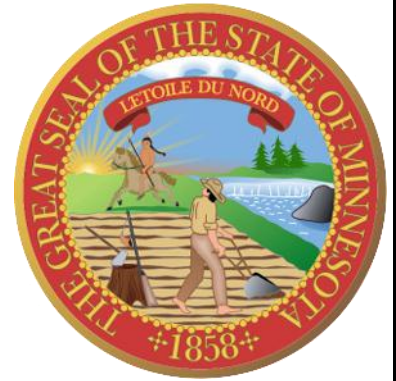
- CMHSPs who received TTI funding hired Certified Peer Support Specialists (CPSS) to improve outcomes through health care integration. Some of the roles that peer specialists performed included working in hospital emergency rooms, assisting consumers in finding primary care providers, attending physician visits as health care navigators, and working with Federally Qualified Health Centers (FQHC) and CMHSP sites integrating health care.
- The Chronic Disease Self-Management Program, an evidence based practice model developed by Stanford University, was selected as the statewide health and wellness curriculum. The initiative in Michigan is called Personal Action Toward Health (PATH). PATH is a six-week workshop conducted in two and a half hour sessions in community settings. The success of the PATH workshop is based, in large part, on participant interactivity that includes problem-solving, decision-making, information sharing, and support for change. The Stanford model employs a train-the-trainer model, in which master trainers are trained by core Stanford staff, and then provide leader training for agencies and organizations that are interested in delivering the program in their communities.
- So far over one hundred CPSS in Michigan have attended leader training and are conducting classes in their communities. Twenty-four CPSS participated in master training with five individuals currently achieving Master Trainer status awarded by Stanford University. Approximately thirty PATH classes have been led by peers in fifteen CMHSPs across the state. By December of 2010 at least two CPSS will be trained at each of the Pre-paid Inpatient Health Plans (PIHP) who oversee the 46 CMHSPs as part of the 1915 (b)(c) Managed Care Specialty Services Wavier. In addition, 75% of consumer run programs will have two PATH leader trainers to run classes to support long term sustainability.

- Some of the PATH outcomes include: smoking cessation, weight loss, initiation of an exercise routine, decrease in stress, change in diet habits, improved blood sugar levels, decrease in cholesterol, attending free community health classes, and less visits with mental health and physical health providers.
- On June 22-24, 2009, Michigan held its first Statewide Peer Specialist Conference in Dearborn with over 450 CPSS in attendance.
- Working closely with the TTI Whole Health Peer Support Projects in New Jersey and Michigan.
- Some CMHSP health care coordination successes are:
  - Development of walk-in clinics for consumers. These clinics will allow consumers to see a doctor if they've missed an appointment, meet with a nurse and spend time learning about various health topics.
  - Some hospital Administrations are so pleased with the peer assigned to their Emergency Rooms that they have asked them to participate on their Recipient Rights Committee.
  - Memorandums of understanding and monthly meetings between FQHCs and behavioral health providers to develop the clinical screening/assessment/treatment protocols.
  - Declarations of an Organized Health Care System have been completed. These declarations will allow the Federally Qualified Health Clinics (FQHC) and CMHs to exchange information without a release. This declaration is in compliance with HIPAA regulations.

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# Minnesota



## **FY2008 TTI PROJECT:**

*Develop a mechanism for multiple reviewers to simultaneously conduct the Illness Management and Recovery (IMR) and Integrated Dual Disorder Treatment (IDDT) evidence-based practice rating scale reviews while maintaining the integrity of the individual scale.*

## **KEY OUTCOMES:**

- The State of Minnesota contracted with Case Western Reserve University Co-occurring Center for Excellence to develop a mechanism for conducting the IMR and IDDT rating scales at the same time while maintaining the integrity of the individual scales.
- The format and process was piloted with Assertive Community Treatment teams in August 2008. These and additional scheduled reviews will provide information to inform Case Western, the State and treatment providers on any changes helpful to the review process. Other states and treatment providers will be able to use the format to conduct IMR and IDDT quality improvement reviews in a more efficient manner than is currently done when conducting rating reviews singly.
- Many states and mental health treatment providers are currently conducting quality improvement reviews using the single rating tool for IDDT and the tool for IMR. Respected researchers in the field have successfully combined the review process to enable reviewers to conduct both IDDT and IMR within a single review. The integrity of the scales are not comprised because the results of both IDDT and IMR ratings remain intact. The combined rating review accomplishes this by eliminating duplicate questions found in both IMR and IDDT, by combining the initial request for information from the provider into one comprehensive request for information, and utilizes a revised ordering of the questions to support efficient collection of information.
- The format and process allows states and treatment providers to measure existing service capacity and to develop a quality improvement plan based on the results of the review. Each IMR and IDDT fidelity scale review has historically taken one full day per review (each includes staff and client interviews, evaluating treatment records, and observing treatment services). With the combined IMR and IDDT fidelity scale process, reviewers can now conduct two reviews simultaneously in the time it has previously taken to conduct one – meaning that staff time for the reviews is cut in half.

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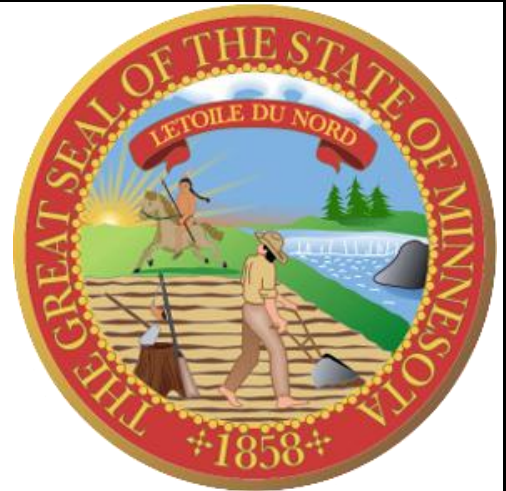
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# Minnesota



## FY2011 TTI PROJECT:

### *Embedding Primary Care into Act Teams*

#### KEY OUTCOMES:

The discovery that people with serious mental illnesses are dying 25 years earlier than the general population – often from disorders that are inherently preventable or treatable – has pushed the integration of mental health and primary medical care into the top tier of issues nationwide. In response to this public health problem of catastrophic proportions, the *Minnesota 10x10 ACT Initiative* has three objectives:

1. Jump-start a statewide public-private campaign known as the Minnesota 10x10 Initiative by focusing initially on assertive community treatment (ACT).
2. Strengthen the work of Minnesota's 26 ACT teams in the goal area of physical health and wellness.
3. Extend the lessons learned in ACT to our entire state system.

*The funding was helpful, but TTI provided the focus that put us in a position to do a good job without micromanaging.*

The ultimate goal is to increase the life expectancy of Minnesotans with serious mental illnesses by 10 years in 10 years – identical to the goal of SAMHSA's 10x10 Wellness Campaign.

#### Why Start With ACT?

Certain features of the ACT approach make it a useful “laboratory” for designing and field-testing strategies to improve the primary care received by adults with serious mental illnesses. These ACT features include:

- a focus on participants who have significant functioning difficulties and who are also, as a result, at a disproportionately high risk for co-occurring medical and substance use issues;
- a multidisciplinary staff team that already includes the all health disciplines;
- generally excellent working relationships with local primary care providers; and
- strong support among ACT psychiatrists and nurses for organized efforts to improve the physical health and wellness of the people they serve.

#### Components of the TTI Project

Kick-Off Symposium. We launched the *Minnesota 10x10 ACT Initiative* with an all-day symposium attended by about 200 invited stakeholders in Maple Grove, a suburban community northwest of Minneapolis, on June 24, 2011. Invited participants from all parts of the state included ACT psychiatrists, nurses, and team leaders; consumer and family advocates; health plan and primary care representatives; managers of local mental health authorities; and other interested stakeholders. The program featured major

national and Minnesotan speakers, and audience evaluations were overwhelmingly positive.

Stakeholder Advisory Group. Minnesota convened an Advisory Group of key stakeholders, who met on a quarterly basis to provide ideas and advice to AMHD staff and contractors.

Baseline Survey of ACT Teams. The Project Manager conducted a telephone survey of Minnesota's ACT teams to determine the baseline status of their practice in the area of physical health and wellness. Interviews were conducted with all 26 teams during April and May of 2011. The survey included 23 questions probing consumer characteristics, staff composition, staff roles in the team's health efforts, current wellness approaches found to be most effective, and remaining challenges.

Process Improvement Coaching With Seven Pilot Teams. Minnesota selected seven ACT teams to be pilot sites for process improvement coaching by expert staff from the Institute for Clinical Systems Improvement (ICSI), a nationally respected quality improvement organization whose members include most major health plans, hospital groups, and physician groups.

The seven ACT teams were strategically chosen to provide a diverse sample of urban, suburban, and rural settings. In addition, one team was intentionally selected because of its focus on individuals who have been homeless on a long-term basis; another was selected because of its formal relationship with a managed care organization. The sample included teams operated by counties and groups of counties, mental health centers, and both nonprofit and for-profit provider agencies. Although some of the pilot teams had already demonstrated exemplary work in this area of practice, service quality *per se* was not a selection criterion.

ICSI started its work with a one-day collaborative meeting of all seven pilot teams on July 28, 2011. This meeting was followed by monthly conference calls in which ICSI staff helped the teams to develop their own uniquely defined process improvements, based on their particular situations and local realities.

Despite the variety of process improvements developed by the pilot teams, the overall effort was clearly focused on three basic, face-valid goals:

1. Every ACT participant will have an annual physical.
2. This physical will include the key 10x10 health and wellness indicators (body mass index, tobacco and alcohol use, blood pressure, LDL cholesterol, and blood sugar).
3. Any indicator falling outside the "normal/desirable" range will be followed up by the team.

Thus far ICSI and/or ACT team members have noticed that:

- Consumers are experiencing a larger number of primary care visits, resulting in a time shift in how ACT team members spend time with them.
- Some mental health psychiatrists, or other professionals, are increasingly obtaining physical vitals.
- Obtaining BMI scores and assessing monthly tobacco use is increasingly routine.
- At least one ACT team is having a "lab day" at the clinic, and are adding incentives like breakfast for clients to encourage fasting for blood-work.

#### Getting Every ACT Team Involved

Minnesota recognized that every ACT – not just the seven pilot teams – needs to pay closer attention to annual physicals, 10x10 indicators, and systematic follow-up. Thus far, efforts to include all 26 teams in the 10x10 campaign have included these activities and system-level interventions:

- All teams were included in a two-hour interactive videoconference to introduce the 10x10 issue to ACT team leaders, program directors, psychiatrists, and nurses on March 14, 2011.
- All ACT teams were included in the April and May, 2011, two-hour baseline telephone survey.



- All ACT teams were included in Assistant Commissioner Maureen O’Connell’s formal invitation to the June 24, 2011, kick-off symposium, and most teams sent at least one representative.
- A financial incentive equal to 5% of each ACT team’s annual budget will be paid starting in calendar year 2012 if the team (a) submits to AMHD a plan to implement the three 10x10 goals itemized in the previous section and (b) begins to implement the first goal – annual physicals for all participants – immediately.

#### Updating AMHD’s Statewide Data Collection System

One or more national experts will consult with AMHD on the opportunities and challenges associated with integrating the basic 10x10 health and wellness indicators with other data sets – including program outcomes and claims data – in system-level analyses. Our goal is to begin monitoring Minnesota’s statewide progress in the 10x10 effort as soon as possible.

#### Planning for the Future Beyond TTI

The final phase of this project will include a planning process to determine the next steps for Minnesota’s 10x10 Initiative. AMHD staff, contractors, and interested stakeholders will address the ways in which lessons learned in the *Minnesota 10x10 ACT Initiative* can be extended most rapidly and effectively beyond ACT to all parts of our statewide system.

#### Wrap-Up Symposium for Stakeholders

A two-day wrap-up symposium was held in the Spring of 2012 that allowed us to share:

- What Minnesota has learned through the TTI project.
- What Minnesota intends to do next in this critically important area of practice and system design, and
- How all ACT teams can benefit from participating.
- There has been a noticeable, and surprisingly early, increase in annual physicals, BMI documentation and assessment of tobacco-use.

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# Mississippi



## **FY2010 TTI PROJECTS:**

- 1) Transportation needs assessment, 2) statewide training for co-occurring disorders, and*
- 3) housing needs assessment and planning.*

## **KEY OUTCOMES:**

### **Transportation Needs Assessment**

TTI built on work by the Mississippi Transportation Coalition - a group of 35+ transportation stakeholders (from consumers to state agencies) – including the first "real life" study on how the Coalition's transportation plan can help persons with mental illness. Through the project:

1. Trained 17 staff of the Life Help CMHC on the Coalition's transportation needs assessment.
2. The trained Life Help staff administered the needs assessment to 130 Life Help customers to determine their transportation needs and then worked with them to prioritize these needs.
3. Potential transportation service providers were identified. In addition to transporting individuals and providing call center services, providers were required to have the necessary software to a) analyze data from transportation needs assessments, b) schedule and route transports, c) bill and collect payments, d) cost allocate transportation services, e) maintain eligibility rules, and f) produce standard and customized reports. Providers were asked to analyze data from the needs assessments and to offer a plan, including the schedule for and cost of the transports, to meet the transportation needs of these individuals.

As a result of the training, the administration of the transportation needs assessment, and the data analysis accomplished through the TTI project, consumer-based transportation services for Life Help's customers with mental illness have been designed and can be provided when funding for the transports becomes available. Funding for the transports will provide the opportunity to examine these guidelines in a "real life" environment and ensure that the Coalition's plan for the provision of transportation services addresses the requirements of all Mississippians, including those with mental illness.

### **Statewide Training for Co-occurring Disorders**

The TTI grant allowed DMH to provide formalized training on integrated treatment for co-occurring mental illness and substance abuse disorders (COD). Trainers from throughout the state developed the COD curriculum, provided training and technical assistance, and evaluated outcomes of the training in different regions of the state. The trainers attended a three-day workshop on cognitive behavior therapy. The training curriculum implemented included the following components: treatment plan training, coaching employees toward excellence, supervision theory, and motivational interviewing.

Prior to the training, the trainers met with directors and staff at participating CMHCs to tailor the training content. Adult outpatient clinicians and alcohol and drug abuse specialists in the 15 CMHCs and state hospitals were required to attend the 1-2 day training, which was open to all staff. Over 230 staff from 13 CMHCs received the training on integrated treatment for co-occurring disorders. CMHCs in 3 regions requested and received

additional training on motivational interviewing and developing treatment plans. Over 112 staff at North Mississippi State Hospital, South Mississippi State Hospital, Mississippi State Hospital, and East Mississippi State Hospital received training on COD. To facilitate sustainability two trainers were identified in each region and at each state hospital. All COD staff is required to be trained.

As part of the evaluation process, over 300 charts were reviewed after the training. Treatment plans, alcohol and drug abuse assessments, progress notes, and required COD paperwork were included in chart reviews, which reflected that services were more integrated following the training. Therapists in each region who attended the COD training were interviewed regarding whether the training was beneficial and how they had implemented the training. The therapists reported that the training was very beneficial and effective. There were several requests for additional training. Evaluations by consumers reflected positive feedback regarding the quality of services they received following the COD training.

### **Housing Needs Assessment and Planning**

TTI enabled DMH and the Housing Task Force to receive technical assistance in development of the statewide strategic plan - the goal of which is to increase the statewide availability of safe, affordable and flexible housing options and services that support recovery in the community. Consultation activities centered on: (1) needs assessment to research and map current housing stock, needs and demographics; (2) gap analysis to identify priority system issues, to refine strategies for development of housing and supports, and to address consumer and family input on needs and preferences; (3) building housing partnerships at the state and local levels, including work to identify and work around barriers; (4) assessment and planning of service system models, reimbursement mechanisms and capacity to contribute to housing and service system re-design models; and, (5) development of additional funding mechanisms (including Medicaid), maximizing mainstream housing affordability opportunities, and on designing a bridge subsidy program and readiness for use of new federal housing resources.

One important outcome is the commitment by the HUD Hub (state) Office of Public Housing to work with the DMH to develop a Memorandum of Understanding to identify integration strategies, public housing authority (PHA) partnership opportunities, and to increase awareness of services for housing and support service entities. The specific strategy will address: education of PHAs on state services and education of service providers on housing programs, availability, and processes; identification of barriers; collaboration through the statewide planning process; promotion of disability preferences with housing authorities; and, targeting of new development of housing stock targeted for people with disabilities.

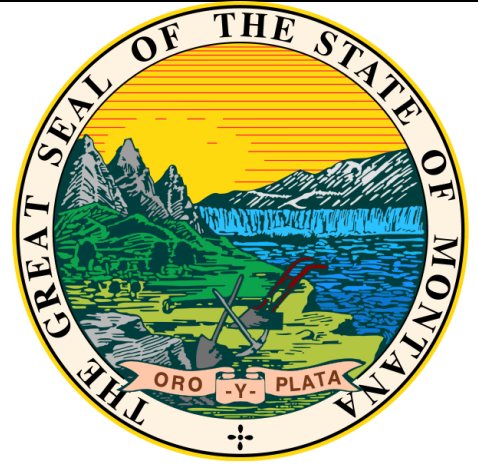
In February, 2011, DMH Planning staff presented the housing planning goals and objectives at the *2011 Annual Housing Affordability Conference*, held by the Mississippi Home Corporation and attended by developers, public housing authority staff, property managers and others. A memorandum of understanding between the DMH and the MS State Department of Health was developed to improve communication and coordination of care for individuals living in homes that fall under the regulatory purview of the agencies, and to facilitate improved oversight of these homes.

As a result of the TTI project, the housing consultants identified key policy and operational issues, and made recommendations to DMH leadership for design and implementation of the DMH Strategic Housing Plan. These recommendations also addressed infrastructure and related budget development to support next steps after the TTI project period. The projected date for finalizing the housing plan document for the Mississippi State Board of Mental Health is summer, 2011.

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# Montana



## **FY2010 TTI PROJECT:**

*Behavioral health and corrections collaboration, including training for law enforcement, criminal defense attorneys, and 911 data collection.*

## **KEY OUTCOMES:**

- Training on mental illness and crisis intervention has been provided to 200+ law enforcement officers & criminal justice professionals. Local providers, advocates, consumers and health care professionals have participated in the training. This Mental Illness Intervention curriculum has also been incorporated into Montana Law Enforcement Basic Training.
  - This initiative will continue into the coming years through funding from the Flex Rural Veterans Health Access Program grant awarded to Montana as one of only three states in the nation to be funded.
  - Legislation passed in 2009, and implemented during the TTI grant period, created three new programs for jail diversion and crisis intervention; including training for law enforcement and first responders. The programs include a matching grant program between the state and local county government to reduce emergency and court ordered detentions to the Montana State psychiatric hospital; a program to provide funding for community based, short term crisis stabilization beds; and provides permissive authority for an individual, in process for civil involuntary commitment, to suspend those proceedings and engage in voluntary inpatient psychiatric treatment. All three programs have been utilized over the past year with early outcomes showing measurable success.
- Each cross-training event was eligible for continuing education credit for law enforcement, social workers, professional counselors and addiction counselors. This cross-marketing ensured mixed audiences for each event and further enabled local coalition development.
  - Montana's existing Local Advisory Council and Service Area Authority structure for consumer involvement and grass roots innovation and problem solving will ensure that these relationships are fostered and continue to flourish. The LACs and SAAs will also serve as "think-tanks" for future training topics or needs.
- More than 60 county attorneys and public defenders from across Montana participated in training events developed under this project. The curricula covered topics including civil and forensic commitment, evaluations, effective communication with clients, moral and ethical responsibilities of representation and the NAMI Voices program. Both forensic and civil commitment training events emphasized cross system collaboration and placement in the least restrictive environment possible. Consumer panels shared personal experiences with the commitment process and provided valuable

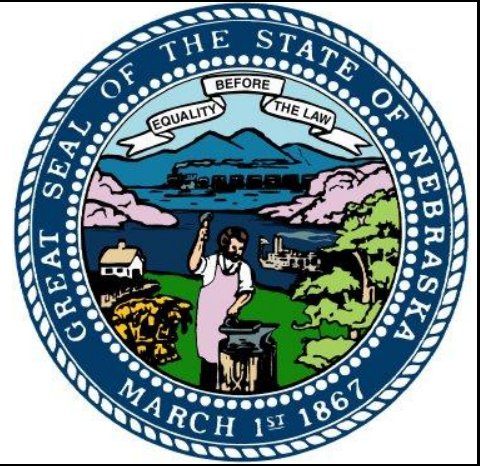
insight to the attorneys throughout these training events. Presenters included a supreme court justice, deputy attorney general, parole officer, forensic psychiatrist, state prison warden, registered psych nurse, law enforcement, advocates, providers and educators.

- Response to these legal training programs has been tremendous. The Montana Office of Public Defender and Department of Justice are committed to partnering with DPHHS for future training events. In addition, the presentations developed are now available for ongoing training efforts.
- A data collection protocol and integrated technology was created to track the aggregate number of calls to 911 with a mental health element. Information generated from this new technology furthers the state's efforts to provide quantifiable data on the needs for community based mental health crisis intervention programs, rather than relying on anecdotal information.
  - Montana's 56 counties are served by numerous vendors providing software programs to dispatch centers. Under this TTI project, the technology upgrades have been coordinated for multiple vendors serving the majority of counties, including the largest jurisdictions. With this technology in place, data collection becomes routine with all other data reporting for dispatch centers.
- A joint Crisis Intervention Team (CIT) workgroup has been formed from the three largest training areas. In partnership with the Montana Law Enforcement Academy and the University of Montana, DPHHS is working to review curricula for consistent learning objectives, evaluation measures and to determine if need exists for competency assessments. The group has plans to post a statewide training calendar, share information on funding options, collect aggregate data on officers trained and discuss a statewide program coordinator position to further enhance our efforts across the state.
  - The Montana Law Enforcement Academy, as the preeminent training entity for all sworn peace officers, has become an integral partner in this project. The academy is committed to assisting with coordination efforts to ensure that all officers, including law enforcement, corrections & detention staff, probation, parole and all other sworn officers receive consistent and outcome oriented education on mental health and crisis intervention.
- Technical assistance was provided to a number of neighboring and distant states. Montana presented on cross-agency collaboration at the 2010 GAINS conference, has provided training materials and resources on criminal justice list serves, and has been invited to submit a presentation to the International CIT conference this year.
  - This project was fostered from a strong commitment to collaboration between the Directors of the Montana Department of Public Health and Human Services and the Department of Corrections and the Montana Attorney General and Department of Justice. This relationship continues into the future and may serve as an innovative model to other states.

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# Nebraska



## **FY2009 TTI PROJECT:**

### *Statewide Peer Support Training.*

#### **Key Outcomes:**

- The Division of Behavioral Health created and hired an Administrator of Consumer Affairs within the department. The new administrator is a trainer in the implementation of peer support.
- As a pioneering state Nebraska is largely rural and peers face great challenges in bridging the great distance to Network. While there is an active Peer Support workforce in Nebraska there is a need for greater statewide coordination and standards.
- University of Nebraska Public Policy Center held three steering committee meetings of consumers of mental health services for input and direction of this project. The consumer steering committee selected Focus on Recovery- United, Inc. (FOR-U) in partnership with Sherry Mead Consulting and Yale University as contractors to provide a Nebraska specific peer support training curriculum. The group will provide an evaluation of the training as well as a curriculum to the State of Nebraska.
- Seven Town Hall Meetings were held across the state. There were meetings in Lincoln, Omaha, at the Omaha's Ponce Tribe facility, Norfolk, Hastings, Scottsbluff, and North Platte, with combined attendance of over 300 people. As a result, a report was created, one person was inspired to open their own business as a clubhouse, and new connections to the Native American community were fostered.
- A Statewide Peer Support Training is on schedule for January 2010 and a train the trainer will follow with a mock training opportunity.
- The State's final report will be available in March and will be presented at a statewide conference of Success Stories.

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# New Hampshire



## 2011 TTI PROJECT:

*Statewide implementation of client level outcome measures for adults and children/adolescents*

### KEY OUTCOMES:

The New Hampshire Department of Health and Human Services (DHHS), Bureau of Behavioral Health (BBH) was awarded a Transformation Transfer Initiative (TTI) grant for statewide implementation of client level outcome measures for adults with a severe mental illness (SMI), and children/adolescents with serious emotional disturbance (SED). These outcome measures are used statewide for all individuals receiving or requesting services from the designated community mental health programs. Two public domain tools are utilized to collect and report on this data: the Child and Adolescent Needs and Strengths (CANS) and the Adults Needs and Strengths Assessment (ANSA). These tools have been demonstrated to be highly effective in supporting a person centered treatment planning process, improving communication and collaboration with an individual's supports and services in the community, empowering individuals and families in the service planning process, and promoting a more effective management of service resources and supports over time.

The CANS and the ANSA are both available as a web based application, which not only has the capacity to provide online training and certification to clinicians administering the tool, but also track client progress over time and generate client level, regional and statewide outcomes reports. These reports are reviewed with stakeholder groups, including the NH State Planning Council, the NH Consumer Council, and the Community Mental Health Center (CMHC) providers to promote the continued improvement of services, identify regions which will be identified as centers of excellence, and also identify areas where additional resources may be needed to improve the effectiveness of services.

*TTI significantly increased collaboration between the state mental health authorities and the community mental health centers*

Accomplishments and the hurdles encountered to date:

- ❖ In December 2010, BBH developed a supplemental job description for a Planning Analyst/Program Coordinator whose scope of work is centered around managing and supervising the collection, analysis, reporting, and interpretation of community mental health center contract performance measures and individual client outcomes data for use in the planning and management of the community mental health service delivery system. To provide technical assistance and training to community mental health programs in the implementation and development of sustainability plans for client level outcomes measures. The Planning Analyst/Program Coordinator was hired in May 2011.
- ❖ Contacted Dr. Lyons, a national trainer and developer of CANS and ANSA, regarding consultation and training. Training started in April. In the focus groups, Dr. Lyons and BBH designed the first draft of the NH version of CANS and ANSA. It was felt that the NH CANS/ANSA was very inclusive of assessing the individual's needs and treatment options that some required documentation could be eliminated or combined. Concluded that

eligibility criteria for services, and quarterly reviews of the treatment plan could be folded into the CANS/ANSA assessment.

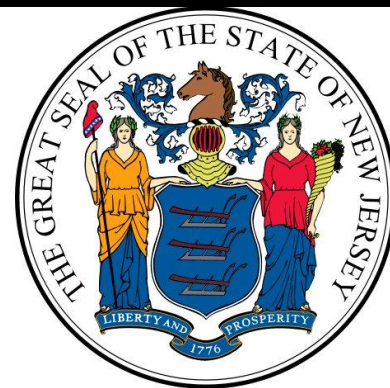
- ❖ The CANS/ANSA training and certification will be web based. Reviewed vendors, chose one and drafted an RFP. Since the program was a Commercial Off-The-Shelf Software program, an RFP was required. Over four months, what was originally a 6 page RFP developed into an 89 page RFP. The RFP was posted on the website on August 22, 2011. The process was quite helpful to BBH staff in understanding how the program would interface with the data collection that was needed.
- ❖ As of July 1, 2012 all 10 CMHC's have Electronic Medical Records (EMR) established. Five out of the 10 centers will have the same type of EMR. Staff began working with the representative of the company they are using to input the CANS/ANSA into their EMR. At the time the original RFP was written, it was stated that the centers would import data into the vendor and they could export the data to their centers. Because of this development where all centers would have EMR's by the end of the year, the RFP was re-written to state that the 10 CMHC centers could export and import data into the system.
- ❖ BBH met with Children's Directors, Community Support Program Directors, Older Adult Directors, and Quality Improvement Directors to solicit feedback on the NH version of the CANS/ANSA. Two staff from BBH attended the CANS/ANSA conference in Virginia, for a Train the Trainer, to become certified in the assessment tools. New Hampshire consulted with other states (such as Pennsylvania and Indiana), which have used these tools, to discuss how they rolled out these tools in their states.
- ❖ Each CMHC was offered 5 seats in the Train the Trainer training of CMHC managers. Training of all clinical staff statewide will begin to take place. Staff will have several options to become trained and certified:
  - Individuals can utilize the web based training when it becomes available.
  - Individuals can utilize their centers' staff that were trained as trainers.
  - Individuals can utilize BBH staff that were trained as trainers.
- ❖ Final accomplishments:
  - A draft has been finished of the NH CANS and ANSA.
  - Negotiations are ongoing to add CANS/ANSA to the managed care contract.
  - Providers and centers continue to train. Two have finished; the remaining 8 will train post-RFP.
  - BBH will begin organizing a Super User Group of the CANS/ANSA with those individual staff who were initially trained.
  - In October 2011, BBH will modify NH He-M rules to reflect the changes in eligibility and utilizing the CANS/ANSA.
  - One year after using the CANS/ANSA, the focus groups will reconvene to make any necessary changes that may be required.

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# New Jersey



## FY2009 TTI PROJECT:

*Creation of and training of Peer Specialist Wellness Coaches and a State Medicaid Plan Amendment to allow for reimbursement of peer specialist services.*

### KEY OUTCOMES:

- Five regional peer focus groups were held throughout January and February confirming both the need and demand for Peer Support Wellness Coaches throughout New Jersey.
- Partnered with the University of Medicine and Dentistry, New Jersey (UMDNJ) for curriculum integration and development. Four academic departments of SHRP (psychiatric rehabilitation, nutritional sciences, physical therapy, dental hygiene, complementary and alternative medicine) and CSP-NJ Institute for Wellness and Recovery were involved in the curriculum development.
- A statewide wellness and recovery conference was attended by over 400 participants in March 2009.
- Two regional meetings with Providers in April 2009 were very successful.
- Twenty-two peer specialist have completed six full days of training in the curriculum (42 hours). Topics included: overview of health/wellness needs of persons with severe mental illness, explanatory models of health and wellness, developing health habits/stopping unhealthy habits, basics of communication including responding, paraphrasing, and facilitative questions, as well as two full days on life coaching skills.
- Beginning on June 10, 2009, twenty peer specialists began training as Peer Wellness Coaches. Classes ran two consecutive days over the course of eight weeks. They participated in 96 hours or 16 full days of intensive learning. Six semester credits of academic programming successfully delivered to seventeen students who successfully completed course in terms of mid-terms, final exams and projects.
- Recruitment for new class commenced this November and additional funds to supplement TTI funding to provide additional students with scholarships to attend classes this fall were negotiated. Eight peer specialists will be supported with TTI funds, and eight additional will be supported with NJ DMHS funds.
- In order for the Peer Wellness Coaches to effectively apply what they had learned and to provide an opportunity for further skill refinement, the project established formalized “**Coaching Tele-classes**” for peer specialists to get continued support, encouragement, and to have a forum for problem-solving.
- New Jersey has begun data collection for the program evaluation process.
- New Jersey has submitted a draft State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) for Community Support Services (CSS) in the spring of 2009 under the Medicaid Rehabilitative Option and has had several collaborative conversations with CMS staff in an effort to finalize a formal submission that would receive favorable consideration.
- Working closely with the TTI Whole Health Peer Support Projects in New Jersey and Michigan.

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# New York



## **FY2009 TTI PROJECT:**

*Using "Recovery Centers" focused on consumer/family education, peer support and assistance with treatment planning to restructure care in New York State.*

## **KEY OUTCOMES:**

- Partnered with Dartmouth University to conduct research on the development of recovery centers and enhance the use of supported employment.
- One hundred peer organizations and individuals were identified to conduct the search, interviews and summary of promising practices that informed the peer forums and focus groups and ultimately will inform the Recovery Center model.
- Conducted interviews of thirty-five peer organizations and individuals which were identified as representative of innovative or promising practices.
- New York conducted six regional peer forums that served as the avenue for soliciting peer input related to Dartmouth's research:
  - August 27 - St. Francis College, Callahan Center, Brooklyn, NY
  - August 28 - Islandia Marriott, Long Island
  - October 8 - Newburgh, NY
  - October 9 - Saratoga Springs, NY
  - October 14- Syracuse, NY
  - October 15 Batavia, NY
- Dartmouth data and peer feedback regarding the development of recovery centers has been strong enough for the New York State Office of Mental Health to dedicate \$1.5 million for fiscal year 2009-10 (annualized) and \$3 million for FY 2010-11, to begin two Recovery center pilot sites in New York City and Rochester.

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# North Carolina



## **FY2008 TTI PROJECTS:**

- 1. Training and support to the Local Management Entities (LMEs) to learn from each other and foster evidence-based practices; and*
- 2. Improve LME responsiveness to consumers and improve the delivery and management of mental health services by training licensed clinical social workers, masters level psychiatric nurses and certified clinical addictions specialists to conduct the initial (first-level) examinations of individuals to determine if they meet criteria for involuntary commitment under North Carolina law.*

## **KEY OUTCOMES:**

### *LME Training*

- North Carolina's community mental health centers, or Local Management Entities, are no longer providers and have assumed a new role as intermediaries to manage and oversee providers. The Local Management Entity manual revised for this project is supporting their adjustment to this new role by utilizing Evidence-Based Practices. The web-based manual links to forty documents and training presentations created and in use by the original Local Management Entities. It also links to over seventy websites considered to have relevant information and strategies for developing evidence-based practices.
- The manual will assist greater understanding of the local centers' new role and the development of an infrastructure for supporting and sustaining the implementation of EBPs.

### *Improving LME Responsiveness*

- Development of a stakeholder advisory committee to assist the implementation of this project.
- Development of a training curriculum.
- Nine LMEs participated in this project.
- Three-day statewide training for twenty LME representatives.

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# North Dakota



## **FY2008 TTI PROJECT:**

*Peer Support Training and collaboration with State Medicaid Office in a statewide peer support initiative.*

### **KEY OUTCOMES:**

- Creation of a 35-member statewide stakeholder Peer Support Work Group, with five subcommittees:
  - Certification & Training Curriculum
  - 1915(i)/rehab plan
  - Research & Outcomes
  - CMS/3<sup>rd</sup> party reimbursement
  - Information technology support;
- More than eighty individuals attended each of the workgroup's three meetings.
- Developed a Management and Implementation Plan.
- Developed Peer Support Certification Curriculum.
- Held Stakeholder Training in eight regions to ready providers and systems for these new services.
- Worked with the state Medicaid Office to submit Medicaid Requirements for statewide Medicaid funded Peer Support service in the form of a Medicaid State Plan Amendment and a Medicaid Waiver.

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# North Dakota



## **FY2010 TTI PROJECT:**

*Development of the Transition Aged Youth Pilot Project.*

### **KEY OUTCOMES:**

The North Dakota Division of Mental Health and Substance Abuse Services provided a pilot project to address the needs of transition-aged youth at risk. The pilot site was North Central Human Service Center in Minot, North Dakota with service coverage of seven counties representing 82,159 North Dakota Citizens. In early 2009, the Sixty-First Legislative Assembly of North Dakota passed House Bill 1044 to enact programming for services to transition-aged youth at risk. The legislation calls for the Department of Human Services to develop a service program for transition-aged youth at risk by using a wraparound planning process.

The Transformation Transfer Initiative Project at North Central Human Service Center targeted transition-aged youth ages 14 -24 and built upon current transformation services as well as Bill 1044. This project collaborated and worked intensively with multiple community resources to provide the necessary supports to youth in transition.

The Transition Team at North Central Human Service Center reviewed requests for assistance by youth or their case managers and made recommendations to the Children's Mental Health Program Administrator for approval. Outcome of each youth receiving flex funds and wraparound case management services were tracked through the electronic health record systems of ROAP & FRAME.

As of March 31, 2011 the Transition to Independence Pilot Project has a case load of 18 transition aged youth/young adults. There were five males (ranging from ages 18-23) and 13 females (ranging from ages 18-24).

There have been 63 grant fund requests to assist youth/ young adult in their transition to adulthood. Grant requests included assistance in the following areas:

- Eye Appointment & glasses
- Birth Certificate
- GED - General Education Degree
- Transportation (bicycle, taxi, bus)
- Rent Deposit
- Rent Assistance
- Food

- Clothing
- Miscellaneous (household items, baby items)
- College expenses (books, equipment)
- Honorariums

The Transition Facilitator average 7-10 consultation cases each month between Partnerships, Extended Care and other systems partners throughout most of the TTI grant term.

The TTI grant also assisted with several activities which will continue post-TTI, including many of the above described activities, the development of a regional transition advisory committee, a state wide advisory council and several partnerships.

- A state wide Transition Interagency Advisory Council was formed and held its first meeting on December 14, 2010. The Council will specifically advise the Department of policy issues, delivery of services, and methods for reaching potential consumers. The Department will provide oversight of the transition program along with development and facilitation of the advisory council meetings. The Council will meet on a regular basis. A statewide survey was completed in January 2011 to determine the tops transition needs across the state. The survey had a 65% response rate with five over all themes being pulled out of the responses: 1. Housing and Transportation; 2. Jobs and Employability; 3. Support Systems; 4. Health (Mental & Physical); 5. Management Systems. These areas will be used to develop a strategic plan for the State Advisory Council at subsequent meetings. This Council is advised by subcommittees formed in each of the eight North Dakota human service center regions, which have a regional representative at the Council.
- An MOA has been established with the National Network on Youth Transition (NNTY) for consultation services, training and technical assistance for implementation and sustainability of the Transition to Independence Process (TIP) Model for Transition Facilitators in ND. Discussions with the National Network on Youth Transition continue on how the TIP model would best work in ND. Collaborative discussions are occurring with states who have implemented the TIP program to determine the best route for implementation in ND. It was decided that ND will train all Transition Facilitators in the TIP model of practice for case management services for transition aged youth and this program. The TIP training was held on May 17-20, 2011 in Bismarck ND.
- The Transition Facilitator (formerly the Transition Coordinator under the TTI grant) continues to provide consultation services to case managers with transition aged youth being service through Partnerships & SMI/Extended Care case management along with case management services for those youth who do not receive services through either of these programs. The Transition Facilitator continues to provide case management services for 12 young adults with 11 infants/toddlers. Finding affordable, appropriate and safe housing continues to be the biggest struggle.

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# Pennsylvania



## **FY2008 TTI PROJECT:**

*Older Adult Peer Support Services Initiative.*

### **KEY OUTCOMES:**

- Developed an Older Adult Peer Support Competent one-day curriculum.
- Developed an Older Adult Peer Support Enhanced three-day curriculum.
- Recruited twenty Certified Peer Specialists age 50 and over to specialize in working with older adults;
- Piloted the three-day Older Adult Peer Support Enhanced curriculum in Harrisburg, PA, with twenty older adult Certified Peer Specialists.
- Piloted regional one-day Older Adult Peer Support Competent trainings, recruiting twenty Certified Peer Specialists in each of three regions of the state (a total of sixty trainees).
- Seventy-eight Certified Peer Specialists' completed the trainings. Sixty-eight percent (68%) were female and thirty-two percent (32%) were male. Ages ranged from 28 to 67, with an average age of 51.
- Created specialized work opportunities for Certified Peer Specialists who completed the enhanced older adult curriculum.
- Collaboration among state agencies (OMHSAS and PA Department of Aging and Long Term Living) and university staff (Center for Mental Health Policy and Services Research, University of Pennsylvania).
- Leveraging of this TTI grant to secure another grant from the University of Pennsylvania to build and continue these services after the end of the TTI project.

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# Pennsylvania



## FY2011 TTI PROJECT:

*Older Adult Peer support training and training infrastructure*

### KEY OUTCOMES:

**Introduction.** In efforts to reduce barriers to treatment the Office of Mental Health and Substance Abuse Services (OMHSAS) has been developing a cadre of older adult peer specialists to provide recovery services to older adults. At the time of the 2008 TTI grant, 854 Pennsylvanians were trained as Certified Peer Specialists (CPS). This core group includes many older adults, who were identified in 2008 for a special training initiative, Older Adult Peer Specialist Training. In 2008, sixty peer specialists were trained to work with older adults in recovery; twenty were certified as Older Adult Peer Specialists.

#### ***Goal 1: Train the Trainer Curriculum Development.***

A modification of the Pennsylvania Certified Older Adult Peer Specialist(COAPS) train the trainer curricula was developed and implemented with existing older adult peer specialists and targeted professional trainers. The curriculum included learning objectives, content training information, experiential techniques, and performance measures in methods for working with adult learners and the prescribed behavioral health modules that are currently used for the COAPS Training. The curriculum format was designed for use in the field by COAPS.

#### ***Goal 2: Recruitment.***

OMHSAS developed and implemented a training application process beginning in December 2010 to identify and select up to 2 out of state trainer candidates and two training vendors. Each vendor contracted with two professional trainers and two COAPS trainers. Recruitment and selection was operationalized through an application and selection process that was conducted by an OMHSAS organized review and selection committee, using the recruitment and selection process devised under the original TTI grant for recruiting up to ten older adults (age 50 +) to provide peers services to older adults. The recruitment strategy included distributing a statewide training announcement and utilizing the Pennsylvania Peer Support Coalition to publicize the training opportunity.

#### ***Goal 3: Pilot the Train the Trainer approach.***

The train the trainer approach was piloted with 10 trainer candidates and 10 certified peer specialists. Counties and providers were notified of the availability and location of the training session; grant funds were used to pay for the hotel costs and the trainee costs. Evaluations of the training were completed by all participants and feedback from these pilot trainings session will be used to develop the final curriculum package. All training was delivered through training dyads comprising one professional trainer in partnership



with a certified older adult peer specialist trainer.

***Goal 4: Follow-up evaluation.***

Both trainers and students will be surveyed at the end of September, then again in December and March. This evaluation process will be used to inform the continuing development of both the trainer curriculum and the peer specialist curriculum. The curriculum and the training processes will be modified to reflect the participant input in the final edition.

***Goal 5: On-going COAPS training.***

The two professional training vendors are contracted with OMHSAS to deliver the COAPS curriculum in PA through 2014. Each entity had their first COAPS training in November 2011, in two different regions of Pennsylvania. PA also reviewed the entire training curriculum with both vendors looking for possible changes and improvements – one change was the addition of gambling sections. Each vendor will conduct two trainings annually through 2014. OMHSAS has presented on COAPS at the annual Area Agency on Aging Directors meeting as well as 5 regional Behavioral Health and Aging “Share the Care” trainings.

***Goal 6: Follow up data collection and consultation.***

Two conference calls will be scheduled for all Trainers at 3 and 6 months following their completion of the course. These calls will be instituted on a quarterly basis thereafter for two years to develop a national COAPS learning community, starting with PA and other selected states. The calls will be used to collect data about the trainers and their training programs, provide cross-fertilization for the trainers and provide technical assistance to the trainers.

**TRAINING**

Certified Older Adult Peer Specialist training was held in two parts: August 1, 2011 10 individuals participated in train-the-trainer activities. This one day training followed four teleconference TA calls. The training day addressed issues of adult learning theory and public speaking techniques. Participants became familiar with the curriculum and had the opportunity to practice the modules.

Older Adult Peer Specialist Training was held August 2-4, 2011 for 10 participants (total of 20 trainees). Potential trainers participated in the training both as trainees and as trainers.

The 8 Pennsylvania trainers began training Pennsylvania peers, and each vendor has held 1 training with 20 people per class. Each vendor is scheduled to have two trainings this year and each of the following two years as well (6 per vendor).

With the work accomplished in this TTI project, PA now has over 2,000 certified peer specialists, some of which are specialized in areas of Older Adult, Wellness and Forensics.

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# Puerto Rico



## **FY2008 TTI PROJECT:**

*Integration of behavioral health into rural primary care settings.*

### **KEY OUTCOMES:**

- Increased knowledge in the physical health professionals of signs and symptoms of emotional illness and procedures for referral (Pre/post SSEI scale).
- Increased access to integrated physical and mental health services for patients of the Northwestern Region, and particularly of the Isabela municipality (service log attached to each medical record).
- Early detection, evaluation and intervention for patients presenting symptoms of mental illness within the Isabela primary care clinic (Evaluation and intervention checklist attached to each medical record).
- High satisfaction (staff survey) of the integrated health team members with the IPC model.
- High satisfaction (on client survey) with the IPC model with the integrated physical and mental health services received.
- Reduced ER visits of patients with co-morbid disorders attended through the project (Pre-post ER and outpatient data).
- Positive outcomes in the Isabela pilot have fueled other Mayors to reach out to the Department to collaborate to fund similar projects in other rural areas across the commonwealth.

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# Rhode Island



## **FY2011 TTI PROJECT:**

- 1. Creating/Deepening a Recovery Culture in RI Community Mental Health Centers*
- 2. Cultivating a Skilled Peer Specialist Workforce through Competency-Based Training in Peer Support*

## **KEY OUTCOMES:**

The TTI project in Rhode Island has gained tremendous momentum by engaging with stakeholders and through the formation of a Transformation Advisory Group. This group recently met with members of Yale University's Program for Recovery and Community Health (PRCH), and has contracted with The Rhode Island Council of Community Mental Health Organizations (RICCMHO), who in conjunction with the Yale University group will be providing all training components of the TTI. BHDDH also contracted with NAMI of Rhode Island to support the internship phase and supervision of trained peer specialists.

On September 29, 2011, BHDDH hosted a recovery training kick-off facilitated by the PRCH group at Yale with participating Community Mental Health Organization CEOs and other members of their leadership teams. This event provided clarification on the direction of the TTI program, the trainings that were provided, the role of peer specialists and the supports that were provided for all participants.

*Flexible funds and timing led to great, responsive, innovative results.*

Following this initial kick-off, the Yale PRCH team scheduled individual recovery trainings for each CMHO. Prior to the actual trainings, BHDDH and RICCMHO provided Yale with agency policies, documentation examples, and Recovery Readiness Survey results to aid in their assessment of each agency's recovery orientation.

### ***Component 1: Creating/Deepening a Recovery Culture in Rhode Island CMHCs.***

This was a one-day comprehensive learning event (e.g., *Recovery: From Theory to Practice*) for each of the nine involved CMHCs. Training included a mix of didactic material with rich interactive/experiential exercises to reinforce learning.

- There was an emphasis placed on how "concepts" of recovery translate into concrete practice-based strategies which are reflective of recovery-oriented systems, i.e., the training focused not only on key recovery values and philosophy but also on the "nuts and bolts" of practical implementation at the level of the individual service practitioner. It discussed the roles of clinical and rehabilitation staff, as well as

the potentially powerful role of Peer Specialists, in implementing person-centered planning.

- There was an emphasis upon the unique value and contributions of Peer Specialists within a recovery-oriented menu of services as well as ample time for discussion around frequently asked questions which arise as systems strive toward the integration of Peer Specialists within Community Mental Health Recovery Support Teams.
- After each CMHC training, there was specific tailored technical assistance and follow-up to each regarding their implementation of recovery-oriented services and best-practice peer support. This largely occurred via web and teleconferencing forums without decreasing the impact of the interventions.

### ***Component #2: Cultivating a Skilled Peer Specialist Workforce through Competency-Based Training in Peer Support***

After an initial set of requests for participants, Rhode Island ended up with 50 responses for peer training. 28 individuals were trained in the 8 week Yale PRCH curriculum. All took the qualification exam for statewide certification purposes. 25 will be placed in Health Homes, and as part of that assignment each will take the Wellness Coaching training provided by Peggy Swarbrick's group from the UMDNJ-SHRP Department of Psychiatric Rehabilitation and Counseling Professions. That training will occur Jul 16-18, 2012, followed by an exam held on July 20<sup>th</sup> which will confer an advanced certificate in health and wellness. The remaining three individuals received additional training as employment specialists and will be placed in vocational programs, receiving supervision from an IPS certified vocational rehab counselor as they offer assistance to people looking to find and maintain employment. Rhode Island is hopeful that these processes will ultimately lead to a streamlining of the certification process and result in declining costs for certification and training. Rhode Island has also obtained the rights to use these training materials in the future, so this will be a self-sufficient program that will not need additional outside consulting visits.

Following certification, the certified peers started internships in community settings. These internships are occurring at the intended places of eventual employment. Some CMHCs are opting to immediately begin the employment phase of the peers. ***Certified peers are required on Rhode Island health home teams, and are part of the health home bundled rates.***

The training was highly experiential based on prior experiences designing similar training models/ curriculums with other systems of care, including the following:

- SAMHSA Ten Fundamental Components of Recovery and implications of this for a wide range of Peer Specialist interventions;
- Core values and key practices within the Intentional Peer Support (IPS) model developed by Shery Mead;
- Core values and key practices within the delivery of Wellness Recovery Action Planning (developed by Mary Ellen Copeland) and the Pathways to Recovery Program (developed by Priscilla Ridgway); and
- Role of Peer Specialists as mentors/educators in training and supporting people in recovery in person-centered planning models and maximizing the participation of all persons in decisions regarding their care and life.

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# South Carolina



## 2011 TTI PROJECT:

*Models of Integration for Community Health Centers and Community Mental Health Centers*

### KEY OUTCOMES:

The South Carolina Department of Mental Health used their TTI funding to initiate a partnership and planning process with the South Carolina Primary Health Care Association: to identify, adapt or develop bidirectional models of integrated care for both Community Health Centers (CHC) and Community Mental Health Centers (CMHC); and provide statewide training forums.

The SC TTI provides a mechanism for expanding collaborative partnerships for integrated primary care and behavioral health services and meeting the statewide goals which are:

1. To expand stakeholder involvement and leadership coordination for joint planning and shared decision-making;
2. To identify promising practices and models of integration;
3. To identify and address cross training needs for integrated workforce development and client coordination strategies;
4. To engage local partnerships for assessment of integration opportunities, gaps in service delivery and provide infrastructure funding support;
5. To conduct regional and statewide training forums; and
6. To identify effective methods and benchmarks for implementing and sustaining integration partnerships and improving access to care.

*The flexibility to create a framework allowed South Carolina to plan better. It's not a popular statement, but the limited TTI funding can produce better results because it produces a stronger focus, prevents lackadaisical planning, and forces an immediate focus on sustainability.*

During the course of the TTI, eight pilot sites comprised of county CMHC and CHC were developed and are now in various stages of implementation of their collaborative efforts to provide integrated care. Seven of the eight pilot sites were able to implement various infrastructure building components of the integration initiative. However, one of the CMHC pilot sites decided not to execute a contractual agreement for the proposed integration planning initiative due to significant administrative barriers and low patient referral rates within the targeted geographical area. This pilot site represented a very rural area of the state with no prior relationship between the CMHC and CHC. However, the CMHC pilot site has entered into an arrangement with another primary care community health center for which it has a longstanding partnership.

The state has identified key staff responsible for integration policy/program planning and direct clinical treatment staff for participation in the University of Massachusetts Certificate Program in Primary Care Behavioral Health, a six month training program for strengthening its administrative and clinical capacity for an integrated workforce.

An additional part of the TTI planning process involved the establishment of a Leadership Advisory Council to facilitate a joint planning and shared decision-making forum for behavioral health, primary care, consumer advocacy and other key stakeholders in order to develop integrated policies and to create the state's vision of service delivery. In addition, the SC Primary Care Association has formed a Behavioral Health Network among their members.

As part of the evaluation process of the TTI, a short integration baseline survey was conducted to gather background data on pilot project sites. At baseline, nearly three quarters of survey respondents indicated that they were currently collaborating with other organizations to provide integrated care, however, collaboration methods varied and were found to be both formal and informal.

The TTI funding enhanced South Carolina's capacity to develop a blueprint of behavioral health and primary health care integration options to enhance access to care for our citizens.

Highlights of SC's accomplishments include:

- Establishment of the state level partnership between the South Carolina Department of Mental Health (state mental health authority) and South Carolina Primary Health Care Association;
- Establishment of state level Integrated Health Leadership Advisory Council and quarterly forums;
- Establishment of eight (8) integration collaboration partnerships;
- Engagement of supportive partnerships (Medicaid Agency, Consumer Advocacy Organizations) for expansion of policy development and future planning infrastructure;
- Increased awareness of TTI partnerships through presentations at behavioral health and primary care providers and policy forums;
- Preliminary assessment of training needs and resources for future workforce development efforts;
- Collected and compiled baseline integration data collection of each pilot site;
- Ongoing tracking of new patient admissions for integrated treatment tracks; and
- Implementation of Whole Peer Health Training.

South Carolina continues to receive feedback from both state and local level integration partners regarding strategies to overcome barriers and challenges encountered. Keys areas of focus include:

- Orientation to each entities' organizational policies and procedures to ensure a streamlined approach to subcontracting and sustainability of partnerships;
- Best practices for client referral, service delivery and adhering to regulatory requirements;
- Sharing of client information and outcome measurements;
- Implementation of cross-training of staff; and
- Involvement of consumer advocacy organizations regarding patient engagement strategies.

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# South Dakota



## **FY2009 TTI PROJECT:**

*Strengthening rural MH transformation through the development of family-voice in implementation efforts. South Dakota is also expanding an existing System of Care Pilot Project by implementing Wraparound training in two regions of South Dakota that are actively working toward the creation of an integrated services system for children and their families.*

## **KEY OUTCOMES:**

*Development of and Utilization of the Family Voice in Development and Implementation  
Of a systems of care frame work.*

- Families in both pilot sites met with Amanda Lautenschlager, South Dakota Parent Representative, Barbara Huff, consultant and Phyllis Arends, NAMI South Dakota Director, to discuss family options for support and education as South Dakota moves forward.
- Parent Professional Partnership Trainings were held in both Pierre and Sioux Falls and were the catalyst for development of Family Support Meetings in each community led by a Parent Representative that is also involved in the community-wide efforts to support a system of care framework. This is an important first step to building family/provider partnerships in the future. There is excitement among training participants about changing the way South Dakota does business with children and families.
- South Dakota providers are strongly considering parent positions. One mental health center has employed a parent partner through grant funds and is working on sustainability plans. The Rapid City group is considering a parent position, but this will likely resemble more of a consultant relationship with specific deliverables.
- Dialogue and relationship building has begun with Parent Connection- the states' only Parent Training and Information Center (PTI), Navigator Program (alternative dispute resolution), and Family to Family Health Information Center (F2F HIC) to further support the infrastructure needed to sustain family involvement in all aspects of systems of care development.

*Build Capacity for Wraparound Implementation to help children and their families realize their hopes and dreams. The wraparound process also helps make sure children and youth grow up in their homes and communities.*

- Wraparound Training was delivered in both Rapid City and Pierre and subsequent technical assistance coaching visits were provided to both sites as follow-up. Both providers and families participated in the trainings and follow-up visits.
- Mary Grealish conducted an individualized training/orientation meeting for Pierre to help them gain commitment and participation from the community stakeholders involved. She then completed additional coaching on Wraparound for Pierre and Rapid City.
- Discussions are underway for cross-agency training on Family Group Decision Making utilized by the Rapid City Child Welfare agency.

*Relationship building and coordination of efforts.*

- Multiple child-serving agencies working well in tandem at both the state and local levels.
- Local level governing and planning groups are established.
- State agency directors met with financing consultants from Nebraska to discuss options for restructuring their current funding streams to more effectively support a system of care framework.
- Both Pierre and Rapid City's local system of care steering committees have realized that the majority of youth and families have co-occurring substance use issues and are interested in coordinating their efforts with some of the existing infrastructure provided through the South Dakota Co-Occurring State Infrastructure Grant's Change Agent group.
- Utilizing the core principles and values of a system of care, South Dakota has been able to coordinate its efforts towards the State's Co-SIG, suicide prevention, and Data Infrastructure Grants as it relates to TTI outcomes.

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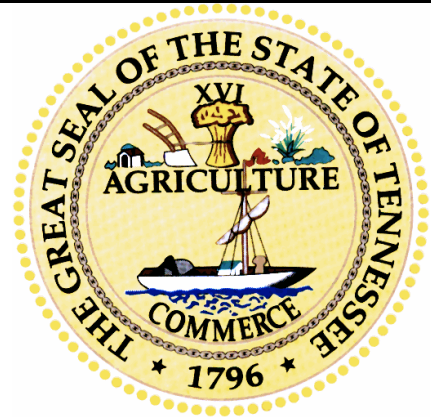
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# Tennessee



## FY2008 TTI PROJECT:

*Transforming their juvenile forensic mental health services by providing courts with alternatives through a program of outpatient screening and forensic evaluation.*

### KEY OUTCOMES:

- Supplied training and technical assistance to community providers for the transformation of the juvenile forensic mental health evaluation service to a community-based service and connecting juveniles to other age-appropriate mental health services.
- Established working relationships with essential departments in Tennessee's Executive, Legislative and Judicial branches, including the Administrative Office of the Courts, the Attorney General's office, the General Assembly's Fiscal Review Committee, and the Governor's Office of Child Care Coordination.
- Collaborated with the Tennessee Council of Juvenile and Family Court Judges and the Administrative Office of the Courts to revise and distribute model court orders for both inpatient and outpatient, including the training for judges and contact information for providers for each court.
- Engaged additional judicial leadership through the Tennessee Council of Juvenile & Family Court Judges to establish an understanding of the needs of judges for mental health evaluations, DMHDD services, and the proper approach to implementation of a wider use of outpatient evaluation, access to services, and competency training.
- Prepared, at the TDMHDD level, to respond to a crucial decision by the Tennessee Court of Appeals directly affecting all courts and all evaluation providers.
- Provided key leadership in the development of legislation to complete the transformation.
- Proposed funding availability for an increase in outpatient evaluations *prior* to seeing any cost reductions from a decrease in inpatient evaluations.
- Identified the primary missing resource resulting in the over-reliance on restrictive, expensive inpatient evaluations.
- Placement alternatives for juvenile justice system youths other than detention or home.
- Began an effort to create a new database to streamline data across state agencies.

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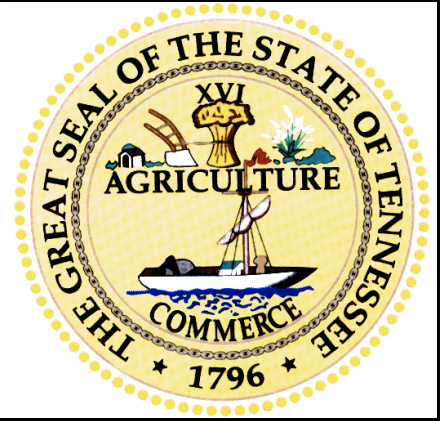
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# Tennessee



## 2011 TTI PROJECT:

### *Early Intervention for Prevention:*

### *Improving Access to Mental Health and Substance Abuse Services for Youth in Juvenile Courts*

**Transformation Goals:** To deploy a public health approach of early intervention to improve access to mental health and substance abuse services for youth in juvenile courts as well as to support follow-through with and participation in available services which contribute to diversion from the juvenile justice system and reduce recidivism.

#### **Background:**

This project focused on putting Family Service Providers in place to assist youth (and their families) with charges in juvenile courts in accessing a broad array of services. A Family Service Provider (FSP) is a self-identified parent/caregiver or family member of a child or youth with a SED which has required mental health and/or substance abuse treatment. FSPs have to complete a certification process provided by the Tennessee Department of Mental Health (TDMH) which is similar to a Peer Support Counselor. The specific role of the FSPs was defined to some extent by the needs of each individual juvenile court and each individual case. Family Support Provider typically include:

- Provide support to individual families to assist them in accessing services and in navigating the various child-serving systems in the following ways:
  - Assist families in overcoming barriers to accessing services
  - Provide support and information on community resources
  - Assist caregivers in learning how to build collaborative relationships with service providers involved with their children
  - Assist caregivers in establishing a support network of formal and informal support persons
  - Empower families to advocate effectively for their children
- Participate as a member of the Child and Family Team
- Are responsible for timely and concise case documentation, as well as entry of accurate demographic and other information into the database
- Collaborate with local providers, Juvenile Court staff, and school staff in the best interest of the child and family
- Participate in weekly supervision with Supervisor and for following case direction
- Participate in collaborative meetings/trainings and team building activities with the program staff

*Flexibility around timing allowed TN to pick the best battles to fight as opposed to having to use all the money in a certain time period.*

#### **Implementation:**

Implementation of this TTI project capitalized on the cross-agency collaboration established in Tennessee's first TTI grant in FY 2008 with the Administrative Office of the Courts, the Department of Children's Services, the Vanderbilt University Center of Excellence, the Tennessee Council on Children and Youth, Tennessee Voices for Children and the Governor's Office of Children's Care Coordination. A task force with representatives from each of these agencies established a court screening project in which youth who had cases in ten volunteer juvenile courts were screened by youth service officers with a 33-item Juvenile Justice screening version of the Child and Adolescent Needs and Strengths survey (CANS). This is a service-planning instrument which rates the presence and intensity of needs related to mental health, substance abuse and delinquency. Any identified need resulted in a referral.

This TTI project established FSPs in four of the courts, who followed up to help the youth and family identify the proper services and overcome barriers to access for those services. FSPs provided a wide range of services, from working directly with caregivers on parenting strategies to providing coordination among a number of treatment providers on a single case. Specific examples include:

- ✓ Diversion of female juvenile to residential program (Operation Hope) resulting in dismissal of shoplifting charge;
- ✓ Coordinating services for a child with alleged delinquent behavior and disclosure of being sexually victimized;
- ✓ Arranging a cross-discipline caregiver meeting for a child receiving multiple services;
- ✓ Coordinating aftercare services for youth discharged from inpatient psychiatric treatment post- suicide attempt;
- ✓ Educational advocacy to secure additional testing for a juvenile with Tourette's syndrome who had been referred to Juvenile Court for behavior problems at school (the FSP planned to advocate for a behavior plan to be integrated with the educational plan);
- ✓ Assisting the mother of a child with ADHD referred to court for school behavior problems by coordinating the child's mental health care and the mother's physical care. This child's mother has significant mobility problems due to advanced diabetes and associated foot problems. The FSP was able to assist her in applying for a lift chair for her vehicle, a shower chair, a diabetes bracelet and transportation options that will improve her ability to get her daughter to the mental health center for services; and
- ✓ In a case opened in April on a female with behavior problems at school, the FSP's initial interventions were to assist with a referral to local mental health services for the juvenile and parenting classes for the mother (actually requested by the mother-she knew what she needed but not how to get it). The FSP also helped the mother to request school records so she would be more able to talk to the school about educational needs.

A meeting of staff and project coordinators from all the courts involved was held during the annual Tennessee Juvenile Court Staff Conference, and anecdotal feedback indicated strong support for FSP services, particularly in rural areas where services were distant and difficult to identify. One juvenile court judge said:

*"Macon county is one of the counties participating in the CANS Pilot program. We also have a Family Support Specialist working with us in the program. She can verify Macon County's lack of services for our children. Ms. Howell has been a big help for us, but we could benefit from more of her time in Macon County. I am writing to request more of her time in Macon County if possible. Thank you, Ken Witcher, Juvenile Court Judge."*

### **Sustainability:**

TennCare has approved FSP services as a cost-effective alternative, reimbursements are ongoing on a case-by-case basis, and formalized reimbursement (leading to potential program expansion and continuation post-TTI) is expected by the end of 2012.

### **Next Steps:**

- ➔ Current TTI funds will allow for the continuation of FSP services through June 30, 2012, including additional hours of service available in those counties currently being served by FSPs;
- ➔ In 2012, data from the participating counties will be analyzed for patterns of need and effects on recidivism, and structured interviews will be completed with court staff to identify strengths and weaknesses of the FSP services;
- ➔ Data analysis and feedback will guide the task force in determining how to identify the best county and court environment for expansion and the best method for implementation;
- ➔ The TTI FSP project will be integrated into TDMH's broader goal of developing local Systems of Care which are comprehensive, culturally and linguistically competent, child-driven and family-focused with an emphasis on keeping children in their homes; and
- ➔ The program is currently largely rural; Tennessee next hopes to expand it into more urban areas.

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# Vermont



## FY2011 TTI PROJECT:

### *Vermont Evidence Based Practices Cooperative*

#### KEY OUTCOMES:

The Vermont Department of Mental Health (DMH) is establishing an independent, cooperative organization focused on mental health practice improvement and workforce development. This new organization, referred to as an *Evidence-Based Practices (EBP) Cooperative*, will work with mental health providers, consumers, family members, and other service organizations to support the adoption of promising, evidence-based, and recovery-oriented practices within the state's community mental health system and improve the quality of life outcomes for individuals receiving services from that system. The EBP Cooperative will also focus on establishing and supporting core competency training for Vermont's community mental health providers to ensure that our workforce has the core values, skills and knowledge to meet the needs of the consumers they are working with.

Vermont has previously used other federal grant funds (*New Freedom Initiative – State Coalitions to Promote Community-Based Care*) to support a multi-stakeholder (consumers, family-members, mental health providers) panel to review and make recommendations regarding how evidence-based practices should be implemented in Vermont. The panel has been responsible for 1) evaluating reviews of the scientific and practice literature on specific practices, as well as "lessons learned" from in-state pilots and state-wide implementation of those practices, and 2) creating recommendations about the scope and scale of implementation of those practices in Vermont. The panel has evaluated and produced recommendations for eight EBP's to-date. Based on these recommendations, the panel has also developed recommendations to create an Evidence-based Practices Cooperative as the primary method for implementing their recommendations. The TTI award has taken these recommendations and sought to implement them.

#### ***Description of the EBP Cooperative***

The Evidence-Based Practices (EBP) Cooperative will serve as an independent practice improvement and workforce development organization focused on the adoption of evidence-based practices, recovery oriented practices, core competency practices, and practices that are supported by efficacious outcomes (i.e. practice-based evidence) within Vermont's community mental health system. Membership of the cooperative will include community and inpatient mental health providers, consumer and family support organizations, higher education, and consumer and family members. Each stakeholder group will share responsibility for supporting the work of the cooperative to identify, implement, and sustain EBP's in Vermont.

Specific functions of the EBP Cooperative will include:

1. Perform systematic review, evaluation, and analysis of new evidence-based and promising practices for possible implementation in Vermont.
2. Operate as a state clearinghouse for resources and information on evidence-based practices (this will include specific information on EBP's for consumers and families to support informed consumer choice).
3. Develop and sustain in-state resources to support the implementation of evidence-based practices (e.g. training of

trainers to establish in-state experts on specific EBP's, web-based training, training materials, and consumer and family panels). Develop opportunities for new learning and continued education.

4. Assist agencies in specific practice reviews and perform outreach, evaluations and fidelity assessments of mental health services to determine availability and quality of evidence-based practices in the state. Support peer review processes for agencies when they are desired.
5. Coordinate training, case consultations, technical assistance, and other workforce and program development activities to support adoption of core mental health competencies and evidence-based practices.
6. Identify state and local implementation opportunities and barriers (e.g. policies, funding) and facilitate efforts to address barriers (i.e. the creation of flexible funding to purchase trainers/consultants).
7. Support the use of data collection, outcomes-monitoring and community-based research to evaluate the effectiveness of practices being provided by the community mental health system.
8. Grant writing acquisition and fundraising to support the EBP Cooperative activities.

To create the Cooperative, Vermont has:

- Utilized stakeholder input to revise the original proposed timeline for the initiative and recognized that a business model should be developed to ensure that the services being envisioned for the EBP Coop should be clearly described and reflect the researched wants of the mental health provider system. In doing so, Vermont reconvened the original Clinical Practices Advisory Panel (CPAP) of the Community Rehabilitation and Treatment (CRT) programs of the 10 designated community mental health agencies in the state of Vermont.
- The members of CPAP affirmed that a business model and a smaller EBP Coop Development Committee should be developed to continue the initiative process. Additional recommendations enabled the Development Committee to add a strong consumer advocate with significant business acumen in the highly competitive computer software market and a family advocate member with long standing ties to service with DMH and specifically the state hospital. CPAP also reaffirmed the mission statement, vision statement, and revised the desired business functions as outlined in the original initiative application. This unique committee structure, which in the past would have been dominated by only provider members, has provided greater confidence that the created final business model will create an entity that has a greater chance of surviving and flourishing in financially uncertain time periods.
- Market survey interviews have been done with a portion of the possible end users have been ongoing. This information has been used to modify functions further and provide for a clearer picture of the core needs of the system providers which could be met by the EBP Coop. Several revisions and re-constructions of the structured market interview survey tools were developed, and the final tool appears to be effective in garnishing the desired information in an efficient format during the brief interview time periods.
- Research by DMH staff members into the various e-learning opportunities has also been a constant activity which has revealed some deficits in the current e-learning provider system, but has also lead to the discovery of some promising curriculums.

As a result of these activities, Vermont has issued an RFP for the creation of the Cooperative. Next steps will occur in the Summer of 2012.

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# Virginia



## 2011 TTI PROJECT:

### *State CIT conference and CIT expansion*

The Department of Behavioral Health and Developmental Services (DBHDS), in collaboration with NAMI Virginia, the Virginia Organization of Consumers Asserting Leadership (VOCAL), the Virginia Beach Department of Human Services (VBDHS), the Virginia Crisis Intervention Team Coalition (VACIT) and the Virginia Beach/Commonwealth of Virginia Steering Committee overseeing the Crisis Intervention Team International (CIT I) International Conference sought to advance Virginia's comprehensive and ongoing systems transformation by addressing the area of behavioral health and criminal justice transformation. Virginia utilized this funding to focus on: 1) improving its statewide Crisis Intervention Team Initiative through greater involvement of consumers and families in local programs and 2) with the VACIT, identification of key barriers and solutions for effective implementation of the CIT model and increasing awareness of Virginia's activities, challenges and opportunities to address comprehensive systems change throughout the criminal justice and behavioral health interface utilizing the Sequential Intercept logic model as a foundation.

The core activity of the TTI initiative was to entrench CIT within Virginia Communities and empower peers and families by overlapping and supporting NAMI Virginia's annual statewide conference with the CIT International and Statewide Conferences September 12-14, 2011. Bringing Virginia's consumers, family members, law enforcement personnel and mental health stakeholders together provided a unique opportunity to focus on Virginia's behavioral health and criminal justice transformation challenges and opportunities. Concurrently, it also exposed Virginia's stakeholders to the breadth of information, innovation and insights available from participation in the CIT International conference.

*This is the kind of grant that lets you do the kinds of things that you are never able to do.*

TTI funds were utilized to:

1. Support overlap of the NAMI Virginia Annual Statewide Conference with the Virginia Statewide CIT and the CIT International Conferences in September 2011;
2. Develop a series of workshops targeting Virginia stakeholders to be presented at the Conferences which enhanced consumer-family member participation in Virginia's CIT initiatives and strengthened local and statewide stakeholder relationships, b) provide joint conference programming that addressed Virginia's particular challenges in creating successful CIT programs, including limited access to services, models for developing therapeutic alternatives to incarceration, the significance of data development and need for improved consumer-family member integration;
3. Provide a Virginia-only program track as part of the joint conference which exposed participants to the full spectrum of Virginia's criminal justice and behavioral health transformation initiatives, with presentations based on a) the Sequential Intercept Model, b) Virginia's Cross Systems Mapping project, c) Virginia's 10 site cohort, representing a variety of jail diversion and jail treatment approaches, and d) significant consumer training and

support programs and initiatives;

4. Provide 168 scholarships for consumers, law enforcement and mental health stakeholders to attend the overlapping Conferences; and
5. Hire a part time VA CIT coordinator to work with stakeholders and improve CIT program outcomes by a) serving as a liaison with Virginia's CIT programs and communities for the VACIT Coalition to improve information sharing, coordination and program strengths, b) providing guidance and technical assistance to Virginia's 24 CIT programs to help implement all three elements of CIT in Virginia's programs, d) assisting the VACIT in developing statewide policy and minimum expectations which set out these elements for CIT programs and e) providing coordination among stakeholders to assure that Virginia participants received the greatest benefit for themselves and their programs from the overlapping conferences.

Virginia consumer representatives are members of the CIT I Conference Steering Committee and were involved in all aspects of program development and participation at the joint conferences.

Post-Conference outcomes:

- 316 attendees at the CIT conference.
- As a result of the interest in the CIT conference, Virginia was able to quickly create an RFP for six small planning grants (\$20K-\$50K) by re-tasking current state funding. There were 13 applicants for these 6 month planning grants.
- New state funding has been awarded – up to \$600,000 annually for developing CIT assessment sites.
- In October, 2012, DBHDS, DCJS, NAMI-VA and the VACIT Coalition are collaborating to hold a 2<sup>nd</sup> Annual Virginia CIT statewide training and conference in Charlottesville. This event will specifically focus on veteran's issues, leadership roles, and advanced CIT issues (the initial conference focused on CIT fundamentals). The conference is also partnering with the Virginia Wounded Warrior Program to provide a one day Train the Trainers event giving regions in Virginia the resources to enhance the effectiveness of their CIT response to Veterans involved in the justice system.
- TTI brought together a large set of diverse people who helped to create CIT as a common activity within most parts, but not all, of Virginia. This has allowed Virginia to dramatically expand CIT at a very fast rate.
- A May 22, 2012 planning meeting was held regarding subsequent Virginia CIT activities. Dr. Fred Osher, Council of State Government (CSG) led the meeting, and provided significant information regarding the current state of national efforts, data outcomes and challenges across the BH and CJ spectrum. 120 people from communities across Virginia attended.
- The TTI initiative has helped localities across Virginia improve community readiness to successfully apply for and implement such grant opportunities and enhance CIT program outcomes which will help them to sustain and increase local, state and federal funds.

One bonus activity that arose during the award period was an opportunity for a number of Virginia representatives, including Commissioner Stewart, to go to Montana to meet with various Montana representatives (including law enforcement, prison personnel, and state mental health officials) on the nexus of criminal justice and mental health activities (see the Montana TTI summary for more information on Montana's activities). As a result of this visit, cooperation between Virginia's Department of Criminal Justice and Department of Behavioral Health have dramatically increased, and now includes changes in both agencies' plans and mutual strategic planning.

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# West Virginia



## FY2009 TTI PROJECT:

*Integration of physical and mental health at CMHCs and rural primary health care clinics.*

### KEY OUTCOMES:

- A Statewide “Call to Action” conference was held May 1 and attended by over 100 primary care physicians, nurse practitioners, psychiatrists, CMHC staff, state leaders, and consumers/ families.
  - Keynote-An Avoidable Tragedy: The Relationship of Premature Death and Serious Mental Illness. How Do We Respond? Joseph M. Parks, MD and Dale Svendsen, MD
- Other Speakers included:
  - Kathleen M. Reynolds, MSW (Director, Washtenaw Comm. Health Org./Univ. of Mich)
  - Jeannie Sperry, PhD (West Virginia University Dept. of Family Medicine)
  - Mary T. Bliziotis, RN Larry Dent, JD, and Craig Robinson, MPH (WV Primary Care Assoc.)
  - Daniel Elswick, MD and James Stevenson, MD (WVU Behav. Medicine)
  - John Bianconi (Commissioner, WV **Bureau for Behavioral Health and Health Facilities**)
  - Hilda Heady, MSW (WVU Associate Vice President for Rural Health)
  - Patricia A. Rehmer, MSN (Commissioner, CT. Dept. of Mental Health and Addiction Svcs)
  - David Sanders (WV Mental Health Consumer’ Association)
- Clinical partners/clinical sites were established for integration projects including: Valley Health Care Primary Care Clinic (Community Mental Health Setting); and Reedsville, WV Primary Care Clinic (Ambulatory Care Setting). In June, the WVU Department of Behavioral Medicine and Psychiatry, in partnership with University Health Associates, hired a Physician’s Assistant (“PA”) to help with a Serious and Persisting Mental Illness Day Program at Chestnut Ridge Comprehensive Behavioral Health in Morgantown. Residents of Monongalia, Harrison, Preston and Taylor County, West Virginia and Green and Fayette County, Pennsylvania utilize the day program. The PA supports the patients that are seen in this program with a primary care clinic (twice a month). They will be seen by the PA for metabolic monitoring and screening.
- Frank Ghinassi, PhD, Vice President, Quality and Performance, University of Pittsburgh Medical Center, had a site visit to Morgantown on June 25, 2009 and is assisting West Virginia develop a “Dash Board” for Integrative Clinics to submit data. This will be transportable between varying types of centers including academic institutions, CMHCs, and ambulatory primary care clinics.
- W.V. held a conference in August to provide integrative care training for psychiatry residents, behavioral health staff and psychology trainees at the West Virginia University School of Medicine Department of Behavioral Medicine and Psychiatry Scholarship Retreat. The conference was a continuation of the theme from their statewide TTI conference in May. They addressed the research and scholarship opportunities related to primary care/psychiatric care integration.

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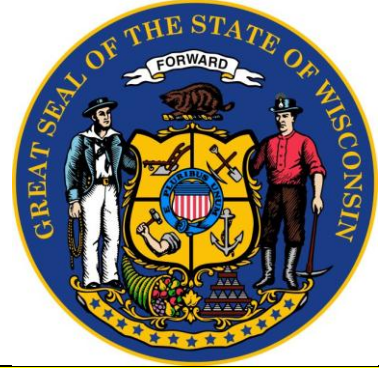
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# Wisconsin



## **FY2009 TTI PROJECT:**

*Integration of trauma informed care into the state system via Trauma Care Champions.*

### **KEY OUTCOMES:**

- Collaboration has been a major theme for Wisconsin's TTI activities. The Department of Health Services (DHS) Trauma Services Coordinator has worked successfully with the Department of Children and Family (DCF) staff to participate in parallel to develop trauma-informed care (TIC) within Child Welfare programs.
- On March 31<sup>st</sup>, Dr. Rob Anda presented the ACE (Adverse Childhood Experiences) Study to a group of seventy-five people representing DHS, DCF and other stakeholder groups.
- On April 22-23, sixteen consumers participated in a Person-Centered Planning/TIC Consumer Champion (PCP/TIC) training.
- On May 11-12, over 430 people (72 teams) attended a statewide Trauma-Informed Care Conference. In order to promote consumer involvement in all aspects of TIC organizational action planning, the PCP/TIC Consumer Champions assisted teams in creating their TIC action plans; teams commented on how helpful it was to have consumer perspectives in the group. Approximately fifty people attended an optional 'TIC educational campaign' focus group held at the close of the conference.
- The Trauma Services Coordinator presented TIC overview on May 15<sup>th</sup> at the rural Mental Health Summit to fifty participants and a full-day TIC workshop to approximately seventy-five people at the Wisconsin Association of Alcohol and Other Drug Abuse Conference.
- On June 23<sup>rd</sup>, DHS co-sponsored a Children and Families Public Policy Forum attended by approximately one hundred people featuring Dr. Bruce Perry and Dr. Robert Anda.
- Two hundred and thirty seven people from the May 11<sup>th</sup> and 12<sup>th</sup> conference gathered on August 31<sup>st</sup>. This conference highlighted the PCP/TIC Consumer Champions and their availability to provide consumer-focused Person-Centered Planning and TIC trainings.
- During August and November the Wisconsin Resource Center (WRC – a specialized mental health facility established as a prison) held a series of trainings. On August 6<sup>th</sup>, WRC introduced the concept of 'creating sanctuary' using lessons learned from the maximum security psychiatric hospital in Dane County, Wisconsin (Mendota Mental Health Institute). On August 10<sup>th</sup>, Community

Connections staff introduced WRC to 'M-TREM' (Men's Trauma Recovery and Empowerment Model). On November 20<sup>th</sup>, John Briere presented information on complex trauma to 150 attendees representing seven Wisconsin correctional facilities.

- The Lac Courtes Oreilles (LCO) tribe held a three-day GONA (Gathering of Native Americans) event September 21-23. LCO contracted with 'News from Indian Country' to tape/record the event. People from Indian Country have posted several interviews on YouTube; this can be accessed by going to [www.youtube.com](http://www.youtube.com) and searching for the word "skabewis".
- Over the course of the TTI grant, DHS worked with Witness Justice to create an educational campaign plan to promote trauma-informed care as an effective approach for providers working with trauma survivors. Resulting products include a poster, brochure, handouts, website and a Wisconsin TIC List Serve.
- The Wisconsin Association of Family and Children's Agencies (WAFCA) presented Wisconsin's Department of Health Services (DHS), Division of Mental Health and Substance Abuse Services with the John R. Grace Outstanding Leadership Award for Trauma-Informed Care and Positive Behavior Supports Initiatives. WAFCA identified Wisconsin's highly collaborative and successful approach to reducing seclusion and restraint and infusing trauma-informed care in the network of children providers. In particular, they recognized the work of Marie Danforth and Elizabeth Hudson.

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# Wyoming



## **FY2009 TTI PROJECT:**

*Developing a statewide housing network across Wyoming's five regions designed to build a regional provider system for consumers and bolstering that effort with statewide SOAR training.*

## **KEY OUTCOMES:**

- A regional housing specialist and a housing planner have been identified in each region to coordinate this project.
- A regional housing task force is now in place in four of five regions.
- SOAR training was held May 4<sup>th</sup> – 6<sup>th</sup> in Casper and attended by over forty mental health staff and case workers, including all housing specialist and planners. The training was also attended by several representatives from the Wyoming Social Security office.
- A Housing 101 Training was conducted in April in Cody by two Housing regional specialists from Tennessee. All Wyoming Housing Specialists and planners attended, as did many of the organizations with which the department will be partnering in this project.
- The state's first Statewide Housing Conference was held in July in Lander, Wyoming, with over 100 attendees. Regional plans were drafted and taken back to all five regions.
- The state has leveraged its TTI funding to secure a fulltime, three-year, statewide Housing Coordinator position. This will be the first statewide, full time position in all of state government, and their focus will be housing people with Mental Illness.
- A team of ten will venture to Memphis, Tennessee, for "hands-on" three-day Creating Housing Initiative training. The team will visit projects in Memphis proper and sites in rural Tennessee, meet local officials/partners to glean the processes and nuts and bolts of how to build similar local partnerships and projects in Wyoming. Attendees scheduled to attend include representatives from WY Dept. of Health: MHSASD, Habitat for Humanity, NAMI, and a veterans groups, as well as city housing directors and housing executives.

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