Panelists:
Patrick J. Kanary
Kraig Knudsen
Phyllis Panzano

Please note: The following is a direct transcription and has not been edited.

Kraig Knudsen: I want to thank you for joining our panel presentation today. It's called Informing the Implementation of Evidence-Based Practices through Research, Policy and Practice. My name is Kraig Knudsen and I am the Chief of the Office of Research and Evaluation of the Ohio Department of Mental Health. And I will be facilitating today's panel discussion, presentation and discussion. We have very distinguished panel for you today. They are Ohio's leaders in Implementation of Behavioral Health Evidenced-Based Practices for Children and Adolescence. They are champions in our state in Ohio for providing consumers of mental health services across the lifespan with the best possible treatment and care that can be provided today you know.

When people contact me and want information on implementing evidence based practices in Ohio I send them to these two individuals and so I believe that we are very fortunate to have them here today. So, I mean oops, let me guess, I want to go through in this. So, of course there I am and then we have Phyllis Panzano, Chief Visiting Professor from the University of South Florida and she is also the President of Decision Support Services Inc and we also have here Patrick Kanary. He is the Director of the Center for Innovative Practices what we call CINP at Case Western Reserve University. It's part of the Mandel School of Applied Social Services.

Phyllis Panzano: Did you mean to do this or?

Kraig Knudsen: No. It's a point. All right. We're going to have a few technical approaches to that. So, today we are going to discuss the framework and findings regarding Ohio's Department of Mental Health's use of Coordinating Centers of Excellence, CCOEs as we call them, beginning in 2001 to support the adoption and sustained use of evidence-based and promising practices. First, I will discuss the context of the decision to support evidenced-based practices statewide; second, Phyllis Panzano will discuss the longitudinal field study of sustaining implementing and sustaining evidenced-based practices in the Ohio public mental health system. After this presentation, we will hear from Patrick, who will describe the nature, evolution and outcomes of strategies to facilitate the adoption and sustained use of particular EBPIs statewide and summarize relevant performance and outcomes data in the process. Okay.

After this I will come back to discuss how practice and research-based data can be used to inform state mental health authority policy and then we will open it up for discussion, okay. For some reason, I haven't, lot of problems right. Okay, so here is Ohio's quality agenda from the Ohio Department of Mental Health, okay. So, this is just of the context.

I'm going to give you a little history about Ohio's quality agenda in the public mental health system. So, what we have here is little you are here marker like one of those that you see at the directory in the mall. This triangle represents the core of the department's quality agenda.

The Director at that time Mike Hogan, who is now the Director in New York in their Department of Mental Health, I don't think it's a department, he is…

Phyllis Panzano: Commissioner.

Kraig Knudsen: He is a Commissioner there. Anyway he announced this in January of 2000. Part of the quality agenda have been the idea of reducing the detailed process regulations we had in our certification standards, like how many signatures you need on what pages of a treatment plan, things like that and instead increasing these three things, okay. We have the use of evidenced-based practices, doing rigorous quality improvement instead of old style of quality assurance, okay and systematically measuring consumer outcomes. So, we have different strategies for each side of this triangle.

And the major one for the left side has been our Coordinating Centers of Excellence or CCOEs that have been promoting evidenced-based practices around the state. We initially had a hard time with the choices about these CCOEs which ones would they be, what practices should the department actually promote. There were three factors that drove the choices we made. First, we very much wanted to see services delivered that had a high degree of scientific rigor behind them. Okay, so that makes sense. So, level of evidence was extremely important. At the same time, there are issues and populations are very high salience okay for the public mental health system. So, criminal justice diversion, the what we call the substance abuse, on the spot relation duly diagnosed individuals and severely and emotionally disturbed children in schools okay.

And this is especially if the Governor happens to be have a real high priority on some of these populations obviously, right. So, those were, so that's our quality agenda. Now, let's see if I can actually advance this without going five slides, yes I spoke too soon. Okay. These two dimensions, scientific rigor and program salience is what we were, we start to talk about can become the x and y axis on the graph like this. There was the third sort of intervening variable that you can't see here and that was what kind of resources we had in the state that had both the expertise and interest to take the challenge of being a CCOE. For some of our interests there were matches and for some there just weren't any matches for it.

So, we try to go. I'm so sorry about this.

Patrick Kanary: There you go.

Kraig Knudsen: Well, we ended up with from these three variables at the beginning of the endeavor were, was eight CCOEs okay, we have the SAMI, Integrated Dual Diagnosis Treatment, family psycho education, multi-systemic therapy, cluster-based

planning, OMAP, Mental Health Criminal Justice Jail Diversion Alternatives, mental health and schools especially alternative programs for disturbed children, consumer advance directives, okay. So, this slide reflects where we were with regards to CCOEs when the research actually started, okay. There have been a couple of changes since then while there have been many changes since then, but at the time we had it and they were doing the things you see here, okay.

So, for the folks in the audience who might not know I want to tell you a little bit about what a CCOE is and what it does, because the CCOEs are an important part of the Department's evidenced-based practice initiative. And they form an important part of the research context for Phyllis's research that was conducted and that she is going to be actually discuss it. Okay, here we go. How many slides we'll go forward? Shall we guess, two, three, I wish we got a preview you know of what I'm going to be talking about. So, how is the structure of CCOEs actually originally conceptualized? Each CCOE would be based in a university or an organization or partnership. Each CCOE would concentrate on one EBP, okay. So, this is no longer the case by the way, some CCOEs as is Patrick's have many evidenced-based practices. And they would be a resource for the whole system as well as their particular practice, okay.

Here we go. In this we're going to find some new works. Okay. Role of CCOEs. The CCOEs had a number of important roles in the implementation and dissemination continuum. They promote the evidenced-based practice to education and training. They develop the capacity to do the actual practice. They do fidelity measurement with practices that have established fidelity scales okay and they promote cross-system sharing about the practice so people can help each other, okay, almost like a learning community. It's sort of a cooperative extension service model, okay. Our resource out there to help people do something, so the Department started out with these CCOEs and we hope that this strategy would increase the use of best practices in the Ohio mental health system okay, but we also put in place the endeavor to see how successful it was to find out more about the process, so we also in addition to doing the programming and the policy, we put research in place.

So, we put together a complex piece of research to try and track over time the extent to which EBPs are successfully adopted and what variables predicted the success. So, of course you can see all the things that Ohio was doing with the pictures. So, this is the Ohio state band.

Phyllis Panzano: They were not involved.

Kraig Knudsen: They were not.

Patrick Kanary: Then we try to get them involved.

Kraig Knudsen: We try to get them involved.

Patrick Kanary: They wouldn't, but they wouldn't.

Kraig Knudsen: Just I don't think so.

Phyllis Panzano: You know the football team might get involved.

Kraig Knudsen: All right. Now, all right, here we go. Yeah, okay. Okay, so our overarching research question at that time was what factors and processes explains the adoption and implementation of evidenced-based and promising practices by behavioral health provider organizations. In other words, what explains the organizations' decision to adopt or not adopt to particular practice okay and what explains whether the adoption really lasts over the long term and is successful now. This research question evolved over time and the research became much more robust you'll see when Phyllis tried to go to, it's really quite impressive and one of the first of its type too in the country.

So, the independent variables for this, for the IDARPs day, which we call the IDARPs day, we're looking at four things, the characteristics of the EBP itself; the characteristics of the adoption decision and implementation process; the characteristics of the adopting organization; and the characteristics of the working relationship between the adopting organization and the CCOE. This is the different kind of research for us probably for a lot of people in this room we used, we're used to client focus you know client focus on research and we all know those measures, but here we've got an organization as the focus of the research not the client level research project. So, it's really about what makes the organization one of the critical decisions in the organizations and to what extent it and its staff will adopt a particular evidenced-based practice.

So, these are organizational level issues. We went looking for researchers with deep familiarity with varied literature and on organizational behavior and change particularly around adoption of innovations. Yeah, then we found Phyllis. So, with that I'm going to pass it to Phyllis, even try to pass it to Phyllis.

Phyllis Panzano: After unhooking a lot of time.

Kraig Knudsen: I've done, yeah.

Patrick Kanary: But we can take if there is any questions.

Kraig Knudsen: Yeah.

Patrick Kanary: Or comments at this point before we, so we can use this time productively.

Kraig Knudsen: Yeah.

Patrick Kanary: Or not.

Phyllis Panzano: One thing that I will throw in the hopper as Kraig changes this is that when the Ohio Department of Mental Health put this effort out there, there were kind of two perspectives that the Department was interested in. One was kind of the on the ground perspective that could be provided by the CCOEs and the data that CCOEs were gathering around fidelity and outcomes and so forth, so that perspective and sort of some of the rules related to that contracting process took that information and sort of filtered it up. And then the perspective that we took in the research was more of a bird's eye view perspective from the perspective of decision makers in the organization who were actually engaged in deciding to adopt to deadopt, to invest resources in the implementation process and kind of high level implementation people as well, but it was a different perspective that we were taking. We also get information from CCOEs along the way which I'll talk about.

So, the Department was trying to get information from a variety of angles to sort of inform the policy. So, any of these pieces alone really we're just telling kind of part of the story. And my background was industrial psychology so most of the research that I had done in the previous say 10 years was really focusing organizational decision processes, implementation of my dissertation was on the implementation of the Mental Health Act of 1998 to try and see how it would predict a Board behavior. We have 53 local mental health boards in the state predicted their you know hypothesize how they were going to respond to the act in terms of some financial decisions that were being made. So, when this came about, the Director at the time kind of really had shown an interest in that model and found that the decision maker perspective was useful and had predicted a variety of things to answers in a lawsuit taken against the Department and so forth and so on.

So, my perspective of course will be different from Patrick's, but we sort of converge in terms of some of the big picture findings that we have. So.

Female Speaker: Kraig question.

Phyllis Panzano: Sure.

Female Speaker: When did this story started over what period of time can we hear anything about it?

Phyllis Panzano: I'm going to be talking about that, but basically…

Kraig Knudsen: Over the last 10 years.

Phyllis Panzano: This is just, about 10 years yeah.

Patrick Kanary: 10 years.

Phyllis Panzano: Yeah.

Kraig Knudsen: Yeah.

Phyllis Panzano: So, I think…

Male Speaker: I have one question.

Phyllis Panzano: Sure.

Male Speaker: Was it the one model of implementation that was that you have already chosen for the, you know you used to.

Phyllis Panzano: For this, it was really and Patrick will talk more about that. It was really kind of, the CCOEs use different models because the practices were different. So, and we're not really going to be able to talk about that in any length today, really today, we're just giving you a very wide rush view and one thing that I will say that my part here I like except for some of the papers directly related to this research, I pulled out all the citations, mental citations I have versions that have many citations, but I really try to keep this simple because I'm talking about findings over 10-year period and really only the smattering of insight that we think maybe present a big picture about some of the factors linked to sustaining practices over that 10-year period. So, this is by no means exhaustive and I try to be really non-techy about it. So, hopefully that will be okay with all of you.

Female Speaker: All right. Second question is on the changes in the CCOE, correcting, are they actual providers or they're supporting the providers?

Kraig Knudsen: They're reporting providers.

Female Speaker: Okay, that's fine. Okay. That's great.

Patrick Kanary: And in the implementation literature, sometimes they are references to Intermediary Purveyor Organizations or IPOs where we don't actually provide direct service, but we provide the linkage between the developer and the implementer at the agency level. So, we do the quality assurance, the training and consulting the coaching.

Female Speaker: Okay thanks.

Phyllis Panzano: Another technical bullet here.

Kraig Knudsen: Now, we can see it on this screen. We can see it on that screen. Okay.

Phyllis Panzano: You know it's now not showing here.

Kraig Knudsen: Okay. So, now it is.

Phyllis Panzano: Function F7 isn't doing it.

Kraig Knudsen: Function F7.

Phyllis Panzano: No.

Kraig Knudsen: Sorry about this.

Patrick Kanary: This is why we chose research and practice as our profession and not technical assistance and computer technology.

Phyllis Panzano: Yeah, I'm just going to try and just go ahead this way. I'm going to use…

Kraig Knudsen: You could brief that this is really good a problem…

Patrick Kanary: How many research does it take to?

Kraig Knudsen: Yeah, exactly. How did you do that?

Patrick Kanary: Tada.

Kraig Knudsen: Function F7.

Patrick Kanary: Magic.

Kraig Knudsen: I insist you actually.

Patrick Kanary: Magic F7.

Phyllis Panzano: Okay, so I am going to really just give a very broad rush view. There are papers available and I have more detailed information if anyone is interested. So, anyway, so I am going to take a top tell a tale and four acts that picks up on the piece of research that Kraig referred to. And sort of what these four acts, these kind of four analysis pieced together in narrative form might suggest that factors that account for sustaining evidence-based practices and state mental health system. So, the primary goal of the presentation itself is to explore the question of what accounts for the long term success I have success in quotes because success is measured in a whole bunch of different ways of healthcare provider organizations' efforts to implement evidence-based and promising practices.

Although we're focusing on mental health practices in this study one of which is a child practice, we would argue that some of the factors that we are looking at are really robust and would apply to any best or promising practices be it's child welfare practice or whatever. So, anyway that's one of the primary assumptions went off really well.

The study that Kraig alluded to was the innovation diffusion and adoption research project I was the PI on that study. It was funded by the Ohio Department of Mental Health and the MacArthur Network on Mental Health Policy, many, many people are to be thanked primarily the folks that participated in the research, but some other key people that I'd like to mention are the former Director Mike Hogan who is now instituting a similar system in New York, Dee Roth, former research of -- former Head of Research for the Department and Kraig of course, sort of folks associated with MacArthur Network, Howard Goldman, Pam Hyde, she is now at SAMHSA, Ohio State University Psychology Department and College of Business were heavily involved and of course the CCOEs such as Patrick.

So, anyway there were a lot of people that contribute to this research and it was really a collaborative effort. So, you had asked the question earlier about how long this process went on. And it went on for, it began in about 2001 when the CCOEs were funded, but the research didn't really kick-off until close to a year later. So, the way the research was set up is the CCOEs were getting off the ground and we actually gathered some information right at the end of 2001 but it was really 2002 we had 80 plus self identified potential adopter organizations and that was the fixed group that we looked at to this study. That's a real good thing to say.

And then our last look at this group was around 2008 ending into 2009 when there were 40 plus of those original 80 plus potential adopters who were still sustaining the practice. The acts that I'm going to talk about kind of four things that happened along the way. We first wanted to try and understand the adoption decision which of those 80 plus adopters potential adopters decided to adopt. What were some of the factors that explain that? When I came to those that did adopt, what were some of the factors that explain success from the perspective of top decision makers and program managers and CCOEs, we also looked at an unexpected event I guess it shouldn't have been unexpected, but the deadoption decision in some cases adopters decided to step away and then finally sustained use.

So, those are the four acts which I will connect through and narrate it. Because I'm an industrial psychologist and because we're using this sort of you know an organization behavior model, there is assumptions many of our assumptions are too really tied to organizational behavior research and methods and they may not be familiar to many of you, not all of our assumptions aren't, but I want to mention some of the biggies I can talk about each one at great length and I'm not going to, but just to mention them at this point.

This is not an OB or IO assumption. It's a general assumption. Context is caveat. We recognized that the OS, the Ohio system is unique. It has the CCOE structure, the CCOEs are being funded by the Department. We were not just looking at evidence-based practices the highest. We're looking at practices that were supported by range of evidence, the decision was gone. That might not apply to many systems. So, I think it's really important to keep that in mind. We also viewed the focal EBPPs, evidence-based and promising practices that are studying on an innervations. Innervations have been

technically defined by internal standard something seen as new by the adopter whether it's new in the marketplace and there is also external criteria for identifying innovations and that would be resensing. Is that something new in the marketplace or different from this?

We would argue that these innovations were all seen as new by the adopters and they're also recently developed. So, the innovation adoption diffusion literature therefore then become relevant. We saw these decisions as you know the decisions to adopt and implement and continue to implement as strategic decisions. Organizational important decisions that involved you know the expenditure of lot of resources, time et cetera. They are not tiny little decision. They are high; they are salient decisions. So, the strategic decision making literature is relevant. We also move forward with the assumption that the strategic value of innovations can be economic and be effect, you know effectiveness might be an issue. Efficiency might be an issue, but there is considerable literature playing out that their sociological decisions are driven by sociological concerns like legitimacy power or by Abramson, Dunne and a whole bunch of folks point out it's just not an economic decision and it's a decision that's made within a strategic issue agenda. It's not just sitting out there on its own.

Scientific evidence may be neither necessary nor sufficient to adopt innovations and there is literature I'll point out the study by Dunne and all from Canada as a good one to look at. And so we didn't want to just have practices that worth a top of the payroll, I mean top of the ladder in terms of evidence, because then you wouldn't get variability. We wanted variability on variables that we thought might be important to understand what's happening. Another important thing is organizations think. I won't go into this at great length, but in my field, there are paradigms to sort of under -- to study organizational decision processes in the Academy of Management there is a division called managerial organizational cognition.

Organizational cognition is seen as more than the lots of an individual person of their own interests. It brings organizational history and broader interest into account. Vantage point affects view point. And what I mean by that if we're focusing on EBP which is shown down at the bottom, and that's teaching for example, implementing a practice, the vantage point of the folks actually on the ground implementing may not be the same as the upper echelon that's getting news about new laws coming down the play, do financing and so forth. So, even the same information may be viewed relatively differently. And we were interested in more of this upper echelon view that was informed by the ground level view and CCOE view, but different. It might be different than somebody who's on the actual ground doing the team working.

And finally many ways to spell success. If you know look at implementation studies some success measures you will see is simple adoption is success. Duration of adoption is success. Fidelity is success. Spread is success. There is lots and lots of measures of success real impulse chapter written around 2005 is really kind of good overview, Fichman 2002 was also, but many, many ways to spell success. As Kraig pointed out you know our two major research questions fell into two camps. The first dealt with

adoption, what factors explain adoption, and the second, what factors explain implementation success. Again I would put success in quotes as we define success in different ways that really kind of emerge.

Okay. I'm first going to look at the first three acts. And the reason and those first three acts I have that timeline there and I'm showing kind of one-to-one data sweeps with our participants, the adoption decision. We started out with 84 sites 56 adopting. We then followed this 56 sites and looked at implementation climate of the 56, 12 deadopted leaving us with 44 and then at the tail end here, we ended up having 43 of those 44 still doing it. So, I guess we expected maybe a sharper drop off but it was really kind of sustained use there. Why am I doing this? It's because we started out with those 86 sites and that's the on effects that you need to know moving into that last step. One of my big issues of implementation research in general is not even the adoption decision as we really looked at. You start with people who are willing to implement. And the strategic decision making literature would suggest that might not be investing to do. You have to know what the difference is.

Male Speaker: Can I ask a quick question?

Phyllis Panzano: Sure.

Male Speaker: So, that's the adoption of any evidence-based practices…

Phyllis Panzano: If we -- I'm going to talk about that now. We focused on four in the study.

Male Speaker: Okay.

Phyllis Panzano: Of those eight CCOEs we had two primary and two secondary because that's our resources would allow study, okay. And I need to, you have the microphone and I don't want to take it. Make sure moving here I need to be moving that one. Okay. And I'm going to kind of just fly through this now hopefully you'll get a big picture. Okay, so IDARP was an observational field study with up to four data gathering points along the way. Our focal practices were both two team based practices and they tended to be on the high end of the evidence spectrum integrated dual diagnosis treatment and that was for folks who are -- have co-occurring substance abuse and mental health issues adults and MST which is a child's practice that Patrick will be talking about two other practices a little bit lower on the spectrum.

We were trying to get maximum variability on key innovation attributes that have been oops sorry about that. When did that go on? I didn't…

Kraig Knudsen: Just right when you…

Patrick Kanary: Two minutes ago.

Kraig Knudsen: Just two seconds ago.

Patrick Kanary: Yeah.

Phyllis Panzano: Okay, I'm going to just kind of keep going.

Patrick Kanary: Okay, there is something going on in this room. I don't know.

Kraig Knudsen: There is an arm…

Patrick Kanary: Yeah, there is some resonance here that I'm looking forward.

Kraig Knudsen: Something not want us to get through this first finish it in five minutes.

Phyllis Panzano: Is it? Or should we be waiting?

Kraig Knudsen: Here we go.

Patrick Kanary: I, eek.

Phyllis Panzano: Sorry.

Kraig Knudsen: Well, you have 17 slides.

Phyllis Panzano: Yes. One of my slides are mixed up right now.

Patrick Kanary: So, I just want to say when you do your evaluations, please factor all of this in you know or otherwise still evaluation and…

Kraig Knudsen: Yeah.

Patrick Kanary: She is going to do for us.

Kraig Knudsen: Yes.

Phyllis Panzano: I wonder what happened.

Kraig Knudsen: Here we got.

Patrick Kanary: Okay.

Kraig Knudsen: Here we go. At least we're not losing the audience yet.

Phyllis Panzano: Okay, so we had two primary practices which I just described two secondary that were lower sort of on the evidence-based spectrum. We were trying to maximize variability on key attributes that have been studied by Rogers and so forth that

we thought might have a bearing on the decision to adopt. So, we're trying to get some variability in there. The way we recruited organizations, organizational participants was through CCOEs. All CCOEs are interested in participating in the study thankfully for opting. What they did was when an organization approach that they would then refer the organization to us and they would refer organizations that were right now important one you adopt or thinking about it or were, so we got a mix of organizations. So that was our starting point of it.

It was voluntary participation in both in the research on the part of organization and CCOEs. Our participation rates from start to finish were over 90% on the BHO side down to 75% at time four which you'll see and high participation by the CCOEs. We used interviews with the BHO informants. Follow-up survey with BHO informants, surveys from the CCOE personnel who were working most closely with the organizations and archival data. We develop generic methods because we wanted to be able to I mean measures because we needed to be able to use measures that apply to all the CCOE, all the practices not so fine-tuned and specific that they would generalize. They are theory based and in most cases adapted from existing measures and organization behavior literature and related literatures. Our key informants were primarily on the BHO side members of the top management team, CEOs, CCOs, CFOs and like a program manager for like the MST team, the team lead and the CCOE liaisons working most closely with that organization.

As I said we started with 84 adoption decisions and then followed tracking 50 plus efforts. We used methodology that was akin to this approach we're using looking at agreement among informants and reliability before we move forward and did an analysis, but again are just as typical in this kind of research, small ends, small organizational ends and small informant ends by definition your top management team doesn't have always keep that. But this is really a common paradigm in the literature that I've accustomed to. I'm not going to spend a lot of time here, but basically over top contact points we had, we did interviews 587 over the course of the study, surveys 547, CCOE surveys 230 and our actual data points excluding archival data was modest as I said. Contact one starting 7.0 and about 4 for contact four in terms of pieces of data we gathered surveys, interviews from our informants.

So the adoption decision model from this point forward I'm just kind of talking really kind of broad terms I refer to as the power chart model that's not what we referred to it in the paper that was published but here I do. And basically what that model says is the decision to adopt depends like calculated risk, the size of your chip stack does matter. And to put this in poker terms, if you have a good that your hand represents the perceived risk of staying in the game, the chip stack is your capacity to manage risk, the bigger the chip stack the more you can sort of negotiate and then the third thing is your propensity to take risk. Once your historical propensity on risk take or not and then depending on those factors the worse the hand the more likely you are to fold. The bigger the chip stack the more likely you are to go forward, the greater propensity to take risk, the more likely you are to go forward.

That's the basic idea behind this model. So, perceived risk of adopting, capacity to manage risk, risk taking propensity, we suggest it would discriminate adopters from non-adopters and sort of like how far long people were at that first point of contact. And we did find support for the hypothesis, the pain were noted explain this in much more detail and also describe the scales, the measures and so forth we used, but generally the higher perceived risk, lower likelihood of adopting, higher capacity to manage risk, greater likelihood of adopting, risk taking propensity positively related to adopting and moving forward.

Okay, so that was really the adoption model, a risk based model. The next couple of acts focus on implementation. First one here is climate for implementation which I call the Dilbert model. Projects can rise and fall depending on how soundly they're supported and managed. No big surprise to anybody in this room. One of my mentors in the Ohio State College of Business Paul Nutt, who is the implementation guru has said for based on his research if you ask managers what they need to do to make implementation successful, virtually everybody would tell you what they need to do. They know what they need to do. There is a difference between what they need to do which might be formal policy and procedures and what actually happens. So, most people recognize elements of climate that are important to focus on.

I want to make a couple of comments about climate. Again this is a top that you can talk about for hours, but just to discriminate what we're talking about, we're talking about climate for implementation for other, from other forms of climate. First of all, organizations have more than one climate. In the old days, 25 years ago you would see this kind of on the best climate research. Then you know over the last couple of decade you see research on specific climates, climate for safety, climate for service, climate for creativity, climate literature is extremely rich literature. And the level at which climate operates in an organization is both a theoretical and empirical issue. So, there is a ton of staff who got climate out there.

But what we are focusing on so climate can be ubiquitous, local, focused. Our focus is on innovation specific climate for implementation as discussed by Klein and Sorra and others since then, Alfred, Callahan and others. So, our focal interest is on the sub union in the organization like an MST thing engage them permutation and where our climate for implementation is what's happening around those people to support their efforts to do this right. Implementation success and again this follows Klein and Sorra. We're looking at two things execution, how all those implementation being carried out in terms of things such as fidelity and then impact. How is this implementation affecting stakeholders in the organization?

So, the dimensions in our study that we looked at climate for implementation surrounding specific implementation of specific practices were top management support, goal parity, dedicated resources, access to training and technical assistance, rewards for implementing removal of obstacles, performance monitoring, freedom to express doubts. We had informants from the organization and also the CCOE given us their points of view about this. And basically what we found was for our implementers the stronger the climate the

better the execution. You know and this was over two time periods. We look at climate at point in time and then they, you know the impacts the next week. Better execution, better impact and we also found that impact worked through and the impact was felt through the execution. So, better climate, better execution, better impact, so that's the climate for success model.

So, it tells us climate is important for success is measured in the ways we looked at it here, fidelity and impacts on stakeholders. Then the deadoption situation happened which we were not expecting, we didn't have hypothesis, but what we did have was we had a real rich data of things that we could look at in an exploratory way try and see what separated deadopters from adopters. And that model we call if the glove still fits keep wearing it, external and internal developments influent goodness of fit of a practice. Things change. It may not fit so well now. Might have fit well before you might have thought would fit well at the time when things change. So, again it was unanticipated. It was exploratory based on data from BHO, key informant interviews and surveys. We compare 12 sustainer sites with 12 matched deadopter sites. We match them in every way possible, the practice, the size of the organization, locale, when the deadoption occurred relative to the match parents of what, so very small sample size. We had 12 and 12, but we found some really interesting results.

We essentially found without going into great detail here the sustainers reported that the practice fit better with the mission, the resources, and so forth of the organization. They reported a stronger climate for implementation and their view is they're reporting greater effectiveness impact of the practice. So, fit climate and effectiveness sorted out. So, those are the three acts leading up to like what we found at the end in terms of sustainers. We thought we might see half deadopting. We didn't have any idea, but as I mentioned most were still up and running 43 or 44. So, the end is where we start from, where we start talking about sustainability all that stuff that I just talked to them is the starting point from looking at sustainability.

So, our act one told us that adopters essentially oversimplify, we're talking about risk, so, again exceeding losses, success implementing was related to stronger climate and in terms of the deadoption we saw that organizations reporting better fit, stronger climate, better impact with ones that kept going the deadopters fill out. So, it's these 44 that fit this mold that we then talk about and we look at sustainability. 43 out of 44 sites, our focal success measure ended up being assimilation scale not sustained use, duration was about the same in terms of how long they were up and running. So, we're using this in a relation scale to find as the extent to which an innovation is seen or has become part of regular organizational procedures.

Informants, TMT and program managers at BHOs and the CCOE liaison working with the informant with that organization, surveys and interviews again and here is you know we have again limited end here. Of our 43 projects or 44 projects we got 35 covered by the BHO surveys and interviews, 34 by our CCOE surveys, but only 25 overlapping. So, I looked at the data based on the overlapping and then separate and I'm going to briefly kind of go through and tell you what we kind of found.

Our model, our general theoretical model was the stronger the fit and this model emerge from our research those first three acts but also from the literature. Fit, better fit, better climate, more resources devoted to supporting the practice, better climate, more effective execution which that would lead to more effective outcomes and then assimilation. We had five scales. We looked at to the right there gives you the alphas for those scales, the CCOE and organizations and all the alphas were point eight went up so they were pretty good. When we looked at the 25 sites in common, on those scales we saw that BHOs had a rosier view than CCOEs on four of the five measures little bit more positive views with the exception of fidelity the one in the middle and those are just simple like T test, match T test.

We found similar by varied associations and absolute magnitude between our key model variables between the CCOE surveys, the BHO surveys. One of the questions we asked does climate mediate or carry the influence of strategic fit to assimilation, is climate still a key variable here? And we found, yes that it does and this how that for the third, the BHO data, the CCOE data and the 25 common sites, so it's consistent across all three analysis. We found that fit influenced work through climate to explain assimilation. We also wanted to know whether or not fidelity continue to be an important mediator of climate on the assimilation. And what we found was that it partially mediated. So, climate influenced fidelity and that explain variability and assimilation and this held up for three of the four tests, three of the four several tests.

Then we just want to kind of throw everything in the hopper and say what is you know if we do a step wise regression what comes out is being most important in explaining variability in assimilation. And we looked at the BHO data and the CCOE data separately and essentially found the same thing. Climate 44% and 57% variance explained, fidelity 13% and 9% explained, strategic fit work you know kind of works through fidelity, so it was zero explained in the step wise regression and then we had about a third on explained variance.

Then we asked the question to CCOEs, relationships with CCOEs seem to add value, explain variance and simulation. And we found that according to BHOs because we only ask the BHOs about working relationships with the CCOEs, their relationships good working relationships with CCOEs added additional 18% of variance explained. So, this is hefty variance explained when you look at these figures. And we also looked at our T3 data for the same variables. Our T3 and T4 is about 2.5 years or more. We said do T3 variables explain variance and assimilation at time four from both the perspective of BHOs and CCOEs and the only variables that explain variance were working relationships with CCOEs. The other ones there was not significant variance explained. And of course these are really tiny sample sizes. So that's a huge implementation here.

Recap methods and finding, the presentation itself is a narrative account of possible links, about separate but related analysis involving and fixed and small group of sites. We use the oppression and paradigm, paradigm which by definition has limited within organization informant ends, but we had good agreement in our among our informants, a

good reliability and convergence of measures, party variance explained small provider BHO at huge limitation but in organizational studies of this sort that's still a pretty good sample size believe it or not.

We had multiple sources and methods and contact points that we looked at and as many of our announced this is possible we did over time. And the measures that we developed we think might be useful for other studies of this sort. Recap of finding, sustainer BHOs tended deadoption risk is lower than non-adopters and again these are general across these narrow acts. Compared to deadopters sustainer BHOs tend to view EBPs as more effective and fitting better operationally and strategically. TMT members and CCOE consults are justifying factors are tied to assimilation amongst sustainer strategic fit, climate for implementation, fidelity and CCOE BHO working relationships, a few really important reflections that I think reflect big questions and concerns with this study.

One is do the relationships among these measures I just showed you sustainability assimilation measures represent implicit models about the way the world should work or the way things are actually happening. What I mean there is if the CCOE informant has direct exposure to information about fidelity and maybe fuzzy information about climate and the other things, is there gap filling that goes on where assumptions are drawn, good fidelity, you know there must be a strong climate. So, you know implicit models exist. The variance explained suggest to me your some of the implicit models that exist here.

Another question, are the independent variables, climate, fidelity, good working relationships predictors or proxies for assimilation. When it comes to evidence-based practices as opposed to other innervations, when you ask somebody has this practice been assimilated there the condition that they might look to is fidelity. So, are these, is this just a constellation of variables that represents how assimilation is operationalized in the minds of people engage and implementing evidence-based practices.

Another question, what array of values does external purveyor organizations bring to the assimilation or sustained use equation and does assimilation signal the disappearance of the innovation from an organization's active strategic issue agenda. Many years ago when Yung came up with his implementation stages the last stage was identified as disappearance. Meaning, it's just part of what we do nobody notices it anymore. Does that account for why 43 or 44 organizations are still doing it or why? So, there is tons of questions out there and we barely have scratched the surface. I think we've raised way more questions than provide any answers. And that's it for me. So, I will turn this over I will try and I guess you're going to stay on this one, right Andrew.

Andrew: I am. I hope.

Phyllis Panzano: End this line. Click 2x.

Female Speaker: Just a question.

Kraig Knudsen: Yeah.

Phyllis Panzano: Oh yeah.

Female Speaker: Shall we determine…

Kraig Knudsen: Text me.

Female Speaker: In your study did you look at all at some of the little level variables that were impacting Ohio some of those measures on top of that with our institutionalized workers and their help pressure from outside the state?

Phyllis Panzano: We did. I mean we had and I've just covered picked a handful things. We really didn't look. What we looked at was environmental variables like people's views of professional norms and resources state level resources facilitating and at that level we found so little variance in our sample that it's within the state that it did really, I'm not saying it didn't explain any variance, but overall, it was sort of blend because there wasn't much variability.

Female Speaker: Outside of the state federal law and pressures among Ohio do you still manage care and all that?

Phyllis Panzano: Well we ended up as I said we created, we're using generic scales. So, we would have and I'm sort of let me just see if I can give you a couple of examples like I don't know if you know like Kathleen success measures of environmental stability, instability, professional norms and so forth and so on. So, we use scales and so the perceptions reported to us from say the CEOE or CEO, we didn't ask how they came to the conclusion. We just asked how they viewed that dimension. So, it could have been federal initiatives. It could have been stuff happening in their board area. So, you know what I mean. So, we were using those scales, but there wasn't a lot of your ability on that.

Female Speaker: Okay. I just have another question. You talked about climate, is that, could that be another means that looking at organizational readiness or as you're using something it would be different?

Phyllis Panzano: That's a really great question. And then I feel like I cannot give you a fixed answer. I think that you know there is measures up there and Patrick might use some I know the case center uses, I'm using like a general organizational index to go in and see are the resources in place to be receptive to this new practice and I think that's a little bit more generic than what we're talking about here because these questions are really practice specific. Then you can only judge when the practice is actually up and running.

Patrick Kanary: And I think…

Phyllis Panzano: So that's a really great question.

Patrick Kanary: Yeah, I think maybe some of what I talk about might get to that, but ask that again later, because I think…

Phyllis Panzano: That's a great question.

Patrick Kanary: Yeah. So, I'm going to talk a little bit about so with Phyllis was at 30,000 feet I'm at about 15,000 feet with the overview of our center, the Center for Innovative Practices. And as Phyllis said in the initial days of the CCO implementation our initial and sole purpose was the dissemination of multi-systemic therapy. I'm assuming most of you have some familiarity with MST, home-based intensive model, okay. And that was you know kind of a decision that was made and then the Department went in search of an infrastructure in order to implement that.

What I would say is that in the 10 intervening years we have included these other services as part of our portfolio and that our clients now if you will or our stakeholders include children services, community mental health providers, State Department of Mental Health, Department of Youth Services, Juvenile Court, county level and other collaboration. So, we have gone beyond the initial intent if you will and in fact one of our initial discussions with Director Hogan former Director, Hogan, was do you have any problem with the fact that we may want to move on to other services besides MST. His response was that's up to you. What we're going to pay you for is the dissemination of MST. But if you find opportunities otherwise, which clearly we have.

So, you know to kind of ask the obvious question from children's mental health, children's behavioral health, children's services organizational perspective, you know why do we care so much about EBPs. Well, the literature is pretty clear that we have a huge unmet need in our country for children with serious behavior and emotional disorders. I'm not going to say the statistics. You can get them online, but this report to me is one of the better ones that's come out recently that really begins to look at you know the current data and of course not surprising to any of us the early onset of these disorders in kids.

This NIMHW talks about that you know behavioral health and mental health disorders now occur at a higher frequency than many major feasible conditions. And again that's not news to you all, but I think it's to reminder to us about why we're doing this work and why it indeed continues to be a rather uphill challenge. These are just some of the highlights from the study. I'm not going to go through this too dense slide. I'm also running that. I supposed to have fewer words and more pictures and Phyllis is a great role model for that. So, I'm trying to reduce what I put up there. And I don't know if all of these PowerPoints are going to be available, okay. So, they will. Yes sir.

Male Speaker: *[Indiscernible] [00:56:55]*

Patrick Kanary: Pardon me.

Male Speaker: This is in morbidity to say unless…

Patrick Kanary: Yes, yes. And so these are just some of the highlights the reasons that are kind of the motivators you know for us in field. And again looking at that early onset and why we ought to be moving down the ladder in terms of we're replacing our interventions. This study might be also resonate with you in from the Child Welfare, excuse me, the Child Welfare system and that is and although the study is about four, five years old, I don't know that this exchanged substantially in terms of the level of mental health disorders among kids in the Child Welfare system. I mean again we're kind of off the scale. And if we looked at this study replicated for kids and the Juvenile Justice system as you all know you would see actually higher numbers than 47.9%. You're probably looking more at 65%.

So, we have kind of a critical mass of youth who are sharing common disorders and who are also kind of transversing multiple systems. So, you know again to state the obvious and one of the reasons that we think a center approach helps is that some of the challenges that we face in our field is this kind of continued focus on the kind of the siloing effect that we know that children and youth with serious emotional disturbances are underserved. We know that multiple systems are serving those systems including as I said primarily Child Welfare and Juvenile Justice. The preponderance of toolkits, so if you go to the NIMH website or the SAMHSA website and look at toolkits or look at resources, you know not that it's all lot, but compared to what's there for kids, there is a lot for adults. And I think part of the CCOE effort in Ohio was Director Hogan's response to the lack of toolkits, the lack of resources, the lack of effective interventions that seem to be out there for kids and so thus led to the decision around MST.

One of the things that we're finding however is that there is and I'll talk about this a little bit later, there is a challenge to implementing some of these models especially with adherence and with fidelity and with the rigor in which -- to which the developers expect implementers to conform. So, one of the things that's emerging in our field that I think is really intriguing, a lot of it is coming out of the work of Bruce Chorpita at UCLA, this notion of what are the active ingredients in some of the very effective services that we ought to be importing into treatment as usual, because that's where we're stuck. We're stuck in this zone between evidence-based practices or whatever you want to call them, I talked about them as interventions that kept results with data and treatment as usual and we kind of treated those as warring camps, if you will to some degree. They don't need to be nor should they be. I think one of the strategies that can link those camps is looking at the elements that are effective and train to those at least for a significant population of practitioners. Because the reality is the adoption of some of the specific models is largely probably going to be in the minority for a while to come.

So what's our role as a center or a network partner or an intermediary prevail organization. We have a lot of terms now for something that's relative new spot on the equation of here is a service, here is a provider go do it. We now have some of these intervening mechanisms to help we hope have that happen and as I think Phyllis research showed, I think we do.

So when I talk about what our role is, with our providers in Ohio and with our state partners in Ohio and county partners, our role is to help coordinate, to help navigate, to help motivate, to help advocate, your take which if some of my colleagues were here we will tell you probably what we do best. And help them to evaluate. And that really -- those really are key roles.

Phyllis talked about de-adoption and what I wanted to comment on is that we have seen an erosion in MST across Ohio over the years. We hit our highlight in 2008. There was a huge surge, when I say huge, was still talking about relatively small numbers when you talk about the state of three million kids and three hundred and some providers across the state. But we saw a surge in the uptake of MST. In the last several years not surprisingly compared in consistency with the economy what we have seen is a downturn.

I would tell you that almost to attain maybe one exception but also to attain that decline is related to the ability to finance the program. I have never had a program discontinue their relationship with us because of lack of outcomes or because of lack of satisfaction with the program.

The issues are we haven't figured out how to sustain it over time and quite honestly there are lots of administrative challenges, like turnover, hiring, rehiring, retraining and the cost to go with that. But the issue is never about we didn't get the outcomes we thought we would get or we didn't please our stakeholders. Those were not indicators of de-adoption.

So real quick, just Ohio did, so we kind of we would issue every quarter to the Department of Mental Health and then individually to our providers what we call the dashboard – MST Dashboard that would show the results of both our teams on an aggregate level as well as the information we would provide to teams on an individual level. We never shared other teams results with each other unless that was okay with that.

So this was the compellation of the last three fiscal years and our key indicators at the time of discharge as you can see on the left are kids at home, kids in school, percentage of kids with no new arrest, percentage of kids completing treatment and the average adherent score and as you know the adherent score is what indicates that you are achieving the program with fidelity.

So on all of those levels we are doing extraordinarily well and across our network of teams, we are always on average at least meeting and exceeding – often exceeding the adherent. And one other things we learned was as you know, the good news about numbers is that they are good, the bad news about numbers is that they can look bad but what we have been able to do is help people understand the context. So for example if the adherence goes down, some stakeholders might assume this team is not doing well. Well, when we go in as consultants and talk about how to compact that adherent score just to say you know what you lost 2 therapists in the past year, you retrained two new

people, your case load went down. Those aren't excuses. Those are the realities of maybe why you went from 0.61 to 0.59. And it does had a different context for understanding it's not about upper or down back or forth.

Audience: I was a wondering if you made a distinction of kids who do involve in *[indiscernible] [01:04:45]*.

Host: No, we haven't. We haven't. But what I can tell you is that we do have some teams that are dedicated only to juvenile justice population then we have two teams that are dedicated to only kids from the child welfare system. So our constellation of teams are kids from all over referral sources primarily probably behavioral health. But also some dedicated teams for the primary or *[indiscernible] [01:05:08]* juvenile justice system or child welfare. So that's up t the local.

Audience: Not public.

Host: But not public.

Audience: It's dual.

Host: But I would say that within those profiles of kids you would probably find, you will certainly find both of them, yes. So when we look at what are we expecting from the programs that that we support, we are, our focus is all about intensive home-based and community based services. We do not venture into the world of placement. We don't venture into the world of residential treatment. So our focus, our portfolio is really about doing the work in the community.

So again similar to the MST Dashboard, our clinical and functional outcomes that we look for, our supporting programs were focuses on families are staying together, kids are succeeding at school or at work, we see a reduced involvement in the justice system. We reduced involvement in child welfare and so on.

And the physical issues that we are looking at is the fact that we are looking at kids that and families that are consuming high levels of resources and cost. How do we help to manage that as part of the fiscal challenge, how do we help reduce out of home placement cost, we are not anti-residentials by any means. We think that's important piece of the continuum. But it's not the piece that we are focusing on. And what we found is that by implementing some of our services, we are actually saving money in other systems. So having a mental health provider do a good incentive time home based program. You are in essence keeping kids of the out of the justice system, keeping kids out of the child welfare at least reducing the impact of the involvement.

So again we also did, several ago, not several years ago, couple of year sago, we got a grant from ODMH to look at a number of intensive home-based treatment program. So this was mostly non-MST programs. These were kind of more home grown and intensive home-based treatment programs that met a certain standard. And we looked at the kinds

of outcomes that they were getting and we provided them with the support and training and consultation through the implementation of their programs.

So again, you see results very similar to that results we gotten actually from MST, which is an interesting scenario for us to be thinking about internally. So these are programs where we saw 86% of the kids were maintained at home, we saw kids getting better grades. We saw decrease in discipline, we saw a big drop in rearrest and probation and youth detained substance abusive and the mental health outcomes that we measured were youth functioning, youth mental health significantly improved and the subscales that we used on the Ohio scale all showed improvement.

This I'm not going to ask to you obviously digest in this setting but given that these are going to be available to you online as we felt it was important to also begin to share with our stakeholders particularly at the state level. Some of the cost-benefit analysis, and I would say to you that probably the cost-benefit analysis is way too formal of the term that what we do. This was our effort to kind of take information that we had fairly ready access to and to demonstrate the effectiveness of in-home treatment.

So, when you have a chance to look at this, I think you will see what we feel pretty strongly about is that for a very reasonable course of treatment which in our case in Ohio seems to hover around $5,000 to $10,000 results in a pretty substantial savings. What we haven't figured out is physically how to get those dollars back into the system in a real world where that actually supports sustainability. That is the huge big missing element in this whole story.

So again here is kind of a comparison of the costs that we see I don't know what it is in your state, but juvenile justice in Ohio has now peaked over $108,000 for a year of incarceration and what we are finding is that some of the kids that are indeed being incarcerated or indeed eligible for intensive home based treatment. We have a really good movement going in Ohio with our justice system around trying to devote kids from institutional care.

So the implementation reality, so you know, so as Phyllis said, it's not an event, but it's an ongoing process. And we have found that if our role was to simply go in at 1 and help people get started and going left not sure what the results would be. But we are also dealing with how long do we stay involved? Now with some EBPs, you stayed involved forever, with some you don't. And I think that's an interesting study in and of itself regarding sustainability.

What we do know, is that it typically takes our agencies about 2 to 4 years to really kind of rock and roll with the intervention and actually when I show this to people who are interested in doing the service they kind of blanch in that. Because in our grant making world, you get the grant in September your program is supposed to be up and running by January and you are first set of outcomes by June. And that simply is not the way it's going to go. So we want to be really clear with people that even if you sign on the dotted line and promise that here is what the reality is probably going to be.

So why the challenges if there are such good outcomes and such good cost effectiveness. And I think there is at least three, I'm sure there was 100, but those three that we think about a lot infrastructure, financing and stakeholder commitment.

So for infrastructure a reliable partner in implementation efforts that would be us -- ability to address the problematic organizational needs. The ability to turnaround outcome data almost immediately nobody wants to wait for their results then you need to be ready to get them their results and so you need a system that gets the data and the outcomes back to people. You need that pipeline from the developer and the research that puts it all in a context for folks and helps educate your providers around what it is that they are seeing and reading and maybe even more than providers, the stakeholders and funders.

The ability or at this point the inability for us to kind of take things to scale, I would argue that even 10 years into this movement that the implementation of evidence based practices is still the exception to the rule and that's one of the challenges that we have to deal with. And the support and understanding local dynamics I think that's one of the roles of the CCOE, is really understanding how this is going to play out in this particular community and in this particular agency.

From a financing point of view, our real world experience is that it is complicated and unincentivizing and the reason we have – I have that picture there is that when the pool of water dries up, you either going to have folks share the water, or you are going to have folks battle over the water that's left. Not always sure on any given day where we are with that. But what we do know is that the water is shrinking and that we have yet to figure out a way to really take advantage "of that situation" by maximizing our relationships.

Funding and financing our drivers to reductions in treatment services there is no question about it. And our federal and state funding practices are far behind the clinical implementation knowledge, they are just eons beyond what we know works and what you need to have in place that gap – I don't know that its growing but its there. And actually I think it's probably shrinking a bit, but it's still there.

Another challenge area, do you have the stakeholder engagement or we sharing a vision or are we looking at the same 3D picture with our magic glasses, isn't competition or collaboration. We have found that you really need to articulate to all of your stakeholders the value of anyone program. And I think the power of implementing a particular practice comes that folks can see outcomes that are relevant to them regardless of whether the child welfare, juvenile justice or mental health.

So shared outcomes and benefits and value access and timeliness of the outcomes in the data. So as we kind of move on from Phyllis work, as we continue on, some of the evolution of our strategy is to going from this organic let's home it works to a much more

strategic way of thinking from naïve, to inform, so to going from the gut to more data but also informing that with our own enthusiasm.

Forgetting kind of the ideal orientation of practice and really talking to implementers about what it will really take. I have people who tell me what I do the introduction with communities that are interested in implementing, why do I make it sound so difficult to do. And I tell them because it is. And I want you to know that now. I don't want you to know that six months from now once you are in your knees and wonder who knew it would be this complicated.

We need to maximize the stakeholders not rely on a single funding source or a single system to step forward. We need to have a intersystem focus and then we really do need to highlight the continuing challenges. Sometimes people get what I call kind of the allure of the list or the promise of the practice. And I think that's great. It's good to have a positive outcome and thoughts about what you are going to get. But you really have to keep focusing on the challenge its going to take.

So our next-generation strategies is I think we need to use data in a heavier way. I don't mean more complicated but in a heavier way, a bigger part of the toolkit. I think we need to track local outcomes on a longer term basis. I think people want to know longer than 6 months, 12 months what's going on with these kids. We need more policy makers and decision makers engaged in this whole discussion and I think this alliance that's emerging between behavioral health child welfare and juvenile justice can only do us good.

So where I think we got it right so far is partly the vehicle the content, the process, the data, the relevance, the value, the quality I think we've gotten or maybe we are not excellent on all of this. But I think we are at least good to excellent on all of this. Where I think we are still challenging is in the world of post collaboration, I think we really need to talk about beyond collaboration. I think we need to talk about critical alliances, effective financing, messages on costs in a very different way than we have. Alignment of policy and practices and integration with healthcare still a real challenge again.

So that's where you can get a hold of me, if you have more questions and again once you have the chance to look at this.

Guest: I was wondering if you can have a little bit about the cost piece, and I know one of the challenges a lot of states or at least where we are, they are pretty called out for that evidence based, I have taken evidence based practices over there actually supporting the infrastructure for Managed Care and supporting the service delivery, but not *[indiscernible] [01:16:34]*, I guess, how you address that in Ohio, it sounds like you always spelled…

Bill: We are strolling with it but I think the advantage of ten years of experience, I think gives us some creditability to say if you do not have these in place be for warned, this is

likely what will happen. And not that it feels good to be able to say that. But it feels right to be able to say that. And we can provide folks with evidence.

And I think it does give people pause to say what's it really going to take for us to do this well. A lot of programs MST specifically do site assessment exercises that really require that the stakeholders be involved. So if it's, we try to actually discourage an individual provider from being the champion of the program because then it's seen as their program. So its ex-mental health agency that's fighting for their program as opposed to a co-funded program. And our co-funders are typically mental health, child welfare and juvenile justice.

If we can get their resources together, the infrastructure and the platform for funding is much more solid. If it's a provider who's got 8 grant for three years, I would be very, very cautious about some of these programs, not all of them, but I think some of the ones that require great deal of fidelity and a great deal of monitoring. You just really need to be honest with people. You got to have that in place.

I know that's not a great answer, but I mean we just keeping putting that message up.

Guest: Do you have any examples of states who have that, I mean, then provide, for example?

Host: Yeah, we try to counter-balance, what I call, the promise, the over-promise of the intervention, that's what people get excited about. Oh, my god, we do MST, we're going to have 90% of our kids take on.

Okay, but let me tell you what that's going to cost you? Not necessarily in dollars, but there is that, but this is what it's going to cost you in a community to make that reality in a day and easy and we say that from day one because it's not smart otherwise, I don't think.

Guest: I'm interested in the similarities that you talked about in MST and the other home based approaches…

Bill: Yeah.

Guest: And wondered how much you've drilled down into that do you know cost wise?

Bill: Cost wise, I'm sorry, go ahead.

Guest: Cost wise and then what characteristics they share in common that might have yielded the results?

Bill: Yeah. We haven't drilled down as far as we should. But we are going to, and, actually we are in more informal ways, what I would say is this. The similarities that they share were excellent coaching and training ongoing through implementation. So,

whether it was on MST specific interventions or whether it was on intensive home-based treatment interventions, that was consistent.

Consistent also was a commitment of the agency to do home-based work. To say we embrace the idea of working with families and kids in their homes versus some other type of setting, the cost, interestingly pretty similar. So, let me put it this way, not enough for you to say, "Oh, that's MST, that's home based." It was not like many, many thousands of dollars between differences, but I will tell you that the consulting fee that we charge for MST is often an issue because it's the kind of money that you have to have on hand. It's not something you can build into a bill or a reimbursement.

And quite honestly, there are some agencies that we're working with what we might consider a modest amount of money is not. It's not a modest amount of money. And so, we found great similarities and we're going to spend time kind of dissecting that because I think there are implications for our providers.

Guest: I have a question *[indiscernible] [01:20:31]* how are they funded and how are they initially started *[indiscernible] [01:20:47]* supply, or initially that is how it first was initiated, and now because there is expertise obviously like SIF, for instance, I mean they pretty much have been marketed in Ohio on these specific evidence based practices. And so we fund them through the federal block grant, the mental health block grant every year.

And so, there is a set aside for the CCOEs. And now every year, it has actually been cut, and some years more than others, this last year, we cut it 10%. But we were expecting a much larger cut because we're actually transferring a lot of the block grant funds to actually direct practice at this point because providers lost so much money, I mean, the mental health department itself the GRF funds has been cut within, let's say, about 16 to 18 months, we lost about $135 million from the GRF in a very short amount of time and that was all passed down to providers who are providing correct services. And that doesn't even include the local webby dollars that are generated from mental health services through property taxes. That also will reduce significantly through foreclosures and all of that. So to offset some of that we had to put block grant money towards direct services because Ohio was actually I mean, mental health funding is never halfway, never really is.

It was better than a lot of states. But we've now start to see the funding has actually not adequate so we had to actually put the block grant funding first direct services but we still have these CCOEs because we have a commitment to expanding evidence based practices.

Host: And the concurrent message however from the new administration is no one has said we will not continue from something as Greg said clearly the writing is on the health in terms of where the shift in block grant is probably going to go. And so there is encouragement for us at CCOEs to be looking for others forms of reckoning.

Host: Other CCOEs have actually started looking outside of the states so some contract with Michigan or Indiana to do their practices in other states as well.

Host: I'm sorry.

Host: Go ahead.

Bill: The funding from the Department of Mental Health for us is about hovers between a fourth and a third of our overall funding as a center. So, we've engaged in other activities that help sustain what we do.

Guest: Initially, what's the ballpark *[indiscernible] [01:23:37]*

Host: Our first year funding was $260,000.

Guest: And its now?

Bill: And its now, I mean, it hasn't gone up hugely, it 325 I want to say.

Guest: But that was 10 years ago. So inflation and price, it's not much. Its really is not and the block grant funds have actually gone down every year for the state, we had never gotten an increase in medical block grant funds. It's always going down. So you don't even get an increase for inflation.

Bill: All right.

Guest: *[Indiscernible] [01:24:11] [Laughter]*

Host: Personally yes, thank you.

Guest: We're always struggling with this idea, I understand that the implementation timelines are a huge issue, and there is reasons for why we are looking somewhat finalize in grants, now it's going to split, but if I'm trying to *[indiscernible] [01:24:40]*, what do you think are the key pieces that I need to be funded. So consultants are of course very important.

Host: Yes.

Guest: And in training *[indiscernible] [01:24:55]* funds stacked directly through our grants, but there is *[indiscernible] [01:24:58]* funding goes away. And is that *[indiscernible] [01:25:04]* how much shall we be paying the system level work because we want to have this cross agency coordination, we're going to go around programs – from your perspective, what should *[indiscernible] [01:25:08]*

Host: I would say from a practice point of view one of the hardest things for agencies at the local level to absorb is the training. Because it's a trade-off in productivity unfortunately that's the world we live in.

And the advantage of a grant means that you can do things in a more fluid way the disadvantage of a grant is that it typically goes away in three years. I don't know overall about the track record is for sustainability in terms of folks being able to do exactly what they did and continue on. But we do know that training, retraining, coaching the ongoing consultation fee and the cost for that. Is critical to some of these practices in terms of their sustainability? That is a very hard cost for providers to recoup. They can we have a mismatch of mechanism to actually do billing, I mean, its still a nightmare and it still doesn't match up of what we ought to be doing. But people have figured out kind of the Medicaid how to do this. But, that piece that kind of quality assurance piece and I would say the pieces around the collecting data and having the resources to collect data and to chunk them and to take them back to people I think is important as well.

Guest: This is just sort of a kind of tangential comment too, is that I think when you were asking the question about readiness and so forth, what I kind of seen in the variety of demonstration projects sites and so forth, is those, sites and even a federally funded study, the implementation of certain of the mental health, I mean, practices. The agencies that are more ready and more resourced are the ones that are getting involved. And so that's starting point where the fun will begin with the agencies that are positioned potentially to take action and get up and running quickly. You kind of seeing the cream of the crock. And I really there needs to be some thought invested and trying to figure out ways that agencies that are at the other end of the spectrum can get involved. I'm currently reading this book, this Tracy Kidder book on the Life of Paul Farmer who is an MD, who did a bunch of work TB and TD in Lima. And there was a comment in there that that *[indiscernible] [01:27:30]* was quoting Farmer saying, you know, we need to find the most effective simplest technologies to get this done.

So when Patrick is going and saying, I know Russ will ask out has spoken about this, is trying to figure out what those core active ingredients are what's the simplest technology to try and figure out ways to identify those simplest technologies and make them doable for those agencies that are not the shinning stars, well resourced and positioned to succeed. So I mean, that's just my take, and I think we're just missing the boat in that regard.

Host: The other – this isn't so much what the grant could fund, but maybe how it can leverage. And that is, I don't know this probably come out wrong, but the power of the status quo of treatment as usual even for things that we know don't have a lot of good evidence behind them. It's pretty powerful.

And I think any lever that moves that rock and incentivizes but not for the short-term so that's the trick. But incentivizes people who maybe hovering on that risk scale of okay, I'm interested but not the early adopters not the folks that are ready to rock and roll, they will take every chance and they will make it work. But the folks that maybe in between

but are highly capable of implementing in an effective way. Moving that dial on that to be – it would be very effective use of resources.

Host: Another thing about SAMHSA, we have a number of SAMHSA Grant of course in a couple of them have two components one is an infrastructure component and one is a program component and they don't necessarily give a lot of funds to the development of the infrastructure components maybe 10%, 15% and they don't really actually focus too much on the data part of the infrastructure.

So, I would like to see SAMHSA actually develop that model like we have the TSAC *[phonetic] [1:29:46]* grant for instance that was all about infrastructure. But the data piece of that was kind of weak and using that information for the state was very difficult so having technical assistance on how to actually build infrastructure so it can be sustained at the state level as well as at local level, I think it's very important.

Host: I think there is just considerable underestimation of what it takes to do what on paper looks like, home based team, bit of reprimand. Those of you who are supervisors, managers, directors, know and I think there is a big disconnect in the world of funding that year almost that year of implementation activity, is that readiness that kind of getting your stakeholders and getting your organization ready. That sometimes that huge change was internally that might need to take place to actually house a service in a way that will support it over the long haul.

Guest: *[Indiscernible] [01:30:47]* the question I have for you guys, are working you at all big claim Ohio *[indiscernible] [01:31:35]* that's a great model?

Host: Yes, and actually what the state was – they created even an additional category called this is the Department of Youth Services, Justice a category called targeted reclaim where they focused on the six counties that were actually sending the majority of youth to institutions, and in three years, the daily population in Ohio institutions has gone from 1500 to I think it's now below 800. So, they've very effectively shifted the focus to serving kids in the non-institutional side. And we are pushing on that continually.

Host: One other comment I wanted to make to your question about SAMHSA, are you familiar with the Clinical Trials Network that NIDA funds, it's sort of a network of organization – and I can't give you the details, but I just want to mention it because it's kind of a network of organizations that had been agreed to serve as sort of sites for trying out new practices and so forth and so on. And I know one of the issues there is the sites – those tend to be the cream of the crop sites from my take. But you know – there's funding in there for a researcher to be onsite doing data gathering and so forth.

And I know that's been an issue when the project has – that research part of that has stepped away because the outcomes, etcetera, data gathering were dependent on that position being funded. And so, when these two guys are talking about other ways, to find other ways to build in data gathering that minimize the burden. I think that's a really important thing too, because of that the cost involved and then leaving organizations kind

of without support – getting accustomed to a support piece that then moves away. So, I just wanted *[indiscernible] [01:33:28]*.

Host: Thank you very much.

Guest: Thank you.

Guest: Thank you.

Host: Thank you for your patients with the technical…