Implementing Evidence Based Practices Project
National Review of Effective Implementation Strategies and Challenges
April 7 & 8, 2003 - Concord, NH

MEETING NOTES

The Implementing Evidence Based Practices Project ("Toolkit Project") is being conducted by the New Hampshire Dartmouth Psychiatric Research Center, in collaboration with the NASMHPD Research Institute, State Mental Health Authorities, public and private providers, consumers, and families. As part of the larger movement in health to translate science into practice, the project is funded by SAMHSA and RWJ to carefully examine the implementation and dissemination of selected adult EBPs in real world settings. Eight states are involved in implementing six different interventions across 55 sites. The following list summarizes the states that are involved and the specific EBPs being implemented in these states.

- Assertive Community Treatment – New York, Indiana
- Integrated Dual Disorders treatment – Ohio, Indiana, Kansas
- Family Psychoeducation – Vermont, Maryland, New Hampshire
- Illness Management and Recovery – Vermont, New York, New Hampshire, Ohio
- Supported Employment – Oregon, Kansas, Maryland
- Medication Management – Veteran's Administration

Within a paradigm of quality-driven system reform, the ultimate objective of the project is to ensure that consumers and families have the best options possible in achieving recovery.

Purpose of Meeting:

- The meeting was aimed at persons involved directly in facilitating implementation, including consultants and trainers, implementation monitors, and evaluation consultants. The purpose of meeting at this midpoint in the project was to begin the process of developing a body of knowledge from the toolkit states' experiences that can be shared with each other and other states. The following agenda items were covered: Review of project structure and roles of project staff and partners (i.e., Consultant and Trainers, Implementation Monitors, Evaluation Consultants, Consumers, Families, Agencies, and Mental Health Authorities)
- Review of project goals and objectives for Phase II, and feedback and data sources
- Identification and discussion of challenges and strategies related to various aspects of implementation (i.e., consulting and training, use of toolkits, and partnerships with consumers, families, agencies, and MHAS)
- Identification and discussion of issues related to measuring outcomes, fidelity, and organizational factors

Monday, April 7

Project Structure and Roles

Implementation Monitors (IM)

- IM's serve as resources, consultants, and trainers. Kristine Knoll is an IM and also coordinates all other IM's.
- What is monitoring? IMs visit once per month, check on progress, find out what would work better, what would be helpful, what are we supplementing with? The interview consumers, staff, etc. Monitors do not consult. At baseline they cover questions above primarily. At 6 months they cover fidelity measure.
- The reason for the split between monitoring and training is because training and consultation are the interventions being studied.

- IMs also identify and implement strategies to minimize discomfort of participants being evaluated.

{Related Question: What is time frame for revising toolkits? We will monitor for 2 years. Surveys will be feedback for toolkit authors.}

State Level CAT The purpose of the CAT (consultant and trainer) is to facilitate the implementation of the EBPs at routine mental health center settings across the country. The CATs have been hired on a local basis by each of the systems involved in the project. Each of the CATs received an intensive training in how to provide training and consulting in the practices that they are helping to implement. The CATs work directly with the mental health centers.

State Senior Evaluation Consultants – These positions support the IM, troubleshoot, facilitate, supervise quality of data coming in. The role is a little different in every state depending on state organizational structure.

Project Goals and Objectives for Phase II

Purpose of Phase II is to field test the package and learn from the implementation resource toolkit (IRK). It is important to know we are not trying to put states' practice into boxes, just stimulate and observe the flow.

Quality Improvement Process – The Toolkit project is like a giant QI activity. For 18 months the IRKs went through an iterative developmental process, involving stakeholder groups, panels, final edits, etc. This was accompanied by a shift in language/appreciation. Now we are asking random sites across the nation to participate in focus groups. These are being doing by Dartmouth and IMs, but not with the Consultant/Trainers present.

Atlas Data Base – All of the interviews being done by the IMs are entered into this qualitative data software for coding and searching. Information can be compiled for feedback mechanism, review of strategies, general inquiries, etc. (e.g., What did people think of the DD Workbook?)

Challenges and Strategies related to Consultation and Training

The following table shows the results of an exercise designed to generate a list of the most challenging aspects of consultation and training, and strategies to address these. Four groups of 7-8 individuals, across all EBP types, brainstormed a list of challenges, and then identified the most challenging areas and strategies to address these. The following table shows the raw results of this group exercise, with similar challenges grouped together.

At the end of the exercise comments were made suggesting that all of this information should come back to the group in rich detail, that this information should be added to the toolkit, and that we should extract principles and share these with other sites.

Most Challenging Areas of CAT	Successful Strategies for Meeting Challenges
Early implementation phases, motivating stage, predisposing strategies: Establishing buy-in	
Establishing felt need for EBP at all levels	Identify needs/strengths, and how EBP addresses them Talk through barriers Assess, Assess, Assess Choose agencies with compatible vision (i.e. Early adopters) Focus on What is In It For Me Model “engagement” Monitor “buy-in” and address issues Provide “organizational case examples and change models”
Getting Practitioner Buy-In	Show them benefits of the practice early on and frequently Emphasize how practice will improve outcomes and make caseloads easier Use motivational interviewing in training – use their knowledge to get them involved in training and keep stages of change in mind (in regards to practitioner readiness) Demonstrate competence yourself so they feel good about who they are learning from Work with administration to remove oppositional staff
Getting & Keeping CEO/Upper Administration Buy-In	Joint agreements Make sure they know all the requirements up front (the bad news) Do not go forward until the CEO/UA is “On Board <u>for Real</u>” Truth in advertising – make sure they know all the benefits and expectations
Challenges in admin. agency support / buy-in through all levels of organization	Steering committee with clarification of roles, purposes, goals / objectives, composition (i.e. family, community member) Meet directly with CEO, CFO on regular basis to address problems keep open communication, establish ongoing collaborative relations Need someone to champion / oversee – well respected and/or powerful Administrative training / seminars in time of great change Use fidelity assessment for management information / feedback Give higher profile to major reform we are part of (raise awareness / excitement of movement) “Report Cards” Use of Outcomes
Introducing Implementation Strategies Within Agencies that do not see the Importance (i.e., agencies that assume they are already implementing model)	Asking questions of leadership about change Getting leadership buy-in Agency asking people to volunteer to be part of process

Most Challenging Areas of CAT	Successful Strategies for Meeting Challenges
Enacting stage, enabling methods: Training, consultation, financing	
Building staff competence	CAT access to clients – "supervise in practice"; CAT shadowing experiences Start with motivated staff Focus on skill base vs. knowledge base; incremental skill development Overlap consultation "into" training Require supervisor presence in training
Training for multiple skill & experiences	Promote an internal mentoring process Train in an interactive way, engage more seasoned practitioners to share knowledge Find a way to teach even the more seasoned clinicians new skills and behaviors Assess your audience Get feedback from each session and use it to inform the next session Train to different levels of knowledge Role plays; Videotape clinicians doing skills Quizzes/Assess levels of learning pre/post test
Transfer learning into practice	Trainer has to be present in supervision so supervisors learn the practice well enough to continue Shadowing practitioners who do the practice well Role playing and practical exercises Listen to feedback from consumers receiving the practice Peer supervision in addition to regular supervision Booster trainings
Integration of knowledge into practice, to keep people's attention against competing demands	Spending time with staff in field (1:1) Attending team meetings to address integration Strong steering committee that meets on a regular basis. Structure in place for supervision Working with implementation leaders – rely on their strengths Ask agency what works best Study committee (peer)
Staff turnover	Leadership needs to create a learning environment; invest in workforce Address clinician struggles and accomplishments
Financial issues – limited resources, Medicaid, productivity	Special billing category for EBP (FPE) One funding stream (vs. fragmented funding from different sources) Sharing information about creative finances, productivity across states Helping agencies maximize billing Using resources efficiently (training) Medicare – creating option, means to pay for FPE (Northeast states)
Billing/fiscal issues	"How to" finesse Medicaid regulation Change state regulations to support practice "Dear Provider" letters (i.e., encouraging implementation of EBP via sending tips on financing, etc) Identify different funding streams Teach "How to write a billable progress note, "How to write a treatment plan" Educate "Budget People" re: need to track data for cost effectiveness Disseminate reports broadly Case stories = Cost effectiveness

What have we learned about Partnerships with Consumers in Implementation?

Comments from Consumer Advocate and New Hampshire Experience:

- Consumers should be involved in all aspects of program design and implementation, but professionals don't know how—we have to show them. For e.g., As a CA, I need to ask to be paid to attend these meetings; I have to ask to be invited.
- In IMR, med mgmt., FPE we have to include consumers
- You need to be aware that some professionals still don't believe in recovery. How can they teach illness management and recovery?
- IMR is done by professionals. We need to have consumers doing the training. Consumers endorse Copeland method more at this point (delivered by consumers, home recovery education). They don't think we need IMR.
- There was consumer involvement in developing IMR, but it was not local. Impact of consumer presence is very powerful for credibility. Role model exposure helps both consumers and mental health professionals.
- There is still the question re: stigma within mental health professionals/administrators

Feedback from Other Projects/General Comments:

- Kansas involved consumers in training. There was a power to it that was incomparable. They find it is challenging to get consumers involved in leadership. [The Consumer Advocate shared that it is hard for consumers in leadership roles because of the demands, travel, and the intimidation factor]. Kansas advertised for consumers at the sites and paid them. Consumers were involved in all the stakeholder and skills training. They did a TOT for consumers, planning sessions before next training, and roleplays.
- General question--What can we do if no consumers know IDDT, for example? [CA: That's when consumer role is most important—so even if no one knows, it is helpful to have consumers]
- Consumer Advocate: When you approach a consumer group, don't go in there with all the materials and ask for comments. Really ask for input; don't just use a sales approach.
- New York – The good news is we are implementing 6 EBPs. The bad news is doing all 6 at once may not be the best approach. We have experienced some antagonism from groups, but sharing dollars for training has helped. We have an office in OMH that is related to consumers. We added modules to EBPs re: to consumers. We went over FPE with consumers and Bill McFarlane. They reviewed toolkits line by line and found language issues that needed to be edited. OMH has relationship with a NY Consumers Group. The training leader involved in ACT training is introducing the concept of recovery at start.
- Question re: consumers on steering committee? In Kansas we have struggled with consumer involvement on the steering committee. We often have the same issue with consumers as other stakeholders—not involving soon enough at front of project.
- Must underscore that we need consumer involvement in developing the toolkit. If they can't be in on a conference call, call them later to get their input. Break manuals down into "digestible" sections.
- Consumer Advocate: Terminology of "consumer" is somewhat awkward though it is the best we have now. A & D community uses "person in recovery".

What Have We Learned about Partnerships with Family Members in Implementation?

- Vermont: had experience with 2 other models before EBP.
- Families should be involved in EBPs. They have knowledge and skills, know clients, have advocacy skills, valuable in feedback loop—is program working, helpful to be involved in development as consumers

- Families want respect from providers, open access to communication, competent providers, hope, and information about mental illness. They don't want to be blamed. An important issue for them is where is my family member going to work?
- Barriers – language of recovery is new ("not just maintenance, but moving forward"). There is some tension between EBPs and "Family to Family, also program evaluation, and outcomes.
- We have to help providers work with families, do outreach in the same way as recommended earlier for consumers (e.g., involve them in training also).

<u>Effective Agency Strategies</u>

- In Vermont, we have a Family Intervention Specialist who can identify families; family involvement is part of fidelity measure criteria.
- On ACT Teams, we remind staff must to involve families/consumers in plans; we have good relationship with NAMI. There are mixed results across sites. It is stronger where there are existing family groups. There are changes from "no" family involvement at baseline to 6 months. This comes from persistent efforts of TA to keep prodding providers to involve families
- There is some provider anxiety about involving families
- Some of the barriers we are dealing with are very serious. For example, in the ACT toolkit, there is not much information about how to work with families. Among providers there is still blaming families, assuming families don't have skills. We should be again be reaching out by asking families what helps, what hurts?
- IN IDDT (Ohio) we have been changing the culture of organizations by changing the forms that they use (e.g., I changed our intake forms from items asking "Can we contact your family"? to "What family member should I contact?"
- Some professionals licensed to work with individuals, think they can't work with the family. We need to cross-train therapists so they can see how one hour spent with the family can be more productive than one hour with the client alone.
- In Ohio we struggled with involving families in IDDT because of the situations when consumers do drinking and drugging with the family.

<u>Effective System Strategies</u>

- Expand roles for family to steering committee members; feedback; QI.
- In NY at state level we have professional family advocates. NAMI is a partner on forums. We do needs assessments and the "Dear Provider" letters. Providers don't naturally like FPE because of the hours; think they don't need to do it. So we need to figure out what incentives can be put into contracts to stimulate implementation of EBP.

What have we learned about "The Agency"?

What are the leadership roles? CEO, ED, CFO, Clinical Director, Direct supervisors, team leaders, QA/QI, Medical Records, Medical Directors, Champion

<u>Agency Leadership Skills</u>

What skills should they have/acquire during the project?

- Listening, mission centered leadership, comfort with risk (risk tolerant/risk sharing), conflict management, leading with vision/inspiring, communication skills, role model, resource allocation and system alignment, creativity/problem-solving, open culture—fosters organizational learning, collaborates vs. dictates, delegates and holds accountable, manages by walking around, visibility-connected to community, marketing advocacy, technical competence, supporting/rewarding work
- Are any skills more specific to EBP?-- value of CI, research culture

- Bill McFarlane: Found in implementation study that sites which moved ahead were those in which the leaders were motivated more by serving the community than advancing there careers.

<u>What Strategies Enact Implementation</u>?

- Align with visible partners
- Network with successful leaders
- Sharing ideas—consortium meetings with consultants (NY)
- Ohio - Cross-fertilization with existing sites
- IMR – 2 day training across agencies
- Indiana – State standards for contracting with agencies now specify use of fidelity measures.

<u>What Process/Strategies Helped Promote Cultural Change?</u>

- In CT, it was extremely effective to have the CEO attend the training, state "Here's how we use recovery, here's what we do", set a leadership tone, and create a recovery culture and a vehicle for change.
- Share consumer stories
- Using active feedback
- Outcome focused-client oriented
- Make clear a change is happening which is here to stay
- Identify and address fears
- Carefully articulate values in new culture
- Involve direct line staff (with influence) in developing training manuals.
- Have Steering Committee and CEO address next steps
- Align consistent incentives, e.g. performance review
- How does the leadership use information? How do they know if improvement is happening?
- Questions about the need to address EBP in professional training. In NY they are working with Schools of Social Work to develop curricula and internships focusing on EBP.

What have we learned about sustaining systems in "The Agency"?

Outcome measures –See Handouts

Tuesday, April 8

Feedback from Monday, Pressing Questions

- Need organizational change models--identifying stages of change, behavior change
- How do you set up an organization to adopt innovation? We need some expertise to help in very applied ways. Example: How does the CAT move people from one stage to another?
- (General Question: How long does consultation and training last? What's the next phase? 12 months estimated)
- In next steps, we need to look at supervision
- What happens in agency related to change? Hope that Implementation Monitors and Atlas Database will document some of that.
- Consumer Advocate: Some of the existing interventions (F-F, peer support) that families like are being dropped in place of EBP. My impression of EBP is better than I thought.
- In New Hampshire there are concerns that EBP and programs that families like will have to compete for resources. In reality there is a lot to go around. We need to endorse a continuum of interventions
- We need more research in models that families like
- SAMHSA: One possible next step is for evaluators to help spur the family preferred program

Start Practice Specific Focus Groups feedback on IRK materials

Family Psychoeducation

- Mike Cohen/NAMI perspective/observation on recent training he went to: Trainees were MA level. Did they think EBP was something good to do or just part of research project?
- How to work with families that are somewhat resistant—e.g. re: sending NAMI member a workbook to look over.
- Mike is advocating nationally for NAMI to accept EBP (Lisa Dixon in Ohio is doing the same work—per Betty)
- Need to distinguish F-F from FPE. Bill McFarlane and Mike had been working on a consensus statement—will finish—this states F-F should occur, differences between the two interventions. This might be ready for NAMI National Meeting. Dixon did a good table summarizing the differences between F-F and FPE.
- Question re: staff training. Harry says FPE implementation is fragile because it is dependent on enough families, staff turnover, age of staff—Bill McFarlane said you can start with fewer numbers of families. We should add this and clarification of differences between F-F and FPE to the IRK.

<u>Questions re: IRK materials from David Lynde:</u>

<u>How about the intro video?</u>
Everyone loves, we use as introduction, gives overview, nice racial mix, shows families in good light, purpose of intro achieved.

<u>How about the practice demonstration video?</u>
"Shows balance of socializing and relationship; no family members present—major weakness for training; wanted to see demo of a new groups, not one later in the process as is shown in demo tape Group doesn't pick a "problem"—more of a theme—would be better if focus is more of a specific problem to work on; therapist looks at watch a lot; people impressed by progress made by clients in the demo tape; the practice looked "do-able" on the tape—is that all there is?; quality of tape kind of weak, shaky."

<u>5 Introductory Documents</u>
David says purpose is to provide a brief introduction to engage people. "Good handouts, I'd like it in a brochure, not so academic looking; useful helpful info—how to get enrolled."

<u>Website</u> good for handouts.

<u>Manual/Workbook</u> – "Great; major typo p.14 re: single family; people like it; accomplishes purpose well like it; don't think folks are reading, better to have planned reading time up front or in between trainings

<u>Overall IRK</u> – needs skills training--want materials for structured curriculum, videotape "primer" is good, but need something on role playing exercises; cultural competence is under-addressed. Need to be mindful of cultural language issues. "I feel people are fairly well-trained after the two days. We have group supervision every 3 weeks; meet with senior administration regularly or at 6 month fidelity check.

<u>PP presentations</u> (In workbook?) are useful to generate questions, but too much content for us to master—don't know how to use all of it, selective in what we use.

Supported Employment

Questions about IRK materials from David Lynde:

How about the SE intro video?
Very well received by most folks. Conveys usefulness of this practice from multiple consumer perspectives. Good diversity of people in this video. Many of the consumers do not “appear” as “ill” as other people with severe mental illnesses. Good tool to use in multiple settings, e.g. kick-off trainings, stakeholder steering groups, consumer groups, employment groups. Needs to be closed captioning compatible.

How about the SE practice demonstration video?
Video presents itself, as rather “slow” and “dry”, seems that a lot of people are “tuning out.” Demonstrations need to be edited and faster moving in nature. The use of an integrated team is well demonstrated; it may be more helpful to have the group run by an employment specialist. Comments from the Dartmouth psychiatrist are good. Team meeting is too dry to follow. Many staff in this video seem too nervous. Needs to be shorter and more focused.

SE Introductory Documents
David says purpose is to provide a brief introduction to engage people. Easy to read, using it often. Helpful clear document. A specific and similar handout for case managers would be useful.

Website Only minimal use or access.

SE Manual/Workbook. Should this be in the front of the IRK? This is the piece that most people are looking for in the IRK. Difficult to use this workbook in training, the vignettes need more information/context for training purposes. Would benefit from an explicit section on job development and ways to present for/at job development sessions. Job development section could also include some sample scripts on how to do “cold calls”, ways to talk with employers, and structured role-plays for training and skill building on job development. Vocational profile section should include a section on “proper identification (alien status, etc) for person to be able to go to work.

Overall SE IRK. Would benefit from more scripts on job development and more attention to that topic, including job marketing and pros and cons of disclosure, as well as the whole variety of issues related to disclosure.
Each component could use a brief description of intended use/purpose.
References or more materials regarding motivational interviewing would be helpful.

PP presentations. Overall, useful. Would benefit from more information on job development and skills for the employment specialists on job development. Having structures in places for role-plays and specific role-play ideas would be very helpful.

What have we learned about Fidelity Scales, GOI Scales, and Reports?

Questions asked to each state: Who is doing? How long does it take? Report flow? How to transition task to site eventually? What’s not working? Benefits? Next steps?

Indiana: FI and GOI done by IM’s, scored by consensus. CAT does report with feedback from the IM. They have used both narrative format (from Ohio) and spreadsheet format (Indiana). These go to ED.

Ohio: Done by teams composed of evaluator, trainer, IM; takes a full day to do interviews for each EBP, chart review, review annual reports, etc.; Takes 1-2 hours to assimilate, rate for each person; then rate by consensus; then CAT writes report, feeds back to site; then report to steering committee who does a fidelity work plan in order to follow-up and connect to interventive action.

Maryland: Baseline – IM and CAT scheduled FI/GOI for 2 day process. CT writes report, consensus rating, meet with ED, Steering Committee, then do plan

New York: (ACT) Baseline for all + 6 month done; IM and CAT do together. In 1 day FI and GOI chart reviews alone, separate rating, consensus rating, CT writes IM reviews ideally, asks CEO how to present (i.e., whether individual meeting with CEO, directly to supervisors, group, etc?), baselines emailed then discussed, send copy to MHA. MHA wanted to preview, but we are not really allowing this every time. We don't do work plan now, but want to incorporate. Same process for IMR, but no loop through MHA. NY State has incorporated this into its certification requirements so there is a lot of congruence with EBPs at the system level.

Kansas: 2 days at each site—For IDT: CAT does not sit in on interviews with staff due to possible bias; CAT does consumer interviews, chart reviews. They do consensus rating right after interviews; CAT writes report (like Ohio and Indiana). Report is broken down by item, rating for baseline and 6 months, recommendations; presented to Steering Committee, develop work plan from recommendations.
For SE: Same as above but State QA person is involved also, and we asked agencies to do their own fidelity measure; then compared.

Oregon: Site level IM and CAT do baseline and 6 months (2/3 day + ½ day). CAT writes report; sent to state for review, sent to site supervisor for review/feedback. No process yet for sites doing a workplan via steering committee. State level wants to add an independent rater.

Vermont: 4 IMR programs, and 4 FPE programs. Baseline took 2 days. Six months review is taking about 1.5 days. Raters are the CAT, IM, Eval. Consultant; do interviews together, consensus rating, CAT writes, sent to INM sent to sites. Takes 3-4 hours to write reports.

Challenges

Problems in conducting FI and GOI:
- Chart reviews are very labor intensive
- GOI – it is difficult to make judgments re: adequacy of treatment plans (What do we do when 3 plans look great, 3 are horrible, 3 are average ? May need to revise, per Gary)
- Some items have 2 questions imbedded
- Per Dartmouth Project, psychometrics are planned. We have to live with what we have for now. Save those critiques of individual items. We'll need later, per Gary.

What about the procedures themselves?
- There is some anxiety on sites re: the process of being judged; some feel it helps them prepare for other important reviews like accreditation.

How will you begin to transition the sites to self monitor (i.e., do the FI themselves)?
- Ohio/Indiana – Centers of Excellence have responsibilities to teach sites to do self studies
- Kansas – Already getting sites to begin doing FI themselves (see earlier notes) + State level QA
- Anyone combining with Consumer QA?? (No answer)

Effective Agency Strategies (Change in agencies related to GOI feedback?)
- Fidelity Instrument – Changing pre-vocational program staff into more SE-like functions, spurred big changes

- GOI – In Vermont, monthly summary of treatment plans are more goal-oriented. In Ohio, ¾ sites adopted Implementation /Outcome Teams—from GOI feedback.

Discussion focused back to FI—how to conduct them, need training for sites, some confusion regarding reporting for GOI and making recommendations on first round.

Question re: measuring outcomes—are we supposed to be doing this? State variation (Ohio and NY extensive)—ties into other aspects, funding. Every toolkit has outcomes specified.

What have we learned about Public Mental Health Authority Activities to Support Implementation?

Challenges

- Conflict between billing and service delivery
- Economic crises diverts attention
- Trade association pressures
- ACT Center started up at same time as ACT teams
- Rapid changes makes it hard for agencies to keep up with planning, training, standards development
- Management turnover
- Publicity slow from state level

Impact of the budget shortfall?

- ACT productivity demands are greater, but they have the same productivity standards as other "case managers". In general impacts are: supervision not as great; turnover is greater; and training is harder. Discussion of how to pay via Medicaid fee for service. Would be better to do a capitated daily rate per diem.
- Dollars are shrinking; there is more appearance of competing services, therefore less consensus
- Competition among so many new initiatives in states—trauma, recovery, etc.

Effective System Strategies

Most helpful activities/strategies?

- Message from MHA re: how high the priority of EBP is
- Discussion of funding opportunities
- Source of EBP—whether direct initiative by State MH or contracted to university—more power to influence at state level
- MHA funding using federal block grant funds rather than state
- Support from two champions. They facilitated standards creation for ACT, found ways to fund ACT, got us involved with the project, closed beds to support ACT—but these 2 people are gone now.
- Supporting additional positions
- State very carefully setting up specifications, Medicaid funding for ACT, outcome package & software
- Autonomy and trust
- Had to designate ½ time champion at agency site
- Social Work consortium in NY- classes in EPB and internship in ACT
- In NY philosophy is to take full advantage of every opportunity, every aspect of our authority to advance EBP. For example, we are converting psychosocial clubhouses, etc., via QI, to EBPs;

helping providers figure out how to finance EBPs, reduce barriers, enter into "Center of Excellence" type of contract with University of Rochester.

Next Action Steps
What are things MHA could do to be more helpful?
- Communication/newsletter
- Collaboration among various levels of authority—county, state, local; partner with other leaders with same values and goals
- Regulation – doing licensing and certification, also do consultation and problem-solving
- Summary of cost benefit studies—IMR, ACT, SE, FPE—to provide tools for legislators to ask for $$.

Project Next Steps, NASMHPD, SAMHSA

Crystal Blyler (SAMHSA): Reported on NIMH RFA, training and evaluation RFA, joint communication with other states, Governors' Association imitative re: best practices, National Registry of Effective Programs (NREP) is enlarging to include mental health. Center for Medicaid and Medicare services (via Glenn Stanton with Disabled and Elderly Services Group) is interested in figuring out how to cover EBP via Medicare/Medicaid

Vijay Ganju (NRI):
- New HIPPA codes for billing were set up for some of the EBP (ACT, SE, MST). They have procedure codes and modifier codes.
- Lots of talk about science to service and service to science transfers
- Next meeting in September – build TA Platform for dissemination of EBP to other states
- Howard Goldman doing state level evaluation of EBP (funded by RWJ) – interviewing Commissioner, state level steering committees, practice teams, consumers, families—June and July reports to be released. Initial finding is that different states have different authorities.
- Other issues: Dealing with costs, interface with other systems
- Health Resources Services Administration – focus on EBP, asthma, diabetes, and depression
- Planning a conference on children's EBP – cross-system
- Working with other stakeholders – Consumer Survivors' Group, Consumer TA Center
- NRI Website
- New Freedom Initiative – President's Commission on Mental Health – EBP's and Recovery Vision and "self-determination models"

Bob Drake: Key Points/Values re: EBP- Pay attention to science, individualize services, consumers involved fully (choice, determination, decision-making), clinical competence

Not yet addressed Objectives and Questions

What are sustaining factors?
- MHA commitment
- Funding
- Local champion

What are sustaining mechanisms?
- Continued funding initiatives for EBP
- Institutionalize EBP by state ownership
- Continuity in champions—on going steering committees
- No exit strategy

- Regional network of steering committees and other agencies
- More work with consumer/family advocates
- More work with graduate schools
- Supervisory training
- Booster training

Wrap-up and Evaluation

When you ask, “What can I do with this overwhelming list of tasks that have emerged from this meeting”?

- Remember they are shared tasks at multiple levels
- David Lynne says – Develop and implement work plans from Fidelity Reports, staff development, credentialing, help supervise, monitor who is being enrolled, stimulate focus on outcomes
- Another reason to be optimistic –SAMHSA is in the room
- Consumer Advocate final words: You are taking $$ from their programs. ACT is a practice many consumers are afraid of. So much steam is behind this program. It’s going to happen whether we like it or not. We might as well get on board.

Meeting Attendance List

Name	Affiliation or State	Role	Practice
Ken Braiterman	Consumer Advocate		
Greg McHugo	Dartmouth PRC	Imp. Mon.	
Kristine Knoll	Dartmouth PRC	Imp. Mon.	
Gretchen Grappone	Dartmouth PRC	Imp. Mon.	
Mike Cohen	Family Advocate		
Mike McKasson	Indiana	CAT	ACT
Bruce Jensen	Indiana	CAT	IDDT
Lia Hicks	Indiana	CAT	ACT
Diane Asher	Kansas	CAT	IDDT
Doug Marty	Kansas	S.E.C.	
Linda Carlson	Kansas	CAT	SE
Bette Stewart	Maryland	CAT	FPE/ACT
Eileen Hansen	Maryland	S.E.C.	
Steve Baker	Maryland	CAT	SE
Marie Huddle	NASMHPD Research Institute		
Vijay Ganju	NASMHPD Research Institute		
Jeanne Rivard	NASMHPD Research Institute		
Bill Emmet	NASMHPD		
Harry Cunningham	New Hampshire	CAT	IMR/FPE
William Torrey	New Hampshire/Vermont	S.E.C.	
Molly Finnerty	New York	S.E.C.	
Paul Margolies	New York	CAT	IMR
Tony Salerno	New York	CAT	IMR
Diane Alden	New York	CAT	ACT/IMR
Alice Claggett	Ohio	CAT	IMR
Patrick Boyle	Ohio	C.C.O.E.	IDDT
Rick Kruszynski	Ohio	CAT	IDDT
Wilma Lutz	Ohio	S.E.C.	
Mike Moore	Oregon	D.M.H.	
Sharon Doshier	Oregon	CAT	SE
Crystal Blyler	SAMHSA		
Paul Gorman	Steering Committee		
Bob Drake	Steering Committee		
Howard Goldman	Steering Committee		
Debbie Becker	Super Trainer	s trainer	SE
Bill McFarlane	Super Trainer	s trainer	FPE
Gary Morse	Super Trainer	s trainer	ACT
Susan Gingerich	Super Trainer	s trainer	IMR
Gary Bond	Super Trainer	s.trainer	Fidelity
David Lynde	Super Trainer	s.trainer	CATs
Roberta Hurely	West Institute		
Rusty Foster	West Institute		
Steve Leff	The Evaluation Center at HSRI		