


EBP Implementation and Dissemination Strategies: Learning from Multiple Sources

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EBP Implementation and Dissemination Strategies: Learning from Multiple Sources

Adult Toolkit Project

Implementation Strategies

- SMHA
- Steering Committees
- Provider Agencies
- Practitioners
- Consumers and Families

TA for Infrastructure Development

- System leadership/ planning
- Organizational structures
- Policies and procedures
- Financing
- Human Resources
- Performance Improvement
- Partnerships

Meetings of Child MH Stakeholders

- Drawing out all the issues, assumptions, values, facts re: state of the science and practice re: EBPs
- Identifying broad approaches for implementing, disseminating and sustaining EBPs; and tools and resources needed
- Draft outline of *Resource Guide for Creating an Evidence-based Culture* for Families, Practitioners, Administrators
- Incorporating a family-driven approach in designing the *Resource Guide*

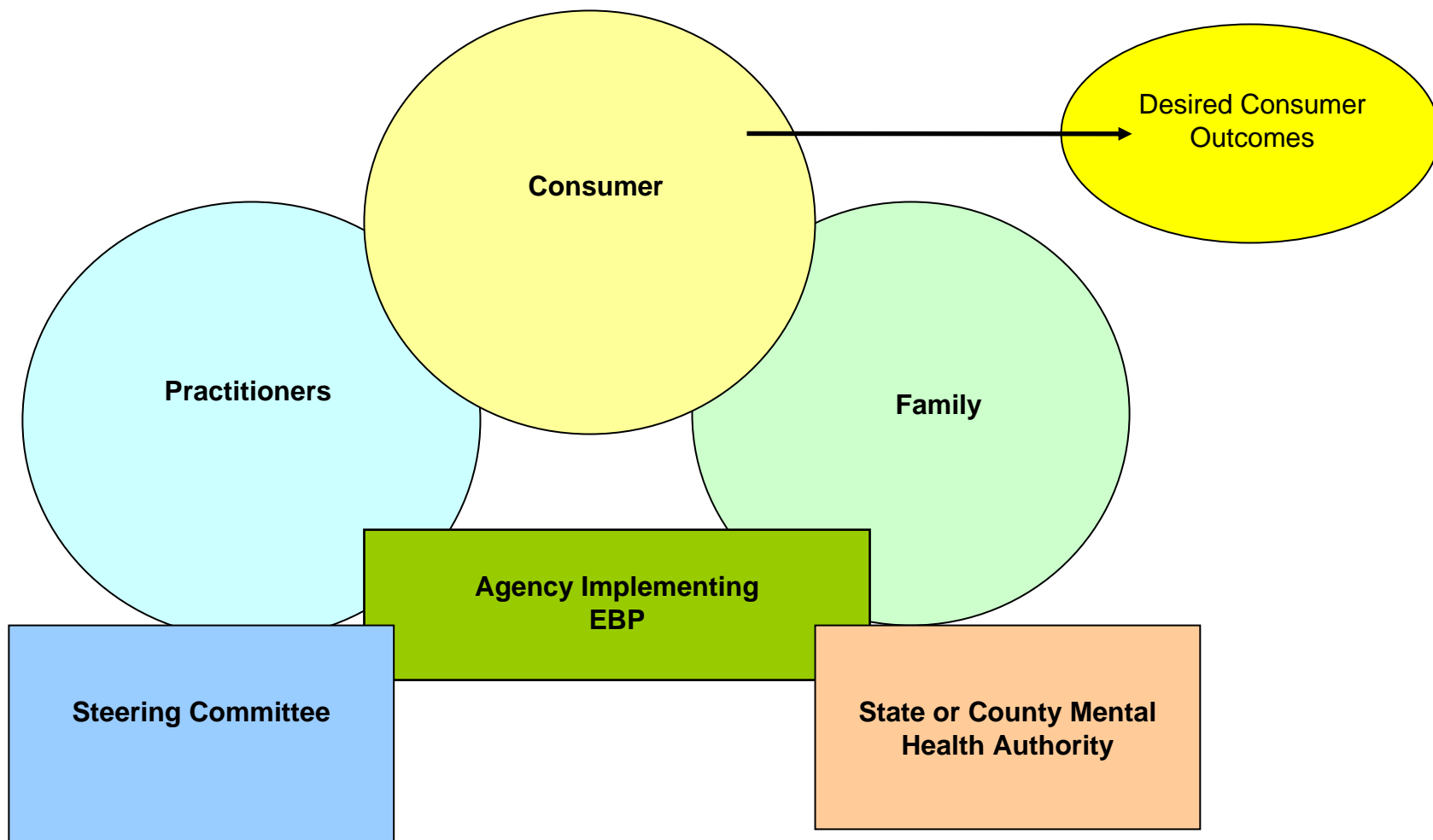
EBP Survey of SMHAs

- Types of EBPs and Promising Practices
- Types of initiatives and approaches to integrating EBPs into service systems
- Financing
- Infrastructure and mechanisms for training and TA
- Evaluation and monitoring fidelity and outcomes, and incorporating these into MIS
- Integrating EBP initiatives and other important initiatives (e.g., Deinstitutionalizing, SOC, Recovery, SIG, Trauma)
- Adapting for ethnic, cultural, rural, frontier areas



ADULT TOOLKIT PROJECT

Strategies that Facilitate Implementation of Evidence Based Practices: Lessons Learned from Meeting of “Toolkit” Consultants, Trainers and Evaluators (April, 2003)





Strategies for the Steering Committee

- Clarify roles, purpose, goals, objectives, & composition
- Meet regularly
- Have a strong committee
- Consumers in leadership role
- Steering Committee and CEO address Next Steps at review times



Strategies for SMHAs

- Need powerful champion(s) at state level
- Create special billing categories for EBP - Learn to finesse Medicaid, Medicare, other insurance
- Change state regulations to support EBP implementation
- Educate budget staff to track data for cost effectiveness
- Train across agencies
- State contracts specify use of fidelity measures
- Give EBP high priority - “Take every opportunity, every aspect of our authority to reduce barriers, help providers advance EBPs”
- Provide TA in form of “Dear Provider” letters to encourage EBP implementation (tips on writing billable progress notes; tips on financing)
- Create Centers of Excellence or other state TA structure
- Collaboration among various levels of authority – state, county, local.



Strategies for Provider Agencies

- Leadership is involved in the initiative
- Agency's vision is compatible with EBP; agency fosters organizational learning
- Organizational culture fits with CI and research, is client focused and outcome focused, articulate values in new culture
- Agency networks; develop joint agreements
- Inform CEO about all benefits & expectations up front
- Full commitment of CEO; CEO attends training
- Regular meeting between CAT and CEO/CFO
- Management seminars to prepare for change management
- Use fidelity results/outcomes/report cards for mgmt. info/feedback
- Staff are asked to volunteer to participate, vs. assignment to new project
- CAT attends team meetings to address integration
- Rely on strengths of agency and implementation leaders; ask what works best
- Involve direct line staff in developing training manuals
- Incorporate fidelity self-monitoring as soon as possible



Strategies for Practitioners

- Interactive training using case examples, role-plays, and videotaping
- Show benefits of practice (outcomes & caseload ease)
- Use motivational interviewing in training
- CAT supervises in practice
- Focus on skill base vs. knowledge base—incremental skill development
- Supervisors participate in training with staff
- Promote internal mentoring, shadowing practitioners with advanced skills
- Use peer supervision
- Engage seasoned practitioners and teach new skills
- Use feedback from sessions to inform future sessions
- Listen to feedback from consumers
- Booster trainings
- Improve videos via matching demographics, showing different phases of treatment process, etc.



Strategies for Consumer/Family

- Consumer and family participation in reaching consensus, program design, training, implementation, decision-making
- Acknowledge and deal with stigma of practitioners
- Formal consumer liaison or Consumer Affairs Office in State
- Family Intervention specialist in agencies to involve families
- Fidelity measures should include family involvement
- Adapt forms to build in family information
- Cross train therapists to work with families
- Partner with NAMI and other consumer/family advocate organizations
- Use language of recovery vs. maintenance

Framework for Technical Assistance Content Needs: Developing Infrastructure for EBPs (9/03)

System Leadership – Implementation Plan

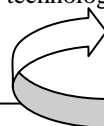
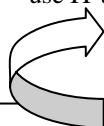
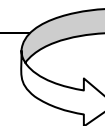
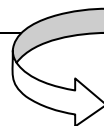
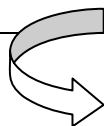
- Long term goal to transform system & sustain
- Vision/mission/values in alignment
- Bridge to other agencies & coalition of partners
- Select & empower project leaders
- Promote consensus building/buy-in
- Priority setting
- Scan horizon and adapting practice to meet needs
- Marketing and PR
- Promote dissemination

Organizational Structures

- Interorganizational collaboration
- Formalize role of advocates/stakeholders in decision-making
- Transformation of MHA/local MHA
- Seamless system of care
- ‘Center of Excellence’ model
- State readiness – ability to monitor
- Engage ‘guilds’ in reform
- Engage local authority
- Incorporate EBP initiative in state plan

Policies & Procedures

- Review all P&P with an eye to “barrier busting”
- Regulations must define and support EBP
- License/certification – individual and agency
- Family/consumer involvement in P&P development
- Focus on process/quality of care – not just ‘paper’
- Align with SAMHSA matrix
- Auditors to be EBP knowledgeable
- LMHA and state MHA needs to be in ‘sync’



Information Technology Assess current IT infrastructure/ web access; state/agency/local integration; standards for IT; use IT as a learning tool; assist local agency obtain technology; high-level system champion

Implementation leading to Dissemination

Funding Methods

- Identify and shift resources
- Must think of all EBPs funded in common way
- Reliable cost modeling
- Medicaid cover services
- Lobbying: mental health is not optional
- Fiscal incentives
- Tie fidelity/outcome to \$
- Define core expectations
- Explicit funding for supervisor/training
- Budget models
- \$ to transform system
- Acknowledge productivity costs offset for initial training

Performance Improvement

- Ongoing fidelity measurement/ refinement-key elements?
- Who does it-who gets information-for what purpose?
- Quantitative & qualitative measures
- Consumer-based outcomes monitoring in all care
- Ongoing avail. of TA
- Assess GOI at state level as well as local
- Stakeholder involvement in performance improvement data loop

Human Resource Capacity

- Develop internal capacity to train state/local agency
- Out source training to state university & community colleges
- Select trainers with credibility in model
- Supervision: practice- specific emphasizing data/outcomes
- Resources for competency-based management
- State sponsored program to train consumers & families to be MH professionals

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Meetings of Stakeholders in Children's Mental Health

Meetings of Stakeholders in Children's Mental Health

December 2002 Meeting

Beginning the dialogue on everything that needs to be considered in advancing EBPs

August 2003 Conference

Drawing out all the issues, assumptions, values, facts re: state of the science and practice re: EBPs

Conference Report

"Summary at a Glance" with recommendations

April 2004 Meeting

Identifying broad approaches for implementing, disseminating and sustaining EBPs; and tools and resources

Draft outlines of *Resource Guide for Creating an Evidence-based Culture* for Families, Practitioners, Administrators

October 2004 Meeting

NRI-FFCMH collaboration to get direct family input on design of the family section of Resource Guide

Reconceptualized in a family-driven paradigm

Shift from 3 guides to one multi-user guide (with detailed breakouts and TOOLS for user groups)

Core outline articulates Values and Key Features of an EB Culture



Resource Guide for Creating an Evidence-based Culture in Children's Mental Health

Main Sections of Outline

- Value of creating an evidence-based culture
- Key features of an evidence-based culture - skills, attitudes, relationship, accountability, infrastructure
- What is evidence?
- What is an evidence-base practice?
- Selecting interventions
- Making it work – Strategies for success



Users of Resource Guide

- Families/Youth
- Practitioners/Providers
- System/Organizational Administrators

Format of Resource Guide

- Web
- Monograph
- Brochures

Content

- Information
- Tools



Example of Section Breakouts for Different User Groups:

Selecting Interventions - Families

- Include a list of critical questions for families to ask
- Benefits and risks
- What is known about underlying, fundamental, concrete issues (population - culture, age, gender, diagnosis, race, etc. it works for and does not work for, environmental context, what interferes with effectiveness – understand who did not get better and why)
- Factors to consider - supports, access, cost, payment, time, investment of energy to make sure families have all the supports they need to understand, engage, and continue to participate
- How does the practice fit with my family values and lifestyle
- Selecting providers to implement practice



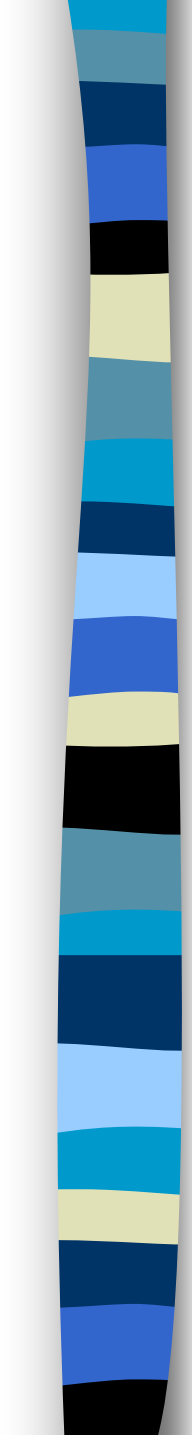
Selecting Interventions – Practitioners/Providers

- **Partnering with youth and families** - Strategies for engagement; Guide for first discussion - what questions to ask in the first meeting, goals of first discussion.
- **Assessing client and family needs** - Recommended standardized process and instruments, review practice guidelines such as American Psychiatric Association.
- **Assessing environment** e.g., local needs – constraints “reality check” - Assesses the resources and capabilities of the provider agency, the individual clinician, and the community in terms of ability to implement/deliver the intervention with fidelity.
- **Descriptive information about each EBP**



Selecting Interventions - Administrators

- Assessing population/needs
 - Importance of basing new program development (i.e, adding EBPs) on needs of community being served
 - Alternative needs assessment guides
- Assessing system and organizational readiness to select, implement, and sustain EBPs (e.g., fit w/context- internal and external, infrastructure capacity).
- Assessing financial readiness to incorporate EBP into menu of services - Current and planned financing strategies? Assess strengths and weaknesses, opportunities and threats. Anticipated positioning of organization to be ready for new policy/procedures that will affect EBP financing
- Decision making guide/process



**NRI Survey of SMHAs:
EBP Implementation &
Dissemination Strategies**



Survey of State Directors of Adult and Child Mental Health Services on Implementation of Evidence-Based Practices (2004)

- The sample was composed of the 50 states, plus DC and territories. Primary respondents were State Mental Health Agency (SMHA) Directors of Child Mental Health Services. Supplemental information was provided by other personnel such as program managers, evaluation directors, or MIS directors.
- The survey was conducted during December 2003 to June 2004 through telephone interviews lasting 1 to 1.5 hours. Interviews were audio taped and transcribed.



Questionnaire was composed of primarily open-ended questions covering the following topic areas:

- Types of EBPs and promising practices being planned or implemented
- Integration of EBP initiatives with other major initiatives such as System of Care or Trauma Initiatives
- How EBPs are implemented in rural and frontier areas
- Description of policy, procedural, or programmatic approaches used to integrate EBPs into practice settings
- Financing strategies
- Infrastructure and mechanisms used for training, coaching, and technical assistance
- Strategies used for evaluating and monitoring fidelity and outcomes; and methods for incorporating these data into management information systems



Example of Results from Children's MH: Evidence-Based and Promising Practices Being Implemented in Different States (N=44)

- Multisystemic Therapy (61%)
- Intensive Home Intervention (27%)
- Functional Family Therapy (30%)
- Wraparound (55%)
- Therapeutic Foster Care (86%)
- Family Support (27%)
- Parent Management Training (9%)
- Respite (23%)
- School-based mental health (46%)
- Clinical interventions (CBT, MDFT) (43%)
- Medication Guidelines or Algorithms (11%)
- Early childhood (18%)
- Trauma interventions (27%)
- Crisis intervention (11%)
- Screening/Assess/Support(5%)
- Independent living skills (18%)
- Telepsychiatry (9%)



Multisystemic Therapy (n=27 states)

■ Initiative/Approach

- Collaboration with Juvenile Justice or Courts to divert youth from the juvenile justice system or for community re-entry (AZ, CT, NM, OK, PA)
- Collaboration with JJ and Child Welfare (GA)
- MH refers to JJ who contracts for MST (Idaho, WA)
- MST projects in state, but not funded by MH (IL, OR)
- “Center of Excellence” (OH)
- Scope of Projects:
 - Statewide (CT, HI)
 - Regional (AZ, GA, NE, SC)
 - Few pilots or sites (KS, Missouri, MI, MN, OK, PA, RI, TX, VA)

MST Continued

■ Financing

- Medicaid, Juvenile Justice, and State Dollars (SC)
- Covered under Medicaid regular program, but developing codes and criteria to cover MST as an in-home service. New codes will reflect the actual clinical and case management services, and out of clinic setting (CT)
- Blended funds through MH, JJ, and CW; and uses Medicaid rehab option for intensive family intervention services (GA, one region)
- State funds and Medicaid amendment for TFC and MST (HI)
- Medicaid managed care organization provides an enhanced service package; State general funds for training and supervision (NM)
- Some MST sites funded by MH; Others by Juvenile Justice (TX)



MST continued

- Training
 - MST services
 - Original training by MST Services, but transitioning to state training/supervision infrastructure (CT, OH, HI)
 - State Coordinator co-located at MST Services (SC)
 - MH contracts with JJ to do the training (TX)
- Piloted, but no longer in existence or still in existence, but on very small level due to challenges in sustaining resources for training and fidelity (5 states)



School-Based Mental Health Services (n=20 states)

- School-based mental health centers (17 in Arkansas)
- MH counselors in schools – In most school districts in SC; training staff in EBPS in NY
- Positive Behavioral Intervention and Supports (KY, CT, NY)
- Funding sources: Block grants, school funding, Medicaid, seed grants, IDEA
- Sustaining factors in SC – long history, school invited and jointly funds, best practice model, state level coordinator for outreach, training, and supervision



Clinical EBPs (n=19 states)

- Types of clinical EBPs:
 - Cognitive behavior therapy (11 states)
 - Dialectical behavior therapy (7 states)
 - Coping Cat (3 states)
 - Multidimensional family therapy (5 states)
- Center for CBT through contract with University in Hawaii
- Center for Effective Practices in CT



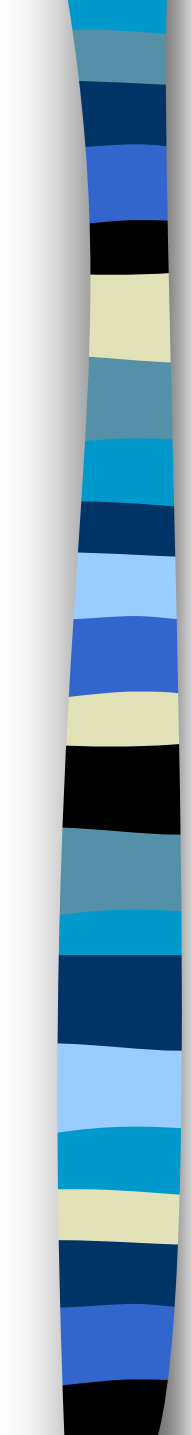
Public-Academic Collaborations

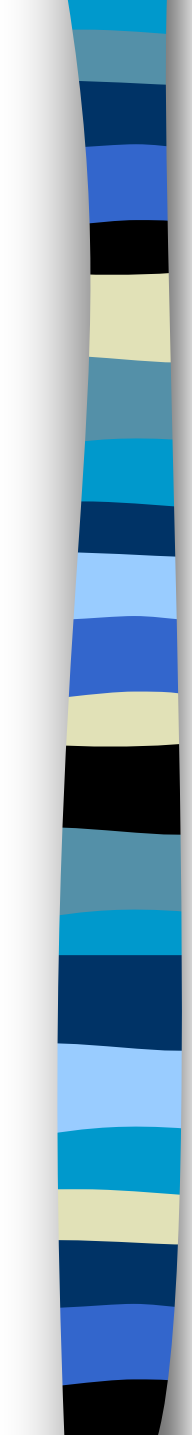
- A synthesis of the literature on dissemination theory suggests that public-academic collaborations provide the infrastructure for research and information/technology transfer needed for training professionals in EBPs, for monitoring fidelity and effectiveness of the interventions as they are disseminated, and for developing adaptations that may be needed for local populations (Stirman, Crits-Christoph, & DeRubeis, 2004).
- Results of NRI's EBP survey showed that most states reported working with their major universities and private colleges to support the implementation of EBPs. These collaborations take many forms.

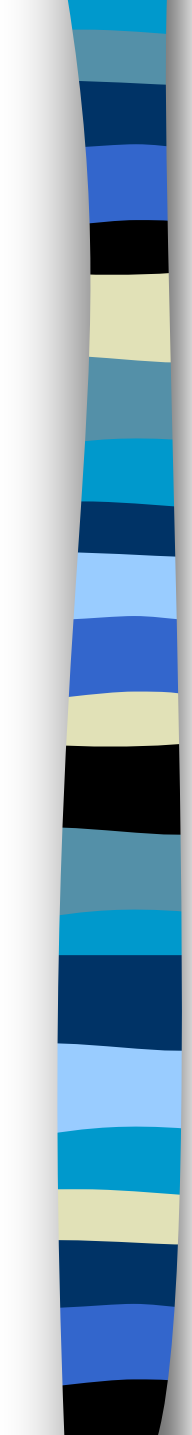


Public-Academic Collaborations

- **California** has relationships with UC Davis, Berkley, San Francisco, and Los Angeles on various projects to develop, implement, and evaluate EBPs. Collaborating researchers are required to build training into their protocols to benefit provider organizations.
- **Oklahoma** partners with the University of Oklahoma to provide training for some of its 18 assertive community treatment sites (ACT). One of the sites is housed at the University's Tulsa College of Medicine where the Dean of the college procured an endowment for a chair for the program.
- **Pennsylvania** collaborates with four major universities to provide training institutes.

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- **New Jersey** is collaborating with the Center of Excellence in Psychiatry at the University of Medicine and Dentistry to develop and implement an Illness Management and Recovery pilot project in six community agencies and two state hospitals.
 - **New York** has a unique arrangement with five Schools of Social Work to develop curriculum for EBPs and to place interns in agencies providing EBPs. Another major initiative with NY schools and universities involves training school-based clinicians in the use of cognitive behavioral therapy for anxiety (Coping Cat Manual developed by Kendall), CBT for depression (STEADY Manual developed by Clarke), Interpersonal Psychotherapy for Adolescents (IPT-A), and the use of functional behavioral assessment (FBA) to develop behavior management plans for disruptive classroom behavior.

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- **Hawaii's** Center for Evidence-Based Practices, which is a collaboration between the state and university departments of psychology, social work, medicine, psychiatry. The schools have responsibility to train professionals in line with the six EBPs identified in the Surgeon General's report (1999).
 - **Connecticut** has relationships with Yale, the University of Connecticut, and nearby Dartmouth and has created a Center of Excellence for promoting EBPs in children's mental health.
 - **Ohio** has gained much recognition for instituting eight "Coordinating Centers of Excellence" (CCOEs), each with a distinct focus



- Several important questions many states have about the Center of Excellence approach:

- Inputs

- Process

- Outcomes:

- Impacts on field, higher education, workforce, community, consumers?

- Key ingredients for success that effect impact?

- Center's plans for the future?