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**Motivational Interviewing Example**

**MHTTC D&I PROJECT TEMPLATE (for Intensive TA Projects)**

**The purpose of this template is to track the course and outcome of intensive TA projects.**

* We will summarize information from forms completed across the Network to inform us about how intensive TA projects are being conducted, and shed light on how we might better use implementation science findings to guide our work.
* Our intention is not to compare Centers to each other. We want to learn how we are all developing TA services and how we can improve as a Network.

**Instructions for completion:**

* #4 Implementation Strategy
  + Format refers to whether the strategy was conducted in person, virtually, via email, phone, or other communication.
  + Full Dose refers to the total number of sessions or units of the strategy.
  + Frequency refers to how often the strategy was set to occur.
* #5 Implementation Process
  + Complete for the units of analysis that make the most sense for your project (organization, program, participants), usually the number of individual participants and organizations.
  + Report overall percentages, such that the denominator is the number enrolled (b). Show your math. This is intended to be like a modified CONSORT diagram.
  + b) How many participants were enrolled at the start of the project?
  + c) How many participants completed the first implementation strategy? To understand whether people or organizations dropped out before the project started.
  + d) and e) – How many participants completed about 50%/80% of the total number of planned implementation activities? To understand where there was drop off or drop out.
* #6 - Implementation/Sustainment Impact
  + a) Reach refers to the number of consumers who received the EBP. Ideally you might also know the number who were eligible to receive the EBP to calculate a percent.
  + c) Adoption refers to the number of providers who started using the EBP. Ideally you would also know the total number of providers to calculate a percent.

**Instructions for piloting:**

* Please complete this template for 2 projects (if possible) that your Center has completed, not projects that are just beginning or are mid-way. We don’t expect this to take a lot of time or that you will go out and collect new information.
* Return the completed forms to Heather Gotham, [gothamh@stanford.edu](mailto:gothamh@stanford.edu) by Wednesday, Feb 26th.
* On the last page, note any questions or comments that you have about the form or the process of completing it.
* Not everyone will be able to answer all of the questions, or have measured all of the outcomes. That’s fine – again, we want to start by getting a sense of our work as we are conducting it now.

**MHTTC D&I PROJECT TEMPLATE (for Intensive TA Projects)**

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|  | **Center:** [example] **Person Completing Form:** Heather Gotham  **Dates of Project:** Jan 2015 – August 2015 **Template Completed At (Pre or Post):** Post  **Title of Project:** Motivational Interviewing for One State | | | | |
| **1** | **Evidence-Based Intervention/Program/Service Being Implemented (*WHAT)***: This project sought to assist 15 behavioral health treatment providers to implement motivational interviewing in their staff and supervisors. | | | | |
| **2** | **Target Audience (*WHO*)**:  a) Specify type of organization(s): 15 regional behavioral health treatment organizations  b) Specify disciplines and job titles of participants: 2 frontline clinicians (e.g., licensed professional counselors, licensed clinical social workers) and 1 clinical supervisor per agency  c) Specify audience relationship to one another (Check all that apply):  \_\_\_Multiple individuals across organizations  \_\_\_Multiple individuals within an organization (e.g., organization-facing intervention; 1 org)  \_x\_\_Teams across organizations | | | | |
| **3** | **Contextual/determinant Considerations** (What are the barriers or facilitators that your participants face?):  a) System factors--external to the organization (e.g., financing; mandates, community, culture): state pressure to implement EBPs; lingering beliefs in the culture that SUDs are a moral issue and MI is enabling; no financial benefit to implementing MI unless can show increase in retention rates  b) Organizational factors—internal to the organization (e.g., leadership; readiness): executive leadership was committed to implement; mixed readiness of staff  c) Individual clinician factors (e.g., alignment with existing practice; complexity): most clinicians saw need for this model; clinicians initially unsure they would be given appropriate time off for training and recording sessions; most clinicians did not want to record and submit sessions for review;  d) How were these considerations ascertained? Issues mentioned during the course of the project | | | | |
| **4** | **Implementation Strategy\* (*HOW*)** (Use strategies from attached checklist; add or delete rows if needed)**:** | | | | |
| **Type** | | **Format** | **Planned # of Units** | **Frequency** |
| Develop stakeholder relationships: signed commitment letter from executive sponsor that included designation of change leader and implementation team | | Written communication | 1 | Once |
| Interactive assistance: 2 virtual meetings with executive sponsors and change leaders to discuss project and implementation barriers | | Virtual meeting | 2 | 3 months apart |
| Train/educate stakeholders: initial online training for clinicians and supervisors | | Online training | 1 6-hour course | Once |
| Train/educate stakeholders: in-person 2-day advanced skills training for clinicians and supervisors | | In-person | 2 days | Once |
| Interactive assistance: participants submitted a recorded session; coded by trainer; 1-hour individual meeting to review results; submitted up to 3 recordings until achieved competence via MITI rating scale | | Session review; virtual meeting | 1-3 reviews | Up to 3 within 6 months |
| Interactive assistance: Monthly group coaching calls for 6 months | | Virtual group coaching | 6 sessions | Monthly |
| Train/educate stakeholders: in-person 2-day supervisor training | | In-person | 2 days | Once |
| **5** | **Implementation Process:** (organization, program, and/ participant level; denominator for % is b) # enrolled; show your math)  a) How were participants recruited: Email through state provider association and state behavioral health authority. Email directly to providers on listserv.  b) # enrolled: \_45\_\_\_\_  c) # (%) initiating implementation strategy (individuals, teams or organizations): \_42 (93%)\_\_\_  d) # (%) completing 50% of implementation strategy activities: \_42 (100%) [made it through the 2-day advanced skills course]\_\_\_\_  e) # (%) completing 80% or more of implementation strategy activities: \_37 (82%) achieved competence\_\_\_\_ | | | | |
| **6** | **Implementation/Sustainment Impact (*WHY*):** | | | | |
| **Outcome** | **How are you measuring the outcome? What were the results?** | | | |
| a) Reach (#/% of consumers) | Didn’t measure | | | |
| b) Effectiveness of Intervention/Program/Services (w/consumers) | Didn’t measure | | | |
| c) Adoption (#/% of providers) | 3 month follow-up after the end of the strategies. Of the 37 who achieved competence, 20 reported that they were using MI in practice. | | | |
| d) Implementation Fidelity/ Adherence/Quality | Measured as whether participants reached competence via the MITI. 37 of the 42 achieved competence. | | | |
| e) Maintenance/Sustainment | At 6 month follow-up, 15 reported that they were using MI in practice. | | | |
| f) Cost | Estimated cost of implementation strategies, including trainers, travel, etc., was $7,500 per participant. | | | |
| **7** | **Other relevant issues?** | | | | |
|  |

**Determine which best describe the implementation strategies used in your project. They may be discrete, multicomponent, or both. Check them off here, and then fill them in under #4 above.**

**DISCRETE STRATEGY CHECKLIST (check all that apply)**

Evaluative and iterative strategies (e.g., Assess for readiness; Identify barriers and facilitators; Audit and feedback)

Interactive assistance (e.g., Facilitation; Technical assistance; Coaching; Clinical Supervision; Mentoring)

Adapting and tailoring strategies (e.g., Based on barriers or facilitators; Stage of readiness; Characteristics of the Intervention; Baseline performance)

Develop stakeholder relationships (e.g., Identify and prepare champions; Inform local opinion leaders; Build coalitions)

Train/educate stakeholders (e.g., Conduct ongoing training; Develop educational materials; Learning Collaborative; Practice Improvement Collaborative)

Support deliverers of the intervention/program/service (e.g. Reminders; Resource sharing agreements; Role revision)

Engage consumers (e.g., Involve consumers and family members; Use mass media or public service announcements)

Use financial strategies (e.g., Access new funding [time-limited grant or 3rd party insurance]; Provide incentives/allowance; Develop disincentives)

Change infrastructure (e.g., Policy mandates; Alter physical environment)

**MULTICOMPONENT STRATEGY CHECKLIST**

Learning collaboratives/Practice Improvement collaboratives

Check components used:

Multi-individual, team or organization meeting (virtual or in person)

Didactic presentations by experts

Common quality measures collected and shared

Participant presentations

PDSA rapid cycle change tactics

NIATx

Check components used:

Walk-thru patient perspective

Engage executive sponsor (internal leader)

Engage champion

Organize change team

PDSA rapid cycle change tactics

Multi-individual, team or organization meeting (virtual or in person)

Coaching

Implementation Facilitation

Check components used:

Assess readiness and existing process

Outcome data audit and feedback

Planning

Coaching

Organize implementation team

A3/LEAN/Six Sigma/QI/Process Improvement

Check components used:

Organize a change team

Define SMART goal

Identify key drivers/levers/barriers

PDSA

Measure changes/outcomes