Is Scaling Evidence Based Practices a Lost Cause?

Lisa Dixon, MD, MPH
Director, Center for Practice Innovations
Division of Behavioral Health Services and Policy Research
New York State Psychiatric Institute
Professor, Columbia University Medical Center

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THE LATEST RESEARCH SHOWS THAT WE REALLY SHOULD DO SOMETHING WITH ALL THIS RESEARCH


"I UTILIZE THE BEST FROM FREUD, THE BEST FROM JUNG AND THE BEST FROM MY UNCLE MARTY, A VERY SMART FELLOW."

Objectives

- To identify *barriers* to scaling evidence based practices in a large system of care.
- To identify *strategies* to scale evidence based practices in a large system of care.
- To identify implementation science frameworks that *facilitate* this process

Agenda

- CPI Background
- CPI Context: What is the Service Setting?
- Conceptual Framework
- CPI Tools and LMS
- Initiatives

What is the Center for Practice Innovations?

- CPI supports the NYS OMH mission to promote the widespread availability of *evidence-based practices* to *improve mental health services*, ensure *accountability*, and *promote recovery-oriented outcomes* for recipients and families.
- CPI serves as a key resource to OMH by spreading those practices identified by OMH as most *critical to accomplish OMH's system-transformation initiatives*.
- CPI operates across the state and must think "scalable"

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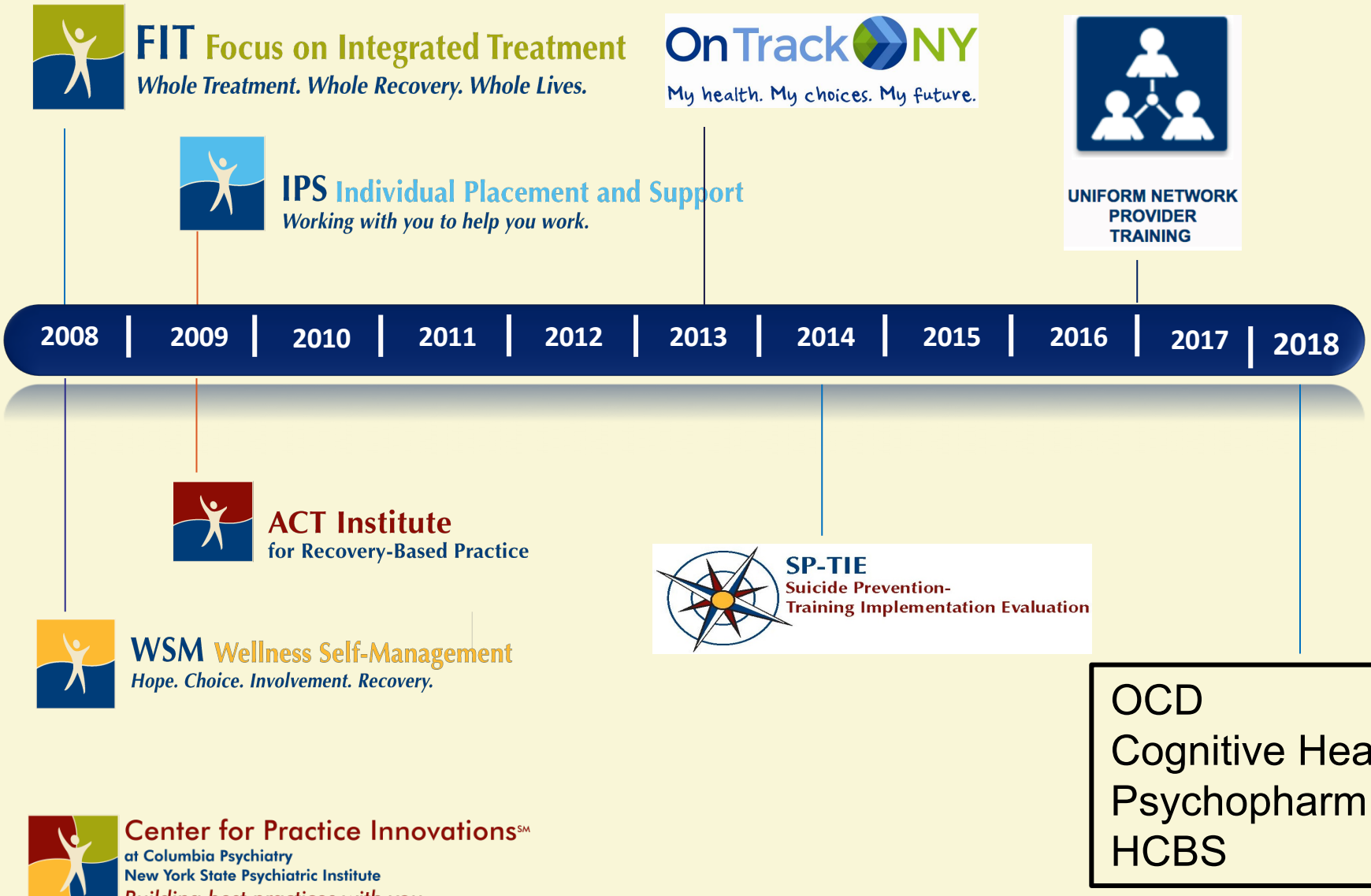
Timeline: CPI's Initiatives



CPI Leadership

Paul Margolies, PhD., Associate Director

Individual Placement and Support (IPS)
Wellness Self Management (WSM)
Module Development

Lisa Dixon, MD MPH, CPI Director

OnTrackNY

Anne Skrobala, MA
Division Administrator

Nancy Covell, PhD
Associate Director

Focus on Integrated Treatment (FIT)
Help Desk
Data Management

Helle Thorning, PhD

Assertive Community Treatment (ACT) Institute

David Lowenthal, MD, JD
CPI Medical Director

Prescriber Workforce Continuing Education

Sapana Patel, PhD
Director of Strategic Planning and Curriculum Development

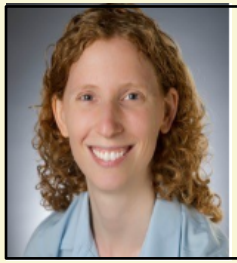
Network Provider/HCBS Training
OCD Workforce Development

Barbara Stanley, PhD

Suicide Prevention-Training Implementation Evaluation (SP-TIE)

Alice Medalia, PhD

Cognitive Health



Ilana Nossel, MD
OnTrackNY
Medical Director

OnTrackNY

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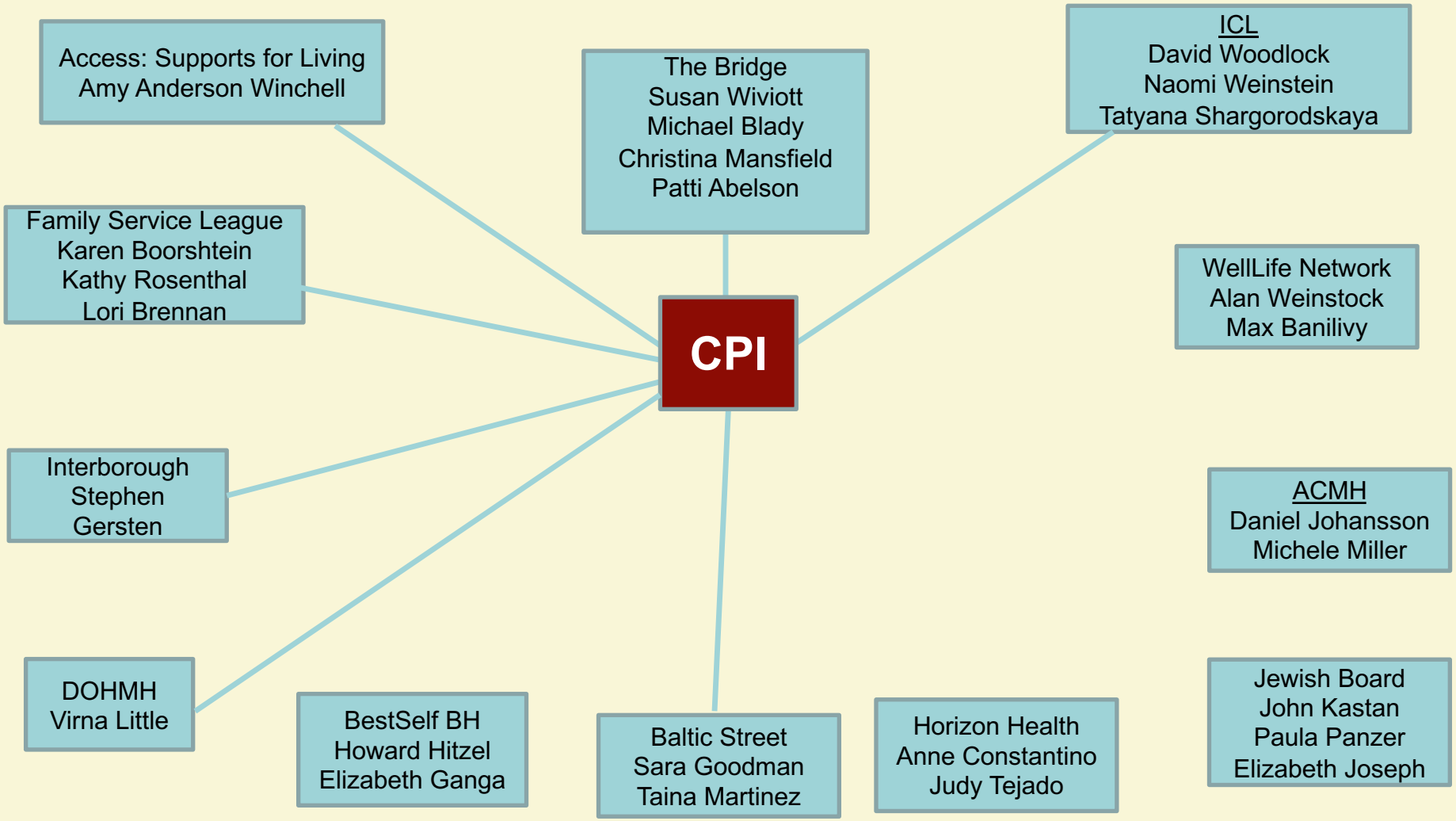
Provider Advisory Committee Members



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Does This Matter? In NYS

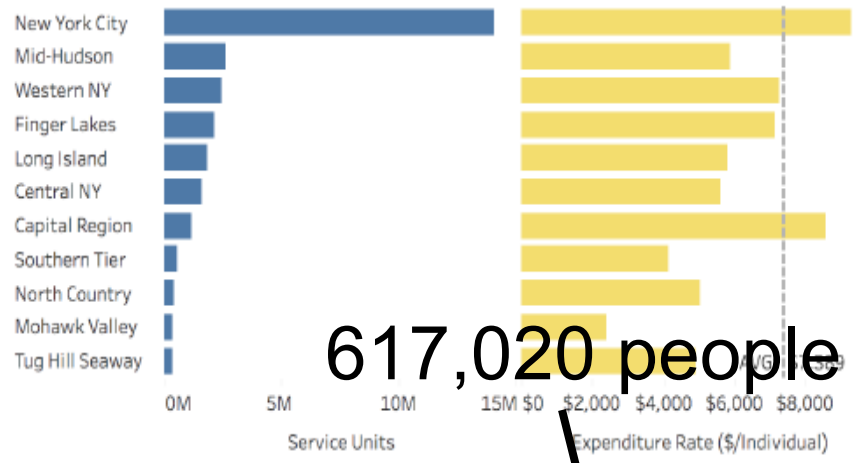
- 38,000 full-time equivalents employed by not-for-profit providers of mental health services
- 6860 ACT slots
- 7773 PROS slots
- 2792 Day treatment slots
- 5127 Inpt Psych Beds in General Hospital
- 42,000 housing beds including licensed and unlicensed

Report 1. Medicaid Service Utilization Comparisons among Regions/Counties for Mental Health Population

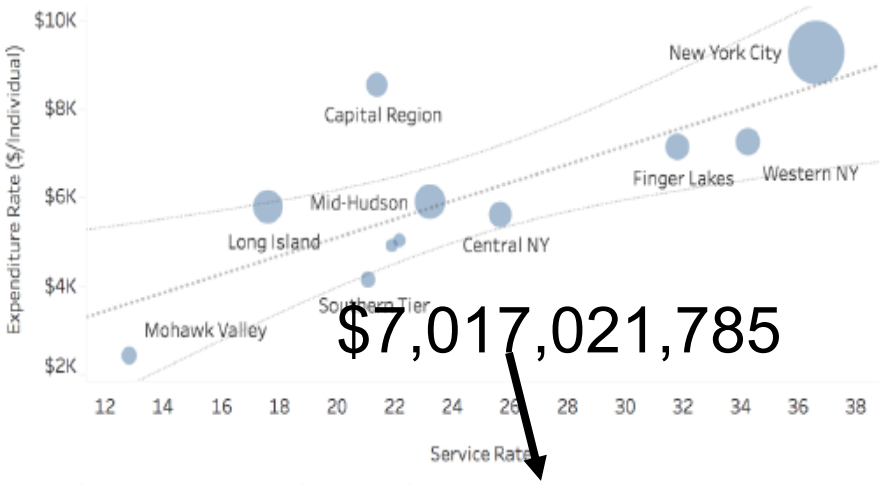
Year	Geo Perspective	Region Type	Statewide/Region	Age Group	Program
2017	Provider	RPC	Statewide	All	All Medicaid Services

Year: 2017 || Geo-Pespective: Provider || Region Type: RPC || Statewide/Region: Statewide || Age Group: All ||
Program: All Medicaid Services

Service Units vs. Expenditure Rate



Service Rate vs. Expenditure Rate



617,020 people

$7,017,021,785

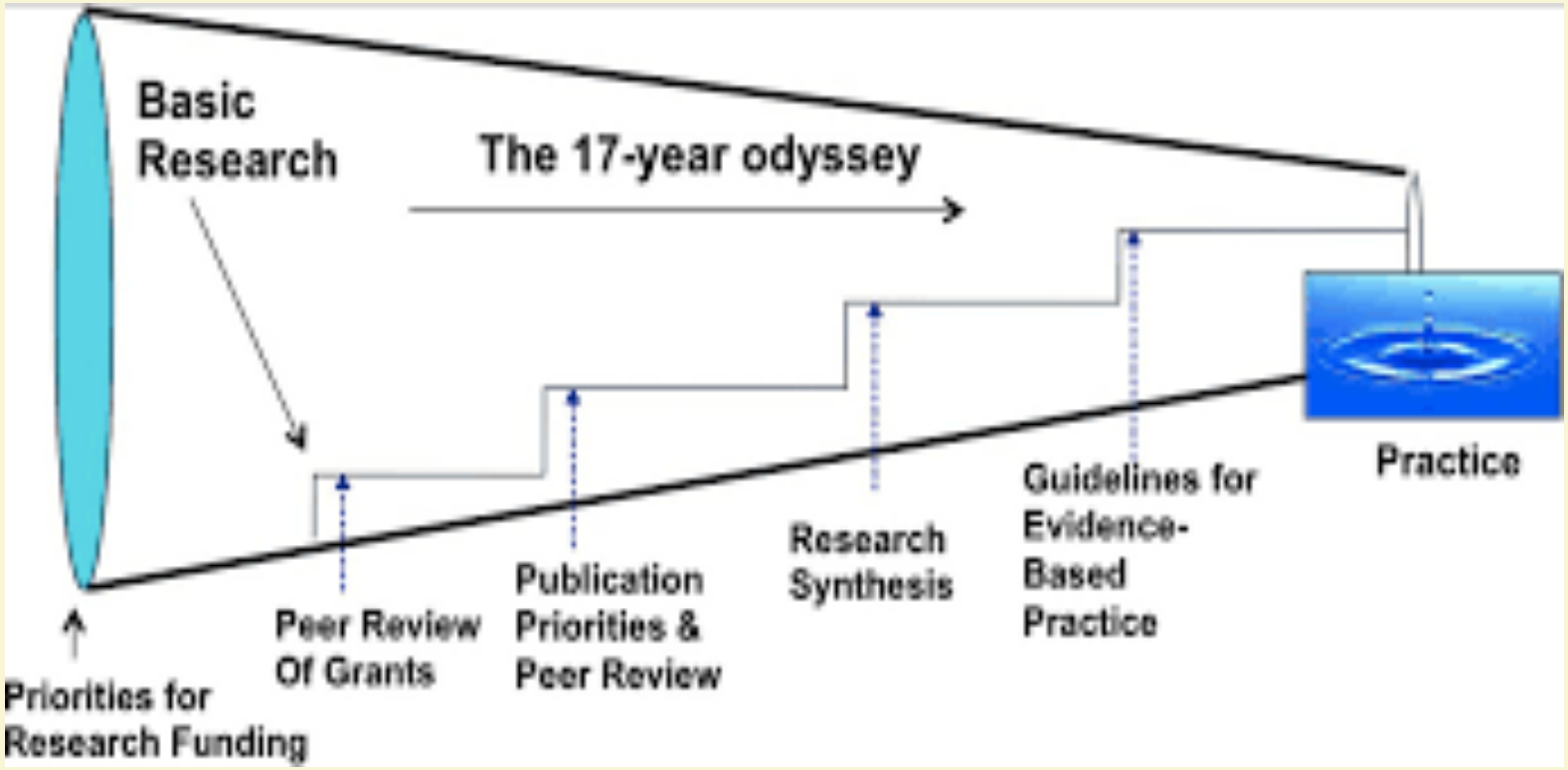
The average Expenditure Rate is calculated as sum of Medicaid Paid ($) per sum of individuals served across levels.

The size of dot is based on number of Individuals Served.
Lines are generated using Simple Linear Regression Model with 95% confidence interval.

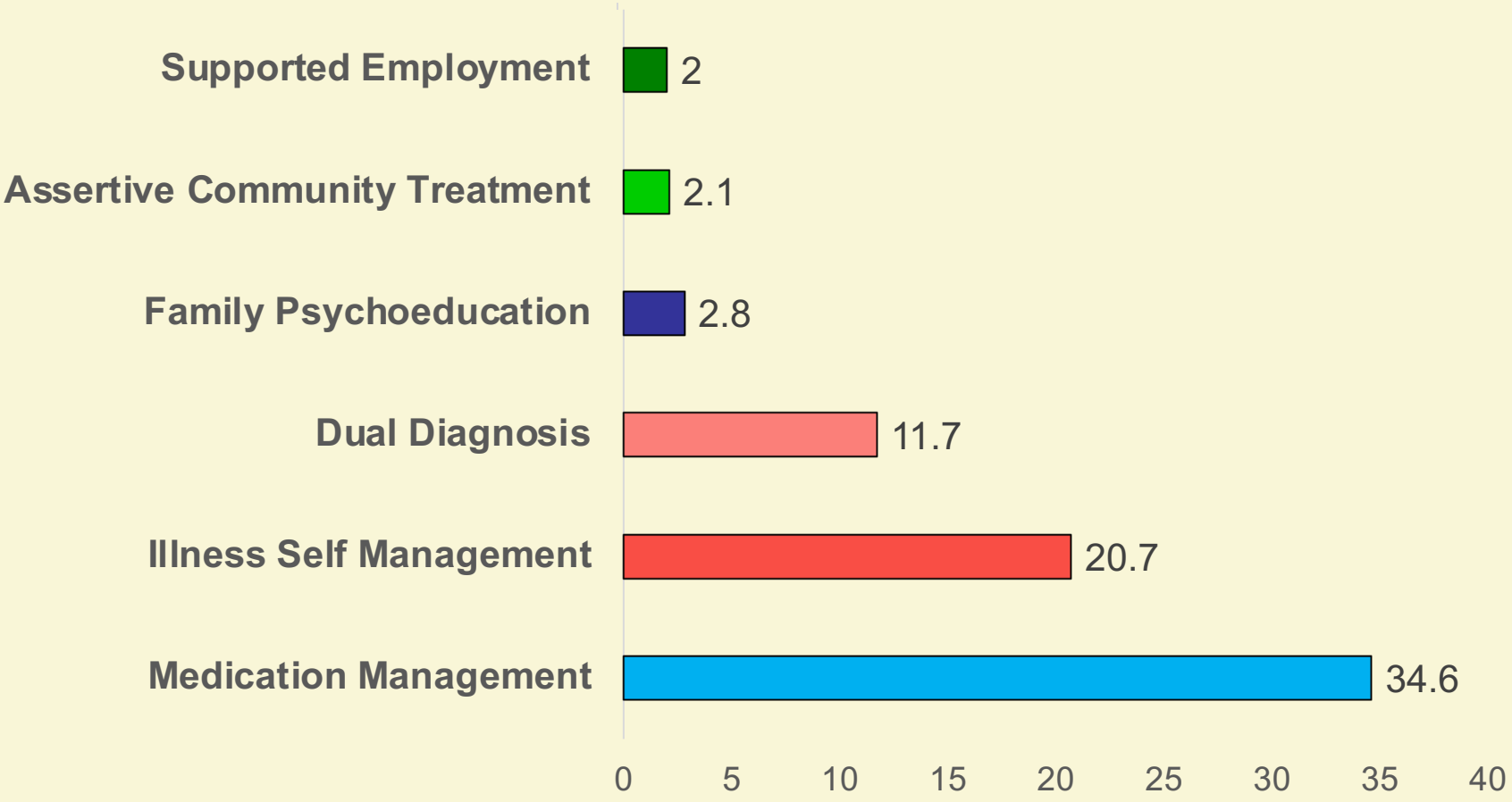
Region/County	Medicaid Enrollees	Individuals Served	Population Rate (Per 10,000)	Service Units	Service Rate (Units/Individual)	Medicaid Paid ($)	Expenditure Rate ($/Individual)
Statewide	6,115,591	617,020	1,009	27,589,063	45	$7,017,021,785	++
New York City	3,517,676	383,665	1,091	14,035,654	37	$3,558,651,626	$9,275
Mid-Hudson	546,884	114,310	2,090	2,651,693	23	$674,149,422	$5,898
Western NY	398,322	71,288	1,790	2,438,990	34	$517,118,483	$7,254
Finger Lakes	317,410	68,056	2,144	2,162,179	32	$485,958,267	$7,141
Long Island	557,318	106,462	1,910	1,871,782	18	$615,912,735	$5,785
Central NY	264,095	61,887	2,343	1,586,318	26	$346,957,098	$5,606
Capital Region	201,354	55,346	2,749	1,182,326	21	$472,979,832	$8,546
Southern Tier	106,729	25,625	2,401	539,366	21	$105,956,106	$4,135
Nor	73,075	18,529	2,508	405,744	22	$92,049,761	$5,022
Mo	70,065	28,985	4,137	370,337	13	$69,950,607	$2,413
Tug	62,663	15,753	2,514	344,674	22	$77,337,848	$4,909

Note:

Research to practice gap



Percentage of Adults With SMI Receiving EBPs: 2017 URS (SAMHSA)



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https://wwwdasis.samhsa.gov/dasis2/urs.htm

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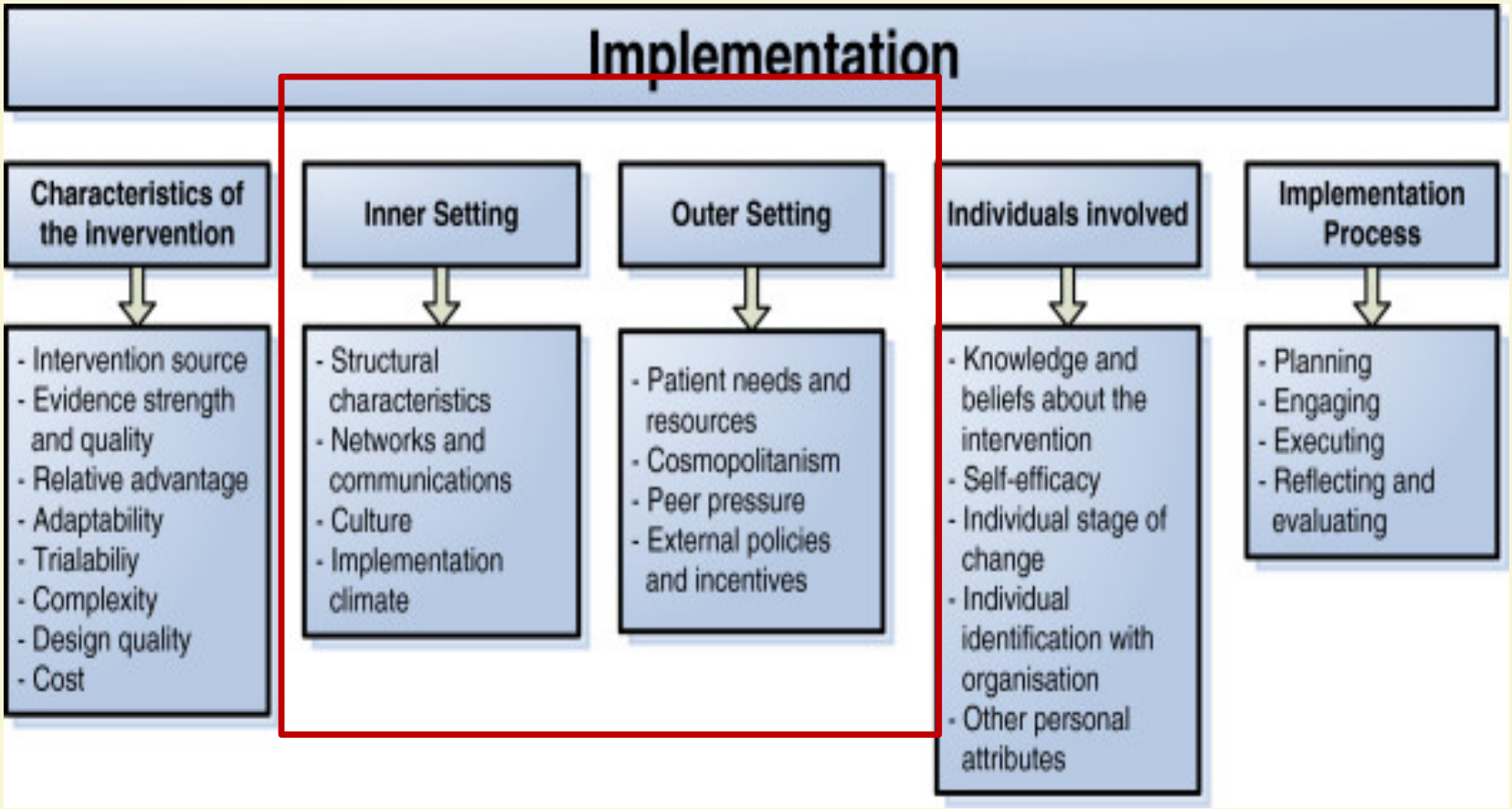
Consolidated Framework for Implementation Research (CFIR)



Offers an overarching typology to promote implementation theory

Damschroder L et al. Implementation Science 2009 4, 50,

Replicating Effective Programs Framework

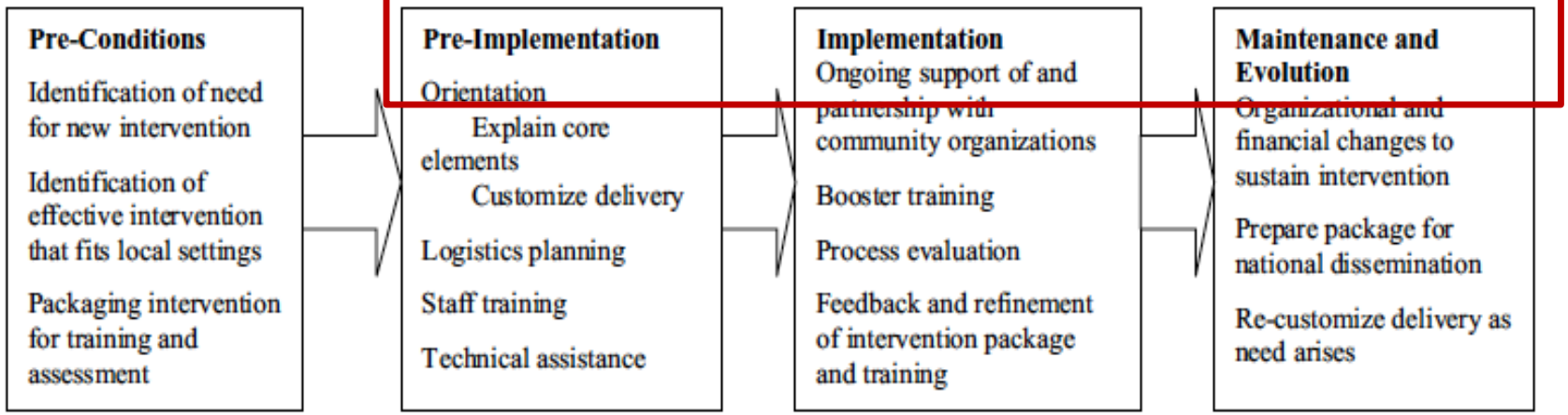
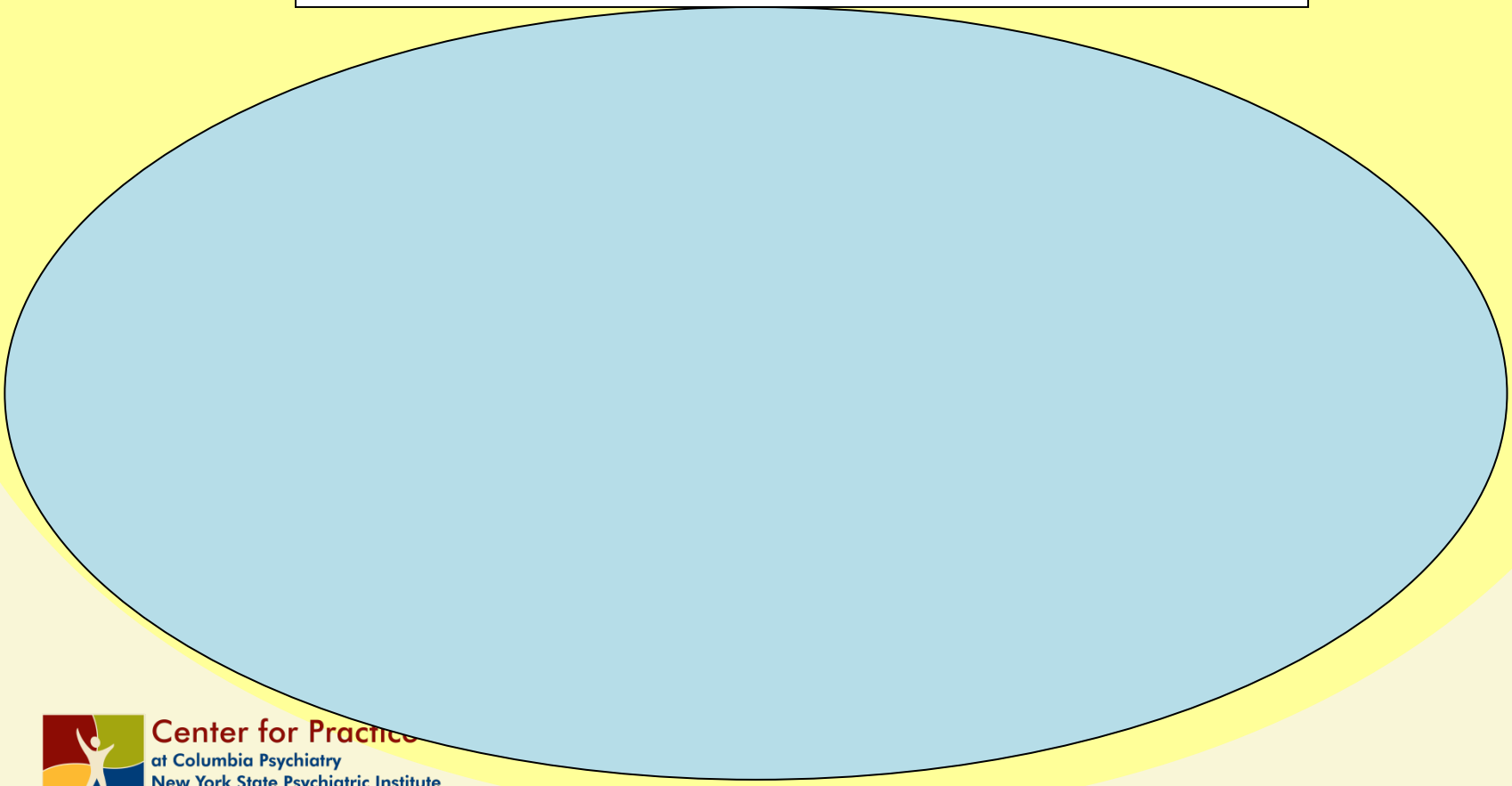


Figure 1
Replicating effective programs framework for health care interventions. This figure outlines the Replicating Effective Programs (REP) process as it can be applied to health care interventions.

Kilbourne AM[1], Neumann MS, Pincus HA, Bauer MS, Stall R. **Implementing evidence-based interventions in health care: application of the replicating effective programs framework.** Implement Sci. 2007 Dec 9;2:42.

Over-Arching Practice Change Model

Outer Setting – policies, regulations, and fiscal reimbursements to programs must align to support the change; State authorities must provide a clear message of importance to programs.



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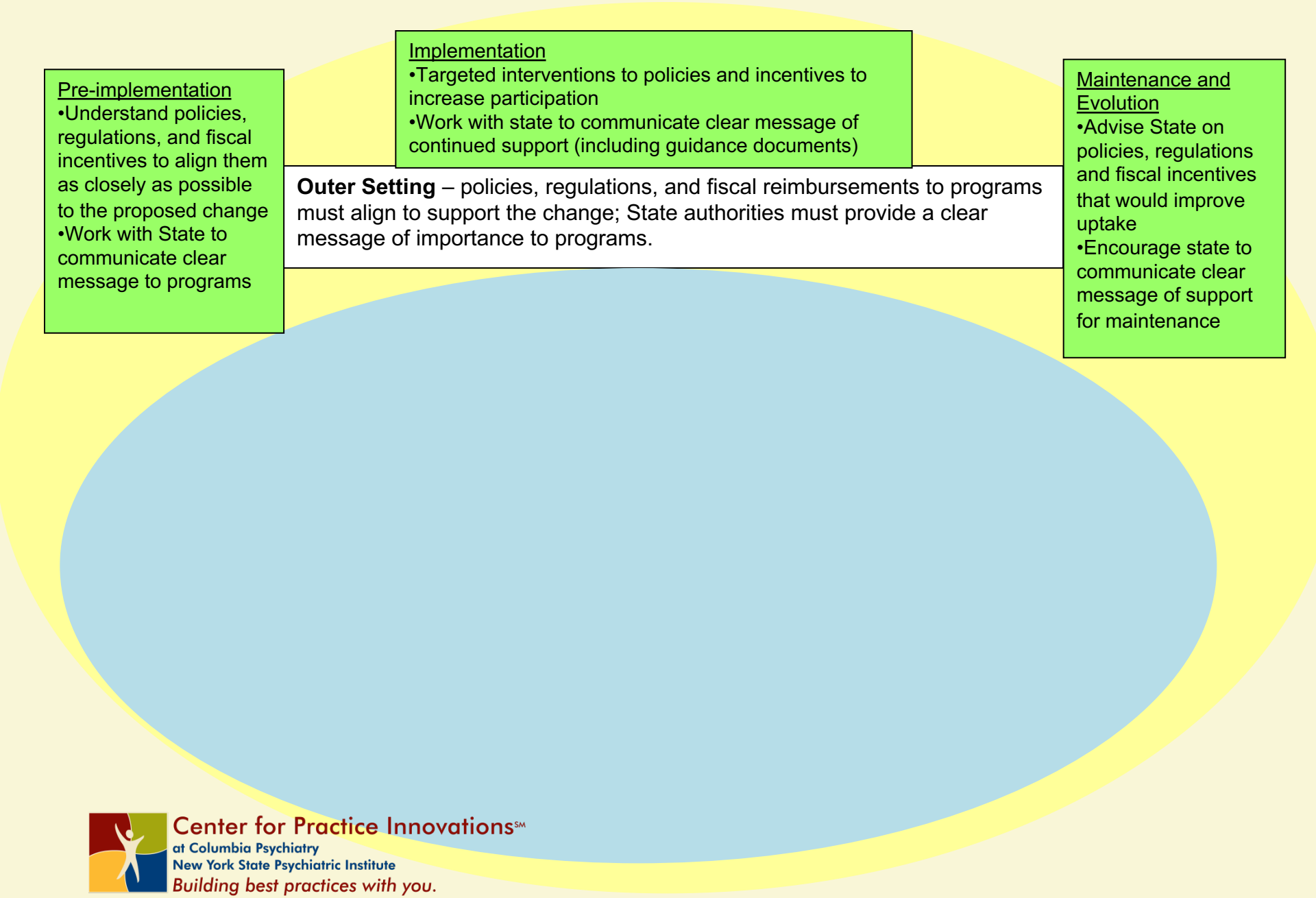
CPI Practice Change Model



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Key CPI Outer Setting Approaches

- Work with OMH
  - to develop clear expectations
  - to develop incentives
  - to embed expectations into program structure (e.g., standards of care that are reviewed during licensing visits)

CPI Practice Change Model

<u>Pre-implementation</u>
•Understand policies, regulations, and fiscal incentives to align them as closely as possible to the proposed change
•Work with State to communicate clear message to programs

<u>Implementation</u>
•Targeted interventions to policies and incentives to increase participation
•Work with state to communicate clear message of continued support (including guidance documents)

<u>Maintenance and Evolution</u>
•Advise State on policies, regulations and fiscal incentives that would improve uptake
•Encourage state to communicate clear message of support for maintenance

Outer Setting – policies, regulations, and fiscal reimbursements to programs must align to support the change; State authorities must provide a clear message of importance to programs.

Inner Setting – intervention must address felt need in programs; leadership must be on board with the changes, and the program must support a culture of change; interventions have to fit into modifiable limits of program structure, workflow, and processes; resources must be allocated to the change (especially time).

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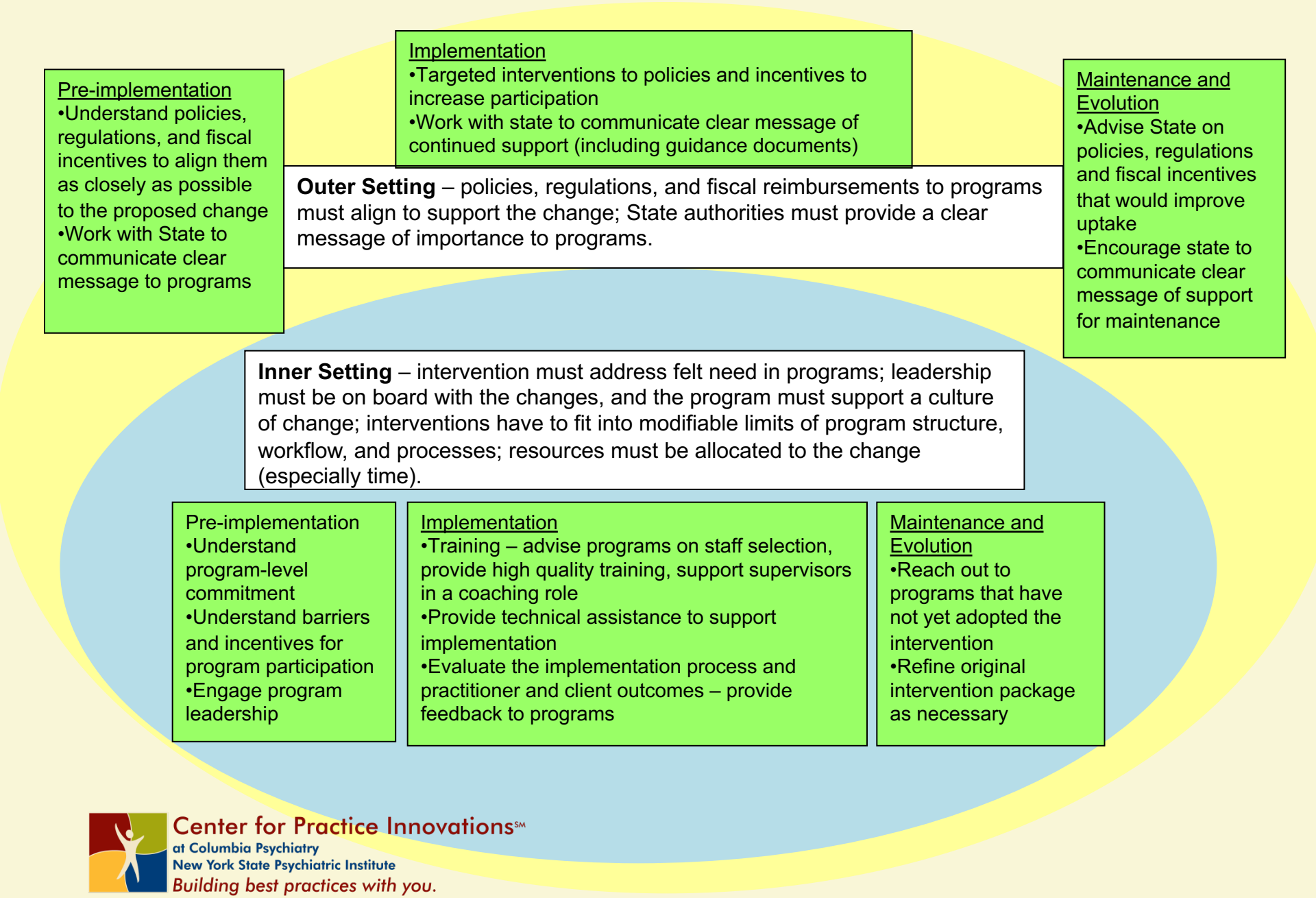
CPI Practice Change Model



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Key CPI Inner Setting Training and Implementation Supports

- Web-based Learning Management System that hosts
  - Interactive Electronic Learning Modules
  - Webinars
  - Resource Libraries
- Face-to-face training (Regional and on-site)
- Face to Face Consultations and Coaching
- Regional and State-wide evidence-based learning collaboratives (face-to-face and online)

Is On-Line Learning Effective?

- Compared to no training, internet-based strategies are superior with robust effect sizes (knowledge, behaviors, pt effects)
- Compared to another training strategy (e.g., in person training), the effect sizes vary, but internet training is at least as good, if not better, with small effect sizes.
- The key issue is that the non-internet approaches may take more staff training time and may be difficult if not impossible to scale up.

Cook DA[1], Levinson AJ, Garside S, Dupras DMErwin PJ, Montori VM. Internet-based learning in the health professions: a meta-analysis. JAMA. 2008 Sep 10;300(10):1181-96.

Are some types of internet-based training better than others?

- While evidence is not rock solid, interactivity, practice exercises, repetition, and feedback may prolong learning time, but also improve learning outcomes.
- Strategies such as automating interactivity may increase efficiency

Cook et al. Instructional design variations in internet-based learning for health professions education: a systematic review and meta-analysis. Acad Med. 2010 May;85(5):909-22.
Cook st al. Time and learning efficiency in Internet-based learning: a systematic review and meta-analysis. Adv Health Sci Educ Theory Pract. 2010 Dec;15(5):755-70.

Is Technology-Enhanced Simulation Effective?

- Simulation technologies encompass diverse products including computer-based virtual reality simulators, high fidelity and static mannequins, plastic models, live animals, inert animal products and human cadavers.
- Compared to no training, technology-enhanced simulation has large positive effects for knowledge, skills and behaviors. Moderate effects for pt related outcomes.
- No differential effects for instructional design type (curricular integration, training over multiple days, feedback, mastery learning, repetitive practice)

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Cook DA, et al. Mastery learning for health professionals using technology-enhanced simulation: a systematic review and meta-analysis Acad Med. 2013 Aug;88(8):1178-86. doi:

What about Self-Regulated Learning (SRL)?

- Few studies in the simulation literature have designed SRL training to explicitly support trainees' capacity to self-regulate their learning.
- Compared with instructor-supervised interventions, unsupervised interventions were associated with poorer outcomes. Those with SRL supports did modestly better
- Recommend shift from thinking about SRL as learning alone to thinking of SRL as comprising a *shared responsibility* between the trainee and the instructional designer (i.e. learning using designed supports that help prepare individuals for future learning).

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Brydges R, et al. Self-regulated learning in simulation-based training: a systematic review and meta-analysis. Med Educ. 2015 Apr;49(4):368-78

Learning Collaboratives

- Form of “learning laboratory”
- 35 States using LC’s through Nat’l Council in US
- Adapted from quality improvement collaborative (QIC) models used in health care, e.g., Breakthrough Series collaboratives of the Institute for Healthcare Improvement (IHI)
- Widely used globally throughout healthcare.

Nadeem E, Olin SS, Hill LC, Hoagwood KE, Horwitz SM. **A literature review of learning collaboratives in mental health care: used but untested.** Psychiatr Serv. 2014 Sep 1;65(9):1088-99.

Are LC's effective?: Structured Review in General Medicine

- Question: For multidisciplinary healthcare teams (and patients that they care for), does involvement in a quality improvement collaborative compared with usual care lead to improvements in healthcare delivery and outcomes and, if successful, is it sustained 6 months or more postintervention?

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Wells S, Tamir O, Gray J, Naidoo D, Bekhit M, Goldmann D. Are quality improvement collaboratives effective? A systematic review. BMJ Qual Saf. 2018 Mar;27(3):226-240. doi: 10.1136/bmjqs-2017-006926. Epub 2017 Oct 21. PubMed PMID: 29055899.

Study Requirements

- A specific healthcare topic;
- A group of experts (clinical and quality improvement) to bring together the scientific evidence, practical contextual contextual knowledge and quality improvement methods, usually within a ‘change package’ or toolkit;
- Multiple teams from multiple sites that elect to participate;
- A model or framework for improvement that includes measurable aims, collecting data on planning and performance, implementing and evaluating tests of change;
- A set of structured activities that promoted a collaborative process to learn and share ideas, innovations and experiences
  - face-to-face or virtual meetings;
  - visits to other sites;
  - visits by experts or facilitators;
  - web-based activities to report changes, results and comparisons with other teams;
  - coaching and feedback by improvement experts

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Wells S, et al. Are quality improvement collaboratives effective? A systematic review. BMJ Qual Saf. 2018 Mar;27(3):226-240. doi: 10.1136/bmjqs-2017-006926. Epub 2017 Oct 21.

Findings of Review of QIC's (N=64)

- Significant improvement in at least one primary effect measure in 83% of the studies ((32/39 (82%) hospital based, 17/20 (85%) ambulatory care, 3/4 nursing home and the sole ambulance QIC).
- By study design, evidence for effectiveness was found for 6/10 (60%) RCT, 20/24 (83%) CBA and 27/30 (90%) ITS studies.
- When a more conservative definition of effectiveness was applied (statistically significant differences in at least 50% primary effect measures studied), positive results were reported in 73% of the studies.
- Eight studies reported sustainability of the intervention effect 6 months to 2 years after the QIC, and four studies reported that the intervention met their definition of cost-effectiveness.

ITS – Interrupted Time Series, CBA= Controlled Before and After

Wells S, et al. Are quality improvement collaboratives effective? A systematic review. BMJ Qual Saf. 2018 Mar;27(3):226-240. doi: 10.1136/bmjqs-2017-006926. Epub 2017 Oct 21.

Elements/Components of Mental Health Learning Collaboratives

- Target, Model, Study sample
- Length, prework, in person learning sessions, PDSA cycles, multidisciplinary QI team, email or web support
- Sites collect new data, sites reviewed data and used feedback, external support for synthesis and feedback
- Leadership involvement and outreach, training on non-qi team by experts or by qi team

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Nadeem E, Olin SS, Hill LC, Hoagwood KE, Horwitz SM. **A literature review of learning collaboratives in mental health care: used but untested.** Psychiatr Serv. 2014 Sep 1;65(9):1088-99.

Findings

- Mostly pre-post designs
- Of 10 that studied providers, all found improvements in care processes or uptake of new practices
- Of 11 that reported on patient outcomes, all found some benefit e.g. symptoms and engagement
- Six of 8 studying sustainability found support

Nadeem E, Olin SS, Hill LC, Hoagwood KE, Horwitz SM. **A literature review of learning collaboratives in mental health care: used but untested.** Psychiatr Serv. 2014 Sep 1;65(9):1088-99.

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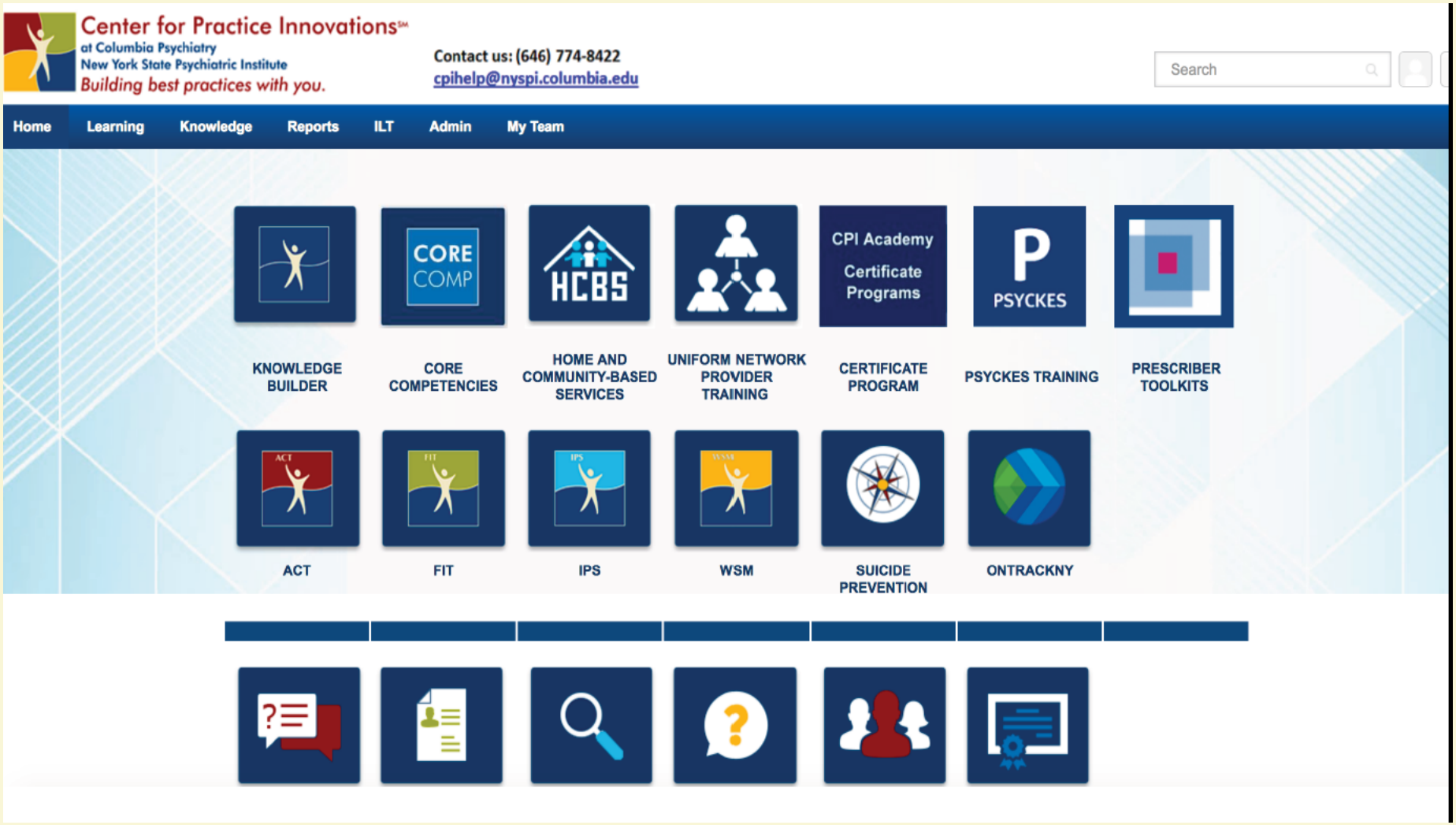
ABOUT CPI

The Center for Practice Innovations (CPI) supports the New York State Office of Mental Health's mission to promote the widespread availability of evidence-based practices to improve mental health services, ensure accountability, and promote recovery-oriented outcomes for consumers and families. The CPI serves as a key resource to OMH by spreading those practices identified by OMH as most critical to accomplish OMH's system-transformation initiatives.

Landing Page in LMS



Big Picture: LMS Modules

Modules By Topic 115			Modules By Type		
	Completed	In Process		Completed	In Process
General Knowledge	44	4	Regular full length	58	4
FIT	42		Knowledge Builders	42	
ACT	6		5 in 5	2	
SP TIE	5	3	Core Comps	1	2
IPS	3		Full length w/micro learning	5	
Core Comps	3	2	Camtasia brief	1	
WSM	2		Videos	6	
OnTrack	10		Animations		3
Total	115	9		115	9

Importance of Resources and Tools for Consumers and Families

- Inspire hope in the possibility of recovery
- Empower consumers and families with knowledge about evidence-based treatments
- Help consumers and families discuss treatment options with providers
- Provide concrete tools for consumers and families to take next steps toward recovery

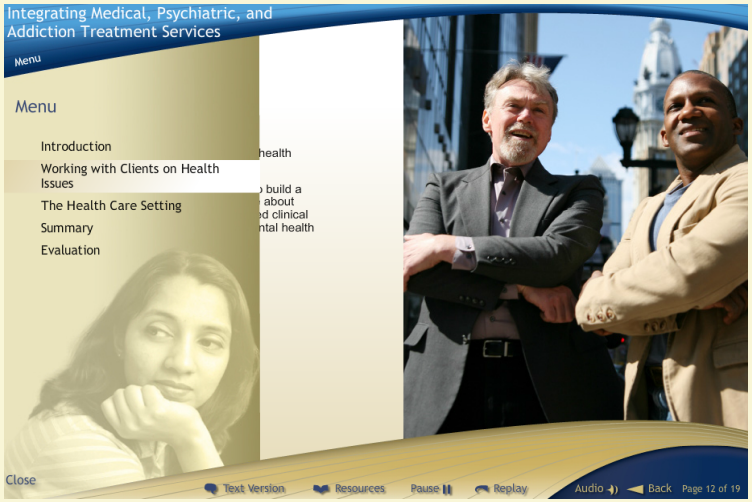
Big Picture: Modules and Videos Available to Public on Websites

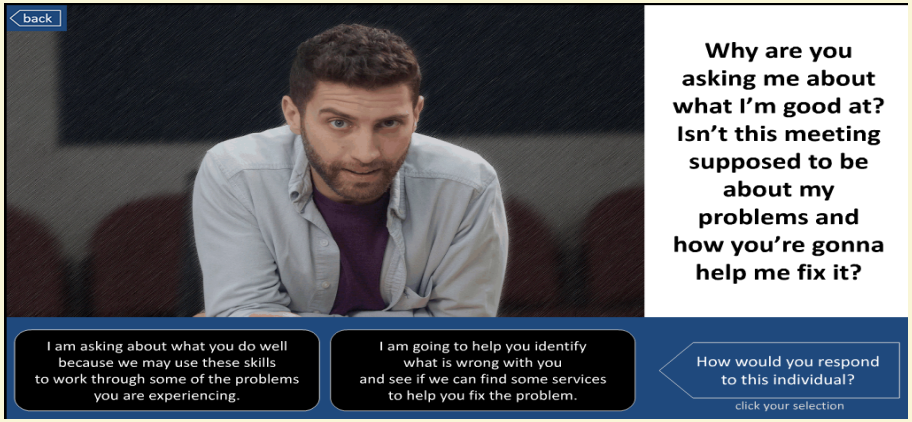
Modules By Topic			Modules By Type		
	Completed	In Process		Completed	In Process
General Knowledge	6	3	Videos	27	
Drugs/Alcohol/ Tobacco	8		Knowledge Builders	2	
School/Work	5		Animations	8	8
Working with Treatment Team	3		Action Planner	1	
Medication	3		Full length w/micro learning	1	2
Symptom Management	5		Brief How-To Video introductions to clinical tools	8	
Family/Community Support	5				
Motivational Interviewing	2				
Peer Services	2				
Systems Transformation		7			

Evolution of Modules: Key Changes

- Expanded audience
- Shorter, micro-learning, emphasis on interactivity, photojournalism, animation
- Some focused beyond initiative—general knowledge and skills, core competencies
- Packaged into curricula

Examples





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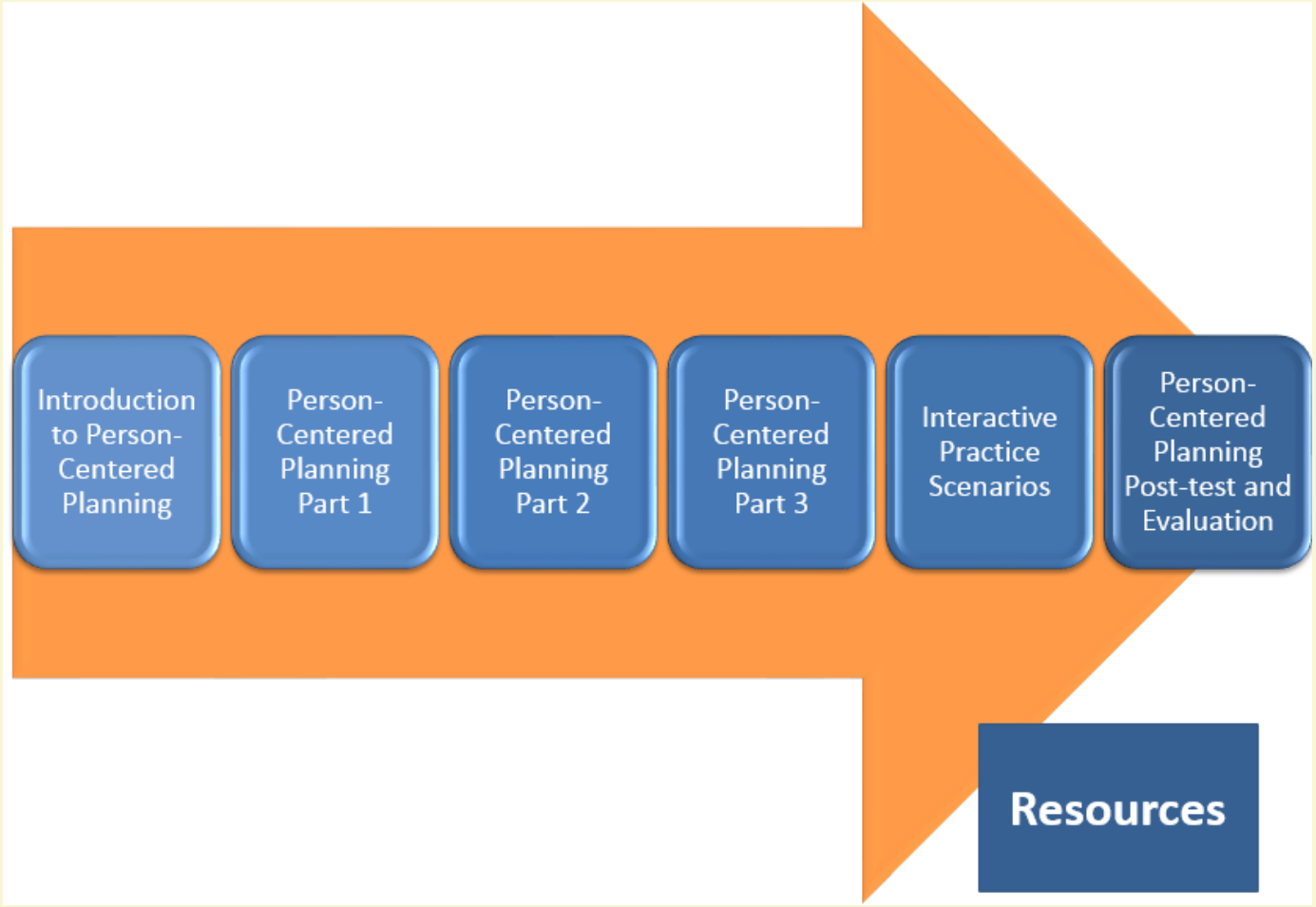
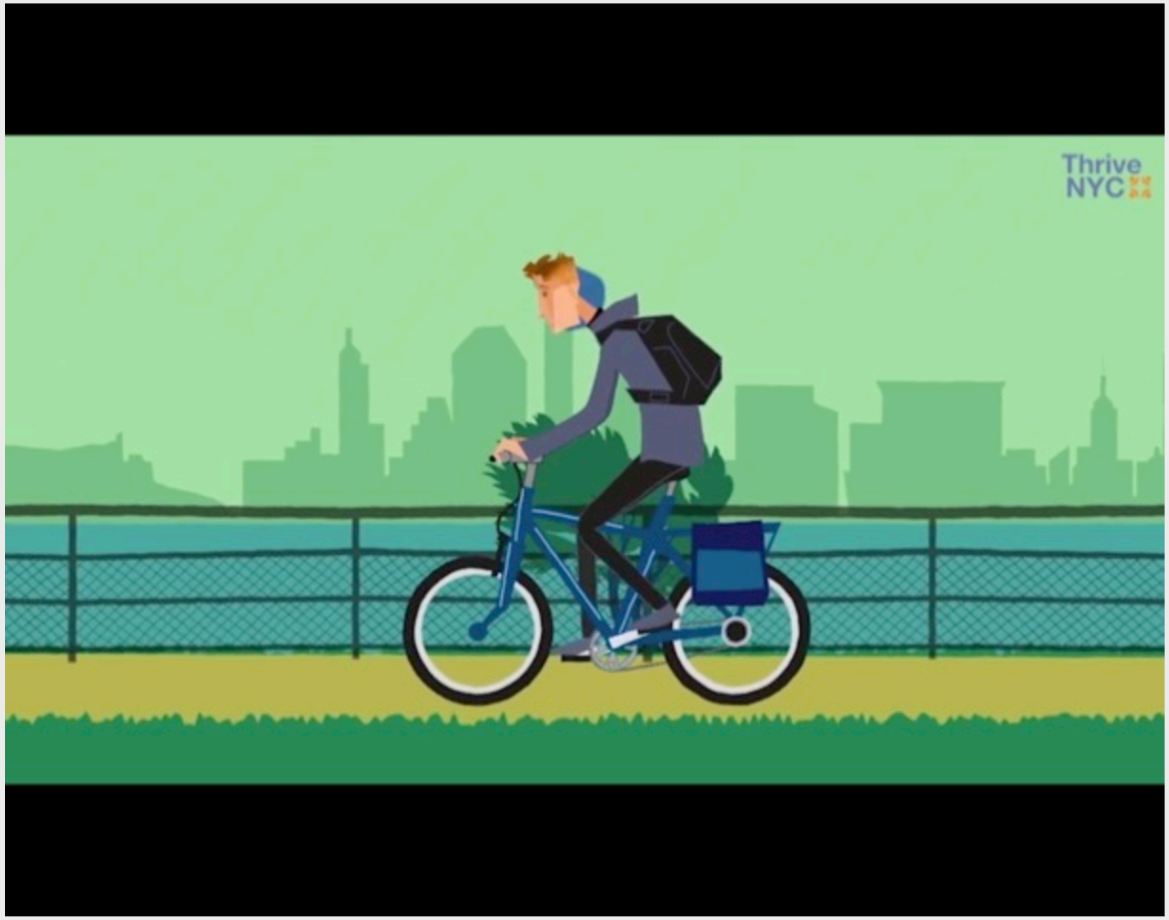
Core Comp with Micro-Learning



Davey AWARDS

WINNERS / WINNERS GALLERY



ModernEpic LLC

What is Psychosis?

Client: Center for Practice Innovations

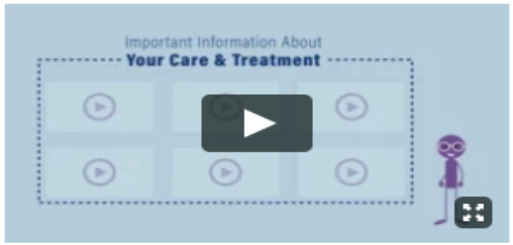
Award: Award: Gold: Online Film/Video - Online Film & Video-Education

Navigating your healthcare

Behavioral Health Managed Care

CPI Resources › Behavioral Health Managed Care

Introduction



Health Homes

Care Manager

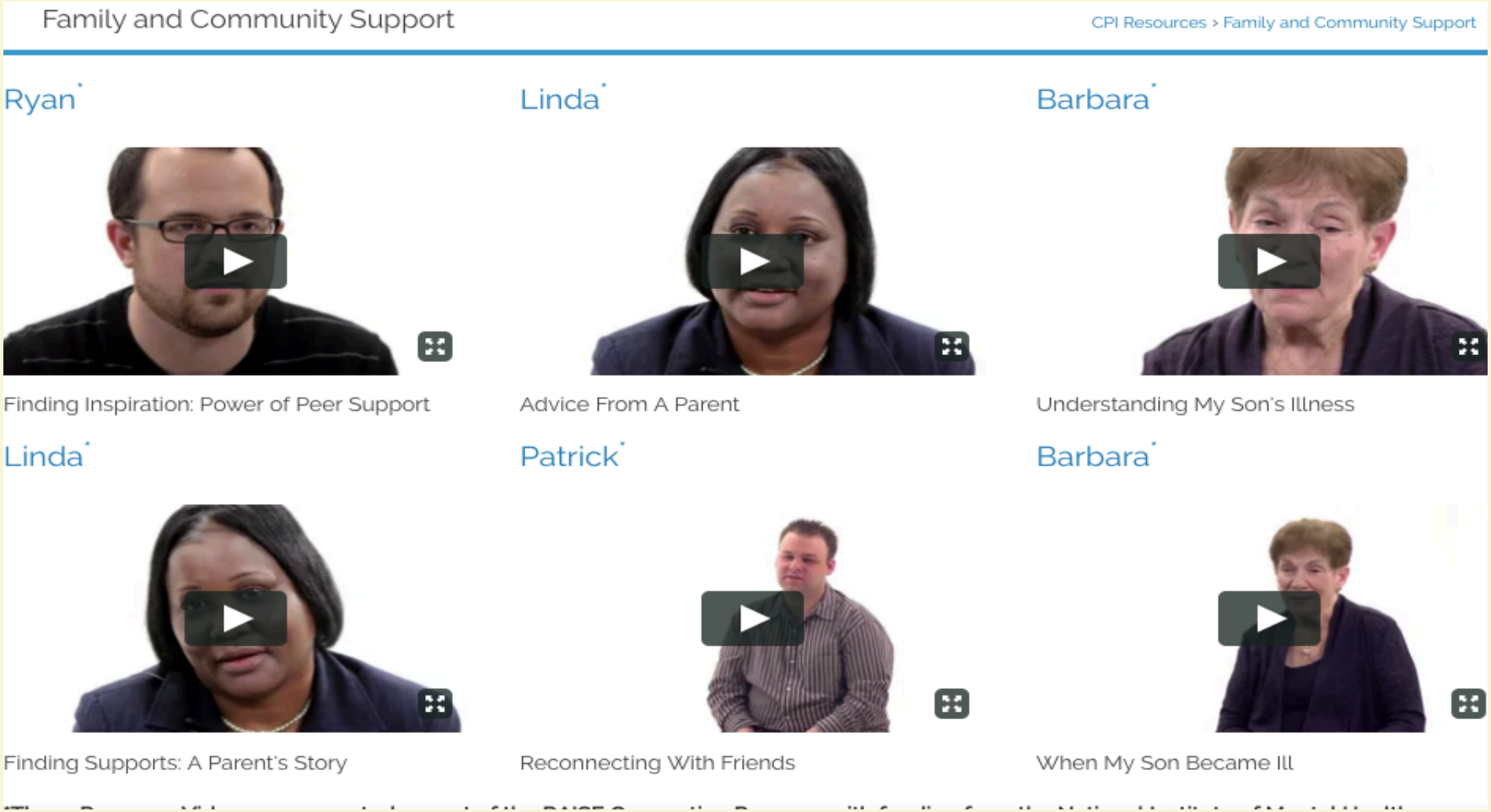
HARPs

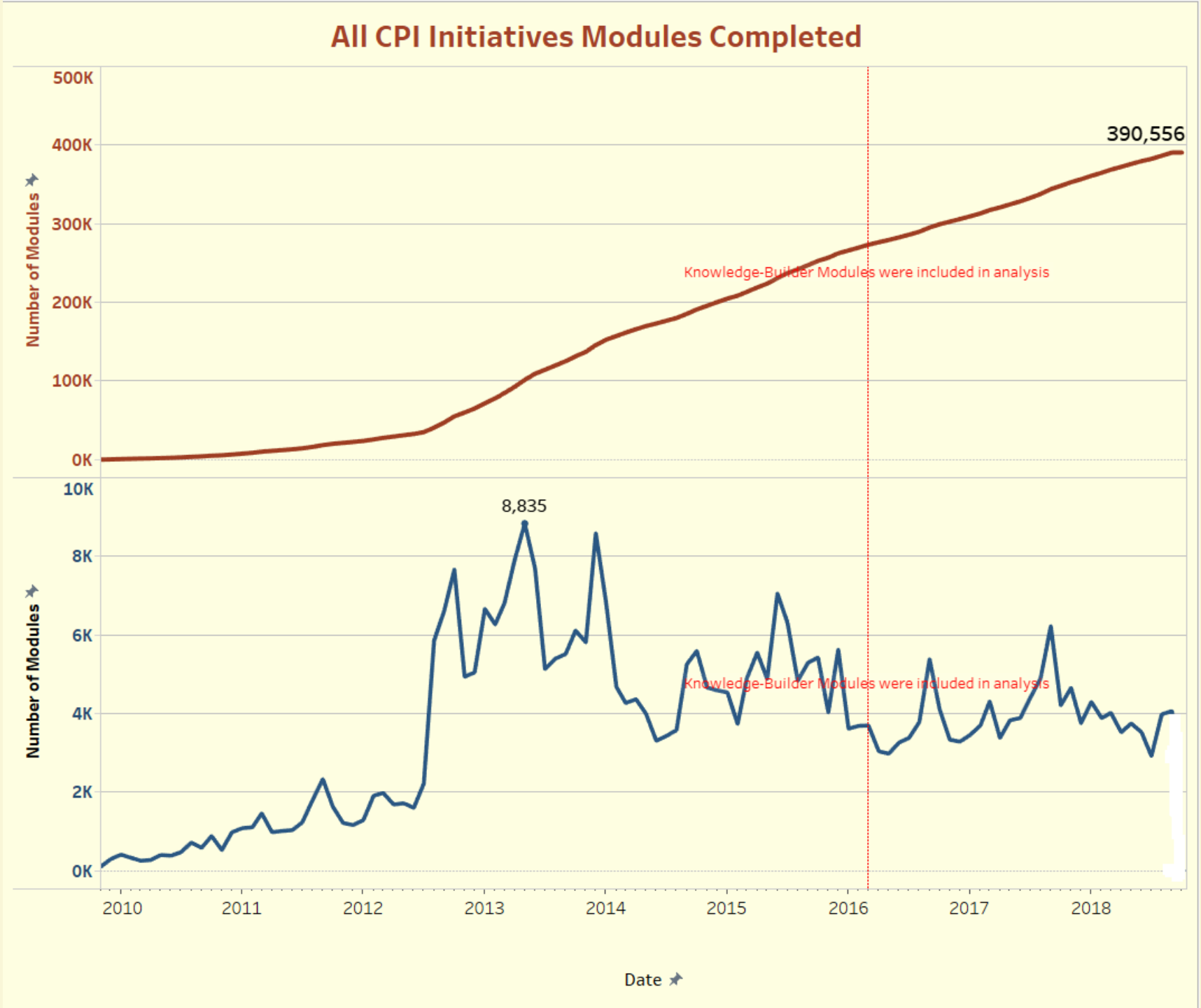
Assessment

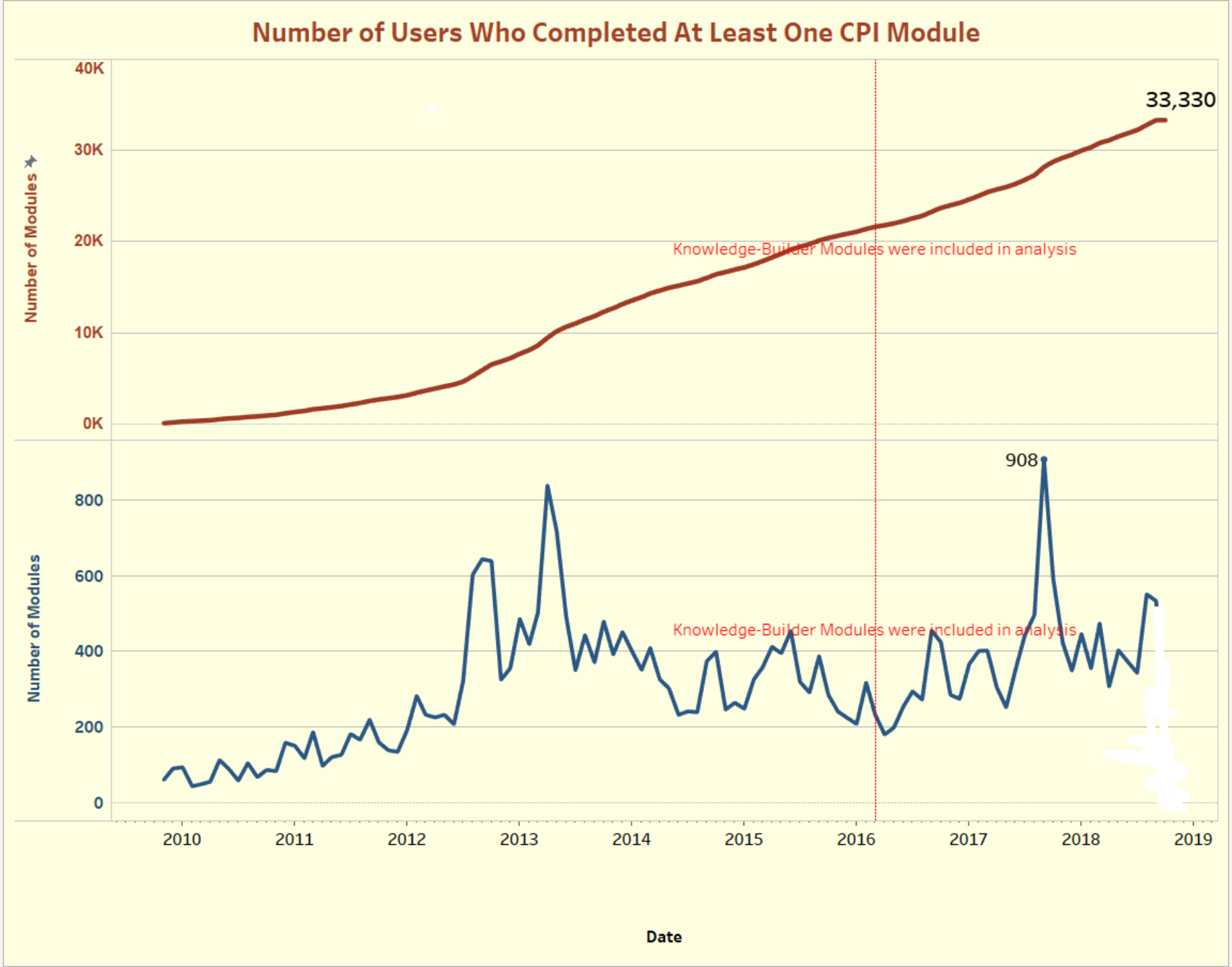
Plan of Care

Services

Family and Community support




All CPI Initiatives Modules Completed
500K
400K
300K
200K
100K
0K
Number of Modules
390,556
Knowledge-Builder Modules were included in analysis
10K
8K
6K
4K
2K
0K
Number of Modules
8,835
Knowledge-Builder Modules were included in analysis
2010
2011
2012
2013
2014
2015
2016
2017
2018
Date


Number of Users Who Completed At Least One CPI Module
Number of Modules
40K
30K
20K
10K
0K
33,330
Knowledge-Builder Modules were included in analysis
Number of Modules
800
600
400
200
0
908
Knowledge-Builder Modules were included in analysis
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
Date

CPI is in every NYS County with one exception!

State Mental Health Policy

Scaling Up Evidence-Based Behavioral Health Care Practices in New York State

Nancy H. Covell, Ph.D.
Paul J. Margolies, Ph.D.
Robert W. Myers, Ph.D.
Douglas Ruderman, L.C.S.W.
Marcia L. Fazio, M.S.R.C.
Liam M. McNabb
Suzanne Gurran, M.S.
Helle Thorning, Ph.D., L.C.S.W.
Liza Watkins, L.M.S.W.
Lisa B. Dixon, M.D., M.P.H.

- Described use of LMS, distance technologies and quality improvement and incentives

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Psychiatr Serv.2014 Jun 1;65(6):713-5.
doi: 10.1176/appi.ps.201400071.

Incentivizing Training Participation

EDUCATION AND TRAINING

Using Incentives for Training Participation

Nancy H. Covell and Paul J. Margolies
Columbia University and the New York State Psychiatric Institute, New York, New York

Robert W. Myers, Lloyd Sederer, Douglas Ruderman, Jayne Van Bramer, Marcia L. Fazio, and Liam M. McNabb
New York State Office of Mental Health, Albany, New York

Helle Thorning
Columbia University and the New York State Psychiatric Institute, New York, New York

Liza Watkins and Melissa Hinds
New York State Psychiatric Institute, New York, New York

Lisa B. Dixon
Columbia University and the New York State Psychiatric Institute, New York, New York

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Psychiatr Rehabil J.2016 Mar;39(1):81-3. doi: 10.1037/prj0000165. Epub2015 Dec 21

OMH/CPI Strategies to Promote Participation in Training

- Financial
  - Quality grant (“QUAL project”),
  - Reimbursement for care planning (PROS)
- Non-financial
  - Performance Profiling
  - Publicizing Performance
  - Technical Assistance for Quality Improvement
  - Practice Sanctions
  - For individuals, certificates

Big Picture: Collaborations

Collaborators	Projects
• MCTAC McSilver Inst. NYU • Center on Addiction • NYAPRS • Coalition's Center for Rehab and Recovery • OASAS • DOH • NYC DOHMH (MH Service Corps) • MCO's • CUCS/Justice Academy • Within OMH (Children's, etc.) • NYS OMH–Schools of Social Work Dean's Consortium Project for EBP • PSYCKES • SPO • C4SI • Center for Excellence in Cultural Competence • Division of Gender, Sexuality and Health	• Network provider training • HCBS roadmap development and training • Training of health home care managers and supervisors • Development of psychiatric rehabilitation modules • Videos for use by peer trainers and others to engage consumers into health homes, etc. • NYC Thrive learning community for faith-based leaders and others • CPI curriculum resources for Social Work Students • ZeroSuicide R01 Grant • Online video game

Collaborations Beyond Initiatives

Collaborators	Projects
• MCTAC McSilver Inst. NYU • Center on Addiction • NYAPRS • Coalition's Center for Rehab and Recovery • OASAS • DOH • NYC DOHMH (MH Service Corps) • MCO's • CUCS/Justice Academy • Within OMH (Children's, etc.) • NYS OMH–Schools of Social Work Dean's Consortium Project for EBP • PSYCKES • SPO • C4SI • Center for Excellence in Cultural Competence • Division of Gender, Sexuality and Health	• Network provider training • HCBS roadmap development and training • Training of health home care managers and supervisors • Development of psychiatric rehabilitation modules • Videos for use by peer trainers and others to engage consumers into health homes, etc. • NYC Thrive learning community for faith-based leaders and others • CPI curriculum resources for Social Work Students • ZeroSuicide R01 Grant • Online video game

An Online Training Module on the Cultural Formulation Interview: The Case of New York State

Neil Krishan Aggarwal, M.D., M.B.A., Peter Lam, M.P.H., Oscar Jiménez-Solomon, M.P.H., Ravi Desilva, M.D., Paul J. Margolies, Ph.D., Katherine Cleary, B.A., Bernadette Cain, B.A., Lisa Dixon, M.D., M.P.H., Roberto Lewis-Fernández, M.D.

Professional organizations and government guidelines recommend cultural competence training for providers, but the lack of a standardized cultural assessment has hindered research. Studies with the *DSM-5* Cultural Formulation Interview (CFI) suggest that active learning during training improves perceptions of the CFI's usefulness as a cultural competence tool. This column reports demographic characteristics and evaluation scores among 423 providers who completed an online CFI training module developed through the New York State Office of Mental Health. Both the module, which uses the principle of active learning, and the CFI were associated with strong favorability ratings.

Psychiatric Services 2018; 69:1135–1137; doi: 10.1176/appi.ps.201800119

Agenda

- CPI Background
- CPI Context: What is the Service Setting?
- Conceptual Framework
- CPI Tools and LMS
- Initiatives

Individual Placement and Support (IPS) Director: Paul Margolies, PhD

- History: Began 9 years ago with a focus on PROS programs and 3+ years ago added state facility clinics. Working with 44 PROS and 39 clinics this year.
- Current Activities: Comprehensive learning collaboratives that include a number of training and implementation supports: online modules, webinars and online meetings, face-to-face regional training workshops, on-site technical assistance, Employment Resource Book, use of fidelity and performance indicator data to drive CQI efforts. For both PROS and state clinics, stratified approach (implementing vs. sustaining) that matches resources to needs. Working with ACT Institute to introduce IPS to ACT
- Future Directions: Plan to expand our focus to include HCBS providers in the near future.

IPS Outer Setting

Outer Setting – policies, regulations, and fiscal reimbursements to programs must align to support the change; State authorities must provide a clear message of importance to programs.

<u>Pre-implementation</u>

•understand how IPS fits into PROS regulations and billing structure; understand how state facility clinic operations can support IPS; align with employment-related HCBS regulations; understand how IPS, NYESS and Ticket To Work initiatives can work synergistically

•key OMH leadership set an expectation for state facility clinics involvement in IPS initiative and strongly encourage PROS programs to do the same

<u>Implementation</u>

•state net deficit funds sent to PROS programs to support IPS activities and staffing

•Governing Body monitoring of facility involvement in IPS initiative at state clinics;

•Clarification documents for PROS programs emphasizing importance of employment and IPS initiative;

•Reports of uptake, participation, implementation fidelity ad outcomes regularly provided to State)

<u>Maintenance and Evolution</u>

•Ongoing discussions with key OMH leadership to advise around challenges and incentives (e.g., billing, staffing, technology, use of Ticket to Work funds)

•Encourage state to communicate clear message of support for maintenance

Inner Setting

IPS Inner Setting

Inner Setting – intervention must address felt need in programs; leadership must be on board with the changes, and the program must support a culture of change; interventions have to fit into modifiable limits of program structure, workflow, and processes; resources must be allocated to the change (especially time).

<u>Pre-implementation</u>

- Ask program leadership to commit to implementation activities
- Needs assessment conducted with state facility leaders
- Discussions with clinic and program leaders to understand how IPS initiative can align with everyday workflow, existing initiatives and priorities

<u>Implementation</u>

- Use of learning collaboratives where clinics and PROS programs learn from experts and one another
- learning collaborative activities include online modules, online resource library, webinars (live and archived), regional face-to-face workshops, site-specific consultation calls, on-site technical assistance, and tools including fidelity scale, Employment Resource Book and IPS implementation guide
- support supervisors in a coaching role (supervisors' checklist, training during webinars and on-site visits)
- implementation sites provide annual fidelity self-assessments and monthly performance indicator data including employment outcomes
- Provide feedback to programs and State

<u>Maintenance and Evolution</u>

- Reach out to programs that have not yet adopted the intervention and encourage their participation in IPS initiative (e.g., newly licensed PROS programs)
- Adapt and refine training and implementation supports for programs experiencing difficulty with implementation and also for those doing well and in sustaining mode)

Individual Placement and Support (IPS)

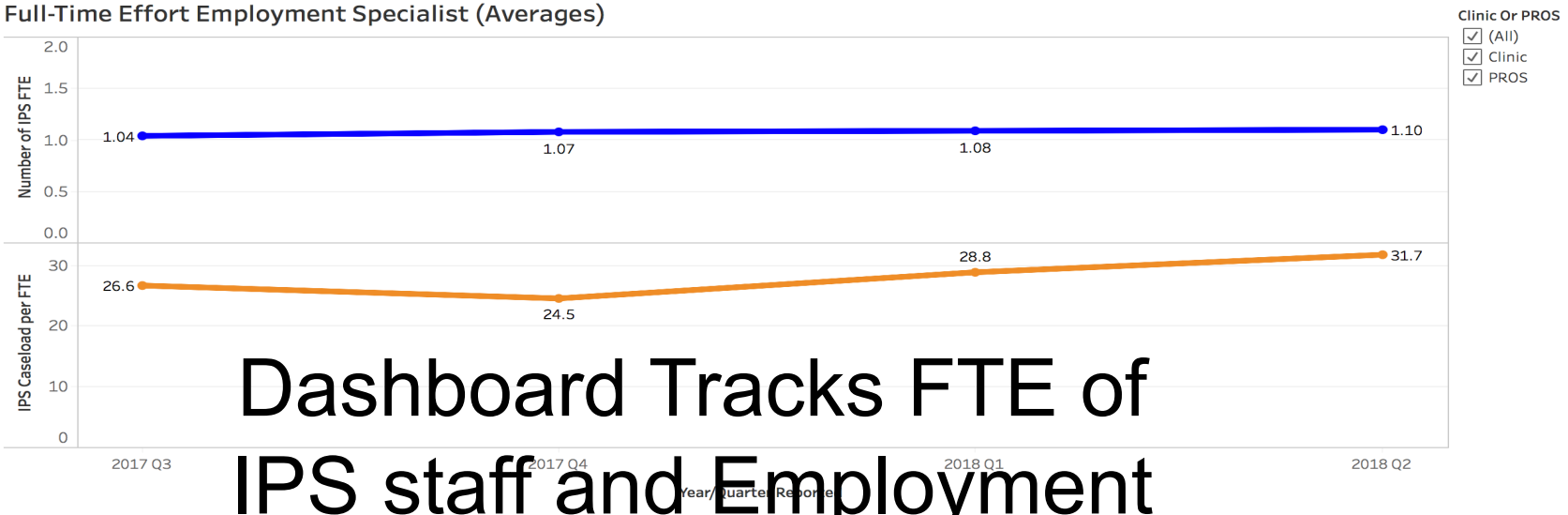
Data summary:

- Mean competitive employment rate of those receiving IPS services (August 2018 data):
  - All PROS and State Clinics combined: 47.0% employment prior 1 month
  - State Clinics: 48.2% employment prior 1 month
  - PROS programs: 45.8% employment prior 1 month, 53.7% employment prior 3 months
- Mean staff FTEs providing IPS (August 2018 data):
  - State clinics: 0.99 FTE
  - PROS programs: 1.31 FTE
- Fidelity scores
  - State clinics 2018: 99.3 mean total score
  - PROS programs 2018: 91.2 mean total score

Dash_ACT | Dash_FIT | Dash_IPS | Dash_OnTrackNY | Dash_SPTIE | Dash_SysTrans

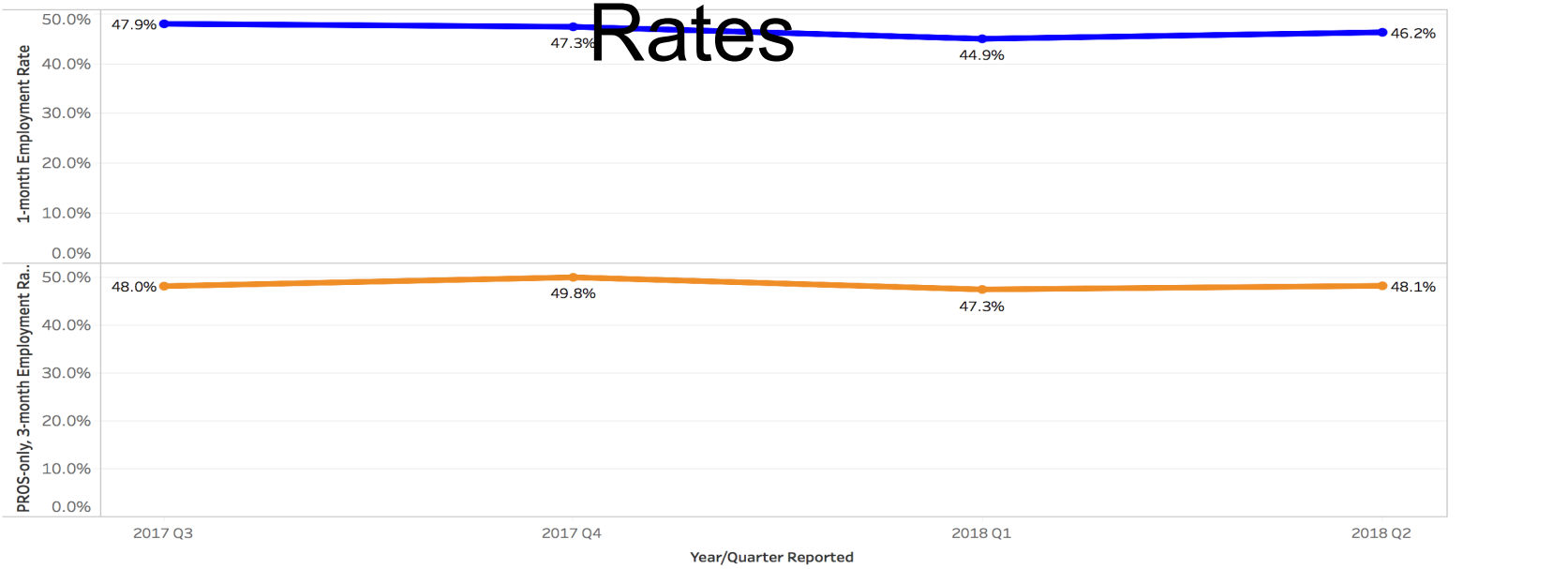
IPS Dashboard

Full-Time Effort Employment Specialist (Averages)



Dashboard Tracks FTE of IPS staff and Employment Rates

Employment Rates (Average Percentage)



Undo | Redo | Revert | Refresh | Pause

Use of Learning Collaboratives by the Center for Practice Innovations to Bring IPS to Scale in New York State

Paul J. Margolies, Ph.D., Karen Broadway-Wilson, Raymond Gregory, Thomas C. Jewell, Ph.D., Gary Scannevin, Jr., M.P.S., C.P.R.P., Robert W. Myers, Ph.D., Henry A. Fernandez, J.D., Douglas Ruderman, L.C.S.W., Liam McNabb, I-Chin Chiang, M.S., Leslie Marino, M.D., Lisa B. Dixon, M.D., M.P.H.

Psychiatric Services 2015; 66:4–6; doi: 10.1176/appi.ps.201400383

Relationship Between Self-Assessed Fidelity and Self-Reported Employment in the Individual Placement and Support Model of Supported Employment

Paul J. Margolies, Ph.D., Jennifer L. Humensky, Ph.D., I-Chin Chiang, M.S., Nancy H. Covell, Ph.D., Thomas C. Jewell, Ph.D., Karen Broadway-Wilson, B.S., Raymond Gregory, B.S., Gary Scannevin, Jr., M.P.S., C.P.R.P., Lisa B. Dixon, M.D., M.P.H.

Psychiatric Services 2018; 69:609–612; doi: 10.1176/appi.ps.201700472

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ACT Institute
Director: Helle Thorning, PhD

- History: Established in 2003 when ACT became Medicaid billable (14 teams). Moved to CPI in 2009.
- Current Activities: Now provides training and implementation support to 108 ACT teams across NYS with focus on ACT as a *Timed* Service using a blended learning approach for required training as well as role training, learning collaboratives, state wide support calls (for unique roles), consultations and technical assistance. Has NYU Provost Challenge Grant with Silver School of SW *to investigate the social networks and their impact on Community Integration for ACT participants*
- Future Directions: Continue on transition and special populations.

ACT: Outer Setting

Outer Setting – policies, regulations, and fiscal reimbursements to programs must align to support the change; State authorities must provide a clear message of importance to programs.

<u>Pre-implementation</u>

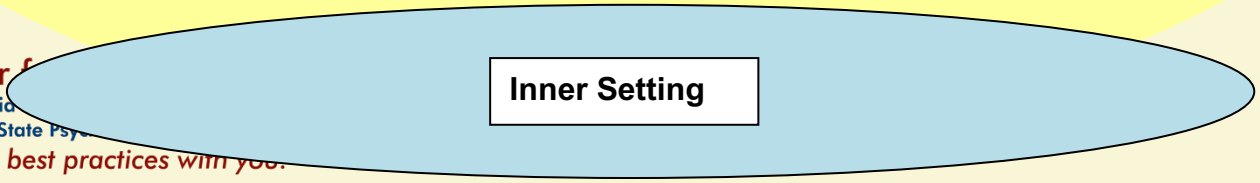
- Understand policies, regulations, and fiscal incentives to align them as closely as possible to the proposed change
- Stakeholder interviews/focus groups/workgroups
- Work with State and City to communicate clear message to programs around importance of participation in training and implementation support (key: OMH leadership set an expectation for ACT providers involvement in ACT training and implementation support)

<u>Implementation</u>

- Targeted interventions to policies and incentives to increase participation
- Work with State to communicate clear message of continued support (Governing Body monitoring of facility involvement with ACT across the state; ACT guidelines/standard of care, emphasizing importance of practice; reports of uptake, participation, and outcomes regularly provided to State and City)

<u>Maintenance and Evolution</u>

- Advise State on policies, regulations and incentives that would improve uptake (ongoing discussions with key OMH/City leadership to advise around challenges and incentives
- Encourage state and city to communicate clear message of support for maintenance
- Ongoing feedback loop with stakeholders



ACT Inner Setting

Outer Setting

Inner Setting – intervention must address felt need for ACT providers and participants; leadership must be on board with focus, and the program must support a culture of change; interventions have to fit into modifiable limits of program structure, workflow, and processes; resources must be allocated to the change (especially time for role specific interventions).

<u>Pre-implementation</u>

•Understand program-level needs& assess (ACT model Implementation & Role Function)

•Stakeholder input (Understand barriers and incentives for ACT program and provider participation; discussions with ACT Teams and program leaders to understand how ACT model and Team Roles can align with everyday workflow, existing initiatives and priorities)

<u>Implementation</u>

• Ongoing Training and implementation support to maintain ACT model with staff turnover

•Using a blended learning approach incl. use of learning communities where ACT teams/providers learn from experts and one another; activities include online modules, online resource library, webinars (live and archived), regional face-to-face workshops, site-specific consultation, training and on-site technical assistance, and tools including fidelity scale (s), practice guideless tools

•Support supervisors in a coaching role (supervisors' checklists, Support Calls, Training during webinars and on-site visits)

•Evaluate the implementation process and practitioner with attention to ACT participant outcomes

•Provide and elicit ongoing feedback to ACT Providers, State and City

<u>Sustaining and ongoing feedback</u>

•Outreach to newly established ACT Teams or New Team leaders to provide individual start up support)

• Adapt and refine training and implementation supports for ACT teams experiencing difficulty with implementation and also for those doing well and in sustaining mode.

•Ongoing communication to all Stakeholders (News briefs, Upcoming Training Newsletter & Targeted mails to unique roles & groups)

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ACT & Emerging Training Needs: Curriculum Development Process

Advisory Board --- Stakeholder Input

Data Collection:
-ACT Participant
Interviews
-ACT Provider
Focus groups
-Policy/Administrators
Forums
-Content
Experts Participation
Literature review

Content Analysis – Assets and Needs

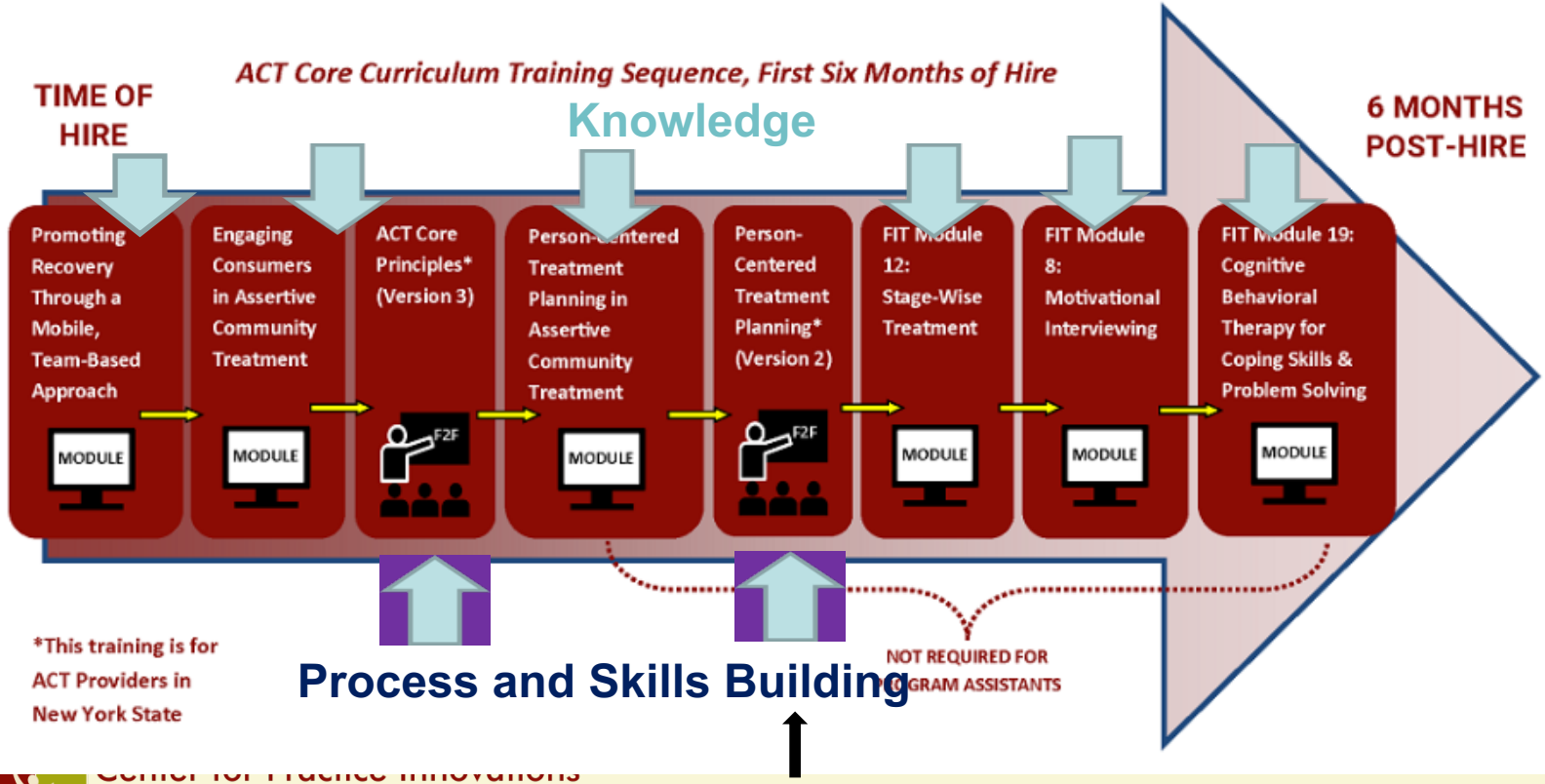
-Knowledge
-Attitude
-Skills

Training and Implementation support

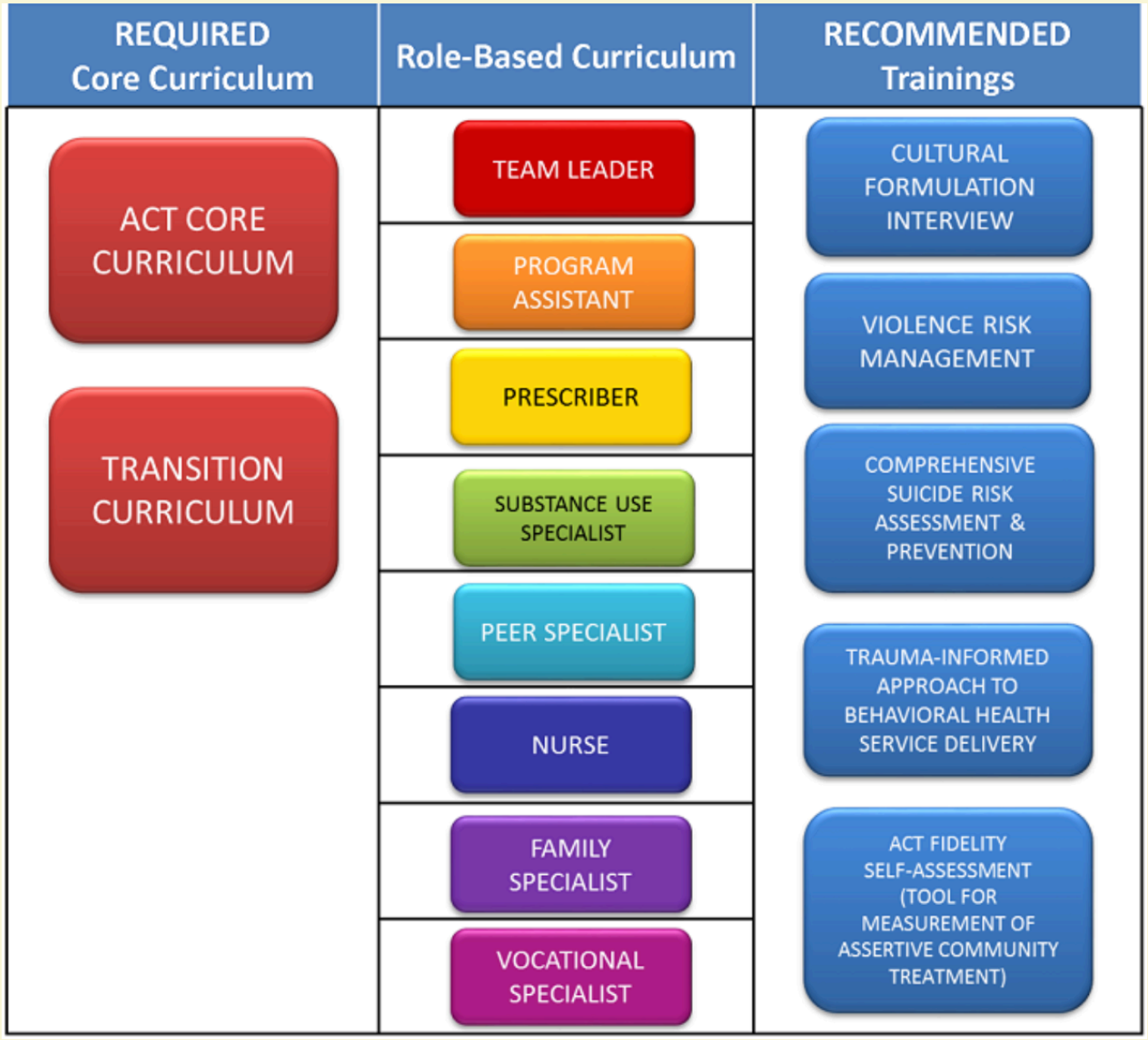
Multipronged Blended Learning approach:
-Online Modules & Tools
- Learning Communities
-Face-to Face Training
-Clinical Care Calls
-Consultations

ACT Core Curriculum

All ACT team staff are required to complete the training (exceptions noted) as outlined below. The training consists of online modules and face-to-face/in-person events (F2F), as indicated. Team members who have completed the Core Curriculum prior to 2012 are required to retake the two F2F trainings.

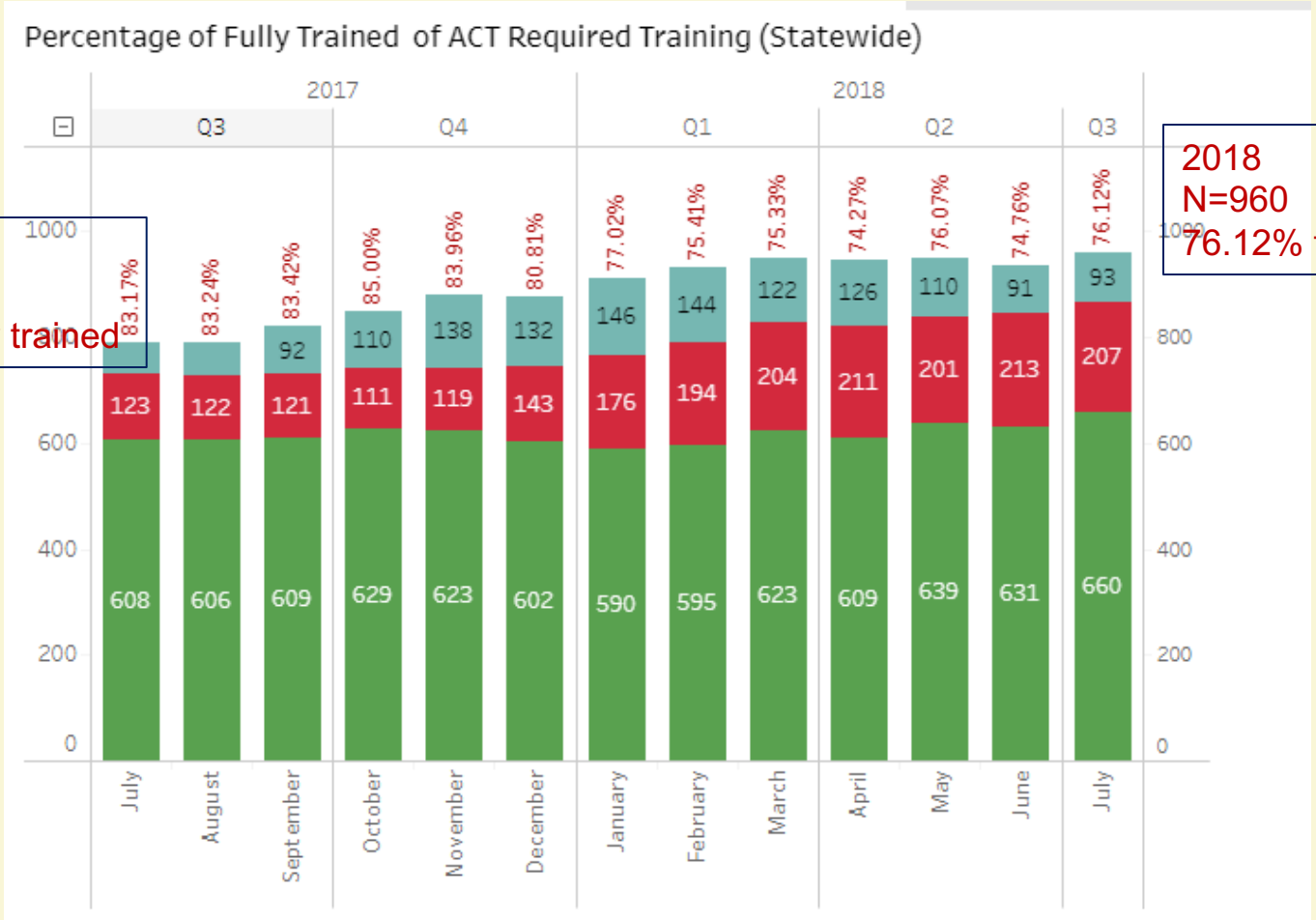


Pre-Post Test Knowledge Tests reflect increase ($p<.001$)


REQUIRED
Core Curriculum
Role-Based Curriculum
RECOMMENDED
Trainings
ACT CORE CURRICULUM
TRANSITION CURRICULUM
TEAM LEADER
PROGRAM ASSISTANT
PRESCRIBER
SUBSTANCE USE SPECIALIST
PEER SPECIALIST
NURSE
FAMILY SPECIALIST
VOCATIONAL SPECIALIST
CULTURAL FORMULATION INTERVIEW
VIOLENCE RISK MANAGEMENT
COMPREHENSIVE SUICIDE RISK ASSESSMENT & PREVENTION
TRAUMA-INFORMED APPROACH TO BEHAVIORAL HEALTH SERVICE DELIVERY
ACT FIDELITY SELF-ASSESSMENT (TOOL FOR MEASUREMENT OF ASSERTIVE COMMUNITY TREATMENT)

Maintain Fully Trained ACT Providers

2017
N=791
83.17 % fully trained



2018
N=960
76.12% fully trained

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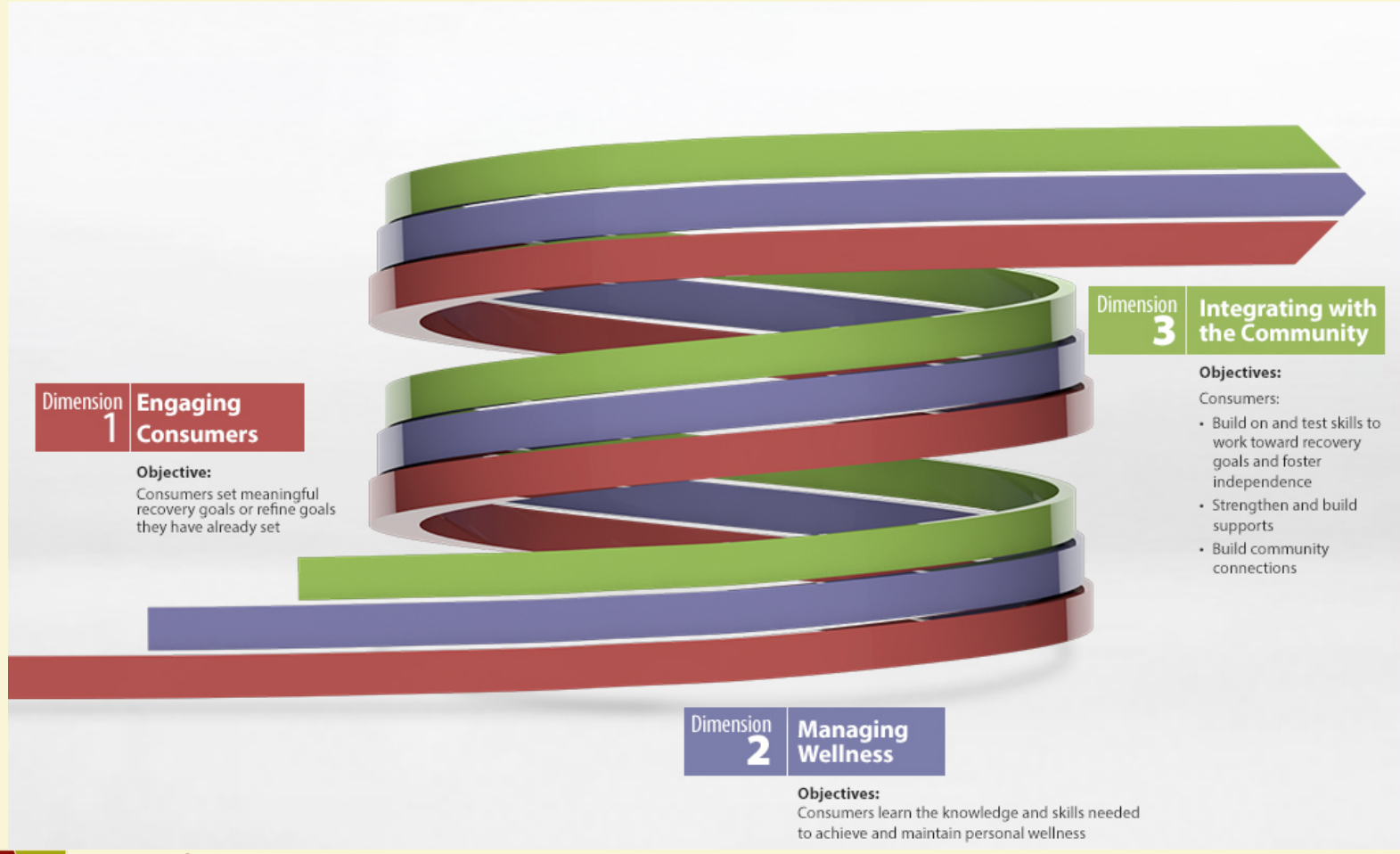
ACT: Transition Practice Framework



Dimension 1 Engaging: Setting life goals	Dimension 2 Managing wellness	Dimension 3 Integrating with community
Transition Manual for ACT Providers (TMAP)	Transition Readiness Scale	Wellness Self Management for Transition Manual
A. Dialog w/ new consumer. B. Dialog w/ existing consumer	WSM Workbook	Client Tracking Form
Value Sort Card	WSM+ Workbook	Linkage/Try-Out
Transition Needs Assessment	Wellness Self-Management Plan	
Family Decisional Balance Worksheet	Group Leaders' Quick Guide to Conducting WSM Groups	Transfer of Care/Follow-Up
Family Values Clarification Exercise -	Employment Resource Book (IPS)	Family Transitional Discussion
Family Motivational Interview		ACT Graduation Activities

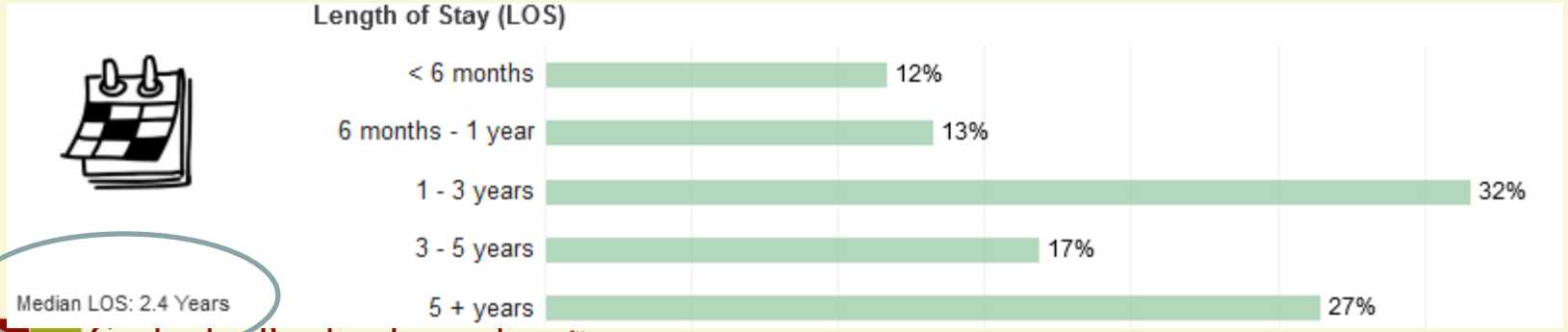
Time in ACT: Key Data Points

- Attention to time in ACT statewide showed reduced length of stay (2008: 44.4 Months – 2014: 32.4 Months)

ACT Transition-Focused Performance Metrics, 2008 and 2014

	2008	2014
Median Time in ACT (all ACT episodes through criterion date)*	44.4 Months	32.4 Months
Annual ACT Participant Turnover Rate **	24.5%	28.2%
Percent of Individuals Leaving ACT Who Met Treatment Objectives ***	13%	25.3%
Post-ACT Ambulatory Follow-Up ****	50.4%	61.2%
Post-ACT Psychiatric Hospitalization *****	14.1%	12.8%

- Length of stay continued to decrease (October, 2018 – 28 Months)



Adoption of a Blended Training Curriculum for ACT in New York State

Helle Thorning, Ph.D., L.C.S.W., Leslie Marino, M.D., M.P.H., Pascale Jean-Noel, L.M.S.W., Luis Lopez, M.S., Nancy H. Covell, Ph.D., I-Chin Chiang, M.S., Robert W. Myers, Ph.D., Douglas P. Ruderman, L.C.S.W.-R., Nicole K. Haggerty, L.M.H.C., Gary Clark, L.C.S.W., Lisa B. Dixon, M.D., M.P.H.

Scant evidence exists in the literature for best practices in training assertive community treatment (ACT) teams to deliver highly effective services to consumers. This column describes a blended training curriculum, which includes both face-to-face and distance learning strategies, developed by the ACT Training Institute in New York State to meet the ongoing training needs of teams across New York State. Data on training uptake, which has steadily increased over time, are reported. The role of the state is crucial in driving adoption of training activities. The column also describes how the ACT Training Institute uses fidelity and outcome data to identify training needs.

Psychiatric Services in Advance (doi: 10.1176/appi.ps.201600143)

Although assertive community treatment (ACT) is a widely used team-based evidence-based practice (EBP), scant evidence informs how to best train ACT teams. Nevertheless, training ranks among the most crucial components of sustainable EBPs (1). Expert consensus and the experience of states in implementing ACT teams provide some general concepts for training. For example, effective training can provide program leadership with a clear concept of the model's goals and principles (2). Others emphasize that ACT teams should be trained in areas such as professional values, attitudes, and beliefs to strengthen team members' ability to interact with consumers in various stages of illness and their families (3). Experiential learning and supervision are also viewed as vital concepts in training ACT teams (4). In addition, training teams together can help enhance practitioners' understanding of the model and encourage mutual problem solving (5).

Specific examples of training programs for ACT teams are also limited. The ACT Training Institute at the University of Illinois at Chicago trained state ACT teams by using traditional didactics, mentoring by experienced ACT team members, and observation of veteran teams (6). Measures of changes in knowledge demonstrated significant increases in posttest scores, but the overall average posttest scores remained low at 60% of questions answered correctly (6). The Washington Institute for Mental Health Research and Training in Washington State trained ACT teams by using several days of in-person didactics on core ACT principles, direct observation of another state's ACT teams, one booster training session, and ongoing phone and on-site support and technical assistance. Contracts required teams to meet specific fidelity scale items; preliminary analyses suggested that these requirements enhanced fidelity (7). The authors described the provision of ongoing training and technical assistance as playing a key role in development of high-fidelity ACT teams (7).

In this column, we describe the training provided by the ACT Institute in New York which utilizes a "blended learning" approach, with both face-to-face and distance learning strategies. Because the New York State Office of Mental Health (NYSOMH) requires training for licensing, we also report on tracking methods and training uptake across the state and discuss the role of the state in driving adoption of training activities. Finally, we discuss how New York State and the ACT Institute use data to guide training efforts and improve outcomes.

ACT in New York State

The NYSOMH first implemented ACT in the early 1990s. The Division of Community Care coordinated training in ACT, which included a four-day, in-person training session for all team members. In these earlier years, teams operated with few guidelines and lacked uniform standards. In 2000, outside consultants and experts in ACT implementation completed a fidelity review that created a foundation allowing NYSOMH to develop standards of care and establish ACT as a licensed model. It also enabled the model to be approved in the New York State Medicaid State Plan, with funding from a combination of Medicaid dollars (50% federal share and 50%

Time in Assertive Community Treatment: A Statewide Quality Improvement Initiative to Reduce Length of Participation

Steven Huz, Ph.D., M.P.A., Helle Thorning, Ph.D., M.S., Candace N. White, Ph.D.Med., Lin Fang, Ph.D., L.C.S.W., Bikki Tran Smith, M.A., M.S.W., Marleen Radigan, Dr.P.H., M.P.H., Lisa B. Dixon, M.D., M.P.H.

The investigators describe a New York State initiative to increase flow through assertive community treatment (ACT) while encouraging transition to less intensive services. This initiative began as ACT approached full capacity and as evidence that participants can sustain recovery post-ACT emerged. Comparison of performance indicators over time showed that time in ACT decreased, turnover rate increased, and the percentage of ACT participants who met treatment objectives rose. Also, post-ACT rates of ambulatory behavioral health follow-up increased while rates of psychiatric inpatient hospitalization decreased. Monitoring utilization of services while demonstrating positive outcomes has become increasingly critical as states shift to managed health care.

Psychiatric Services 2017; 00:1–3; doi: 10.1176/appi.ps.201700127

Assertive community treatment (ACT) is an evidence-based practice that strives to support community-based recovery for individuals with serious mental illness (1,2). Early studies suggested that withdrawal of ACT services led to loss of participant gains (3). However, an emerging literature demonstrates that individuals can transition from ACT successfully, sustaining their recovery when readiness for transition is assessed, the appropriate services are in place, and the transition is properly coordinated (4–6).

In New York State, the Office of Mental Health (NYSOMH) implemented ACT in the early 1990s. In 2008, a total of 79 ACT teams were operating and could serve about 5,000 individuals. By 2014, the ACT system had grown to 82 teams to raise capacity to approximately 5,200. As the NYSOMH ACT program reached full capacity, a growing waiting list developed (7,8). Consequently, NYSOMH policy guidance began to focus on transitioning participants through ACT so that more people in need could receive this service. Thus, strategies were developed to shift the ACT model from its original, time-unlimited orientation to approaches that routinely promote participant transition to less intensive services. A focus on shortening time on an ACT team while maintaining quality has become increasingly critical as New York State shifts to a managed care environment.

Strategies included the development of an ACT Transition Readiness Scale (TRS) to monitor participants' readiness for transition from ACT (9), a learning collaborative focused on transition practices (8), and a biannual report for monitoring the flow of participants through ACT.

The TRS (9) was developed to assist ACT teams in assessing participants' suitability for transition to less intensive services in the community. It uses administrative data from seven substantive domains—housing stability, psychiatric hospitalization, use of emergency services, service engagement, medication compliance, criminal justice involvement, and incidence of harmful behaviors—to produce a report of the number of participants on each team who are likely to be ready for transition from ACT. The learning collaborative demonstration project supported statewide transition efforts while promoting recovery, which led to a series of recommendations for transition practices (8).

The ACT Performance Packet, a set of reports disseminated to ACT teams biannually, includes metrics related to participant flow and post-ACT outcome. To determine how ACT's performance was monitored during this period of promoting transition, we examined the ACT Performance Packet at two time points: 2008, representing the initial dissemination of the packet to ACT teams, and December 2014.

Metrics Examined

The NYSOMH used three administrative data sets to create the ACT Performance Packet. ACT providers enter individual-level information into NYSOMH's Web-based Child and Adult Integrated Reporting System (CAIRS) at admission, annual follow-ups, and disengagement from services. These data were used to construct metrics of time in ACT, rate of census turnover, and reason for leaving ACT

Focus on Integrated Treatment (FIT): Director: Nancy Covell, PhD

- History: Began 2009 with 35 modules. Through learning collaboratives, worked with 67 programs to implement stage-wise treatment, 15 to implement stage-wise treatment groups, 14 to increase capability to treat co-occurring disorders as measured by the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) index, and 52 to implement treatment for tobacco use disorder.
- Current Activities: Tobacco dependence treatment (TDT) Learning collaborative (with 12 state agencies serving adults); NYC Tobacco Cessation Training and Technical Assistance Center (NYC TCTTAC); attention to physical healthcare; support work of Dual Recovery Coordinators and other regional efforts; implementation support and consultation calls.
- Future Directions: Expand work with dual-recovery coordinators, develop larger learning collaboratives around dual diagnosis capability, continue tobacco cessation focus

FIT Outer Setting

Outer Setting – policies, regulations, and fiscal reimbursements to programs must align to support the change; State authorities must provide a clear message of importance to programs.

<u>Pre-implementation</u>
- Align work with DSRIP, Health Homes and other system changes
- Capitalize on enhanced rates for PROS programs
- Embed FIT in QI project for clinics to allow billing at a higher rate
- OMH leadership strongly encourages participation in FIT

<u>Implementation</u>
- IMHATT signed by both OMH and OASAS commissioners
- Guidance documents include FIT training and resources
- Licensing includes training benchmarks for exemplary status
- Reports of uptake and participation regularly provided to OMH for targeted outreach

Maintenance and Evolution
- Ongoing discussions with key OMH leadership to advise around challenges and possible incentives

Inner Setting

FIT Inner Setting

Outer Setting

Inner Setting – intervention must address felt need in programs; leadership must be on board with the changes, and the program must support a culture of change; interventions have to fit into modifiable limits of program structure, workflow, and processes; resources must be allocated to the change (especially time).

Pre-implementation

- Ask program leadership to commit to implementation activities
- Align with existing agency initiatives and priorities
- Provide leadership forums to increase buy-in

Implementation

- Advise programs on staff selection
- Provide high quality training (39 online modules, live and archived webinars, face-to-face training)
- Support supervisors in a coaching role (2 online modules, live and archived webinars, tools and checklists for staff supervision)
- Twice monthly implementation support calls
- Program-specific consultation upon request,
- Focused learning collaboratives
- Provide feedback from capability scale and performance indicators to programs to inform CQI processes

Maintenance and Evolution

- Help programs embed practice into routine care to maximize sustainability
- Adapt and refine implementation supports to meet demands in the changing system and as part of an internal CQI process to refine our work

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Certificate of Completion

IMHATT

This is to certify that **Jane Smith**
Profession & License #_____
Has successfully earned the

The Integrated Mental Health/Addictions Treatment Training Certificate

This certificate indicates that the trainee has completed 21.5 hours of online training modules related to integrated mental health/addictions training.

Social Work Continuing Education Earned: 21.5 Contact Hours Self-Study

Center for Practice Innovations is recognized by the New York State Education Department's State Board for Social Work as an approved provider of continuing education for licensed social workers #SW- 0118.

21.5 CASAC/CPP/CPS education and training clock hours, which satisfies CASAC Renewal; 21.5 hours CPP Section 1; CPP Renewal; 21.5 hours CPS Section 1; CPS Renewal

This training is provided under New York State Office of Alcoholism and Substance Abuse Services (OASAS) Education and Training Provider Certification Number 1007. Training under a New York State OASAS Provider Certification is acceptable for meeting all or part of the CASAC/CPP/CPS education and training requirements.

Mental Health Counselor Continuing Education Earned: 21.5 Contact Hours Self-Study

Center for Practice Innovations is recognized by the New York State Education Department's State Board for Mental Health Practitioners as an approved provider of continuing education for licensed mental health counselors. #MHC-0057.

Arlene González-Sánchez,
Commissioner, OASAS

Ann Marie T. Sullivan
Commissioner, OMH

Date: September 30, 2018

Location: Online (CPI Address: 1051 Riverside Drive, New York, NY 10032)
Instructor: Nancy Covell, Ph.D.

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

OASAS Improving Lives.

FIT Focus on Integrated Treatment

Center for Practice Innovations at Columbia Psychiatry New York State Psychiatric Institute Building best practices with you.

CPI Dashboard

Data through 2018 Q3 (September)

ACT | FIT | IPS | OnTrackNY | SP-TIE | System Transformation

FIT

Learning Collaborative

* 17 PROS programs, 31 state-op (2018), 32 state-op (2017), 14 programs in DDCMHT collaborative

Year/Quarter	Number of Events	Number of Programs Enrol..
2017 Q3	5	48
2017 Q4	5	48
2018 Q1	5	48
2018 Q2	5	48
2018 Q3	5	48

Implementation Calls

Year/Quarter	Number of FIT Calls	Number of FIT Programs
2017 Q3	4	15
2017 Q4	4	15
2018 Q1	4	15
2018 Q2	4	15
2018 Q3	4	15

NYC - TCTTAC

* Note: TCTTAC began offering events in November 2017

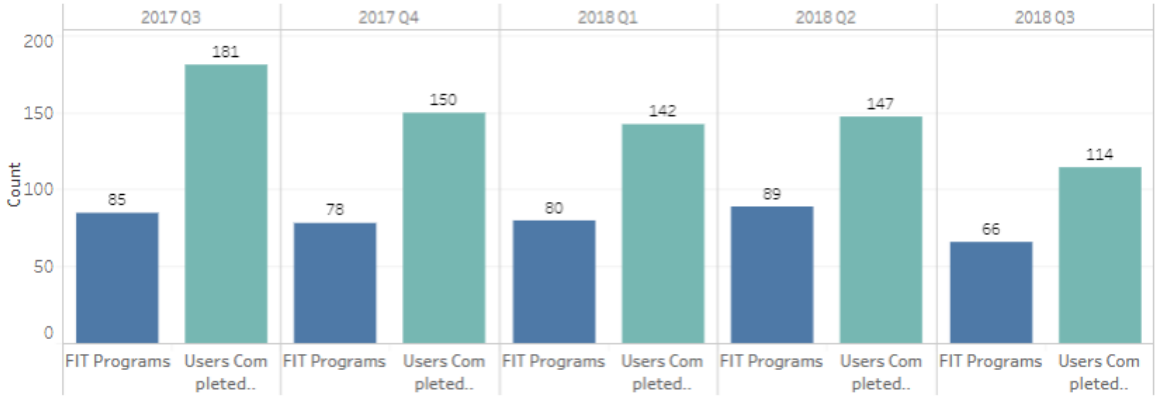
Year/Quarter	Number of Events	Number of Programs R..
2017 Q4	2	12
2018 Q1	12	31
2018 Q2	7	17
2018 Q3	5	45

Special Webinar Topics

Year/Quarter	Number of Events	Number of Progra..
2017 Q3	3	95
2017 Q4	7	132
2018 Q1	0	0
2018 Q2	0	0
2018 Q3	0	0

FIT Module Completions

IMHATT Completions by Program/User



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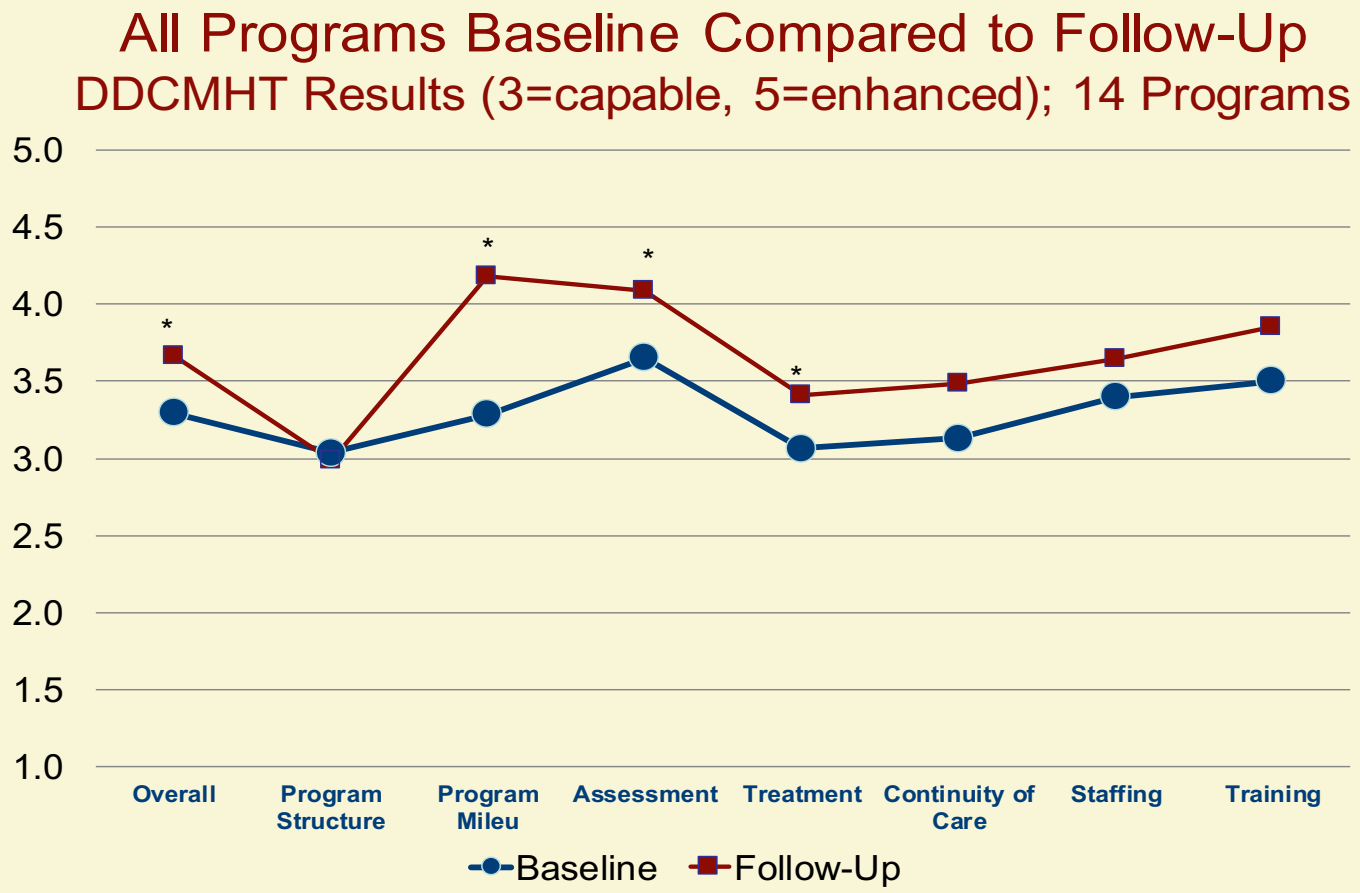
Dashboard Tracks LC Participation, Modules Completed, IMHATT Completions

DDCMHT Learning Collaborative

14 programs (7 PROS, 7 clinics), participated in a learning collaborative to improve capability to treat COD and demonstrated significant improvements through time.



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*Paired Sample t-tests significant at p < .05

Using Distance Technologies to Facilitate a Learning Collaborative to Implement Stagewise Treatment

Nancy H. Covell, Ph.D., Forrest P. Foster, M.S.W., C.P.R.P., Paul J. Margolies, Ph.D., Luis O. Lopez, M.S., Lisa B. Dixon, M.D., M.P.H.

Objective: This report describes experiences and outcomes of an online learning collaborative focused on implementation of stagewise treatment.

Methods: Eleven participating programs convened online monthly for a year. Between meetings, program staff created an implementation plan and programs collected performance indicator data, including assessment of staff knowledge of integrated treatment for people with co-occurring disorders, whether a person's current stage of treatment was documented in his or her chart, and whether the treatments were appropriate for the stage of treatment. Descriptive statistics were used to characterize performance indicators and feedback. Wilcoxon matched-pairs signed-rank tests examined changes in performance indicators over time.

Results: Program staff generally demonstrated significant improvements in performance indicators over time and rated the distance learning collaborative favorably.

Conclusions: Distance learning collaboratives can be structured to provide opportunities for program staff to interact and learn from one another and to implement and sustain changes.

Psychiatric Services 2015; 00:1–4; doi: 10.1176/appi.ps.201400155

In 2009, the Center for Practice Innovations at Columbia Psychiatry and the New York State Psychiatric Institute (CPI) (1) began providing training and implementation supports to New York State behavioral health practitioners to implement integrated treatment for people with co-occurring mental and substance use disorders. The size of the state and the number of providers made this challenging, and thus CPI turned to distance technologies.

Distance technologies may be at least as effective as face-

for a year-long learning collaborative focused on the implementation of one component of integrated treatment, stagewise treatment. Stagewise treatment posits that change is a process, that people go through a series of stages in changing any behavior, and that the treatment provided must be appropriate to the person's stage (6). One program withdrew after a temporary shutdown and relocation.

Participating programs agreed to have at least two staff members join monthly online 90-minute meetings for 12

OnTrackNY: Director: Lisa Dixon, M.D. Ilana Nossel, M.D. & Iruma Bello,Ph.D. (Co-associate Directors)

- History: Created in 2013 as NYS's Coordinated Specialty Care (CSC) program for individuals experiencing early psychosis. The program has a centralized hub for training, financing and evaluation.
- Current Activities: The program supports 21 active teams. Obtained additional federal support with SAMHSA HT grant ($5 mill), OnTrack The Game, CSConDemand, Financial Support Tool, Cognitive Remediation Grant (Medalia, PI)
- Future Directions: Future focus on expansion and financial sustainability. EPINET grant pending

OnTrackNY Outer Setting

Outer Setting – policies, regulations, and fiscal reimbursements to programs must align to support the change; State authorities must provide a clear message of importance to programs.

<u>Pre-implementation</u>
- Understand relevant policies and regulations, e.g. licensing issues for programs to serve youth and young adults
- Develop fiscal plan of support (may include OMH or SAMHSA grant support and billing revenue; CCBHC and state-operated services as alternative models)
- OMH (through field offices) communicates clear message to agencies regarding importance of the program

<u>Implementation</u>
- OMH provides clear guidance on issues as needed, e.g. importance of providing services regardless of ability to pay; obligation of agencies to remain open to enrollment and provide clinical coverage during gaps in staffing

<u>Maintenance and Evolution</u>
- Work with OMH and MCO's to develop model(s) for financial sustainability, including eligibility for individuals with FEP for HARPs and HCBS services; bundled case rate
- Medicaid MCO's will be required to identify and report to OMH on members with FEP and referral to Coordinated Specialty Care

Inner Setting

OnTrackNY Inner Setting

Outer Setting

Inner Setting – intervention must address felt need in programs; leadership must be on board with the changes, and the program must support a culture of change; interventions have to fit into modifiable limits of program structure, workflow, and processes; resources must be allocated to the change (especially time).

<u>Pre-implementation</u>

- Engage program leaders. Leadership must support model: team approach with low caseload, high risk pop, SDM model, assertive outreach, community work
- Understand program level commitment for staffing, participation in training & data collection, supervision
- Understand barriers & facilitators to implementation (e.g. state programs w/ civil service rules, staffing policies or union rules that may impact ability for staff to be on call, pre-existing relationships with referral sources)

<u>Implementation</u>

- Hire or re-allocate staff. Understand qualities needed among staff (engaging, youth and family friendly, recovery orientation)
- Provide team-based and role-specific training in the OnTrackNY model
- Provide technical assistance to support implementation (learning collaborative structure combining team-wide and role-specific calls and online curriculum on learning management system)
- Collect client-level and program-level data and provide feedback to teams
- Assess fidelity and support teams in enhancing high-fidelity implementation of the model
- Teams evaluate training and technical assistance

<u>Maintenance and Evolution</u>

- Support development of new OnTrackNY teams to enhance reach
- Refine intervention as needed, e.g. added cognitive health component to the model, enhanced training and resources in cultural competence and working with LGBTQ participants, piloting screening tool for tobacco and substance use
- Refine methodology for training and technical assistance as needed (e.g. creation of monthly statewide webinar series)
- Refine fidelity scale as needed

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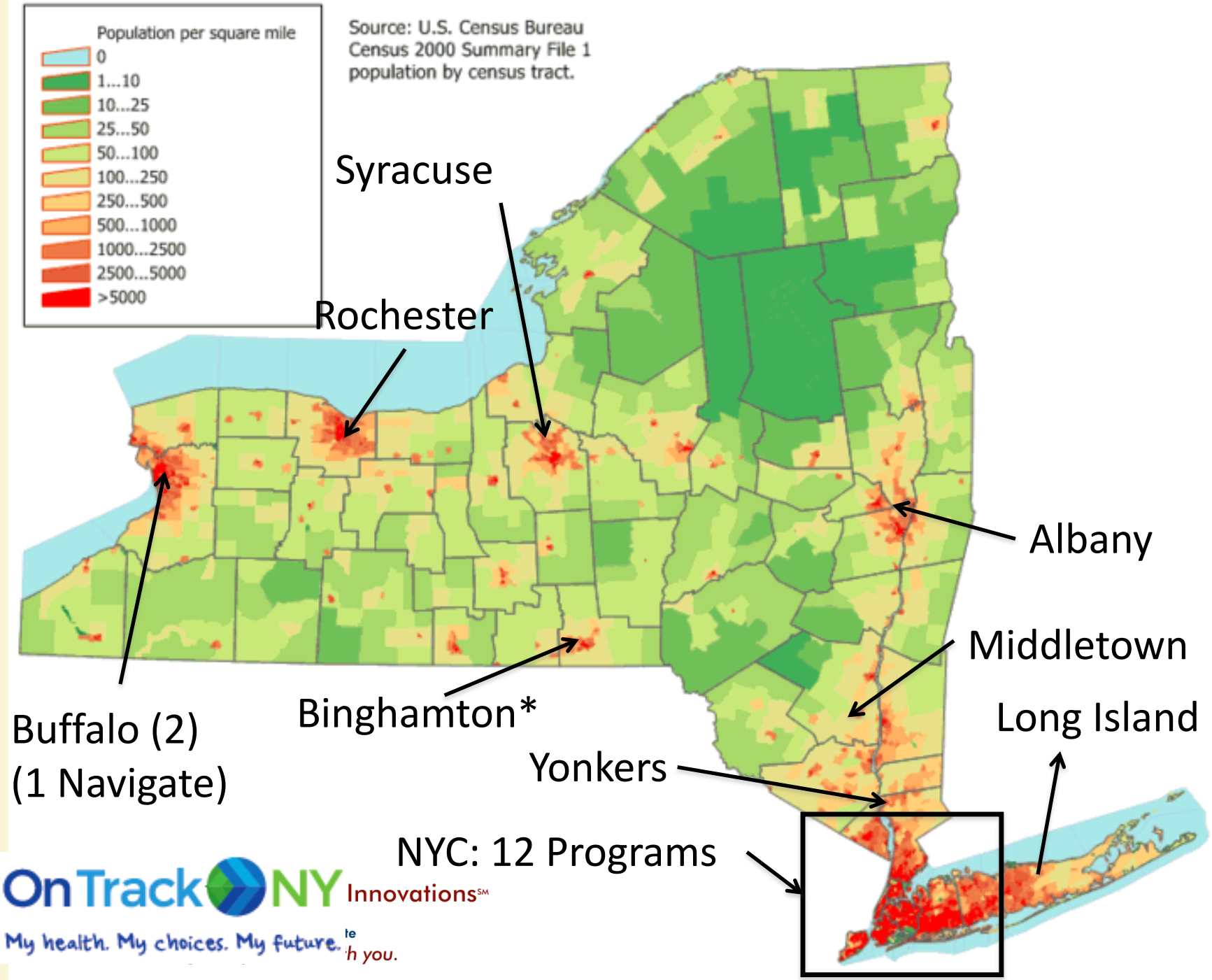


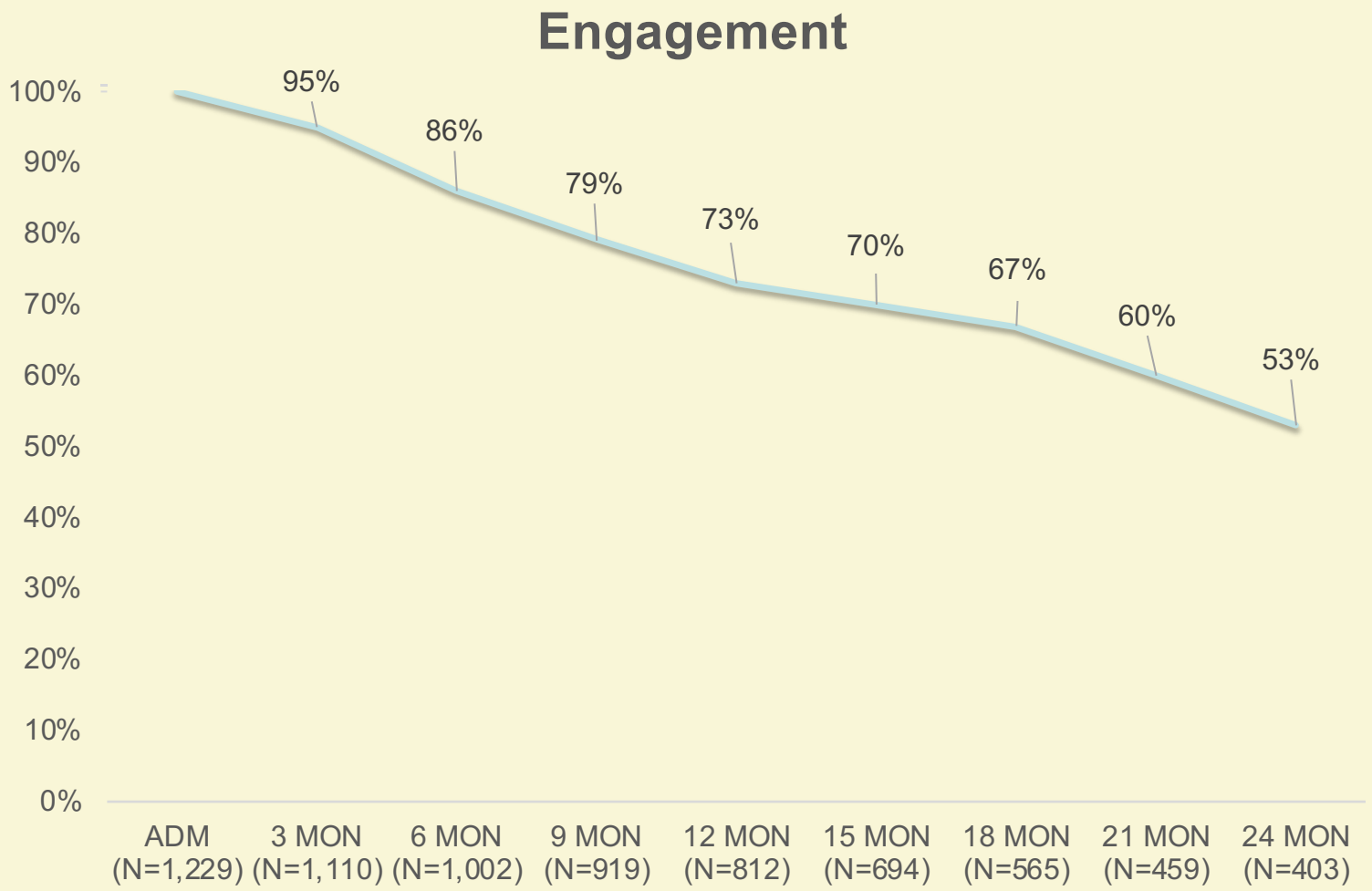
OnTrackNY Innovations℠

My health. My choices. My future. ...h you.

Characteristics of OnTrackNY Enrollees through 9/5/18 (N=1229)

- Mean age= 21, 13% under 18
- 74% Male, 26% Female, 0% Transgender
- 40% White, 39% Black, 8% Asian, 3% Multiracial, 9% Missing
- 26% Hispanic, 72% Not Hispanic, 1% Unknown
- 53% Medicaid, 36% Private, 3% Other, 4% Uninsured; 3% Unknown
- 83% Live with family, 5% Homeless
- Time since onset of psychosis 7.7 months

% Receiving Treatment Over Time (9/2018)



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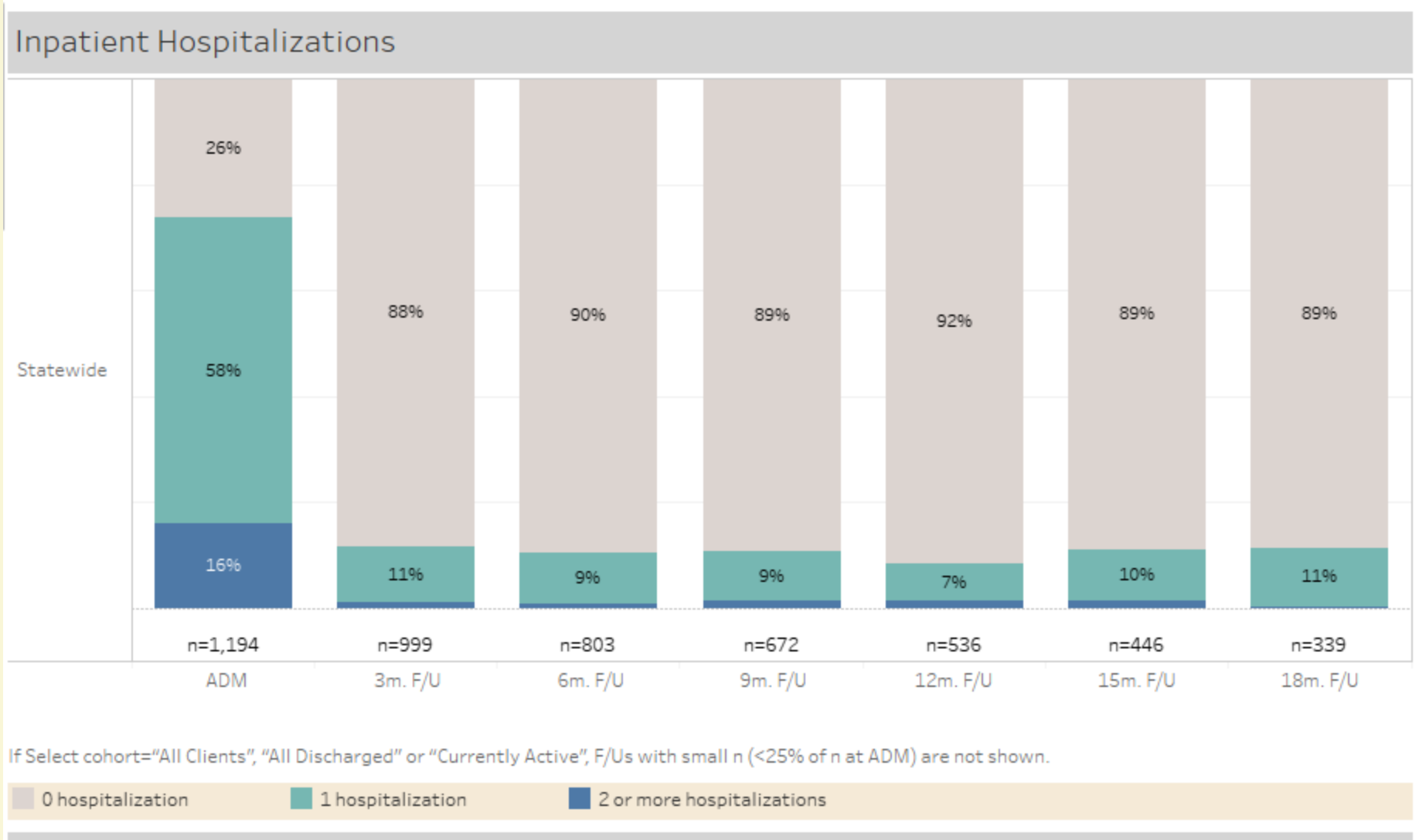
% Hospitalized Each Quarter (9/18)



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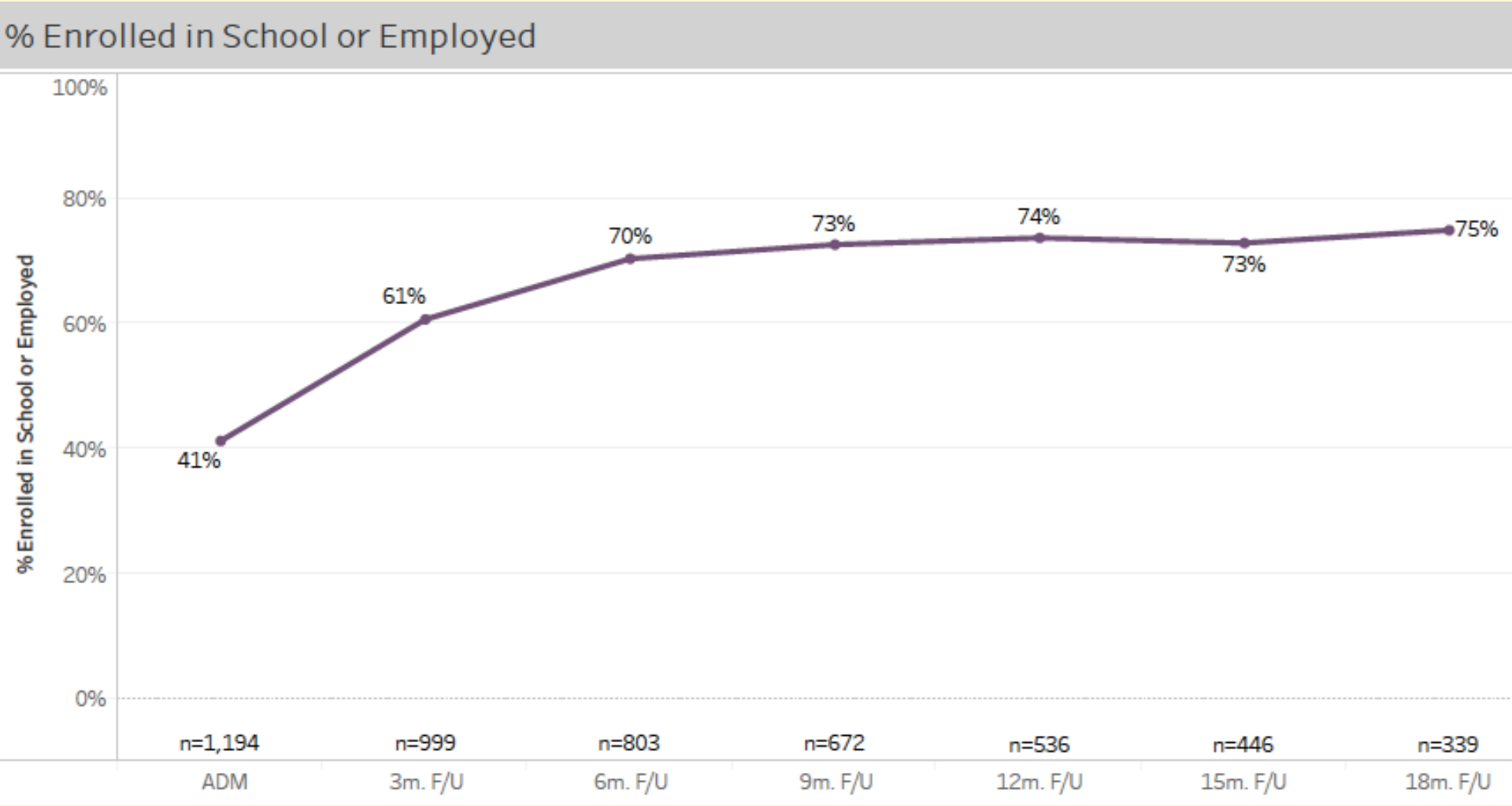
Engagement in Work or School (9/2018)



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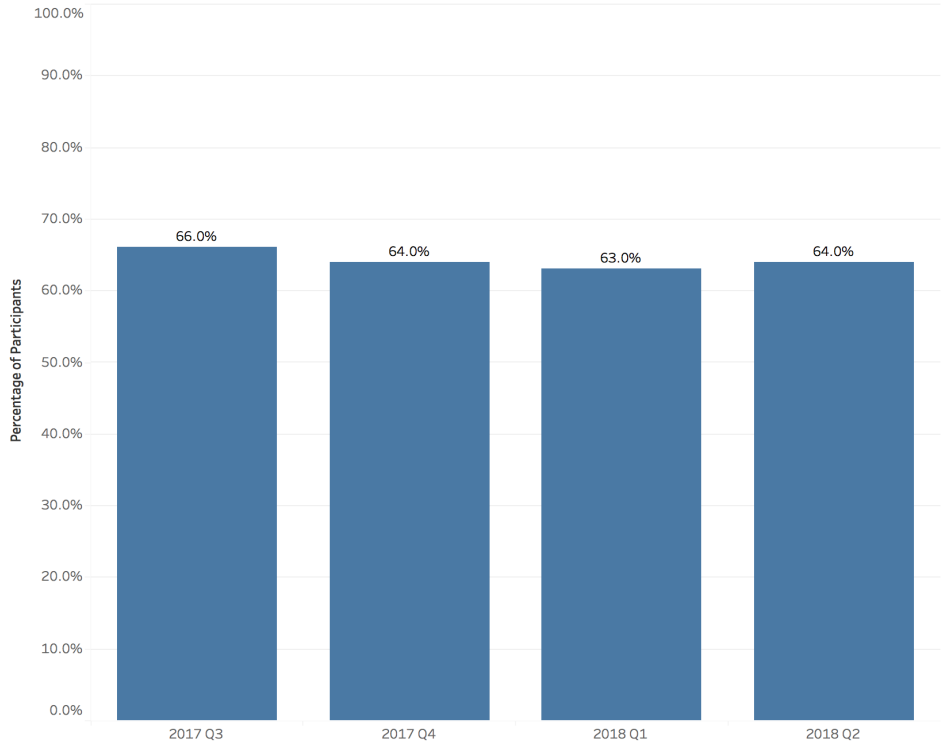
Dash_ACT | Dash_FIT | Dash_IPS | Dash_OnTrackNY | Dash_SPTIE | Dash_SysTrans

OnTrackNY Dashboard

Enrollment by Quarter

2017 Q3	2017 Q4	2018 Q1	2018 Q2	Grand Total
133	86	96	104	**419**

Percentage of Participants Competitively Employed or In School



Dashboard Tracks Enrollment By Quarter and % of clients in work or school

OnTrackNY: The Development of a Coordinated Specialty Care Program for Individuals Experiencing Early Psychosis

Iruma Bello, Ph.D., Rufina Lee, Ph.D., Igor Malinovsky, Psy.D., Liza Watkins, M.A., L.M.S.W., Ilana Nossel, M.D., Thomas Smith, M.D., Hong Ngo, Ph.D., Michael Birnbaum, M.D., Leslie Marino, M.D., M.P.H., Lloyd I. Sederer, M.D., Marleen Radigan, Dr.P.H., Gyojeong Gu, M.P.P., Susan Essock, Ph.D., Lisa B. Dixon, M.D., M.P.H.

Disability Enrollment in a Community-Based Coordinated Specialty Care Program

Jennifer Humensky, Ph.D.
Jennifer Scodes, M.S.
Melanie Wall, Ph.D.
Igor Malinovsky, Psy.D.
Leslie Marino, M.D., M.P.H.
Thomas Smith, M.D.
Lloyd Sederer, M.D.
Ilana Nossel, M.D.
Iruma Bello, Ph.D.
Lisa Dixon, M.D., M.P.H.

Results of a Coordinated Specialty Care Program for Early Psychosis and Predictors of Outcomes

Ilana Nossel, M.D., Melanie M. Wall, Ph.D., Jennifer Scodes, M.S., Leslie A. Marino, M.D., M.P.H, Sacha Zilkha, Ph.D., Iruma Bello, Ph.D., Igor Malinovsky, Psy.D., Rufina Lee, Ph.D., Marleen Radigan, Dr.P.H., Thomas E. Smith, M.D., Lloyd Sederer, M.D., Gyojeong Gu, M.P.P., Lisa Dixon, M.D., M.P.H.

Recent violence and legal involvement among young adults with early psychosis enrolled in Coordinated Specialty Care

Stephanie A. Rolin[1,2] | Leslie A. Marino[1,2] | Leah G. Pope[3] | Michael T. Compton[1,2] | Rufina J. Lee[4] | Barry Rosenfeld[5] | Merrill Rotter[6] | Ilana Nossel[1,2] | Lisa Dixon[1,2]

Suicide Prevention – Treatment, Implementation and Evaluation (SP-TIE) Program Director: Barbara Stanley, PhD

- History: Founded 2 years ago with the creation of the Suicide Prevention Office, SP-TIE developed a suicide prevention model derived from the Zero Suicide framework, **Assess-Intervene-Monitor (AIM**). It provides guidance to clinicians on basic strategies for assessing and managing suicidal clients. The model builds on modules, webinars and LC's.
- Current Activities: Focus on training activities and evaluation as specified by federal grants, creating new interventions (**Suicide Prevention Group Treatment-Inpatient (SPGT-I)** Intervention and Suicide Prevention Peer Support Program) and new electronic learning modules
- Future directions: Continue current projects, extend to other populations including FEP

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SP-TIE
Suicide Prevention-
Training Implementation Evaluation

SP-TIE Modules

Available

- Assessment of Suicidal Risk Using C-SSRS
- Safety Planning Intervention for Suicide Prevention
- Structured Follow-up and Monitoring
- Comprehensive Suicide Risk Assessment
- Suicide Prevention for Healthcare Workers

Go Live This Week

- Means Reduction Counseling for Suicide Prevention (Go live this week)
- Optimizing Clinical Care of Suicidal Individuals (Go live this week)

In preparation

- Suicide prevention for LGBTQ individuals

Federal Grant Support

- **Zero Suicide Implementation and Evaluation in Outpatient Mental Health Clinics** (NIMH) (PI: Barbara Stanley)

Total award: ***$5,000,000*** 9/15/2016-6/30/21

Implements and evaluates national Zero Suicide strategies to reduce suicidal behavior in >200 outpatient mental health clinics in NYS and compares intensive to "low touch" approaches to implementation.

- **Cooperative Agreements to Implement Zero Suicide in Health Systems** (SAMHSA) (PI: S Pechenik; Training Director: B. Stanley)

Total Award: ***$3,500,000*** 9/30/17-9/29/22

Implements Zero Suicide strategies in NYS focusing on EDs and inpatient facilities and develops a Safer Care Network model across health systems

- **Cooperative Agreements to Implement the National Strategy for Suicide Prevention** (SAMHSA) (PI: S Pechenik; Training Director: B. Stanley)

Total Award: **$1,410,000** 9/30/14-9/29/17

Advances the National Strategy for Suicide Prevention to promote "zero suicide" by implementing the Assess, Intervene, Monitor (AIM) model in health care to reduce suicidal behavior in 25-64 year olds.

ZS in NYS Project: Partnership NYS OMH and CU

- Implement the all elements of ZS using the clinical model: Assess, Intervene and Monitor for Suicide Prevention AIM-SP) in ~200 free-standing clinics across NYS, representing >80,000 clients
- Universal screening and risk assessment for all clients and a ***higher level of care*** for clients at elevated suicide risk
- Compare effectiveness of two implementation levels

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Basic vs. Enhanced Implementation Condition

Clinicians in the EI condition were more likely to complete required training as opposed to BI clinicians, suggesting EI superiority in implementation.

Basic (BI)

The BI procedures will follow usual procedures followed by PSYCKES for its CQI projects comprised of a Plan-Do-Check Act approach.

Clinicians and leadership will view modules on

- 1) C-SSRS; 2) comprehensive risk assessment; 3) SPI; 4) Follow up and monitoring

Monthly webinars will be held to address administration and implementation issues by PSYCKES staff

Enhanced (EI)

Follows BI procedures, but also received advanced training and follow up.

Selection and implementation of a clinic ZS site champion

Implementation of monthly learning collaborative meeting to facilitate ZS implementation

Advanced training on the CSSRS, risk assessment, SPI and high risk follow-up

System Transformation: Uniform Clinical Network Provider Training
Director: Sapana Patel, PhD

- History: Founded 1.5 years ago under the NYS transition of behavioral health services into Medicaid Managed care. Collaborates with NYS Health Plan Association and CASA to provide a uniform clinical online training in core competencies to licensed OMH, OASAS clinics and PROS programs statewide
- Current Activities: Enrollment and online training for 279 clinics and 18 PROS programs statewide to date. Provision of real-time reporting of training uptake and provider profile for clinics , state profile for clinics, state partners and Managed care organizations.
- Future Directions: Will support HCBS and other OMH priorities.

UCNPT Outer Setting

Outer Setting – policies, regulations, and fiscal reimbursements to programs must align to support the change; State authorities must provide a clear message of importance to programs.

Pre-implementation
- Responsive to the State request for qualifications of provider network quality and adequacy
- Align with DSRIP, Health Homes and other system changes
- Collaborate with NY State Health Plan Association (MMCO) and OMH, OASAS to understand incentives
- Key OMH/OASAS leadership and HPA strongly encourages agencies and programs to participate in UCNPT training

Implementation
- Guidance documents from state regarding training goals within the context of value based care
- Reports of uptake and participation regularly provided to OMH, OASAS and HPA for targeted outreach and monitoring
- Co-develop strategies to incentivize training participation:
- Embed in quality or performance improvement project
- NYS consider mandating centralized training outside of licensure
- Provider Quality Feedback Program: MMCOs to add this as a quality metric.

Maintenance and Evolution
- Ongoing discussions with key OMH leadership to advise around challenges

Inner Setting

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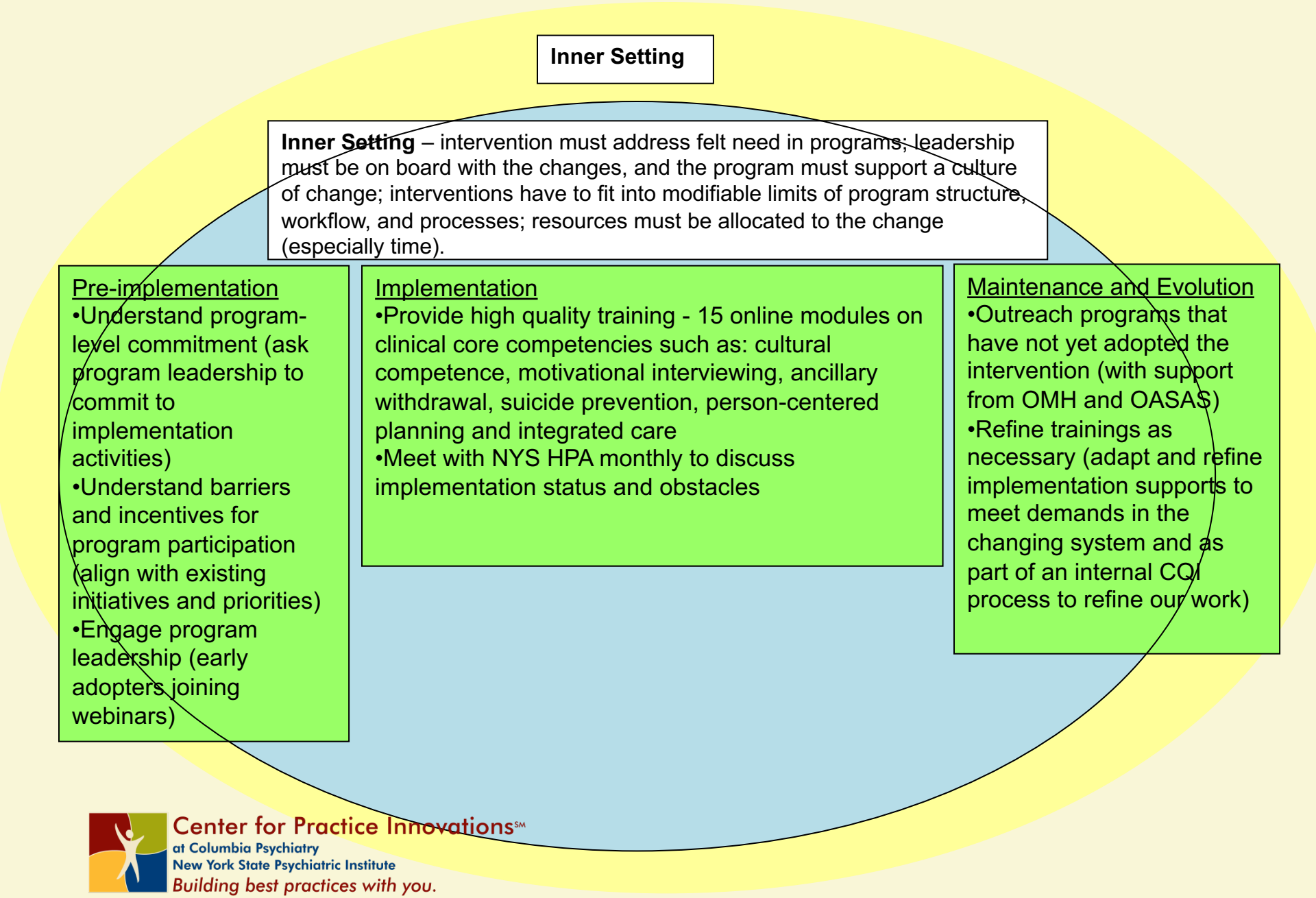
UCNPT Inner Setting



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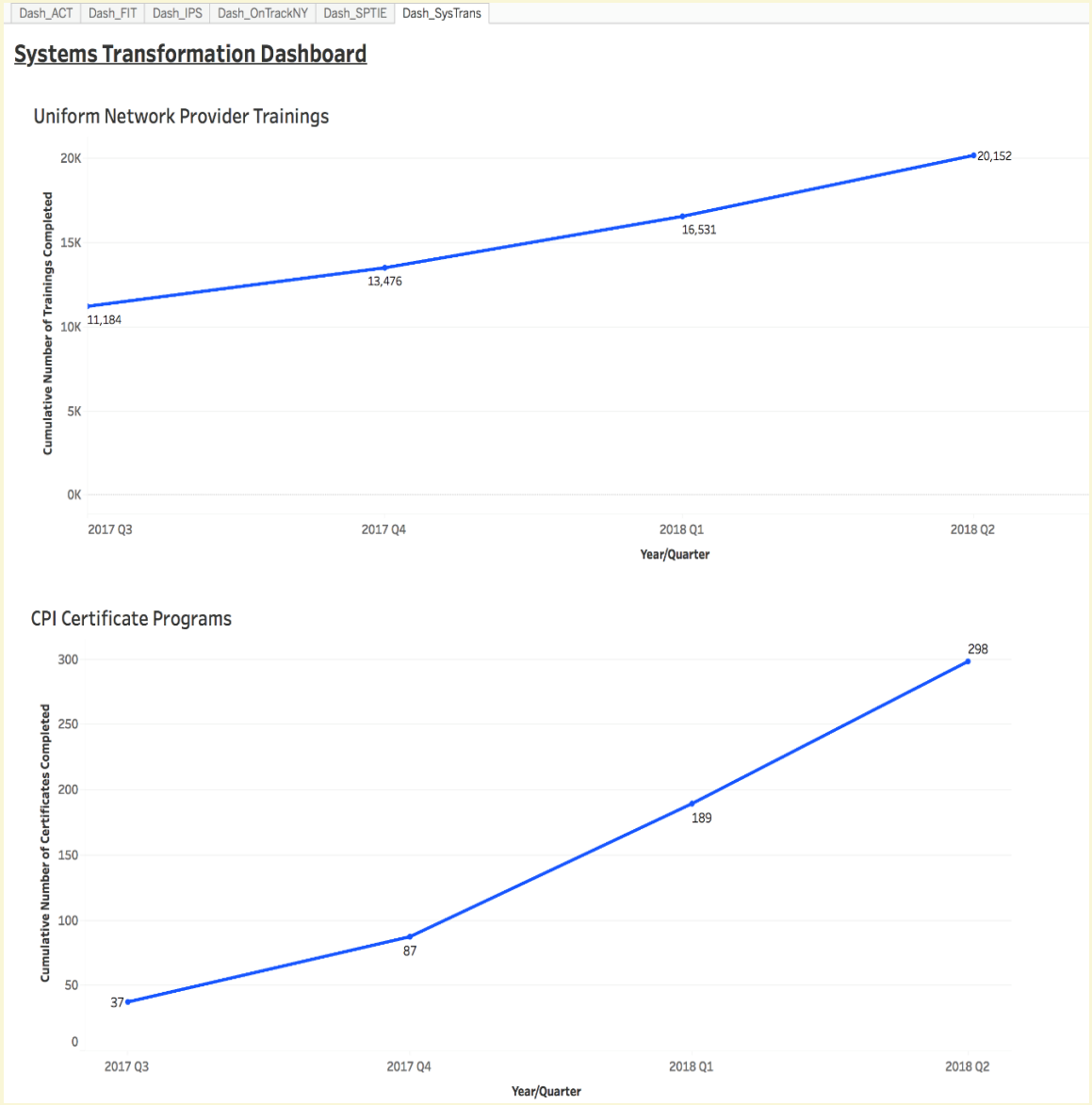

Dashboard Tracks Network Trainings and Certificate Programs

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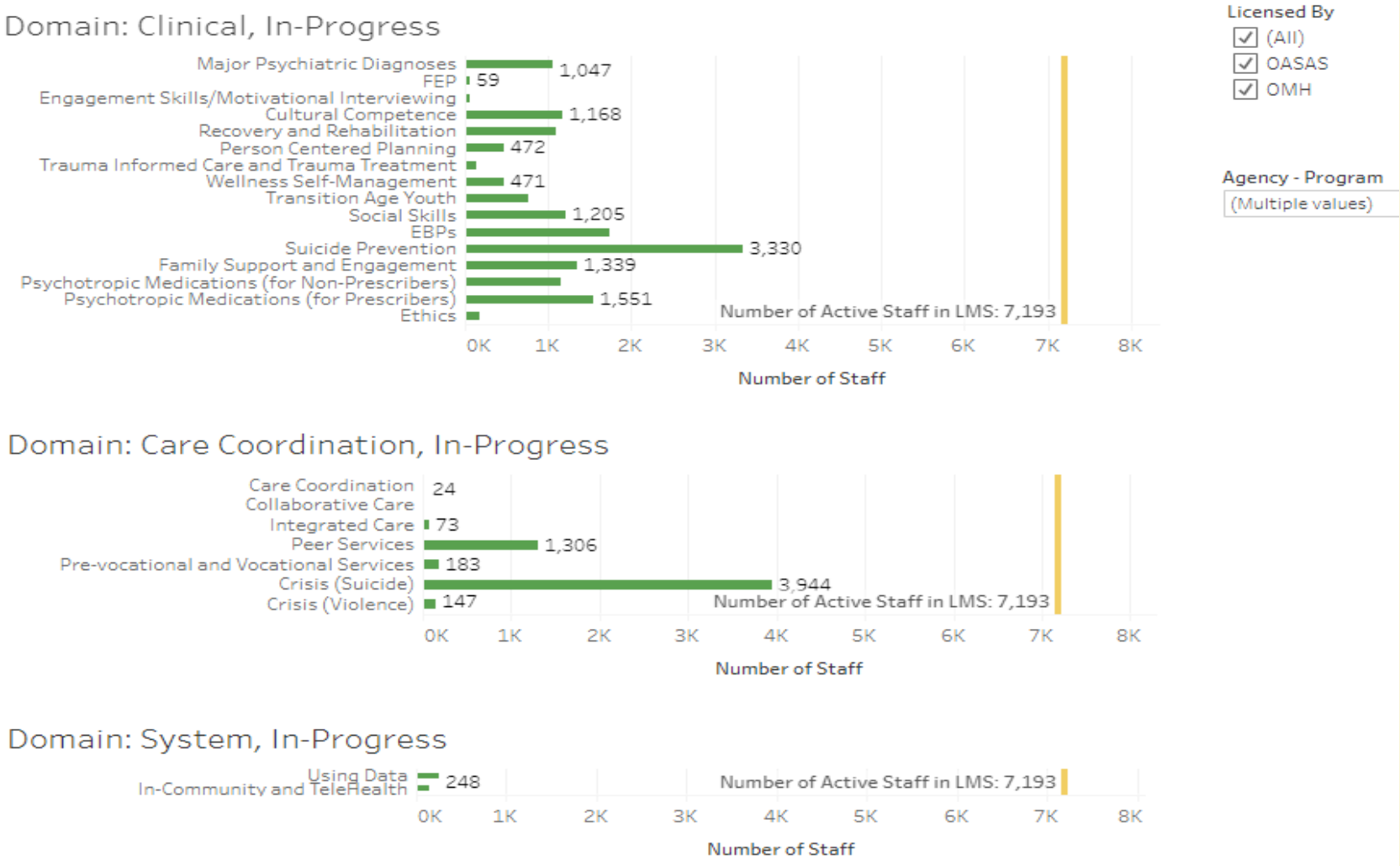
Provider Profiles

Article 31 & 32 Provider Profile Topics

"In-Progress" is defined as completing at least one training within a topic



CPI Medical Director
David Lowenthal MD, JD

- History: DL joined 7/17 in a newly created Medical Director position. 20+ years at NYSPI including many years as an inpatient psychiatrist and nine years as Clinical Director; forensic training as well
- Current Activities: Contributing to OnTrackNY, ACT Institute (Forensic ACT Learning Collaborative), SP-TIE – Means Restriction Counseling module, podcasts with leaders regarding transformation. Developing annual psychopharmacology Update for prescribers (updates, classes of medications, particular uses of medications)
- Future Directions: Complete 6-segment course, learning while commuting), “What is an effective acute care hospitalization?”

CPI Practice Change Model: Psychopharmacology

Inner Setting – intervention must address felt need in programs; leadership must be on board with the changes, and the program must support a culture of change; interventions have to fit into modifiable limits of program structure, workflow, and processes; resources must be allocated to the change (especially time).

Pre-implementation	Implementation	Maintenance and Evolution
•Understand needs of prescribers at different agencies •Engage program leadership using provider advisory committee	•Training – create up to 6 online modules for experienced prescribers focusing on new medications/findings and underutilized best practices."	

Prescriber Workforce

- 45-60 minute learning modules that can be produced in-house and be more engaging than traditional “talking head” slide presentations
- Target audience relatively experienced clinicians
- Have recruited instructional design consultant, advisory board, SMEs for first few modules
- Will offer CMEs to MDs but other ideas to get viewers (MDs and NPs)

Cognitive Health
Alice Medalia, PhD

- History: Dr. Medalia has been studying and implementing strategies to improve cognitive health for 35 years. She began working directly with OMH in 2014 and joined CPI this year.
- Current Activities: Thinking Well is is an OMH campaign intended to focus on the need for Cognitive Health to make a good Recovery. COGNITIVE REMEDIATION to PROMOTE RECOVERY (CR2R) is the first clinical treatment arm of the OMH cognitive health initiative. It has 3 pillars: Maximizing wellness; Improving cognitive deficits; Achieving patient-centered recovery goals
- Future Directions: Create the module *Why Cognitive Health Matters;* develop and test online training for CR2PR clinicians

What is Cognitive Health?

Across ethnic and racial groups people describe cognitive health as :

- staying sharp
- being right in the mind
- being alert
- having a good memory
- being socially involved

Cognitive health allows one to maintain social connectedness, to have an ongoing sense of purpose, to function independently, and better recover from illness.

We Address Cognition to Enable Recovery

Cognitive Services involve

- Shared engagement in the therapeutic process
- Empowerment and hope
- Social Integration

Cognitive remediation is a recovery-oriented and patient-centered practice for individual empowerment.

Cognitive awareness by clinician, consumer, and loved one impacts current and down-stream care (i.e., polypharmacy, improved physical health, vocational support)

Why Cognitive Health Matters

Alice Medalia, PhD
Matthew Erlich, MD

AJPH January 2017, Vol 107, No. 1

CNS Spectrums (2018), page 1 of 11.
doi:10.1017/S1092852918000822

ORIGINAL RESEARCH

Cognitive remediation in large systems of psychiatric care

Alice Medalia,[1,2] Alice M. Saperstein,[1,2] Matthew D. Erlich,[1,2,3] and Lloyd I. Sederer[2,3,4]

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Obsessive Compulsive Disorder
Sapana Patel, PhD & Blair Simpson, MD, PhD

- History and Current Activities: This initiative began in 2018 with support from OMH as a two-year workforce development program to develop on-line trainings and other resources to help front line and other clinicians serve clinicians and adults with OCD.
- Future Directions: Increase clinician competency to identify, diagnose and treat children and adults with OCD and provide informational resources to families of individuals with OCD. Develop methods to increase and support capacity to treat OCD within the OMH system using training, implementation support and mHealth interventions.

Goals

- Raise awareness of the disorder
- Learn what providers need to meet the needs of individuals with OCD and their families
- Develop and test the effectiveness of online training resources for OCD
- Provide support through a consultation service for complex cases

OCD program Outer Setting

Outer Setting – policies, regulations, and fiscal reimbursements to programs must align to support the change; State authorities must provide a clear message of importance to programs.

Pre-implementation
•Engage an advisory board to 1) learn more about how and where individuals with OCD present in the NYS-OMH system; 2) brainstorm strategies to raise awareness about OCD and engage interest of providers and leadership at licensed and state-operated programs serving children and adults

New York State Office of Mental Health	Bob Myers, PhD Donna Bradbury, MA
Center for OCD and Related Disorders	Blair Simpson, MD, PhD Marina Gershkovich, PhD Meredith Senter, MD
Center for Practice Innovations	Sapana Patel, PhD Lisa Dixon, MD, MPH Melissa Hinds, RN, BSN
Provider Advisory Committee	Virna Little, PsyD Chris Lunsford, LCSW Lori Brennan, LMSW Vanessa Proano, MA Jennifer Kramer, LMHC Larry Guttmacher, MD

OCD program Inner Setting

Inner Setting

Inner Setting – intervention must address felt need in programs; leadership must be on board with the changes, and the program must support a culture of change; interventions have to fit into modifiable limits of program structure, workflow, and processes; resources must be allocated to the change (especially time).

Pre-implementation
- Understand program-level commitment (ask program leadership to commit to implementation activities)
- Understand barriers and incentives for program participation (align with existing initiatives and priorities)

Implementation
- Training – provide live webinar on misconceptions of OCD to help providers learn about OCD and its symptoms, understand causes of OCD and learn about treatments.

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OCD in public sector

Psychiatric Services
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Brief Reports

Full Access

Treatment of Obsessive-Compulsive Disorder in a Nationwide Survey of Office-Based Physician Practice

Sapana R. Patel, Ph.D., Jennifer L. Humensky, Ph.D., Mark Olfson, M.D., Helen Blair Simpson, M.D., Ph.D., Robert Myers, Ph.D., and Lisa B. Dixon, M.D., M.P.H.

Published Online: 1 May 2014 | https://doi.org/10.1176/appi.ps.201300192

Psychiatric Services
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Articles

Full Access

Patient Preferences and Acceptability of Evidence-Based and Novel Treatments for Obsessive-Compulsive Disorder

Sapana R. Patel, Ph.D., Hanga Galfavy, Ph.D., Marcia B. Kimeldorf, Ph.D., Lisa B. Dixon, M.D., M.P.H., Helen Blair Simpson, M.D., Ph.D.

Published Online: 17 Oct 2016 | https://doi.org/10.1176/appi.ps.201600092

ELSEVIER
Behavior Therapy
Available online 15 September 2017
In Press, Accepted Manuscript

Acceptability, Feasibility and Effectiveness of Internet Based Cognitive Behavioral Therapy for Obsessive Compulsive Disorder in New York ☆

Sapana R. Patel [a, b], Michael G. Wheaton [c], Erik Andersson [d], Christian Rück [d], Andrew B. Schmidt [a], Christopher La Lima [a], Hanga Galfavy [b, e], Olivia Pascucci [a], Robert W. Myers [f], Lisa B. Dixon [a, b], Helen Blair Simpson [a, b]

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WSM Wellness Self-Management

Hope. Choice. Involvement. Recovery.

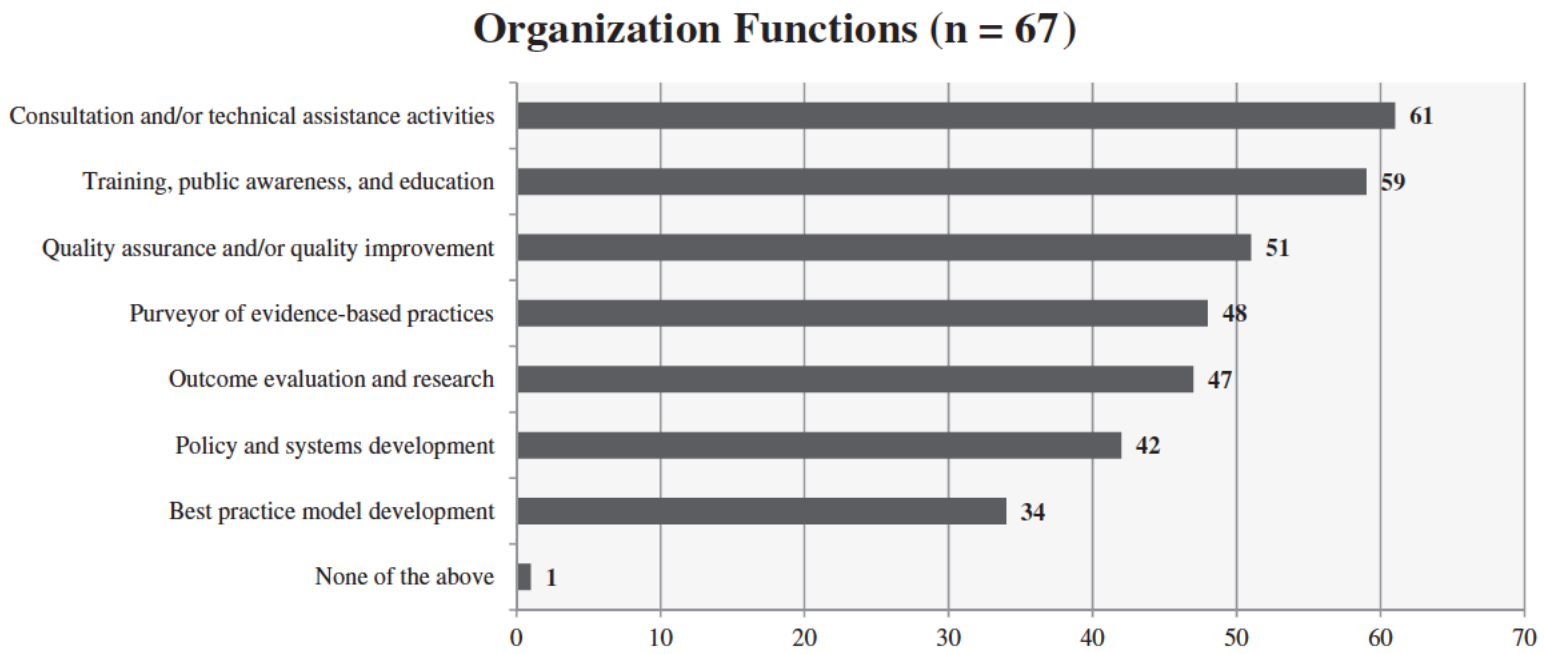
- Wellness Self-Management is a curriculum-based clinical practice designed to assist adults to effectively manage serious mental health problems.

- WSM provides online training and workbooks to OMH-licensed programs that are enrolled in the WSM practice improvement network and OMH- and OASAS-licensed programs that are enrolled in the WSM+ learning collaborative.

Who Supports the Successful Implementation and Sustainability of Evidence-Based Practices? Defining and Understanding the Roles of Intermediary and Purveyor Organizations

Robert P. Franks, Christopher T. Bory

Figure 4.1. Endorsement of Organizational Functions



Franks, R. P., & Bory, C. T. (2015). Who supports the successful implementation and sustainability of evidence-based practices? Defining and understanding the roles of intermediary and purveyor organizations. In K. P. McCoy & A. Diana (Eds.), *The science, and art, of program dissemination: Strategies, successes, and challenges. New Directions for Child and Adolescent Development*, *149*, 41–56.

Is Scaling Evidence Based Practices a Lost Cause?

NO

It can be done!

Center for Practice Innovations℠
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Building best practices with you.

Summary

- It is possible to work within public mental health system to provide strategic technical support for implementation of EBP's. Distance learning can promote efficiency
- Difficult to establish effectiveness of the EBP support without dedicating resources to assessing training processes as well as fidelity and outcomes of treatment.
- Must rely on range of data sources and designs to make inferences, e.g., self-report, administrative data, non-experimental
- Working toward maximizing inquiry and empirical approach into activities
- Redefinition and opportunities in context of Medicaid transformation and move to managed care

What is Success?

- A client who receives IPS who has a competitive job.
- An ACT client who begins his recovery journey, connects with family and community, and graduates to less intensive care.
- An individual with co-occurring substance use and mental illness who shifts from “I have no problem” to “I want to stop using.”
- An individual who when experiencing suicidal thoughts uses his/her safety plan and gets past the crisis.
- A young person experiencing early psychosis who graduates from nursing school.
- An empowered clinician, supervisor and agency lead who knows they contributed to making this happen!