OMB No. 0930-xxxx
Expiration Date xx/xx/xx

SURVEY OF EVIDENCE-BASED PRACTICES FOR MENTAL HEALTH AND SUBSTANCE USE DISORDERS IN STATE MEDICAID PLANS: COVERAGE STRUCTURES, ACCESS AND CHALLENGES

Dear [NAME]:

The U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration is conducting a voluntary survey to gather information about current and planned State Medicaid activities and policies related to evidence-based practices (EBPs) for mental health and substance use disorders. We are contacting you to help us obtain this information for [NAME OF STATE]. It is important that all states participate in this survey, whether or not they currently support EBPs for mental health and substance use disorders, so that SAMHSA can gain a better understanding of coverage of these EBPs in state Medicaid plans, how states are providing the benefits, and the challenges faced by states in including the EBPs in their state plans.

This survey is part of a five-year project by Abt Associates Inc., the National Academy for State Health Policy (NASHP), and the National Association of State Medicaid Directors (NASMD) to increase attention to and understanding of Medicaid mental health and substance use service issues among State Medicaid and Mental Health/Substance Abuse Directors, as well as to improve the effectiveness of State Medicaid mental health and substance use services.

The survey contains three parts: Part I covers general information about your state's Medicaid and mental health/substance use administration; Part II contains questions regarding your state's coverage of specific evidence-based practices for mental health and substance use disorders, including:

- Medication Management Approaches in Psychiatry (MedMAP)
- Assertive Community Treatment (ACT)
- Supported Employment
- Family Psycho-education
- Illness Management and Recovery
- Integrated Dual Diagnosis Treatment
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Alcohol, Tobacco and/or Opioid Dependence
- Medication-Assisted Treatment for Alcohol, Tobacco and/or Opioid Dependence

Part III of the survey collects additional information on future EBP planning within your state. *Please note that the term "behavioral health services" is used in some questions, and refers to mental health and substance use disorder services in general.*

In completing the survey, we anticipate that you will want to consult with your state mental health director and state substance abuse director in identifying specific information on the use of the EBPs in your state.

The information you provide will be vital to increasing awareness and understanding of Medicaid mental health and substance use evidence-based practice activities. Your responses will be used in a nationally disseminated report. This information will also be used to develop resources for those states that seek to include mental health and substance use disorder EBPs in their state Medicaid plans. This project will offer Medicaid, mental health and substance use disorder officials:

- Publications describing model polices and best practices related to the provision of Medicaid mental health and substance use disorder services;
- Opportunities for state policy makers to engage in networking and peer-to-peer learning with Medicaid as well as with mental health and substance use disorder officials;
- An online toolbox with helpful resources about Medicaid mental health/substance use evidence-based practice activities; and

- Webinars featuring national experts and state officials to disseminate findings about promising practices in Medicaid mental health/substance use evidence-based practice activities and policies.

NASHP has conducted preliminary research and pre-completed several survey questions based on existing information. Pre-completed questions are indicated with a note in bold that includes instructions for how to edit the information if it is incorrect.

If you have any questions, please contact Mike Stanek of NASHP, at mstanek@nashp.org or by phone at 207-822-6524.

Thank you very much for your time and assistance.

SURVEY OF EVIDENCE-BASED PRACTICES FOR MENTAL HEALTH AND SUBSTANCE USE DISORDERS IN STATE MEDICAID PLANS: COVERAGE STRUCTURES, ACCESS AND CHALLENGES

PLEASE RETURN THIS SURVEY VIA EMAIL OR FAX BY **[DATE]** TO:
Mike Stanek, Research Assistant, NASHP
mstanek@nashp.org
Fax: 207-874-6527
If you have any questions, please contact Mike at the above e-mail, or by phone at 207-822-6524.

Part I

1. Lead Respondent's Contact Information:
   Name of Respondent: _____
   State: _____
   Title: _____
   Agency and division/bureau: _____
   Telephone #: _____
   E-Mail: _____

2. Would you be willing to be contacted by Medicaid mental health peers in other states?
   ☐Yes, NASHP may share my contact information with other Medicaid mental health contacts.
   ☐No, NASHP may not share my contact information with other Medicaid mental health contacts.

Section 1: Management of Behavioral Health Services

3. Below is NASHP's understanding of Medicaid's delivery system in your state for behavioral health services. **If this information is incorrect, please uncheck the incorrect box, check the appropriate box, and edit the information in the "description" text box as necessary.**
   ☐Managed care organization
      Does your MCO subcontract with another organization to manage behavioral health services?
      ☐Yes
      ☐No
   ☐Fee-for-service
   ☐Behavioral health organization
   ☐Combination of systems (Description)

4. If Medicaid contracts for delivery of behavioral health services in your state, to what entity does it contract? (Please check all that apply)
   ☐Managed care organization (MCO) that delivers a comprehensive set of services, including some or all behavioral health services
   ☐MCO that delivers only behavioral health services
   ☐County/regional authority

5. What was the total number of state Medicaid beneficiaries at the end of your state's most recently completed fiscal year?

6. Does your state or Medicaid agency have any structure(s) in place to gather input from stakeholders outside the Medicaid agency, to gather clinical advisory opinions, or to forge interagency agreements to help shape Medicaid's coverage of evidence-based practices (EBPs) for mental health and substance use disorders?
   ☐Yes (Check all that apply)
      ☐Regular meetings with stakeholders that include discussion of EBPs
      ☐Internal (Medicaid) taskforce or work group dedicated to EBPs
      ☐Interagency taskforce or work group dedicated to EBPs
      ☐Clinical advisory committee that focuses on EBPs in mental health and/or substance use

☐Clinical advisory committee that focuses on a range of issues, including MH/SA EBP
☐Other (please describe):

If the structure is formal, please attach or include links to the structure's membership and charge.

☐No

7. (a) Please check the box next to the evidence-based practice if your state Medicaid agency covers it.

We understand that Medicaid may not cover all components of the evidence-based practice in your state; however, please check the box if Medicaid covers *any* components of the EBP in a braided/blended or otherwise coordinated funding strategy with other funding sources:

☐ **Medication Management Approaches in Psychiatry (MedMAP)** is a set of practice guidelines that includes the use of a systematic plan for medication management; thorough and clear documentation; creation of objective measures of desired outcomes; and shared decision-making by consumers and practitioners.

☐ **Assertive Community Treatment (ACT)** is a program that involves a multi-disciplinary team that provides comprehensive, community-based services. Services are highly individualized and tailored to meet the needs of each person. Services also have the following characteristics: a low staff-to consumer ratio, assertive engagement, 24/7 availability, time-unlimited support, and continuity of care.

☐ **Supported Employment** is a specific set of practices and services, integrated with mental health treatment, that achieves competitive employment for the consumer. Characteristics include eligibility based on consumer choice, emphasis on consumer preferences, a job search process that begins soon after a consumer expresses interest in working, and continuous follow-along supports for employed consumers.

☐ **Family Psychoeducation** is a curriculum-based program that includes introductory sessions, an educational workshop, and problem-solving groups, all of which are designed to provide ongoing education, problem-solving, and social support, as well as develop coping skills.

☐ **Illness Management and Recovery** is a curriculum-based program that provides recovery strategies, practical facts about schizophrenia, the stress-vulnerability model and treatment strategies, and coping mechanisms for stress and persistent problems, along with client assistance in building social support, using medication effectively, reducing relapses and getting their needs met in the mental health system.

☐ **Integrated Dual Diagnosis Treatment (IDDT)** is a comprehensive program in which one team provides comprehensive mental health and substance use services in stages, along with motivational interventions and substance use counseling (including education, problem-solving and coping skills).

☐ **Screening, Brief Intervention, and Referral to Treatment (SBIRT)** is a comprehensive, integrated public health approach to the identification, early intervention, and referral to treatment services for persons at risk of developing alcohol, tobacco, and/or substance use disorders as well as for those with the disorders. A key aspect of SBIRT is the integration and coordination of screening, brief intervention, and treatment components into a system of services.

☐ **Medication Assisted Treatment (MAT)** is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. MAT is clinically driven with a focus on individualized patient care.

For more information on these evidence-based practices, please see Appendix A.

(b)

- **If you checked <u>any</u> of the above boxes, please skip to Part II, Page 6**

- If you did <u>not</u> check any of the above boxes, has Medicaid made a formal commitment to pay for some or all of the components that are part of the above practices by January 1, 2012? (Examples of a formal commitment include dedicated resources (funding or staff time), initial development or completion of a work plan, and/or public statement of intent to implement coverage).

  ☐Yes (Please skip to **Part III (page 26)**
  ☐No **(Survey complete. Thank you! Please return survey to NASHP, c/o Mike Stanek, Research Assistant, mstanek@nashp.org, or FAX 207-874-6527).**

Part II

Section 2: Evidence-Based Practices – Medication Management Approaches in Psychiatry (MedMAP)

8. As of January 1, 2011, does Medicaid cover Medication Management Approaches in Psychiatry (MedMAP) or any components of MedMAP, either solely through Medicaid funding or in a coordinated strategy with other funding sources?
   - ☐ Medicaid covers MedMAP
   - ☐ Medicaid covers some components of MedMAP listed in a coordinated strategy with other funders
   - ☐ Medicaid does not cover MedMAP (Please skip to page 8, Section 3)
   - ☐ Don't know

9. What federal authority does Medicaid use to cover MedMAP, and when was it implemented? (Check all that apply)
   - ☐ State Plan Amendment:
     - Date implemented:
     - Please provide a web link here or attach a copy of the SPA:
   - ☐ 1915(b) Managed Care Waiver to cover components of medication management that are not normally covered under the State Plan:
     - Date implemented:
   - ☐ 1915(c) Home and Community-Based Services Waiver to provide cost-effective medication management services that will prevent a recipient from being institutionalized:
     - Date implemented:
   - ☐ 1115 Demonstration Waiver to cover medication management services:
     - Date implemented:

10. If Medicaid contracts with one or more MCOs for delivery of services for mental health and/or substance use disorders in your state, is there any language in the contract that specifically mentions MedMAP? *(Please note: the term MCO includes both those that deliver a comprehensive set of services including physical and behavioral health and those that deliver only behavioral health services.)*
    - ☐ Yes (please provide a link to (or attach) the pertinent contract language):
    - ☐ No
    - ☐ Not applicable. Medicaid does not contract with MCOs.

11. If Medicaid has an agreement with a county to deliver or manage the delivery of mental health and/or substance use services in your state, is there any language in the agreement that specifically mentions MedMAP services?
    - ☐ Yes (please provide a link to (or attach) the pertinent contract language):
    - ☐ No
    - ☐ Not applicable. Medicaid does not have these types of agreements with counties.

12. Are you familiar with the SAMHSA Fidelity Scale for MedMAP?
    - ☐ Yes
    - ☐ No (please skip to question 14)

13. Was the Fidelity Scale used in the development of any of the following:
    - ☐ Provider Manual
    - ☐ Provider Certification
    - ☐ Contracts
    - ☐ Quality Oversight
    - ☐ Don't know

14. How do you manage access to MedMAP services?
    - ☐ Prior authorization
    - ☐ Surveillance and Utilization Review
    - ☐ Other (please describe):

15. Does Medicaid facilitate blending/braiding of Medicaid funding with other resources in order to support MedMAP services?
    - ☐ Yes
        - ☐ Medicaid provides technical assistance to providers on how to pool funding to support EBP.
        - ☐ Medicaid pools funding at the state level with other state agencies to support EBP.
        - ☐ Medicaid contracts with an MCO or county/regional entity that pools funding
        - ☐ Other (please describe):
    - ☐ No
    - ☐ Don't know

16. Is there a specific billing code and/or modifier that distinguishes MedMAP from other medication management units of service?
    - ☐ Yes (please provide code and/or modifier):
    - ☐ No

17. Please provide the following data about MedMAP claims paid (not denied or suspended) in the most recently completed state fiscal year (SFY). (Please enter the dates of that year here:) If specific data is not available for MedMAP, please write "N/A"

Procedure code (description)	Maximum fee (e.g., $15 per occurrence, $25 per 15 minute increment)	Total amount paid	Number procedures paid	Number beneficiaries who received the procedure at least once	Number providers who submitted at least one claim for the service
H2010 (comprehensive medication services, per 15 min)					
Other (see question 16)					

18. Does Medicaid offer providers any incentives to deliver MedMAP services?
    - ☐ Yes (check all that apply)
        - ☐ Enhanced reimbursement
        - ☐ Reduced caseload
        - ☐ Other (please describe):
    - ☐ No
    - ☐ Don't know

19. Is your state engaged in any activities to promote MedMAP and/or improve access?
    - ☐ Yes (check all that apply):
        - ☐ Work force development/training
        - ☐ Outreach or other promotion to providers
        - ☐ Other (please describe):
    - ☐ No

20. What steps does Medicaid take to ensure fidelity to SAMHSA models or otherwise promote the quality of MedMAP services?
    - ☐ Provider certification, contract, or billing requirements that mandate fidelity/EBP components.
    - ☐ Monitor MCO or county contract compliance to ensure that relevant terms of agreement regarding MedMAP are being met
    - ☐ Conduct or require contractors to conduct performance improvement projects (e.g. measuring and evaluating provider quality of care, then, if needed, developing and implementing a plan to improve care)
    - ☐ Other (please describe):
    - ☐ None

Section 3: Evidence-Based Practices – Assertive Community Treatment (ACT)

21. As of January 1, 2011, does Medicaid cover Assertive Community Treatment (ACT) or any components of ACT, either solely through Medicaid funding or in a coordinated strategy with other funding sources?
    - ☐ Medicaid covers ACT
    - ☐ Medicaid covers some components of ACT listed in a coordinated strategy with other funders
    - ☐ Medicaid does not cover ACT (Please skip to page 10, Section 4)

    - ☐ Don't know

22. What federal authority does Medicaid use to cover ACT, and when was this mechanism implemented? (Check all that apply)
    - ☐ State Plan Amendment:
        - Date implemented:
        - Please provide a web link here or attach a copy of the SPA:
    - ☐ 1915(b) Managed Care Waiver to cover components of ACT that are not normally covered under the State Plan:
        - Date implemented:
    - ☐ 1915(c) Home and Community-Based Services Waiver to provide cost-effective ACT services that will prevent a recipient from being institutionalized:
        - Date implemented:
    - ☐ 1115 Demonstration Waiver to cover ACT services:
        - Date implemented:

23. If Medicaid contracts with one or more MCOs for delivery of services for mental health and/or substance use disorders in your state, is there any language in the contract that specifically mentions ACT services? *(Please note: the term MCO includes both those that deliver a comprehensive set of services including physical and behavioral health and those that deliver only behavioral health services.)*
    - ☐ Yes (please provide a link to (or attach) the pertinent contract language):
    - ☐ No

    - ☐ Not applicable. Medicaid does not contract with MCOs.

24. If Medicaid has an agreement with a county to deliver or manage the delivery of mental health and/or substance use services in your state, is there any language in the agreement that specifically mentions ACT services?
    - ☐ Yes (please provide a link to (or attach) the pertinent contract language):
    - ☐ No

    - ☐ Not applicable. Medicaid does not have these types of agreements with counties.

25. Are you familiar with the SAMSHA Fidelity Scale for ACT?
    - ☐ Yes
    - ☐ No (please skip to question 27)

26. Was the Fidelity Scale used in the development of any of the following:
    - ☐ Provider Manual
    - ☐ Provider Certification
    - ☐ Contracts
    - ☐ Quality Oversight

    ☐ Don't know

27. How do you manage access to ACT?
    - ☐ Prior authorization
    - ☐ Surveillance and Utilization Review (SURS)
    - ☐ Other (please describe):

28. Does Medicaid facilitate blending/braiding of Medicaid funding with other resources in order to support ACT?
    - ☐ Yes
        - ☐ Medicaid provides technical assistance to providers on how to pool funding to support EBP.
        - ☐ Medicaid pools funding at the state level with other state agencies to support EBP.
        - ☐ Medicaid contracts with an MCO or county/regional entity that pools funding
        - ☐ Other (please describe):
    - ☐ No

    ☐ Don't know

29. Is there a specific billing code or modifier that distinguishes ACT from other community support/case management units of service?
    - ☐ Yes (please provide code and/or modifier):
    - ☐ No

30. Please provide the following data about ACT claims paid (not denied or suspended) in the most recently completed state fiscal year (SFY). (Please enter the dates of that year here:) If specific data is not available, please write "NA"

Procedure code (description)	Maximum fee (e.g., $15 per occurrence, $25 per 15 minute increment)	Total amount paid	Number procedures paid	Number beneficiaries who received the procedure at least once	Number providers who submitted at least one claim for the service
H0039 (ACT program, per 15 min)					
H0040 (ACT, per diem)					
Other (see question 29)					

31. Does Medicaid offer providers any incentives to deliver ACT services?
    - ☐ Yes (check all that apply)
        - ☐ Enhanced reimbursement
        - ☐ Reduced caseload
        - ☐ Other (please describe):
    - ☐ No

    ☐ Don't know

32. Is your state engaged in any activities to promote ACT and/or improve access?
    - ☐ Yes (check all that apply):
        - ☐ Work force development/training
        - ☐ Outreach or other promotion to providers
        - ☐ Other (please describe):
    - ☐ No

33. What steps does Medicaid take to ensure fidelity to SAMHSA models or otherwise promote quality of ACT services?
    - ☐ Provider certification, licensing, or billing requirements that mandate fidelity/EBP components.
    - ☐ Monitor MCO or County contract compliance to ensure the relevant terms of agreement regarding ACT services are being met
    - ☐ Conduct or require contractors to conduct performance improvement projects (e.g. measuring and evaluating provider quality of care, then, if needed, developing and implementing a plan to improve care)
    - ☐ Other (please describe):
    - ☐ None

Section 4: Evidence-Based Practices – Supported Employment

34. As of January 1, 2011, does Medicaid cover Supported Employment or cover any components of Supported Employment, either solely through Medicaid funding or in a coordinated strategy with other funding sources?
    - ☐ Medicaid covers Supported Employment
    - ☐ Medicaid covers some components of Supported Employment listed in a coordinated strategy with other funders
    - ☐ Medicaid does not cover Supported Employment (Please skip to page 13, Section 5)

    ☐ Don't know

35. What federal authority does Medicaid use to cover Supported Employment, and when was this mechanism implemented? (Check all that apply)
    - ☐ State Plan Amendment:
        - Date implemented:
        - Please provide a web link here or attach a copy of the SPA:
    - ☐ 1915(b) Managed Care Waiver to cover components of Supported Employment that are not normally covered under the State Plan:
        - Date implemented:
    - ☐ 1915(c) Home and Community-Based Services Waiver to provide cost-effective supported employment services that will prevent a recipient from being institutionalized:
        - Date implemented:
    - ☐ 1115 Demonstration Waiver to cover supported employment services:
        - Date implemented:

36. If Medicaid contracts with one or more MCOs for delivery of services for mental health and/or substance use disorders in your state, is there any language in the contract that specifically mentions Supported Employment services? *(Please note: the term MCO includes both those that deliver a comprehensive set of services including physical and behavioral health and those that deliver only behavioral health services.)*
    - ☐ Yes (please provide a link to (or attach) the pertinent contract language):
    - ☐ No

    ☐ Not applicable. Medicaid does not contract with MCOs.

37. If Medicaid has an agreement with a county to deliver or manage the delivery of mental health and/or substance use services in your state, is there any language in the agreement that specifically mentions Supported Employment services?
    - ☐ Yes (please provide a link to (or attach) the pertinent contract language):
    - ☐ No

    ☐ Not applicable. Medicaid does not have these types of agreements with counties.

38. Are you familiar with the SAMHSA Fidelity Scale for Supported Employment services?
    - ☐ Yes
    - ☐ No (please skip to question 40)

39. Was the Fidelity Scale used in the development of any of the following:
    - ☐ Provider Manual
    - ☐ Provider Certification
    - ☐ Contracts
    - ☐ Quality Oversight

    ☐ Don't know

40. How do you manage Supported Employment?
    - ☐ Prior authorization
    - ☐ Surveillance and Utilization review (SURS)
    - ☐ Other (please describe):

41. Does Medicaid facilitate blending/braiding of Medicaid funding with other resources in order to support Supported Employment services?
    - ☐ Yes
        - ☐ Medicaid provides technical assistance to providers on how to pool funding to support EBP.
        - ☐ Medicaid pools funding at the state level with other state agencies to support EBP.
        - ☐ Medicaid contracts with an MCO or county/regional entity that pools funding
        - ☐ Other (please describe):
    - ☐ No

    ☐ Don't know

42. Is there a specific billing code or modifier that distinguishes the Medicaid-supported component of Supported Employment from other community support or traditional vocational services?
    - ☐ Yes (please provide code and/or modifier):
    - ☐ No

43. Please provide the following data about Medicaid Supported Employment claims paid (not denied or suspended) in the most recently completed state fiscal year (SFY). (Please enter the dates of that year here:) If specific data is not available, please write "NA"

Procedure code (description)	Maximum fee (e.g., $15 per occurrence, $25 per 15 minute increment)	Total amount paid	Number procedures paid	Number beneficiaries who received the procedure at least once	Number providers who submitted at least one claim for the service
H2023 (supported employment, per 15 min)					
H2024 (supported employment, per diem)					
H2025 (Ongoing support to maintain employment, per 15 min)					
H2026)Ongoing support to maintain employment, per diem)					
Other (see question 42)					

44. Does Medicaid offer providers any incentives to deliver Supported Employment services?
    - ☐ Yes (check all that apply)
        - ☐ Enhanced reimbursement
        - ☐ Reduced caseload
        - ☐ Other (please describe):
    - ☐ No
    - ☐ Don't know

45. Is your state engaged in any activities to promote Supported Employment and/or improve access?
    - ☐ Yes (check all that apply):
        - ☐ Work force development/training
        - ☐ Outreach or other promotion to providers
        - ☐ Other (please describe):
    - ☐ No

46. What steps does Medicaid take to ensure fidelity to SAMHSA models or otherwise promote quality of Supported Employment services?
    - ☐ Provider certification, licensing, or billing requirements that mandate fidelity/EBP components.
    - ☐ Monitor MCO or County contract compliance to ensure the relevant terms of agreement are being met
    - ☐ Conduct or require contractors to conduct performance improvement projects (e.g. measuring and evaluating provider quality of care, then, if needed, developing and implementing a plan to improve care)
    - ☐ Other (please describe):
    - ☐ None

Section 5: Evidence-Based Practices – Family Psychoeducation

47. As of January 1, 2011, does Medicaid cover Family Psychoeducation or any components of Family Psychoeducation, either solely through Medicaid funding or in a coordinated strategy with other funding sources?
    - ☐ Medicaid covers Family Psychoeducation
    - ☐ Medicaid covers some components of Family Psychoeducation listed in a coordinated strategy with other funders
    - ☐ Medicaid does not cover Family Psychoeducation (Please skip to page 15, Section 6)

    ☐ Don't know

48. What federal authority does Medicaid use to cover Family Psychoeducation, and when was this mechanism implemented? (Check all that apply)
    - ☐ State Plan Amendment:
        Date implemented:
        Please provide a web link here or attach a copy of the SPA:
    - ☐ 1915(b) Managed Care Waiver to cover components of Family Psychoeducation that are not normally covered under the State Plan:
        Date implemented:
    - ☐ 1915(c) Home and Community-Based Services Waiver to provide cost-effective Family Psychoeducation services that will prevent a recipient from being institutionalized:
        Date implemented:
    - ☐ 1115 Demonstration Waiver to cover Family Psychoeducation services:
        Date implemented:

49. If Medicaid contracts with one or more MCOs for delivery of services for mental health and/or substance use disorders in your state, is there any language in the contract that specifically mentions Family Psychoeducation services? *(Please note: the term MCO includes both those that deliver a comprehensive set of services including physical and behavioral health and those that deliver only behavioral health services.)*
    - ☐ Yes (please provide a link to (or attach) the pertinent contract language):
    - ☐ No

    ☐ Not applicable. Medicaid does not contract with MCOs.

50. If Medicaid has an agreement with a county to deliver or manage the delivery of mental health and/or substance use services in your state, is there any language in the agreement that specifically mentions Family Psychoeducation services?
    - ☐ Yes (please provide a link to (or attach) the pertinent contract language):
    - ☐ No

    ☐ Not applicable. Medicaid does not have these types of agreements with counties.

51. Are you familiar with the SAMHSA Fidelity Scale for Family Psychoeducation?
    - ☐ Yes
    - ☐ No (please skip to question 53)

52. Was the Fidelity Scale used in the development of any of the following:
    - ☐ Provider Manual
    - ☐ Provider Certification
    - ☐ Contracts
    - ☐ Quality Oversight

    ☐ Don't know

53. How do you manage access to Family Psychoeducation?
    - ☐ Prior authorization
    - ☐ Surveillance and Utilization Review (SURS)
    - ☐ Other (please describe):

54. Does Medicaid facilitate blending/braiding of Medicaid funding with other resources in order to support Family Psychoeducation?
    - ☐ Yes
        - ☐ Medicaid provides technical assistance to providers on how to pool funding to support EBP.
        - ☐ Medicaid pools funding at the state level with other state agencies to support EBP.
        - ☐ Medicaid contracts with an MCO or county/regional entity that pools funding
        - ☐ Other (please describe):
    - ☐ No
    - ☐ Don't know

55. Is there a specific billing code or modifier that distinguishes Family Psychoeducation from other family therapy or other psychoeducational intervention units of service?
    - ☐ Yes (please provide code and/or modifier):
    - ☐ No

56. Please provide the following data about Medicaid Family Psychoeducation claims paid (not denied or suspended) in the most recently completed state fiscal year (SFY). (Please enter the dates of that year here:) If specific data is not available, please write "NA"

Procedure code (description)	**Maximum fee (e.g., $15 per occurrence, $25 per 15 minute increment)**	**Total amount paid**	**Number procedures paid**	**Number beneficiaries who received the procedure at least once**	**Number providers who submitted at least one claim for the service**
H2027 (Psycho-educational service, per 15 min)					
Other (see question 55)					

57. Does Medicaid offer providers any incentives to deliver Family Psychoeducation services?
    - ☐ Yes (check all that apply)
        - ☐ Enhanced reimbursement
        - ☐ Reduced caseload
        - ☐ Other (please describe):
    - ☐ No
    - ☐ Don't know

58. Is your state engaged in any activities to promote Family Psychoeducation and/or improve access?
    - ☐ Yes (check all that apply):
        - ☐ Work force development/training
        - ☐ Outreach or other promotion to providers
        - ☐ Other (please describe):
    - ☐ No

59. What steps does Medicaid take to ensure fidelity to SAMHSA models or otherwise promote the quality of Family Psychoeducation services?
    - ☐ Provider certification, licensing, or billing requirements that mandate fidelity/EBP components.
    - ☐ Monitor MCO or County contract compliance to ensure the relevant terms of agreement regarding Family Psychoeducation services are being met
    - ☐ Conduct or require contractors to conduct performance improvement projects (e.g. measuring and evaluating provider quality of care, then, if needed, developing and implementing a plan to improve care)
    - ☐ Other (please describe):
    - ☐ None

Section 6: Evidence-Based Practices – Illness Management and Recovery

60. As of January 1, 2011, does Medicaid cover Illness Management and Recovery (IMR) or any components of IMR, either solely through Medicaid funding or in a coordinated strategy with other funding sources?
    - ☐ Medicaid covers IMR
    - ☐ Medicaid covers some components of IMR listed in a coordinated funding strategy
    - ☐ Medicaid does not cover IMR (Please skip to page 17, Section 7)

    - ☐ Don't know

61. What federal authority does Medicaid use to cover IMR and when was this mechanism implemented? (Check all that apply)
    - ☐ State Plan Amendment:
        Date implemented:
        Please provide a web link here or attach a copy of the SPA:
    - ☐ 1915(b) Managed Care Waiver to cover components of IMR that are not normally covered under the State Plan:
        Date implemented:
    - ☐ 1915(c) Home and Community-Based Services Waiver to provide cost-effective IMR services that will prevent a recipient from being institutionalized:
        Date implemented:
    - ☐ 1115 Demonstration Waiver to cover IMR services:
        Date implemented:

62. If Medicaid contracts with one or more MCOs for delivery of services for mental health and/or substance use disorders in your state, is there any language in the contract that specifically mentions IMR services? *(Please note: the term MCO includes both those that deliver a comprehensive set of services including physical and behavioral health and those that deliver only behavioral health services.)*
    - ☐ Yes (please provide a link to (or attach) the pertinent contract language):
    - ☐ No

    - ☐ Not applicable. Medicaid does not contract with MCOs.

63. If Medicaid has an agreement with a county to deliver or manage the delivery of mental health and/or substance use services in your state, is there any language in the agreement that specifically mentions IMR services?
    - ☐ Yes (please provide a link to (or attach) the pertinent contract language):
    - ☐ No

    - ☐ Not applicable. Medicaid does not have these types of agreements with counties.

64. Are you familiar with the SAMHSA Fidelity Scale for IMR?
    - ☐ Yes
    - ☐ No (please skip to question 66)

65. Was the Fidelity Scale used in the development of any of the following:
    - ☐ Provider Manual
    - ☐ Provider Certification
    - ☐ Contracts
    - ☐ Quality Oversight

    ☐ Don't know

66. How do you manage access to IMR?
    - ☐ Prior authorization
    - ☐ Surveillance and Utilization Review (SURS)
    - ☐ Other (please describe):

67. Does Medicaid facilitate blending/braiding of Medicaid funding with other resources in order to support IMR?
    - ☐ Yes
        - ☐ Medicaid provides technical assistance to providers on how to pool funding to support EBP.
        - ☐ Medicaid pools funding at the state level with other state agencies to support EBP.
        - ☐ Medicaid contracts with an MCO or county/regional entity that pools funding
        - ☐ Other (please describe):
    - ☐ No

    ☐ Don't know

68. Is there a specific billing code or modifier that distinguishes IMR from other Psychoeducation/skill building units of service?
    - ☐ Yes (please provide code and/or modifier):
    - ☐ No

69. Please provide the following data about Medicaid IMR claims paid (not denied or suspended) in the most recently completed state fiscal year (SFY). (Please enter the dates of that year here:) If specific data is not available, please write "NA"

Procedure code (description)	Maximum fee (e.g., $15 per occurrence, $25 per 15 minute increment)	Total amount paid	Number procedures paid	Number beneficiaries who received the procedure at least once	Number providers who submitted at least one claim for the service
H2027 (Psycho-educational service, per 15 minutes)					
Other (please see question 68)					

70. Does Medicaid offer providers any incentives to deliver IMR services?
    - ☐ Yes (check all that apply)
        - ☐ Enhanced reimbursement
        - ☐ Reduced caseload
        - ☐ Other (please describe):
    - ☐ No

    ☐ Don't know

71. Is your state engaged in any activities to promote IMR and/or improve access?
    - ☐ Yes (check all that apply):
        - ☐ Work force development/training
        - ☐ Outreach or other promotion to providers
        - ☐ Other (please describe):
    - ☐ No

72. What steps does Medicaid take to ensure fidelity to SAMHSA models or otherwise promote the quality of IMR services?
    - ☐ Provider certification, licensing, or billing requirements that mandate fidelity/EBP components
    - ☐ Monitor MCO or County contract compliance to ensure the relevant terms of agreement regarding IMR services are being met
    - ☐ Conduct or require contractors to conduct performance improvement projects (e.g. measuring and evaluating provider quality of care, then, if needed, developing and implementing a plan to improve care)
    - ☐ Other (please describe):
    - ☐ None

Section 7: Evidence-Based Practices – Integrated Dual Diagnosis Treatment

73. As of January 1, 2011, does Medicaid cover Integrated Dual Diagnosis Treatment (IDDT) or any components of IDDT, either solely through Medicaid funding or in a coordinated strategy with other funding sources?
    - ☐ Medicaid covers IDDT
    - ☐ Medicaid covers some components of IDDT listed in a coordinated strategy with other funders
    - ☐ Medicaid does not cover IDDT (Please skip to page 19, Section 8)

    - ☐ Don't know

74. What federal authority does Medicaid use to cover IDDT and when was this mechanism implemented? (Check all that apply)
    - ☐ State Plan Amendment:
        - Date implemented:
        - Please provide a web link here or attach a copy of the SPA:
    - ☐ 1915(b) Managed Care Waiver to cover components of IDDT that are not normally covered under the State Plan:
        - Date implemented:
    - ☐ 1915(c) Home and Community-Based Services Waiver to provide cost-effective IDDT services that will prevent a recipient from being institutionalized:
        - Date implemented:
    - ☐ 1115 Demonstration Waiver to cover IDDT services:
        - Date implemented:

75. If Medicaid contracts with one or more MCOs for delivery of services for mental health and/or substance use disorders in your state, is there any language in the contract that specifically mentions IDDT services? *(Please note: the term MCO includes both those that deliver a comprehensive set of services including physical and behavioral health and those that deliver only behavioral health services.)*
    - ☐ Yes (please provide a link to (or attach) the pertinent contract language):
    - ☐ No

    - ☐ Not applicable. Medicaid does not contract with MCOs.

76. If Medicaid has an agreement with a county to deliver or manage the delivery of mental health and/or substance use services in your state, is there any language in the agreement that specifically mentions IDDT services?
    - ☐ Yes (please provide a link to (or attach) the pertinent contract language):
    - ☐ No

    ☐ Not applicable. Medicaid does not have these types of agreements with counties.

77. Are you familiar with the SAMHSA Fidelity Scale for IDDT?
    - ☐ Yes
    - ☐ No (please skip to question 79)

78. Was the Fidelity Scale used in the development of any of the following:
    - ☐ Provider Manual
    - ☐ Provider Certification
    - ☐ Contracts
    - ☐ Quality Oversight

    ☐ Don't know

79. How do you manage access to IDDT?
    - ☐ Prior authorization
    - ☐ Surveillance and Utilization Review (SURS)
    - ☐ Other (please describe):

80. Does Medicaid facilitate blending/braiding of Medicaid funding with other resources in order to support IDDT?
    - ☐ Yes
        - ☐ Medicaid provides technical assistance to providers on how to pool funding to support EBP.
        - ☐ Medicaid pools funding at the state level with other state agencies to support EBP.
        - ☐ Medicaid contracts with an MCO or county/regional entity that pools funding
        - ☐ Other (please describe):
    - ☐ No

    ☐ Don't know

81. Is there a specific billing code or modifier that distinguishes IDDT from other outpatient treatment units of service?
    - ☐ Yes (please provide code and/or modifier):
    - ☐ No

82. Please provide the following data about Medicaid IDDT claims paid (not denied or suspended) in the most recently completed state fiscal year (SFY). (Please enter the dates of that year here:) If specific data is not available, please write "NA"

Procedure code (description)	Maximum fee (e.g., $15 per occurrence, $25 per 15 minute increment)	Total amount paid	Number procedures paid	Number beneficiaries who received the procedure at least once	Number providers who submitted at least one claim for the service
H0036 (Community Psychiatric Supportive Treatment)					
Other (see question 81)					

83. Does Medicaid offer providers any incentives to deliver IDDT services?
    - ☐ Yes (check all that apply)
        - ☐ Enhanced reimbursement
        - ☐ Reduced caseload
        - ☐ Other (please describe):
    - ☐ No
    - ☐ Don't know

84. Is your state engaged in any activities to promote IDDT and/or improve access?
    - ☐ Yes (check all that apply):
        - ☐ Work force development/training
        - ☐ Outreach or other promotion to providers
        - ☐ Other (please describe):
    - ☐ No

85. What steps does Medicaid take to ensure fidelity to SAMHSA models or otherwise promote the quality of IDDT services?
    - ☐ Provider certification, licensing, or billing requirements that mandate fidelity/EBP components
    - ☐ Monitor MCO or County contract compliance to ensure the relevant terms of agreement regarding IDDT services are being met
    - ☐ Conduct or require contractors to conduct performance improvement projects (e.g., measuring and evaluating provider quality of care, then, if needed, developing and implementing a plan to improve care)
    - ☐ Other (please describe):
    - ☐ None

Section 8: Evidence-Based Practices – Screening, Brief Intervention and Referral to Treatment (SBIRT) for Individuals with Alcohol, Tobacco and/or Opioid Dependence

86. As of January 1, 2011, does Medicaid cover SBIRT or any components of SBIRT, either solely through Medicaid funding or in a coordinated strategy with other funding sources?
    - ☐ Medicaid covers SBIRT
    - ☐ Medicaid covers some components of SBIRT listed in a coordinated strategy with other funders
    - ☐ Medicaid does not cover SBIRT (Please skip to page 22, Section 9)
    - ☐ Don't know

87. What federal authority does Medicaid use to cover SBIRT, and when was it implemented? (Check all that apply)
    - ☐ State Plan Amendment:
        - Date implemented:
        - Please provide a web link here or attach a copy of the SPA:
    - ☐ 1915(b) Managed Care Waiver to cover components of SBIRT that are not normally covered under the State Plan:
        - Date implemented:
    - ☐ 1915(c) Home and Community-Based Services Waiver to provide cost-effective SBIRT services that will prevent a recipient from being institutionalized:
        - Date implemented:
    - ☐ 1115 Demonstration Waiver to cover SBIRT services:
        - Date implemented:

88. If Medicaid contracts with one or more MCOs for delivery of services for mental health and/or substance use disorders in your state, is there any language in the contract that specifically mentions SBIRT? *(Please note: the term MCO includes both those that deliver a comprehensive set of services including physical and behavioral health and those that deliver only behavioral health services.)*
    - ☐ Yes (please provide a link to (or attach) the pertinent contract language):
    - ☐ No

    ☐ Not applicable. Medicaid does not contract with MCOs.

89. If Medicaid has an agreement with a county to deliver or manage the delivery of mental health and/or substance use services in your state, is there any language in the agreement that specifically mentions SBIRT services?
    - ☐ Yes (please provide a link to (or attach) the pertinent contract language):
    - ☐ No

    ☐ Not applicable. Medicaid does not have these types of agreements with counties.

90. Does your state require or recommend any particular screening tool in connection with SBIRT Billing (e.g., Alcohol Use Disorder Identification Test (AUDIT); Drug Abuse Screening Test (DAST); The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST); The 5A's Model for Treating Tobacco Use and Dependence (Ask, Advise, Assess, Assist, Arrange))
    - ☐ Yes (please specify screening tool):
    - ☐ No

91. How do you manage access to SBIRT services?
    - ☐ Prior authorization
    - ☐ Surveillance and Utilization Review
    - ☐ Service is restricted to certain populations/settings
    - ☐ Other (please describe):

92. Does Medicaid facilitate blending/braiding of Medicaid funding with other resources in order to support SBIRT services?
    - ☐ Yes
        - ☐ Medicaid provides technical assistance to providers on how to pool funding to support SBIRT.
        - ☐ Medicaid pools funding at the state level with other state agencies to support SBIRT.
        - ☐ Medicaid contracts with an MCO or county/regional entity that pools funding
        - ☐ Other (please describe):
    - ☐ No

    ☐ Don't know

93. Please provide the following data about SBIRT claims paid (not denied or suspended) in the most recently completed state fiscal year (SFY). (Please enter the dates of that year here:) If specific data is not available for SBIRT, please write "N/A"

Procedure code (description)	Maximum fee (e.g., $15 per occurrence, $25 per 15 minute increment)	Total amount paid	Number procedures paid	Number beneficiaries who received the procedure at least once	Number providers who submitted at least one claim for the service
H0049 Alcohol and/or drug screening					
H0050 Alcohol and/or drug service, brief intervention, per 15 minutes					
CPT 99408 Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes					
CPT 99409 Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes					
CPT 99406 Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes.					
CPT 99407 Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes.					
Other					

94. Does Medicaid offer providers any incentives to deliver SBIRT services?

☐Yes (check all that apply)

☐Enhanced reimbursement

☐Other (please describe):

☐No

☐Don't know

95. Is your state engaged in any activities to promote SBIRT and/or improve access?
    - ☐ Yes (check all that apply):
        - ☐ Work force development/training
        - ☐ Outreach or other promotion to providers
        - ☐ Other (please describe):
    - ☐ No

Section 9: Evidence-Based Practices – Medication-Assisted Treatment (MAT) for Alcohol, Tobacco and/or Opioid Dependence

96. As of January 1, 2011, does Medicaid cover MAT or any components of Medication-Assisted Treatment, either solely through Medicaid funding or in a coordinated strategy with other funding sources?
    - ☐ Medicaid covers MAT
    - ☐ Medicaid covers some components of MAT listed in a coordinated strategy with other funders
    - ☐ Medicaid does not cover MAT (Please skip to page 25, Section 10)

    - ☐ Don't know

97. What federal authority does Medicaid use to cover MAT, and when was it implemented? (Check all that apply)
    - ☐ State Plan Amendment:
        Date implemented:
        Please provide a web link here or attach a copy of the SPA:
    - ☐ 1915(b) Managed Care Waiver to cover components of MAT that are not normally covered under the State Plan:
        Date implemented:
    - ☐ 1915(c) Home and Community-Based Services Waiver to provide cost-effective MAT services that will prevent a recipient from being institutionalized:
        Date implemented:
    - ☐ 1115 Demonstration Waiver to cover MAT services:
        Date implemented:

98. If Medicaid contracts with one or more MCOs for delivery of services for mental health and/or substance use disorders in your state, is there any language in the contract that specifically mentions Medication-Assisted Treatment? *(Please note: the term MCO includes both those that deliver a comprehensive set of services including physical health and behavioral health and those that deliver only behavioral health services.)*
    - ☐ Yes (please provide a link to (or attach) the pertinent contract language):
    - ☐ No

    - ☐ Not applicable. Medicaid does not contract with MCOs.

99. If Medicaid has an agreement with a county to deliver or manage the delivery of mental health and/or substance use services in your state, is there any language in the agreement that specifically mentions Medication-Assisted Treatment?
    - ☐ Yes (please provide a link to (or attach) the pertinent contract language):
    - ☐ No

    - ☐ Not applicable. Medicaid does not have these types of agreements with counties.

100. Does your state Medicaid program provide reimbursement for any of the following MAT:
    <u>Tobacco Dependence:</u>
    a. Nicotine Gum
        - ☐ Yes
        - ☐ No

b. Nicotine Patch
   ☐Yes
   ☐No
c. Nicotine Nasal Spray
   ☐Yes
   ☐No
d. Nicotine Inhaler
   ☐Yes
   ☐No
e. Nicotine Lozenge
   ☐Yes
   ☐No
f. Varenicline (Chantix®)
   ☐Yes
   ☐No
g. Bupropion SR (Zyban®, Wellbutrin SR®)
   ☐Yes
   ☐No

Alcohol Dependence:

h. Disulfiram (Antabuse®)
   ☐Yes
   ☐No
i. Naltrexone (ReVia®, Vivitrol®, Depade®)
   ☐Yes
   ☐No
j. Acamprosate Calcium (Campral®)
   ☐Yes
   ☐No

Opioid Dependence:

k. Buprenorphine (Suboxone®, Subutex®)
   ☐Yes
   ☐No
l. Methadone
   ☐Yes
   ☐No

101. Does your state provide a bundled rate that includes counseling (individual or group) for substance abuse/dependence in addition to MAT?
   ☐Yes: please describe
   ☐No

102. How do you manage access to MAT services?
   ☐Prior authorization
   ☐Surveillance and Utilization Review (SURS)
   ☐Service is restricted to certain populations/settings (please describe):
   ☐Other (please describe):

103. Does Medicaid facilitate blending/braiding of Medicaid funding with other resources in order to support MAT services?
   ☐Yes
      ☐Medicaid provides technical assistance to providers on how to pool funding to support MAT.
      ☐Medicaid pools funding at the state level with other state agencies to support MAT.
      ☐Medicaid contracts with an MCO or county/regional entity that pools funding
      ☐Other (please describe):
   ☐No

   ☐Don't know

104. Please provide the following data about Medicaid MAT claims paid (not denied or suspended) in the most recently completed state fiscal year (SFY). (Please enter the dates of that year here:) If specific data is not available, please write "NA"

Procedure code (description)	Maximum fee (e.g., $15 per occurrence, $25 per 15 minute increment)	Total amount paid	Number procedures paid	Number beneficiaries who received the procedure at least once	Number providers who submitted at least one claim for the service
CPT 90804-09 (Individual psychotherapy, with medical evaluation and management services)					
CPT 99406 (tobacco-use cessation counseling; intermediate, 3-10 min)					
CPT 99407 (tobacco-use cessation counseling; intensive, > 10 min)					
S9075 Smoking Cessation Medications					
H0016 (Alcohol and/or drug; medical intervention including physical exam and prescriptions or supervision of medication)					
H2035 (Alcohol and/or drug treatment program, per hour—individualized treatment, including medication administration)					
H2036 (Alcohol and/or drug treatment program, per diem—individualized treatment, including medication administration)					
H0020 (Pharmacologic Support—Methadone; provision of drug by licensed program)					
H0033 (Pharmacologic Support—Buprenorphine (Suboxone® or Subutex®); oral medication administration, direct observation)					
HCPCS J8499 (Prescription drug, oral, non-chemotherapeutic)					
Other					

105. Does Medicaid offer providers any incentives to deliver MAT services combined with counseling?
    - ☐ Yes (check all that apply)
        - ☐ Enhanced reimbursement
        - ☐ Reduced caseload
        - ☐ Other (please describe):
    - ☐ No
    - ☐ Don't know

106. Is your state engaged in any activities to promote MAT and/or improve access?
    - ☐ Yes (check all that apply):
        - ☐ Work force development/training
        - ☐ Outreach or other promotion to providers
        - ☐ Other (please describe):
    - ☐ No

Section 10: EBP Promotion and Impact

107. How are Medicaid providers informed about Medicaid's coverage of EBP services for mental health and/or substance use disorders? Please check all that apply:
    - ☐ Medicaid Provider handbook or manual
    - ☐ In-person training session (specify frequency, e.g., annual or when changes occur)
    - ☐ On-line training or curriculum
    - ☐ Medicaid Provider bulletin or memorandum explaining changes
    - ☐ Joint Communication or training from Medicaid and Mental Health and/or Substance Use Disorders Agencies
    - ☐ Other (please specify):

108. Has your state Medicaid agency produced any analyses or reports that document cost savings or improved care associated with EBPs for mental health and/or substance use disorders?
    - ☐ Yes (please attach or provide a link to the document(s)):
    - ☐ No

109. Has your state legislature passed any legislation in support or in furtherance of a specific EBP, or in support of EBPs generally?
    - ☐ Yes (please attach or provide a link to documents):
    - ☐ No

Part III

110. Please check the appropriate boxes in the table below to indicate which EBPs Medicaid has made a formal commitment to cover (or cover certain components of) by January 1, 2012, the nature of the commitment, and the estimated implementation date for coverage:

EBP	Type of Formal Commitment					Estimated Implementation Date
	Dedicated Staff Time	Dedicated Funding	Initial Development or Completion of Work plan	Public Statement of Intent to Implement Coverage	Other (Please describe)	
☐ Medication management	☐	☐	☐	☐	☐	
☐ Assertive Community Treatment (ACT)	☐	☐	☐	☐	☐	
☐ Supported employment	☐	☐	☐	☐	☐	
☐ Family psycho-education	☐	☐	☐	☐	☐	
☐ Illness management and recovery	☐	☐	☐	☐	☐	
☐ Integrated Dual Diagnosis Treatment	☐	☐	☐	☐	☐	
☐ Screening, Brief Intervention, and Referral to Treatment	☐	☐	☐	☐	☐	
☐ Medication Assisted Treatment	☐	☐	☐	☐	☐	

111. Has Medicaid made a formal commitment to cover any additional EBPs besides those indicated above?
    - ☐ Yes (please specify the EBP):
    - ☐ No

112. Considering your state's efforts to implement evidence-based practices,
    a. Name your two greatest achievements. (e.g. Facilitated multi-agency collaboration about EBPs by creating a workgroup to discuss Medicaid coverage of EBPs)
        1.
        2.

    b. Name your two greatest challenges. (e.g., mental health practitioner shortages in rural areas).
        1.
        2.

    c. Name any practices that you think are unique or innovative.

113. Is there anything else you would like to say about your state's efforts to support evidence-based practices for mental health and substance use disorders?

114. Was your state Mental Health Director and/or state Substance Abuse Director involved in supplying information for responses to this survey?

☐ Yes
☐ No

***Survey complete! Please return survey to NASHP,* c/o Mike Stanek, Research Assistant, mstanek@nashp.org, or FAX 207-874-6527).**

Thank you for your participation.

Appendix A: Additional Information on Evidence-based Practices

Medication Management Approaches in Psychiatry (MedMAP)

MedMAP is a practice involving the systematic use of medications as a part of the treatment for schizophrenia. MedMAP provides research-based guidelines and algorithms to help practitioners and consumers achieve the best possible recovery outcomes. MedMAP was designed specifically to address medication management for persons diagnosed with schizophrenia.

The goal of MedMAP in the treatment of schizophrenia is to improve care through the optimal use of medications. Medication use can be optimized through implementation of the following principles:

(1) utilization of a systematic approach to medication management
(2) objective assessment of the symptoms that the medications are supposed to affect
(3) clear, concise documentation of the treatments and their outcomes
(4) enhancement of medication adherence through consumer education and involvement in medication decisions.

Thorough, evidence-based medication management helps practitioners determine the best treatments for consumers in an efficient fashion, thereby reducing pain, suffering, and the costs of inadequate treatment.

Adapted from:

http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/workbook/appendixd.asp

Assertive Community Treatment

ACT is a service-delivery model, not a case management program. It is a way of delivering comprehensive and effective services to consumers who have needs that have not been well met by traditional approaches to delivering services. At the heart of ACT is a trans-disciplinary team of 10 to 12 practitioners who provide services to about 100 people. ACT teams directly deliver services to consumers instead of brokering services from other agencies or providers. For the most part, to ensure that services are highly integrated, team members are cross-trained in one another's areas of expertise.
ACT team members collaborate on assessments, treatment planning, and day-to-day interventions. Instead of practitioners having individual caseloads, team members are jointly responsible for making sure that each consumer receives the services needed to support recovery from mental illness.

ACT services are highly individualized. No arbitrary time limits dictate the length of time consumers receive services. The primary goal of ACT is recovery through community treatment and habilitation. ACT is characterized by:

- **A team approach** — Practitioners with various professional training and general life skills work closely together to blend their knowledge and skills.
- **in vivo services** — Services are delivered in the places and contexts where they are needed.
- **A small caseload** — An ACT team consists of 10 to 12 staff members who serve about 100 consumers, resulting in a staff-to-consumer ratio of approximately 1 to 10.
- **time-unlimited services** — A service is provided as long as needed,
- **A shared caseload** — Practitioners do not have individual caseloads; rather, the team as a whole is responsible for ensuring that consumers receive the services they need to live in the community and reach their personal goals.
- **A flexible service delivery** — The ACT team meets daily to discuss how each consumer is doing. The team members can quickly adjust their services to respond to changes in consumers' needs.
- A **fixed point of responsibility** — Rather than sending consumers to various providers for services, the ACT team provides the services that consumers need. If using another provider cannot be avoided (e.g., medical care), the team makes certain that consumers receive the services they need.
- **24/7 crisis availability** — Services are available 24 hours a day, 7 days a week. However, team members often find that they can anticipate and avoid crises.

ACT is for consumers with the most challenging and persistent problems. Programs that adhere most closely to the ACT model are most likely to get the best outcomes

Adapted from:

http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/community/

Supported Employment

Supported employment programs assist people in finding competitive employment—community jobs paying at least minimum wage, which any person can apply for according to their choices and capabilities. Supported employment programs do not screen people for work readiness, unlike other vocational approaches, but help all who say they want to work. Extensive pre-employment assessment and training, or intermediate work experiences, such as prevocational work units, transitional employment, or sheltered workshops are not required.

Programs are staffed by employment specialists who help consumers look for jobs soon after entering the program and facilitate job acquisition. For example, they may assist with application forms or accompany consumers on interviews. Employment specialists support consumers as long as they want the assistance, usually outside of the work place. Support can include help from other practitioners, family members, coworkers, and supervisors.

In addition:

- *Eligibility for the service is based on consumer choice.* No one is excluded who wants to participate.
- *Supported employment is integrated with treatment.* Employment specialists coordinate plans with the treatment team, e.g., case manager, therapist, psychiatrist, etc.
- *Competitive employment is the goal.*
- *Follow-along supports are continuous.* Individualized supports to maintain employment continue as long as consumers want the assistance.
- *Consumer preferences are important.* Choices and decisions about work and support are individualized based on the person's preferences, strengths, and experiences.

Supported employment programs:

- are effective for helping people to obtain competitive employment
- address one of the top priorities of people with severe mental illness and their families
- help people to move beyond the patient role and develop new employment-related roles as part of their recovery process
- help to decrease stigma around mental illness by helping people become integrated into community life through competitive employment

Adapted from:

http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/employment/SEpmhainfo.asp

Family Psychoeducation

Family psychoeducation is a method of working in partnership with families to impart current information about the illness and to help them develop coping skills for handling problems posed by mental illness in one member of the family. The goal is that practitioner, consumer, and family work together to support recovery. Psychoeducation can be used in a single family or multi-family group format, depending on the consumers and family's wishes, as well as empirical indications. Single family and multi-family group versions will have different outcomes over the long term, but there are similar components. The approach has several phases, each with a specific format:

Introductory sessions

Family members meet with a practitioner, together or separately, and begin to form a partnership.

Educational workshop

Families come together in a classroom format for at least four hours to learn the most current information about the psychobiology of the illness. They learn important information about normal reactions, managing stress, and safety measures. Families choosing single family psychoeducation may also wish to attend this session.

Problem-solving sessions

Consumers and families meet every two weeks for the first few months in a single or multi-family format while learning to deal with problems in a pragmatic, structured way. The best results occur when the work proceeds for at least nine months. Additional time of up to two years promotes improved outcomes.

The American Psychiatric Association and the Agency for Health Care Policy and Research cite family psychoeducation as one of the most effective ways to manage schizophrenia. Research has shown that there is a significant reduction in relapse rates (by at least 50% of previous rates) when family intervention, multi-family groups, and medication are used concurrently. Recent studies show promising results for bipolar disorder, major depression, and other severe mental illnesses.

Adapted from:

http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/family/

Illness Management and Recovery

The Illness Management and Recovery Program consists of a series of weekly sessions where practitioners help people who have experienced psychiatric symptoms to develop personal strategies for coping with mental illness and moving forward in their lives. This is a model for people who have experienced symptoms of schizophrenia, bipolar disorder, or depression. It is appropriate for people at various stages of the recovery process. The program can be provided in an individual or group format and generally lasts between three to six months.

Practitioners for Illness Management and Recovery can come from a wide range of clinical backgrounds, including but not restricted to the following: social work, occupational therapy, counseling, case management, nursing, and psychology. All practitioners providing the program need training and ongoing supervision.

What is provided in the Illness Management and Recovery Program?

- Educational Handouts for Illness Management and Recovery, written for people who have experienced psychiatric symptoms. These handouts contain practical information, summaries, check lists, and planning sheets for nine topic areas.
- The Practitioner's Guide for Illness Management and Recovery which includes how to help people develop and practice coping strategies, how to help people develop and pursue recovery goals, and tips for responding to problems that may arise during sessions.
- A fifteen minute introductory video.
- Informational brochures for people who have experienced psychiatric symptoms, family members and practitioners.
- A fidelity scale to measure whether the program is being implemented as designed.
- Outcome measures to assess whether the program is having a positive impact on participants.

Educational handouts are provided for the following topics:

- Recovery strategies
- Practical facts about mental illness
- The stress-vulnerability model and treatment strategies
- Building social support
- Reducing relapses and using medication effectively
- Coping with stress
- Coping with problems and symptoms
- Getting your needs met in the mental health system

Adapted from:

http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/illness/

Co-Occurring Disorders: Integrated Dual Diagnosis Treatment

Integrated dual diagnosis treatment differs from traditional approaches in several ways. The most important is the integration of mental health and substance use treatments. One practitioner or one team in one agency provides both mental health and substance use treatments so that the consumer does not get lost, excluded, or confused going back and forth between two different programs.

Integrated dual diagnosis treatments also blend mental health and substance use treatments. For example, substance use treatments focus more on motivating people with two severe disorders to pursue abstinence, and mental health treatments are modified in light of the consumer's vulnerability to psychoactive substances.

Other features

- **Stage-wise treatment**. People go through a process over time to recover, and different services are helpful at different stages of recovery.
- **Assessment**. Consumers collaborate with clinicians to develop an individualized treatment plan for both substance use disorder and mental illness.
- **Motivational treatment**. Clinicians use specific listening and counseling skills to help consumers develop awareness, hopefulness, and motivation for recovery.
- **Substance use counseling**. Substance use counseling helps people with dual disorders to develop the skills and find the supports needed to pursue recovery from substance use disorder.

Adapted from:

http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/cooccurring/

Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Alcohol, Tobacco and/or Opioid Dependence

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention services that include brief screening, brief intervention, and referral to treatment for person who are at risk of developing these disorders, and for those with substance use disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

- Screening is a quick, simple way to identify individuals who may need further assessment and treatment for alcohol, tobacco and/or drug dependence. The goal of SBIRT is to make screening a routine part of standard medical care.
- Brief intervention can consist of a single or multiple sessions of motivational discussion focused on increasing insight and awareness regarding alcohol, tobacco and/or drug use and motivation for behavioral change. Brief intervention can be used as a stand-alone treatment for individuals at-risk as well as a means of engaging those in need of more extensive levels of care.
- Referral to specialized treatment identifies those in need of more extensive treatment than offered by SBIRT. The effectiveness of the referral process to specialty treatment is a strong measure of SBIRT success and involves a proactive and collaborative effort between SBIRT clinicians and those providing specialty treatment to ensure access to the appropriate level of care.

A key aspect of SBIRT is the integration and coordination of screening, brief intervention, and treatment components into a system of services. This system links a community's specialized treatment programs with a network of early intervention and referral activities that are conducted in medical and social service settings.

Adapted from:

http://sbirt.samhsa.gov/

Additional reference
http://www.hipaa.samhsa.gov/pdf/2007_SA_HCPCS_CodeDefinitons.pdf

Medication-Assisted Treatment for Alcohol, Tobacco and/or Opioid Dependence

Medication-Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research shows that when treating substance-use disorders, a combination of medication and behavioral therapies is most successful. MAT is clinically driven with a focus on individualized patient care.

MAT programs can be tailored to address one or more of the following addictions:

Tobacco/Nicotine Dependence

MAT for tobacco dependence combines medication (e.g. nicotine patches, gums, or other pharmacotherapies such as Chantix®) with counseling and behavioral therapies. This may include:

- Providing smokers with practical counseling (giving advice on successful ways to quit) and
- Providing support and encouragement as part of treatment.

Alcohol Dependence

MAT for alcohol dependence involves a comprehensive approach combining detoxification (if needed,) counseling, medications (e.g., disulfiram), and participation in mutual-help support groups (e.g., Alcoholics Anonymous).

Opioid Dependence

MAT for opioid dependence combines pharmacotherapy with a full program of assessment, psychosocial intervention, and support services.

A typical MAT intervention may include:

- Patient evaluation, prescription of the appropriate medication combined with counseling, and relapse prevention strategies.
- Medication maintenance combined with counseling, and relapse prevention strategies

Adapted from:

http://www.dpt.samhsa.gov/patients/mat.aspx
http://www.guideline.gov/content.aspx?id=12520
http://www.guidelines.gov/content.aspx%3Fid=8355
kap.samhsa.gov/products/trainingcurriculums/pdfs/tip43_curriculum.pdf

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