

# IMR Quality Improvement in Indiana

Lessons Learned: Embedding EBPs in Statewide  
Transformation

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# IN State Initiatives for IMR

- Small state-funded pilot project on ACT team
- NIDRR grant: IMR on ACT teams:
  - 2 ACT-IMR with peer specialists
  - 2 control ACT teams
- SAMHSA T&E grant (2 waves)
  - CTT program (some in group homes)
  - Clubhouse, CM
  - PHP + some CM, group homes
  - Clubhouse
  - ACT, Clubhouse, and CTT programs
  - Outpatient + PHP
  - Mix of programs – floundering

# Training Lessons

- IMR: Deceptively simple
- Site-based (2-day) IMR training but move centralized training to accommodate increased/ongoing demand
- Attention to contextual factors of implementation (e.g., politics in state/agency)
- More intensive emphasis on supervision
  - Consultant attends, tapers off, model supervisor role
  - Weekly or twice monthly
  - Case conference model
  - Reinforce MI and CBT use with particular consumers
- Increase initial organizational change/ planning required
  - written, concrete plan of implementation recommended

# Implementation Plan Highlights

- Sequence: Planning then training, etc (resist the urge to jump into training without a plan)
- Share written plan with clinicians
- Concrete role definition
  - IMR supervisor/program leader
  - IMR clinician
  - Agency Director/Other supporting roles
- Role designees – Name names
- Enough clinicians to sustain through turnover
- Site selection process
- List barriers and potential strategies for overcoming them

# Recovery Orientation

- Still struggling to find ways to instill recovery philosophy
- Use consumers in training and consultation
- Encourage use of peer providers
- DMHA use of Consumer Service Review evaluation tool
  - Scoring weighted toward use of recovery principles

# Weak Clinical Skills

- IMR Basic Training Day 2 - mostly clinical skills
  - Psychoeducation
  - CBT
  - MI
- Add 2-day MI workshop/training by MINT
- CBT training
- Refresher trainings on clinical skills
- Clinical supervision: use of skills

# Fidelity Monitoring

- Semi-annual visits
- “Baseline” after 3-6 months is more meaningful
- Emphasis on qualitative feedback rather than numeric score
- Data collection via observation of IMR sessions is vital
- Immediate feedback at the end of visit important for QI function of fidelity

# Outcomes Monitoring

- COMP measures
  - Monthly documentation by teams
  - Quarterly collection via email
  - Site level and statewide reports
  - Not sensitive enough for IMR?
- IMR scale, Hope, Satisfaction
  - May add to COMP reports
  - More sensitive to change in IMR?
  - Track movement into SE programs?

# Penetration of IMR

- IMR structuring within team/program
  - IMR-only clinicians attached
- OR
- Increase # of IMR clinicians (mixed responsibilities)
- Track consumers served with IMR (expectation set for each IMR clinician)
  - Lots of “wasted” training slots
- Urge clinicians in training to start IMR the following week
- Protect IMR time in event of CM/crisis needs
- Supervision update on #served, where in modules

# State Support of IMR

- No extra/incentive funding currently
- Mostly ADL MRO billing (less lucrative vs CM)
- Certification for IMR as for ACT?
  - Fidelity indicators less concrete for IMR
- Emphasis on using IMR to increase CSR scores across the state

# *For more information:*

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