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Adapting the Integrated Dual Diagnosis Treatment (IDDT) Fidelity Scale for Inpatient Implementation

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Introduction and Overview

Patrick Boyle, LISW, CCDC-III

Director, Implementation Services
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Ohio's Mental Health System

- State Originated, County Administered
- 51 Local Mental Health Authorities
- 450 Local Mental Health Agencies
- State Administered “Behavioral Healthcare Organization” – inpatient/outpatient
- 33% SMD
- Separate MH/AOD Cabinet level Depts.

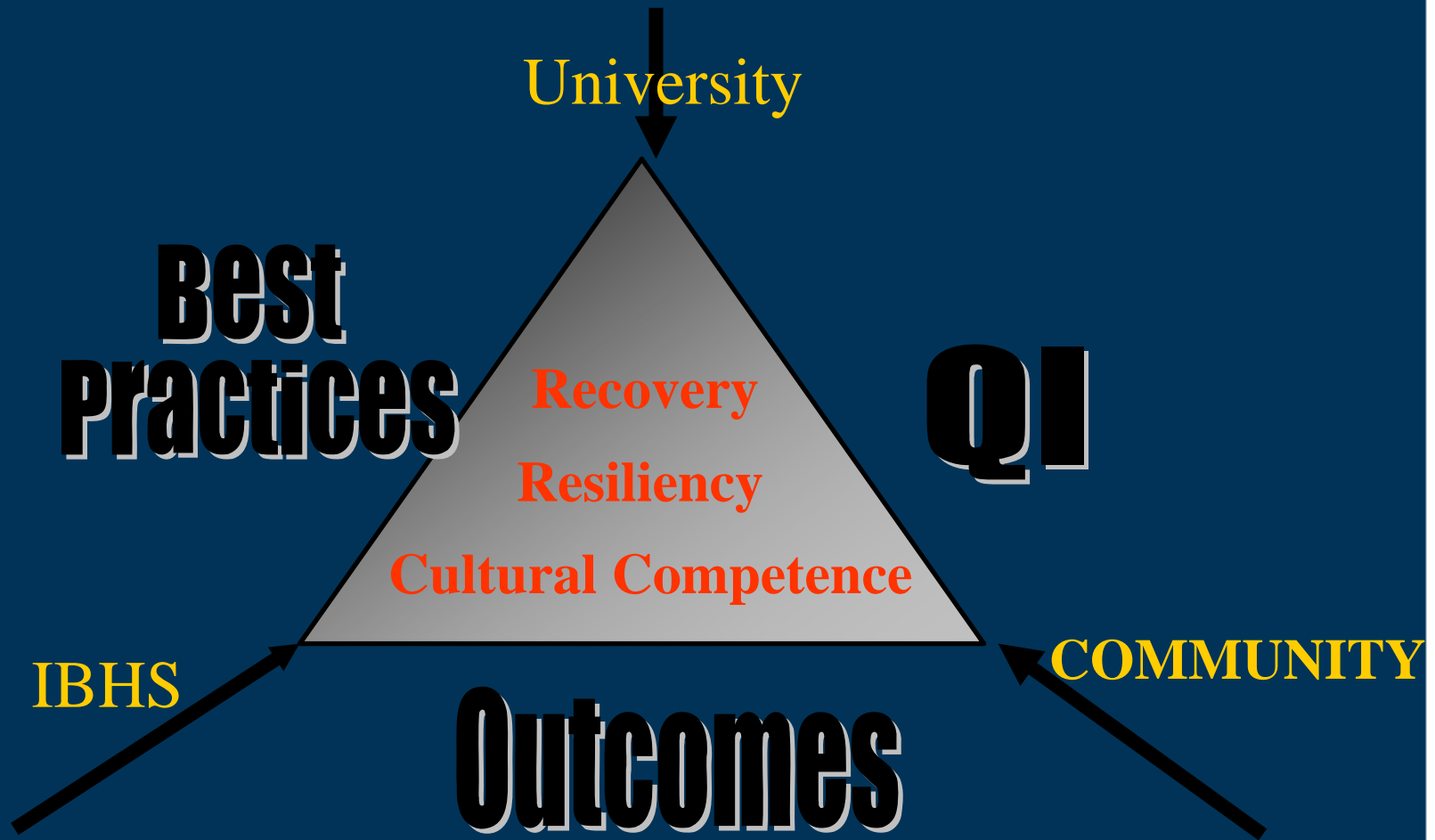
Impact of Reform: 1990s

- Dramatic reduction of state hospital use
- Increased resources devoted to community programs
- Rapid growth of CSP Services
- Erosion of State Financial Support
- Quality and outcomes improve somewhat
- Much work left to do

Ohio's Mental Health System Dynamics

- Consumer-directed Recovery
- Quality and accountability demands
- Static to declining financial resources
- State leadership - improve services to improve outcomes

Partnering for a Quality Mental Health System



Evidence Based Practices: Guiding Principles

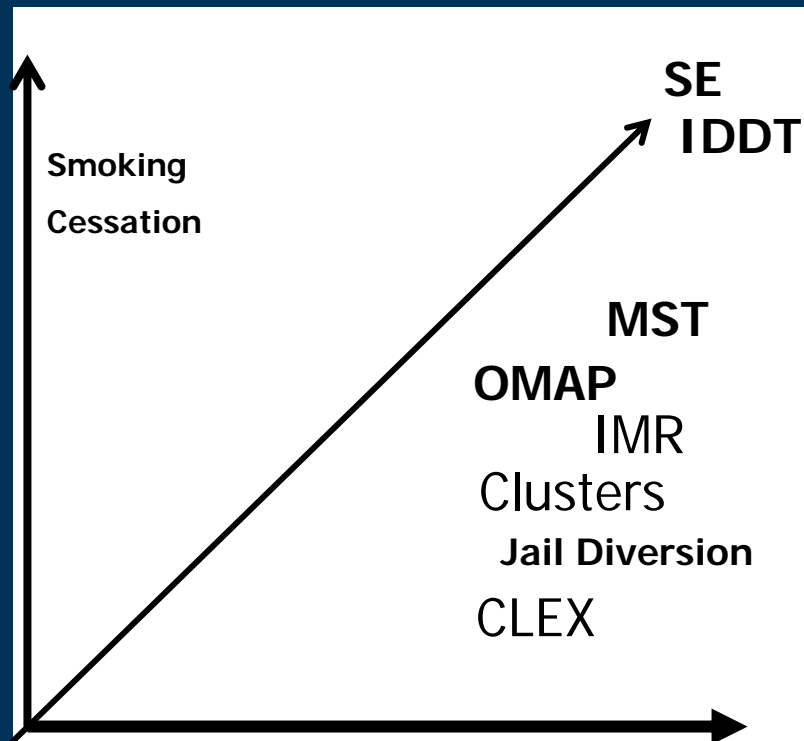
- Recovery and resiliency
- Consumer demand and right to effective services
- Put resources in to **WHAT WORKS!**
- Evidence-based practice utilization will increase *if the right strategies are used*

Role of CCOEs

- Assist local mental health systems develop the capacity to implement Evidence-Based Practices
- Promote the utilization of procedures required to implement Evidence-Based Practices
- Develop and/or utilize proven education and training materials

Ohio's Framework to Prioritizing EBP promotion

Scientific Evidence



System Salience

Ten Treatment Principles - underlying Philosophy of IDDT

1. Integration of substance abuse & mental health treatments

- Same clinicians within program or agency
- Supports cross training

Source: Mercer-McFadden, C., Drake, R.E., Clark, R.E., Verven, N., Noordsy, D.L., Fox, T.S. (1998). *Substance Abuse Treatment for people with Severe Mental Disorders: a program manager's guide*. New Hampshire-Dartmouth Psychiatric Research Center.

IDDT

Guiding Treatment Principles

2. Flexibility & specialization of
clinicians

← cross-trained staff

3. Assertive outreach

IDDT

Guiding Treatment Principles

4. Recognition of client preferences
 - ✓ client centeredness
 - ✓ cultural competence
5. Close Monitoring
6. Comprehensive Services

IDDT

Guiding Treatment Principles

7. Range of Stable Living Situations

8. The Long-term Perspective

9. Stage-wise Treatment

10. Optimism



OHIO DEPARTMENT OF MENTAL HEALTH

Inpatient Implementation of Integrated Dual Diagnosis Services: The Twin Valley Experience

Mark Hurst, MD

Assistant Chief Clinical Officer-Addiction Psychiatry

Twin Valley Behavioral Healthcare

Ohio Department of Mental Health

Columbus, Ohio

Profile of Twin Valley Behavioral Healthcare

- Part of the Integrated Behavioral Healthcare Services (IBHS) of the Ohio Department of Mental Health
- Two campuses
 - Columbus
 - Dayton
- Strong emphasis on Best Clinical Practices and Innovative Technologies for provision of High Quality, Culturally Competent clinical services

Profile of Twin Valley Behavioral Healthcare

- Multiple Product Lines, which serve as vehicle for clinical services:
 - Intensive and Specialized Services (ISS)
 - Acute inpatient
 - Forensic: Inpatient and Outpatient
 - Community Support Network (Outpatient)
 - Culture, Family and Community

Profile of Twin Valley Behavioral Healthcare



- Columbus Campus
 - 206 beds
 - 78 Acute Inpatient
 - 76 Maximum Security Forensic
 - 52 Forensic step-down

TVBH IDDT Inpatient Implementation: Getting Started

Early 1998:

- Hospital CEO targeted co-occurring substance use disorders as a priority area for improved clinical service
- Task force of clinicians with interest and expertise in this area appointed to address the issue:
 - Assessed prevalence of dual diagnosis within hospital
 - Assessed current services being provided
 - Literature review
 - Trainings from recognized experts
 - Established dialogue among local providers
 - Considered local history

TVBH IDDT Inpatient Implementation: Getting Started

Late 1998:

- Clinical leader named to spearhead efforts
- Dartmouth-New Hampshire Integrated Treatment Model recommended to CEO for adaptation to inpatient use
- Presentation made to key administrative staff on IDDT model and implementation at TVBH
 - Administrative approval given to proceed
 - Emphasis on “re-engineering”
 - Plan established for staff training and implementation

TVBH IDDT Inpatient Implementation

Challenges faced:

- New way of doing things (change is hard!)
- Staff attitudes and “buy-in” to model
- Can existing staff provide treatment in this model?
- How do you adapt an outpatient model to inpatient?
- Should there be a designated “dual diagnosis” unit?

TVBH IDDT Inpatient Implementation

Challenges faced (cont'd):

- How to meet needs of diverse patient population?
 - High volume of admissions
 - Varying lengths of stay (a few days to a few years)
 - Civil patients vs. Forensic patients
 - Varying levels of insight and motivation
 - All things to all people?
 - What are reasonable expectations for outcomes?

So What Did You Do?

- Recognize that stages of change apply to clinicians, administrators and facilities as much as to patients!
- Clinical training in IDDT was as valuable in helping the facility progress through the implementation process as helping patients through the treatment process
 - **Engagement**
 - **Persuasion**
 - **Active Treatment**
 - **Relapse Prevention**

Stages of Change

Stage of Change	Major Task	Patient	Clinician
<i>Engagement</i>	Relationship building	“I don’t have a problem”	“We don’t deal with that here”
<i>Persuasion</i>	Insight development	“Maybe I do have a problem”	“Maybe we should deal with that here”
<i>Active Treatment</i>	Skill acquisition	“I have a problem and need to learn how to deal with it”	“We do address it and I need to get better skills”
<i>Relapse Prevention</i>	Maintenance	“I need to be sure it doesn’t come back”	“We need to keep our skills up to date”

Disseminating IDDT Model to Staff

- Training of Department Heads in IDDT model and rationale for implementation at TVBH
- Training of clinical staff in IDDT model with fundamentals of clinical approaches
 - Discipline specific information, where appropriate

The Initial Sale

OR

*Why Inpatient IDDT is Relevant and
Important*

Lifetime Prevalence of Substance Use Disorders

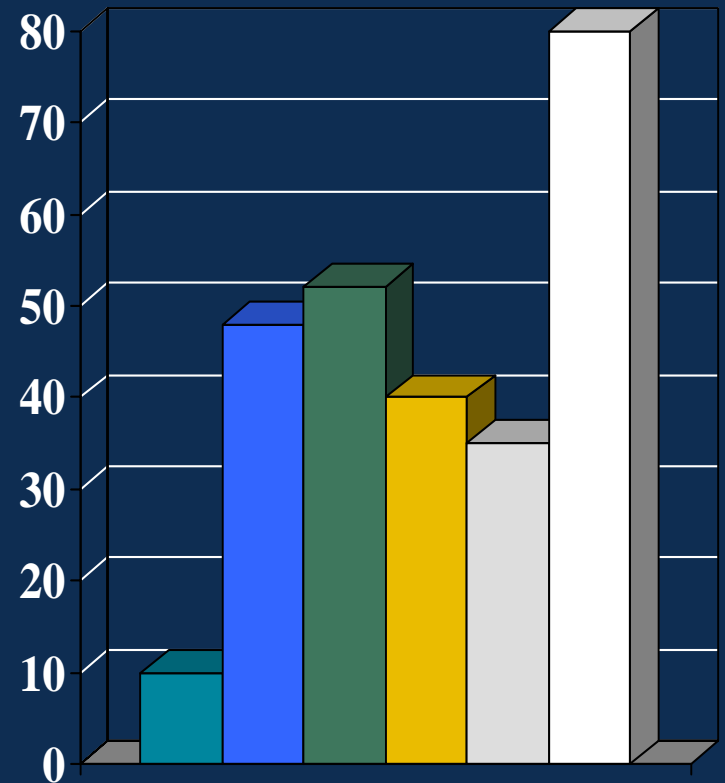
- General Population

10% - 15%

- Persons with mental illness

40% – 50%

- Schizophrenia 48%
- Bipolar Disorder 52%
- Major Depression 40%
- Anxiety Disorders 35%
- Antisocial Personality Disorder 80%



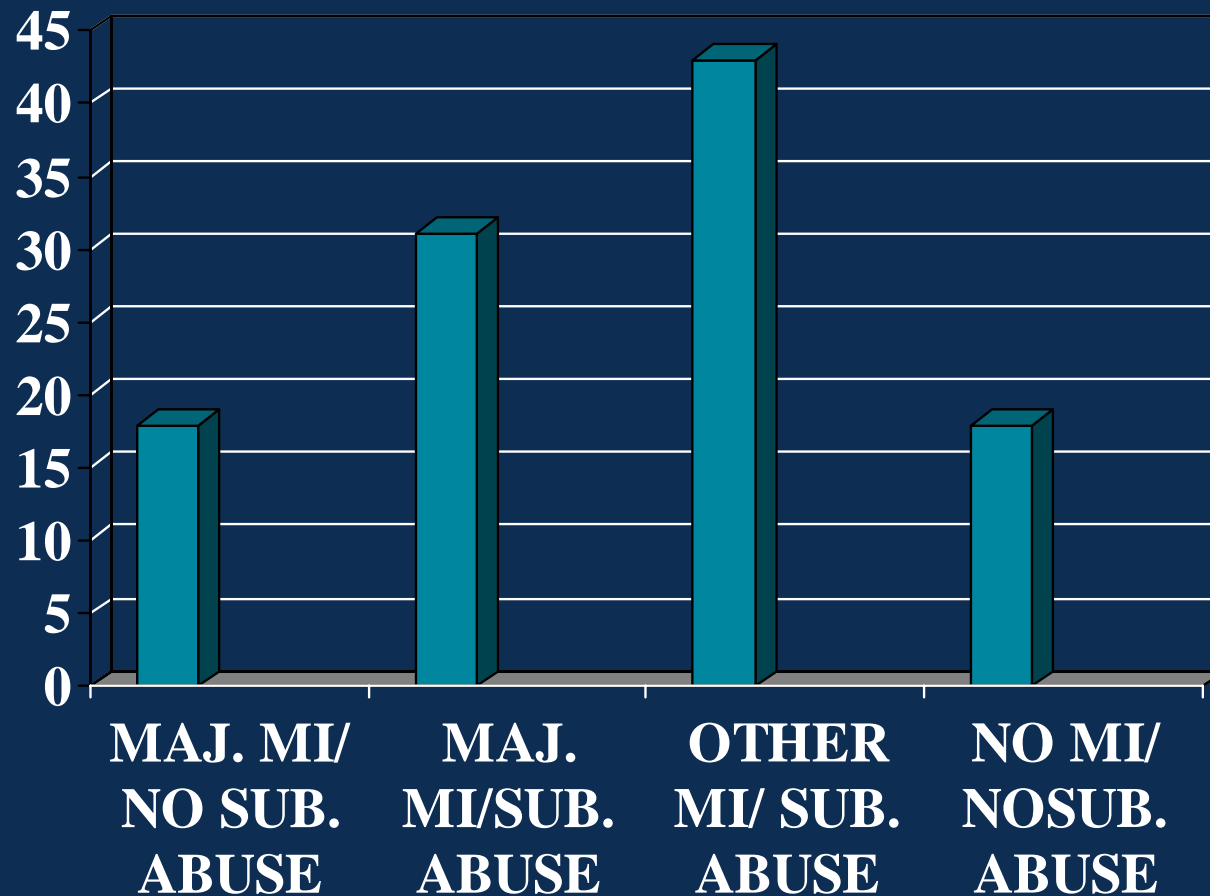
Consequences

- 60% higher costs than single diagnosis
 - Most cost increase is due to higher utilization of acute inpatient services
- Unknown costs for other medical illnesses
- Increased risk of HIV infection
- Increased risk of neurological illness
- Increased mortality rates
- Increased risk of violence as perpetrator and victim

Mortality Rates

- 1.33 times more likely to die from natural causes
- 3.5 times more likely to die due to “unnatural” causes
 - Accidents 2x’s more likely
 - Homicide 5x’s more likely
 - Suicide 15x’s more likely
- Much of the increased mortality can be attributed to substance abuse

Rates of Violence (Steadman 1998)



Risk of Violence in Dually Diagnosed Individuals (Steadman 1998)

- Non-substance abusing discharged mental patients have NO increased risk of violence compared to matched controls
- Substance abuse increases the risk of violence in patients and controls
- Substance abuse is three times more common in patients
- Violence is most common in the first 20 weeks after discharge, and is more likely to be directed at family or friends

Treatment Outcomes in SAMI Clients

- Many can achieve stable remission
- Remission is associated with:
 - Reduced psychiatric symptoms
 - Decreased utilization of resources
 - Improved vocational functioning
 - Improved community adjustment

Integrated Treatment

Focuses on similarities between severe mental illness and substance use disorders

- Biological basis of illnesses
- Chronicity
- Propensity for relapse
- Denial
- Destructive capacity of illnesses

Treatment Approaches: Outcomes

- Sequential Treatment
 - 5% attain abstinence in first year of treatment
- Parallel Treatment
 - 5% attain abstinence in first year of treatment
- Integrated Treatment
 - 15-20% attain abstinence in first year of treatment
 - Higher fidelity to model yields better outcomes

Basic Principles of IT

- Not highly confrontational
- Meet the person where they are
- Assertive outreach
- Treatment tailored to individual level of insight and motivation



Basic Principles of IT

- Abstinance is goal, not requirement
- Flexible use of 12-step groups
- Staged treatment approach
 - ENGAGEMENT
 - PERSUASION
 - ACTIVE TREATMENT
 - RELAPSE PREVENTION

But Isn't This an Outpatient Model? Why Do "IT" Inpatient?

Although lifelong abstinence is not likely to be a frequent outcome of an acute inpatient psychiatric hospitalization, it may represent an important point in the change process when patients may be more receptive to changes than when residing in the community.

Inpatient Dual Diagnosis Treatment: Opportunities

- Reasons for hospitalization may represent a significant “change motivator”
- Psychiatric stability
- No access to substances of abuse
- Improved health
- Improved cognitive functioning
- Improved decision making abilities (?)
- May accelerate the change process and have lasting results

Implementing Inpatient IDDT Services

“The Good, the Bad and the Ugly”

Implementing Inpatient IDDT

- Decision made to NOT have a single “Dual Diagnosis” Unit based on prevalence of Dual Disorders in this population, but have horizontally integrated services throughout the hospital
- Need to meet the needs of all patients, not just a select few
 - How would you determine who those would be?
 - What about the others?

Implementing Inpatient IDDT

- Initial implementation occurred on two acute care units (avg. LOS 14 days) mid-1999
- Goal: stabilization-treatment initiation-referral
- Process:
 - Screening of all new admissions for substance use (DALI, then CAGE)
 - In-depth assessment of those with + screens
 - Detox if needed
 - Psychiatric stabilization
 - Initiation of treatment using staged approach
 - Linkage to outpatient provider

Implementing Inpatient IDDT

- Services then expanded throughout the hospital (acute and forensic units) as more staff became trained and interested in providing IDDT services.
- Focus for longer term patients:
 - Low-intensity, long-term
- All areas of the hospital had staged, IDDT services available by the end of 2000.

IMPORTANT:

Stick to the Basics!

- When in doubt about how to adapt the outpatient model to a hospital, remember:

THE HOSPITAL IS A COMMUNITY

- Dual Diagnosis is the RULE, not the exception
- All clinicians are IDDT providers, not just a select few

IMPORTANT:

Stick to the Basics!

- Integrate MH and SA treatment
- Flexibility and specialization of clinicians
- Assertive outreach
- Recognize client preferences
- Stage-wise treatment
 - Emphasis on Engagement and Persuasion stages
- Hope and optimism
- Keep a long-term perspective (for clients and programming)

Inpatient IDDT Implementation

- New way of doing things!
 - Support, gentle guidance
- Assess staff suitability and adaptability
- Frequent meetings of staff to discuss issues and problems (“burnout” is a problem)
- Frequent trainings following implementation
- Patience! Things most assuredly are not going to proceed as planned. Be willing to accept this and adapt

Inpatient IDDT Implementation

- Establish a support system with other programs and systems
- Accept new criteria for positive outcomes (other than abstinence)

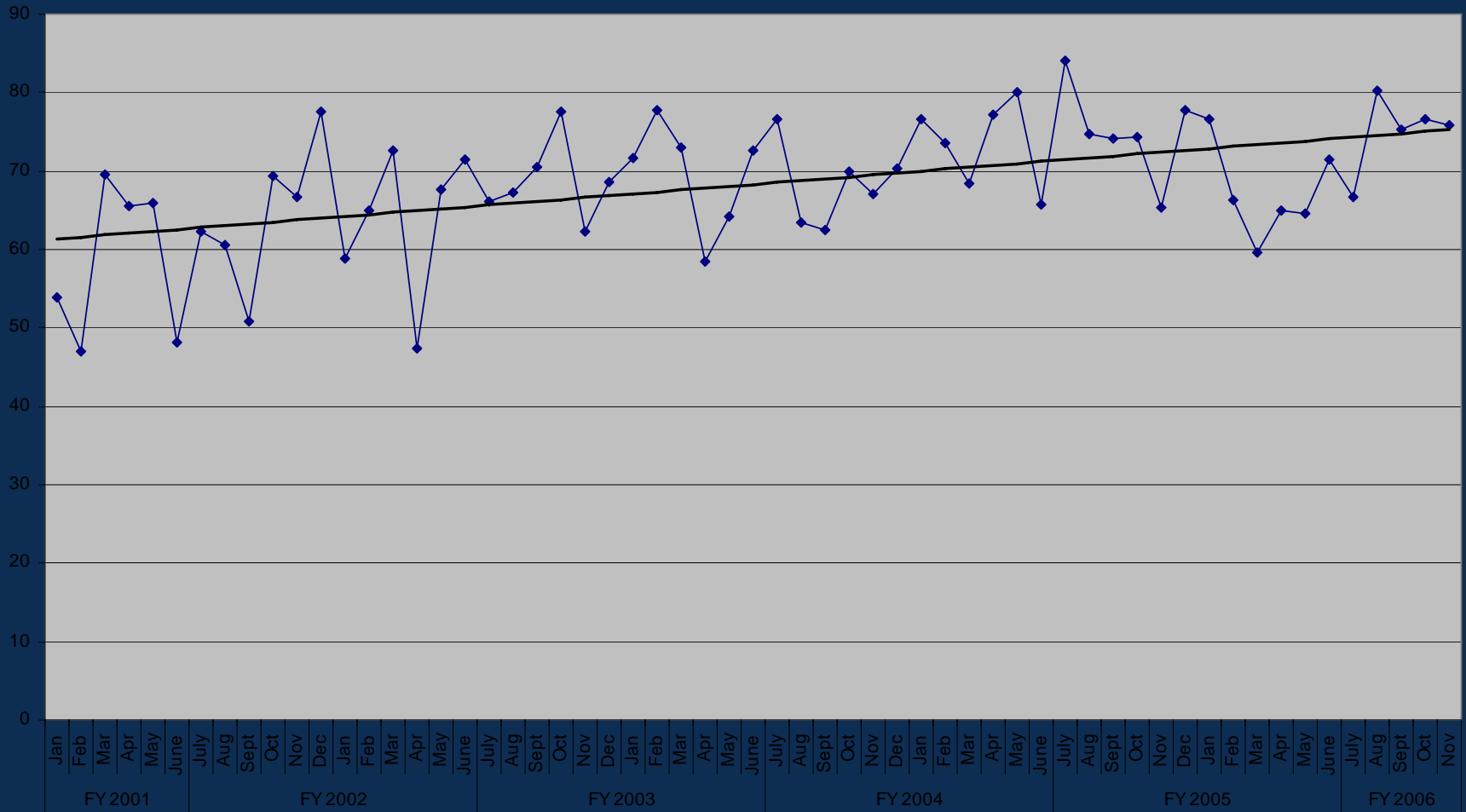
TVBH-Columbus: IDDT Services as of 1/2006

- All patients screened for substance use disorders on admission by admitting MD and nurse
- All admitted patients re-screened by SAMI clinician
- Those with positive screens undergo a complete integrated assessment and staging
- Individualized stage-driven treatment planning and referral then occurs

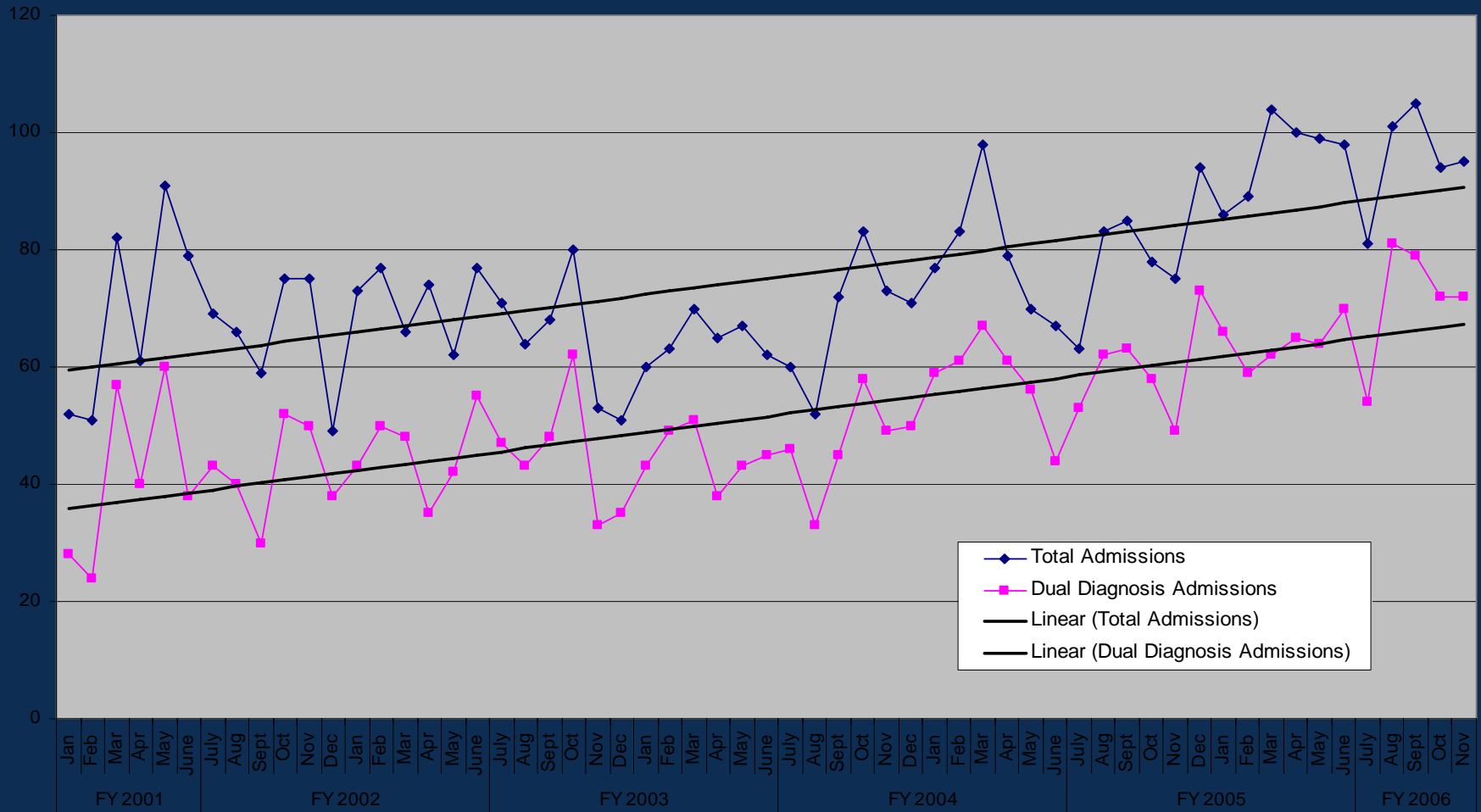
TVBH-Columbus: IDDT Services as of 1/2006

- Engagement stage:
 - Individual sessions to develop rapport
- Persuasion stage:
 - SAMI Basics group using a Motivational Interviewing and educational approach
- Active Treatment stage:
 - Recovery Skills group using a Cognitive-Behavioral approach
- Relapse Prevention stage
 - Relapse Prevention group using a Cognitive-Behavioral approach
- All stages Have the option of individual contact/counseling and AA or NA, depending individual needs and preferences
- Linkage to community IDDT services (where available) and 12-step gr

Percent Dually Diagnosed TVBH- Columbus 2001-2006

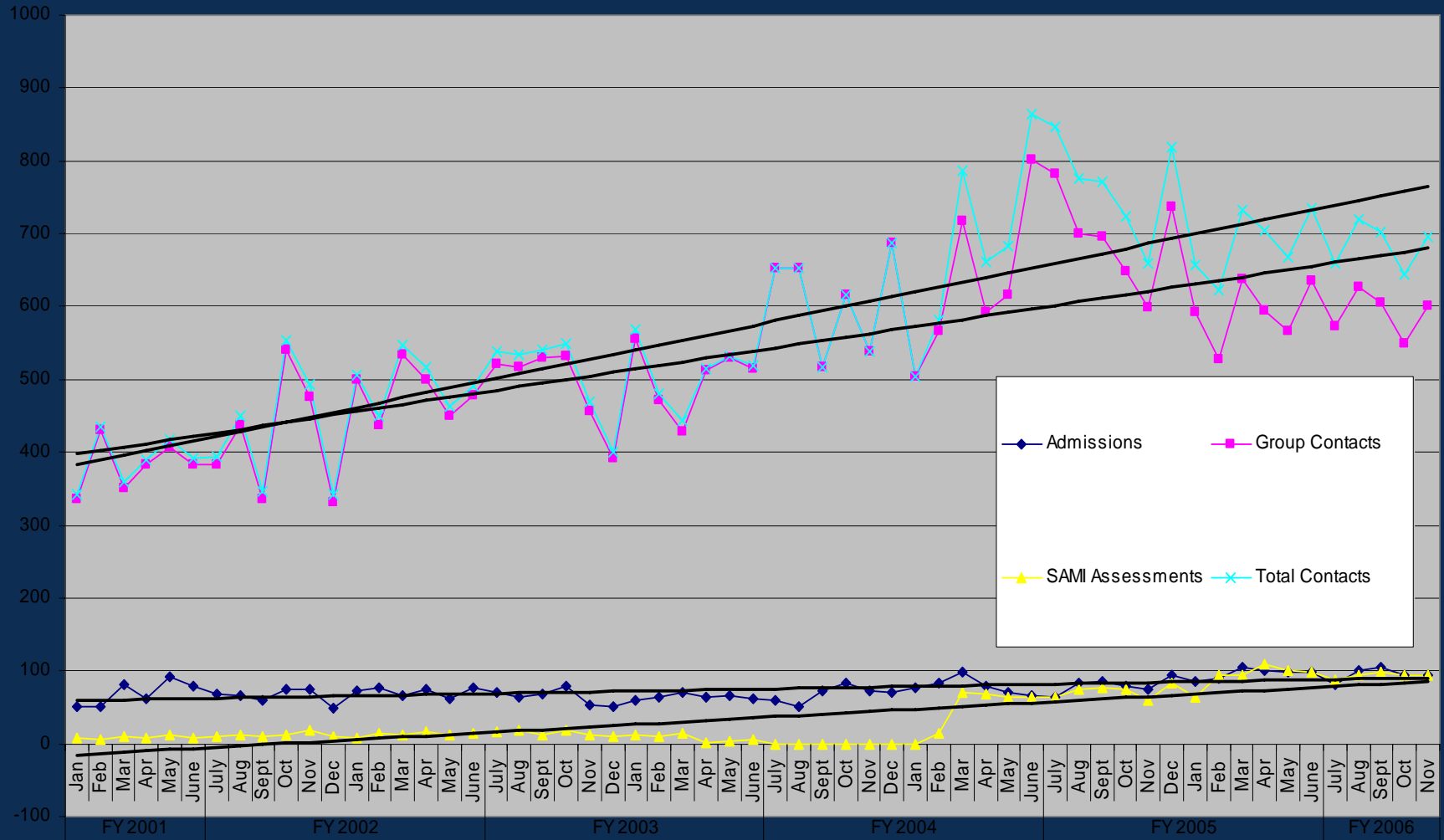


Total and Dual Diagnosis Admissions TVBH-Columbus 2001-2006



SAMI Patient Contacts

TVBH-Columbus 2001-2006



Other IDDT Inpatient Outcomes

- Movement through stages of change
- Controlled drugs prescribed at discharge
- Readmissions
- Fidelity measure



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Evolution of the Fidelity Measure

Barbara Wieder, PhD

Director, Research and Evaluation
Center for Evidence Based Practices

Mid-summer, 2002

ODMH asks for inpatient implementation

- SAMI CCOE is assigned coordination of initiative
- Decision to partner with early innovators

Initiative's Goals

- Adapt outpatient IDDT for the inpatient setting
- Standardize elements of the adaptation for broad implementation
- Develop a mechanism to reliably gauge programs' adherence to the adapted model

Investigators employed the methods that Carol Mowbray and colleagues* outlined as necessary in developing fidelity criteria and measures.

- Solicited observations of practitioners working with experimental inpatient SAMI programs
- Formed collaborative, multi-disciplinary workgroup
- Examined outpatient IDDT Fidelity Measure
- Reviewed literature associated with implementation of the outpatient model

*Mowbray,CT, Holter, MC, Teague, GB, & Bybee, D (2003). Fidelity criteria: Development, measurement, and validation. *American Journal of Evaluation*, 24(3), 315-340.

Methods, cont'd.

- Used qualitative data from CCOE/ODMH fidelity evaluation activities with outpatient providers
- Developed inpatient adaptation procedures
- Developed fidelity measure
- Solicited feedback from experts involved in developing outpatient model

Methods, cont'd

- Field tested IDDT Fidelity Measure:
Inpatient Adaptation
- Used field test feedback to modify
measure

Multi-disciplinary workgroup

Included:

- Leaders of early SAMI inpatient programs (RN, MD, Psychologist)
Drew on: Experiences and expertise of early innovators
- Clinical training/consultant and research representatives from the SAMI CCOE
Drew on: Lessons learned from multiple outpatient IDDT implementations
- SAMI CCOE representatives/Researcher from ODMH
Drew on: Experience and expertise in IDDT and other EBP Fidelity evaluation

Workgroup's Mission: Maintain the integrity of IDDT's core principles while adapting it to inpatient setting

Adaptations to the original IDDT model would “be seen as appropriate as long as they [did] not contradict the underlying program theory.”

Mowbray, et al. (2003)

Task #1: Adapt IDDT for the inpatient setting

Group reviewed most current iteration of the IDDT Fidelity Scale and General Organizational Index (2002 Toolkit Version)

Three categories of index items emerged:

- Model components whose operationalization fit both outpatient and inpatient settings
- Model components whose outpatient operationalization did not fit the inpatient setting
- Elements of inpatient integrated treatment that did not appear in the outpatient model but whose inclusion made sense for the hospital setting

Example: Model component that fit both outpatient and inpatient settings

Identification of Dually Diagnosed Clients

Intent of the original item is to ensure that:

- all clients are screened at intake for co-occurring substance use (both drug and alcohol) using a standardized protocol; and
- clients' substance use is systematically tracked throughout their treatment at the agency.
- the organization knows how many clients have co-occurring disorders to better plan, structure, and staff for service delivery.

For the adaptation, changed:

- “client” to “patient;”
- “intake” to “admission;”
- “treatment at the agency” to “hospital stay.”

Adaptation result:

Identification of DD Patients

Model component that was similar to the original IDDT item but was minimally tailored for the inpatient context.

Other examples of compatible components:

- *Comprehensive Assessment*
- *Pharmacological Treatment*
- *Integrated Treatment Plan*

Example: Outpatient model component that required re-operationalization to fit the inpatient setting

Assertive Outreach

Original IDDT intervention is:

- intended primarily for use with clients in early—engagement/contemplation—stage;
- characterized by provision of practical assistance and meetings in clients' natural living environments, i.e., out in the community;
- focused on developing trust between client and clinician.

Example: Outpatient model component that required re-operationalization to fit the inpatient setting

Inpatient Outreach Capability

Adapted intervention built on innovators' experiences with the challenges of drawing out hospital room-bound patients and redefined "outreach" as –

the provision of services where the patient is versus the expectation that the patient will gravitate to a central location.

Example: Outpatient model component that required re-operationinalization to fit the inpatient setting

Inpatient Outreach Capability includes:

- engagement of new patients soon after admission;
- reaching out to patients for emergency purposes and to attend to basic needs;
- creating and maintaining the therapeutic alliance;
- Inviting participation in group and individual services;
- re-engagement of patients previously engaged who are not participating in hospital services.

Adaptation result: *Outreach Capability*

Model component that required changes in operationalization but retained the intent of the original IDDT item.

Other examples of items requiring re-operationalization:

- *Integration of Services*
- *Community self-help linkages*

Example: Inpatient model component with no outpatient counterpart

Integrated Discharge Plan

Original IDDT model intervention

supports time-unlimited services, for as long as the client wants and needs them.

In contrast, much hospital-based care is short-term, and, despite the need for ongoing treatment, patients are eventually discharged to community-based services.

Example: Inpatient model component with no outpatient counterpart

Inpatient Integrated Discharge Plan

Outlines the need for written discharge plans that address continuity of care for both mental health and substance use disorders following discharge from the hospital to outpatient care.

The item includes an expectation of excellent communication with the community treatment provider who ideally has interacted with the inpatient treatment team throughout the patient's stay.

Adaptation result:

Integrated Discharge Plan

Inpatient model component with no outpatient counterpart that conveys the intent of a core IDDT principle (e.g., time-unlimited services)

Other examples:

- *Types of Group Treatment*
- *Cognitive Behavioral Therapy*
- *Staging of DD Patients*

Tasks # 2 and # 3: Inpatient component standardization and fidelity monitoring

- Because the evidence associated with IDDT or any EBP is based on delivering the intervention as it was designed, the measurement of fidelity to the model is a critical element of successful implementation.
- Though the IDDT Fidelity Measure is used to evaluate outpatient programs, an instrument to measure adherence to an inpatient adaptation did not exist.

The IDDT Inpatient Adaptation Fidelity Index (Draft)

24 Index items were developed

- Each item includes a definition, operationalization, and rationale for its inclusion in the index
- Items are characterized as related primarily to:
 - Organization—11 items
 - OR*
 - Treatment—13 items

Fidelity Measure Item Characteristics

ORGANIZATIONAL Items

General Factors aimed at program's ability to develop sustaining structures and processes

TREATMENT Items

Treatment Factors aimed at program's ability to provide clinical practice

- Definition
- Rationale
- Data Sources
- Ratings

Organizational Items

- 1: Identification of DD Patients
- 2: Assessment
- 3: Staging of DD Patients on Admission
- 4: Integration of the Treatment Plan
- 5: Currency of the Treatment Plan
- 6: Integrated Discharge Plan

Organizational Items

- 7: Clinical Staff Training in IDDT Model
- 8: Process Monitoring
- 9: Outcome Monitoring
- 10: Quality Improvement
- 11: Patient Choice

Treatment Items

- 12: Integration of Services
- 13: Stage-wise Treatment of DD Patients
- 14: Comprehensiveness of Services
- 15: Timeliness and Duration of Services
- 16: Outreach Capability
- 17: Motivational Interviewing
- 18: Cognitive Behavioral Therapy (CBT)

Treatment Items

19: Integrated Group Treatment

20: Types of Group Treatment

21: Patient to Clinician Ratio in Group Tx

22: Interventions for DD Patients and their
Families

23: Pharmacological Tx Approach

24: Self-Help Linkages

The IDDT Inpatient Adaptation Fidelity Index (Draft)

A Fidelity protocol was developed that facilitates a standardized evaluation of program's adherence to components of the index that includes:

- score anchors ranging from 1 (not implemented) to 5 (fully implemented)
- suggested sources of information
- probe questions for each information source
- guidelines for summarizing the evaluation and providing feedback to program stakeholders

Next steps:

- Solicitation of expert feedback
- Field testing
- Collection of data to support measure utility
- Collection of data to measure implementation outcomes
- Collection of data to establish intervention effectiveness and validate measure



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The role of outcomes in monitoring the IDDT inpatient adaptation

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How do we know an implementation is successful?

Intervention Outcomes

- The “Evidence” in EBPs
- Collection of intervention outcomes in every application

Implementation Outcomes

- Fidelity scales measure the success of the implementation effort
- Presence or absence of key elements
- Scores allow us to attribute changes in intervention outcomes (consumer, etc.) to the EBP

Fixsen, et.al., 2005

The research on EBPs tells us:

Effective intervention practices

+ Effective implementation practices

Good outcomes for consumers

No other combination of factors reliably produces
desired outcomes for consumers.

Intervention Outcomes

- Is the practice achieving its intended results?
- Domains defined by the goals of the practice being implemented
- Patient-level data
- Specific outcomes measured determined by goals of the practice and goals/capacity of the implementing site

Intervention Outcomes: IDDT Inpatient Adaptation

- Outcomes used to define practice in outpatient setting need to be adapted for inpatient implementation
- Primary IDDT outcomes
 - Reduction in psychiatric sx/s/distress
 - Reduction in substance use/abstinence
- Secondary IDDT outcomes
 - Decreased institutional use (e.g. hospital, jail)
 - Increased living and social skills
 - Increased overall quality of life

Intervention Outcomes: IDDT Inpatient Adaptation

- Assessment results (e.g. CAGE scores)
- Stage of readiness/movement through stages
- Length of stay
- Quality of life
- Re-hospitalization
 - Reason for readmission (e.g. due to substance use)
 - Length of community tenure before re-hosp.
 - Follow-through with/availability of IT in community

Challenges: Intervention Outcomes

- Whose responsibility is it to track?
 - Time available given other responsibilities
 - Skills/knowledge on data collection
- How will data be collected?
 - Need to develop forms and procedures
 - Data reporting/entry
- How will data be interpreted?
- How will data inform individual treatment?

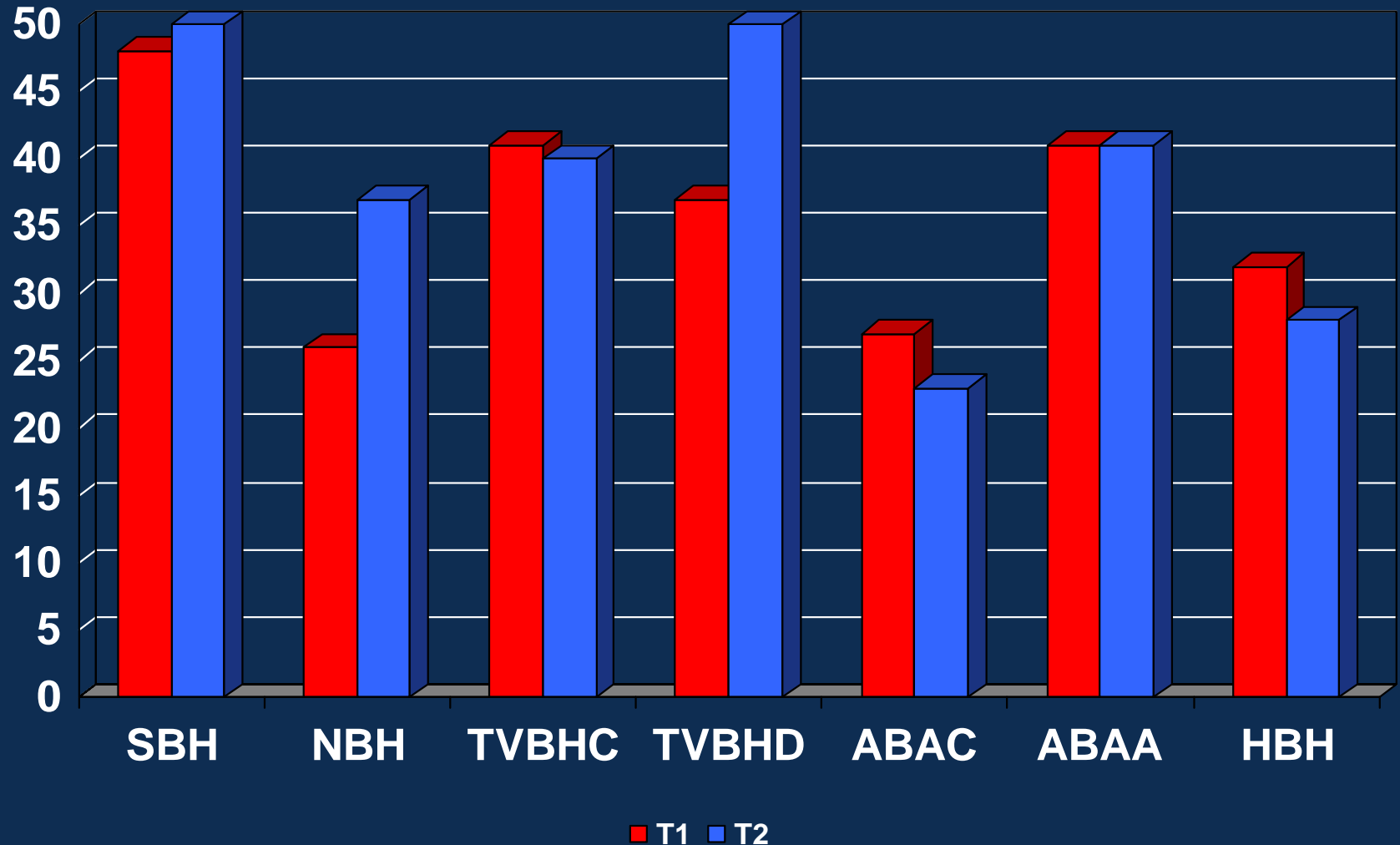
Implementation Outcomes

- Are you delivering the practice as it was designed?
- Model components defined by selected practice
- System/administrative procedures
- Capacity to deliver the practice

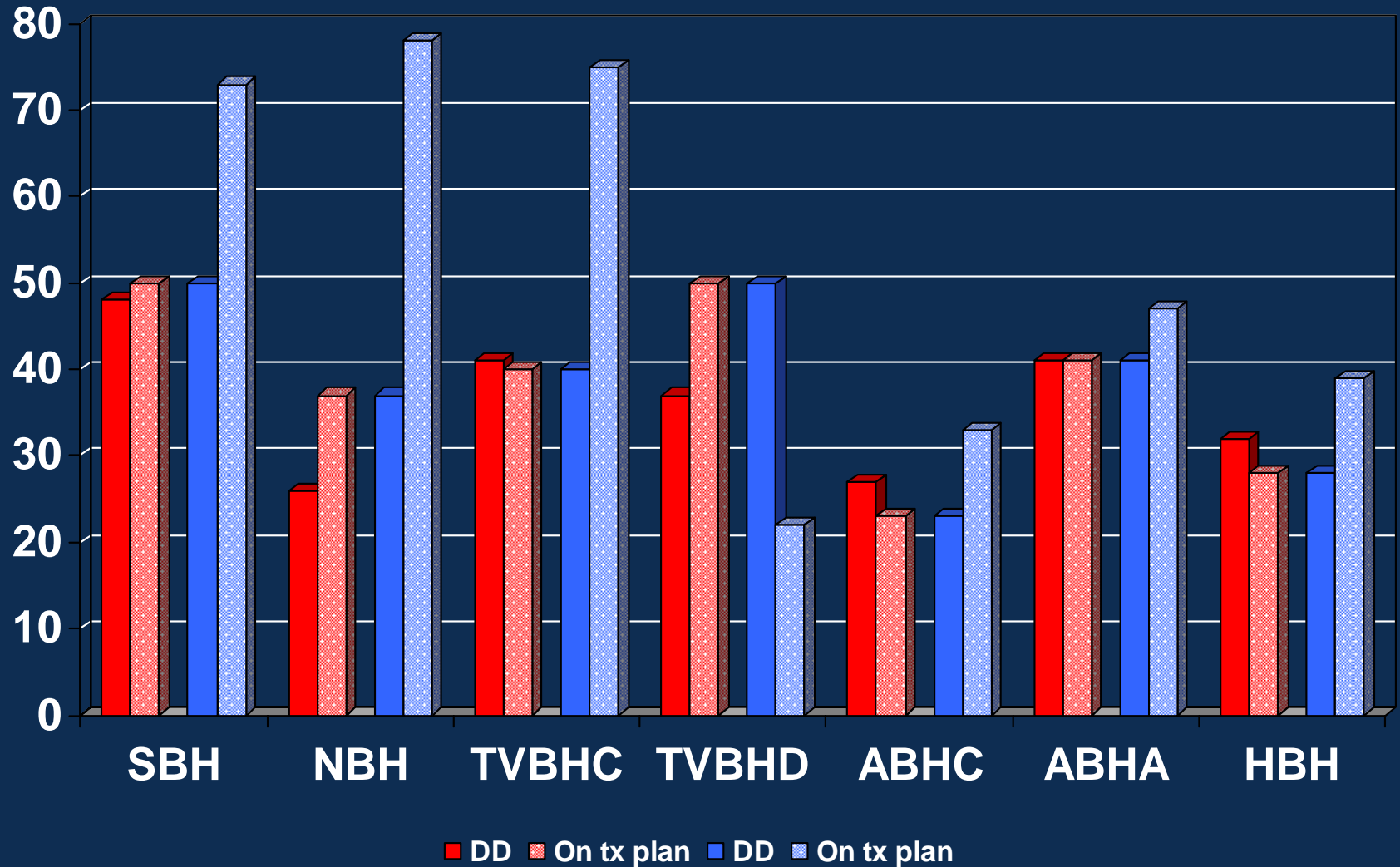
Implementation Outcomes: IDDT Inpatient Adaptation

- Fidelity assessment
- Identification of patients eligible for integrated tx
- Staffing issues
 - Sufficient staff to provide intervention
 - Training in/commitment to intervention
 - Intervention “duties” as priority
- Administrative support

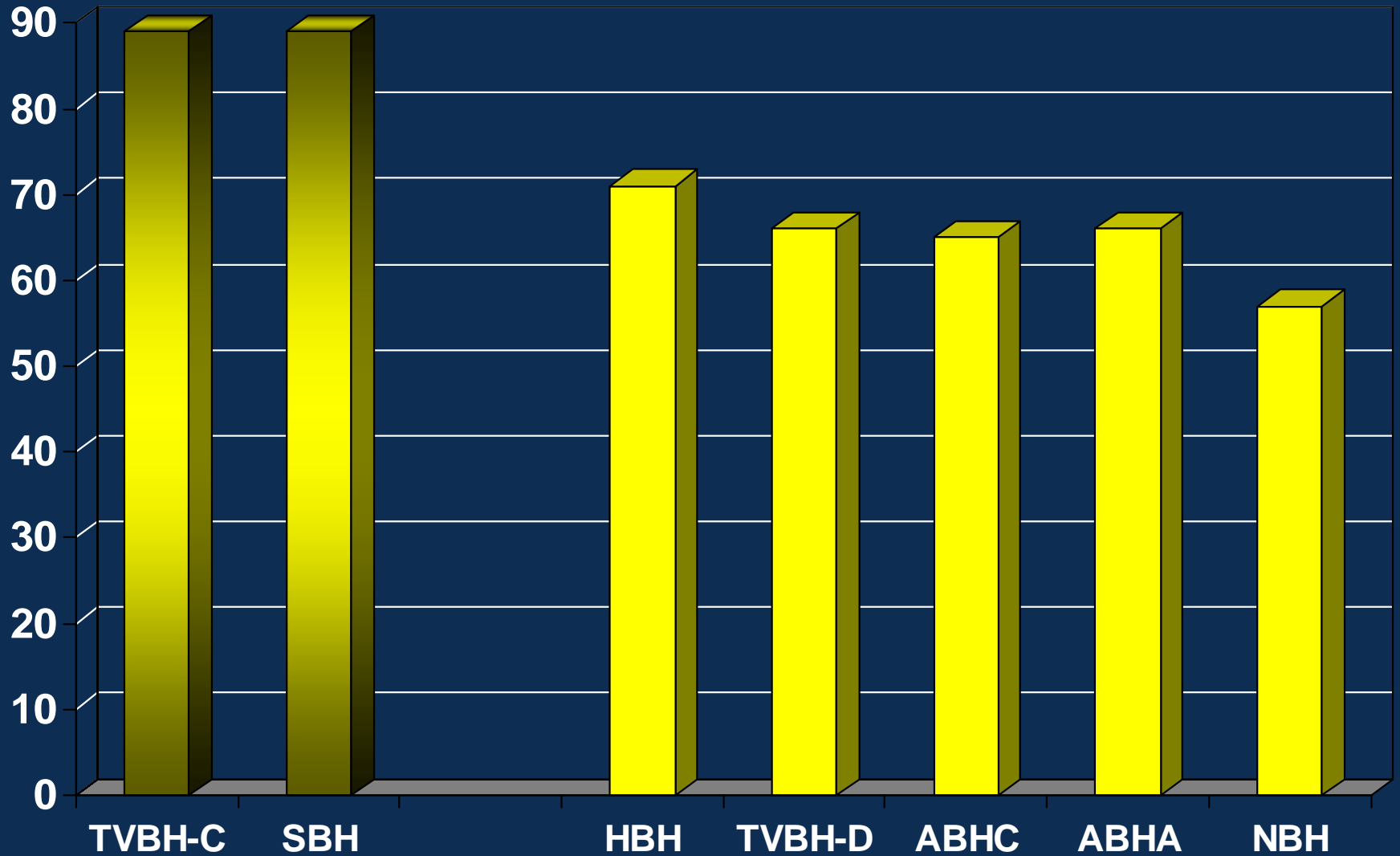
Identifying Appropriate Pts: % Dx DD on Discharge



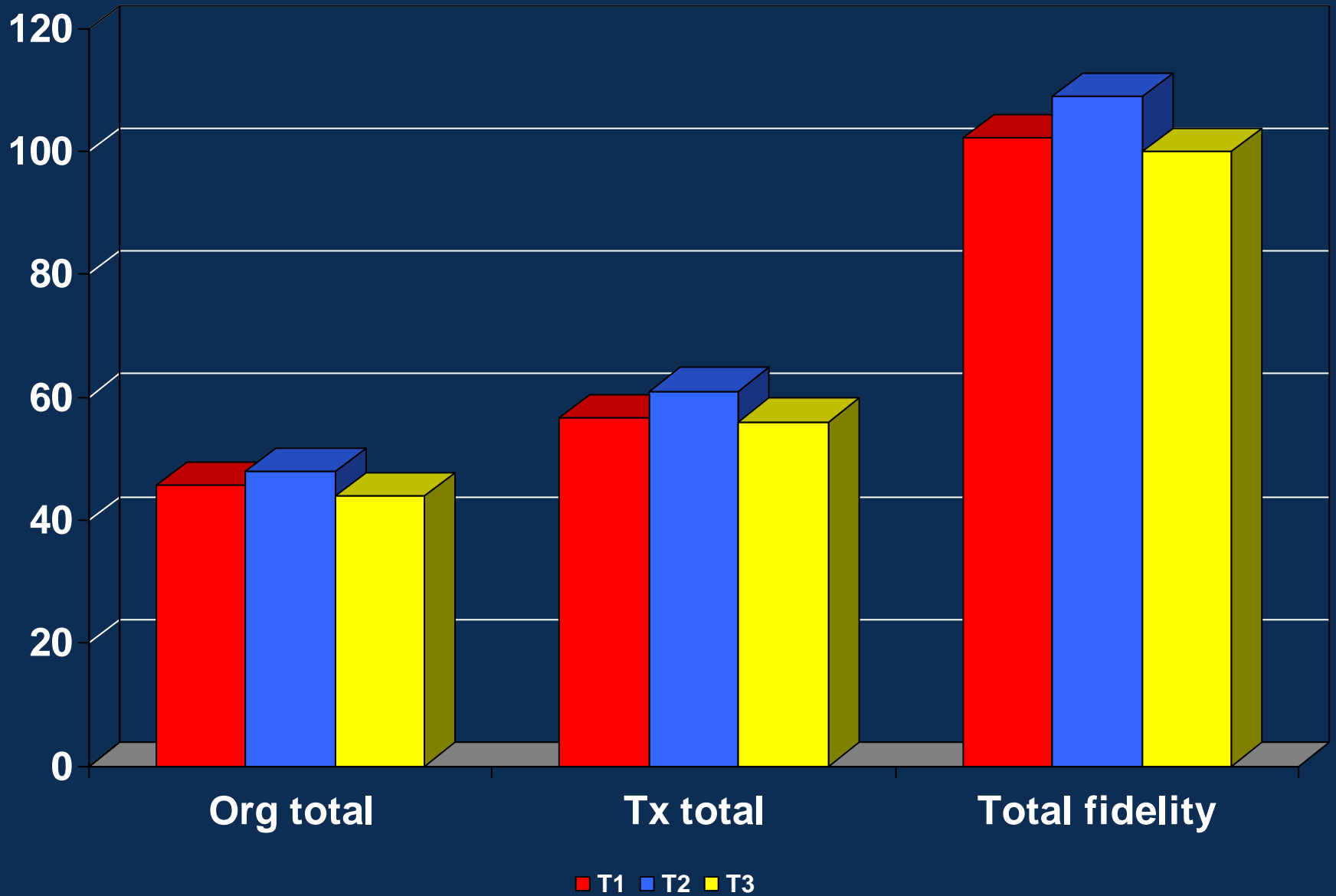
Identifying Appropriate Pts: %DD Compared to %Sub on Tx Plan



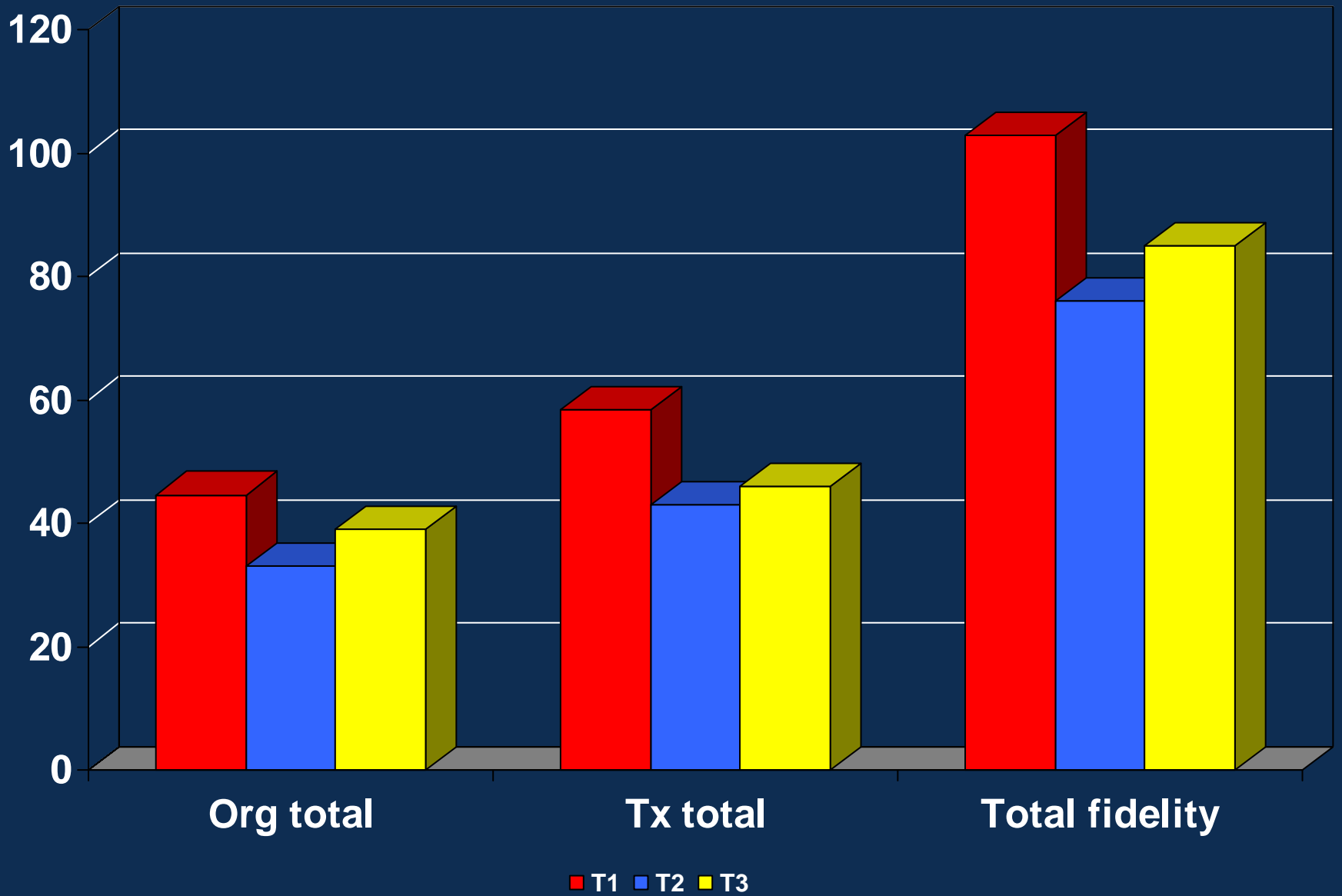
Total Fidelity: 1st Review



TVBH-C Fidelity



SBH Fidelity



Challenges: Implementation Outcomes

- Objectivity to assess fidelity to model
- Verbal buy-in versus procedural buy-in
- Training of all key personnel (on two shifts)
- How to track actual services provided versus “on paper”
- Ability to effectively communicate data not only across this hosp stay but over time

Challenges: Outcomes overall

- Convincing everyone of the utility of collecting data
- Assurance that data are collected well
- Consistency
- Reliability
- Making sure data are useful and used

Next Steps

- Further work on standardizing the practice
- Further work on consistency of collection and reporting of patient-level data
- Seeing progress of implementation outcomes over time
- Analyzing intervention data in context of implementation data

Lessons Learned

- Think about outcomes *before* you actually start the practice
- Have a plan in place to track data
- Gather pre-intervention data
- Use the data for patient treatment *as well as* administrative planning/reporting

Next Steps & Challenges

- Development of hierarchically derived training plan
 - Across disciplines and shifts
- Implementation of training plan
 - Competition with other training mandates
 - Creating and supporting expectations for competency driven skill sets and supervision
 - Identifying training resources

Next Steps & Challenges

- Evaluation
 - Maintaining reviewer pool and schedule for fidelity assessment
- Supportive consultation
 - Program leader network development monthly & quarterly

Summary Remarks

- Historical process for implementation of sustaining structures
 - key for a truly integrated system of care
- Characteristics of IDDT model fidelity scale
 - relevant for inpatient settings
- Outcomes
 - Challenging and informative
- Long term perspective & optimism
 - principles in practice

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