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Building a high quality mental health and addictions system: Learning from four intermediary organizations

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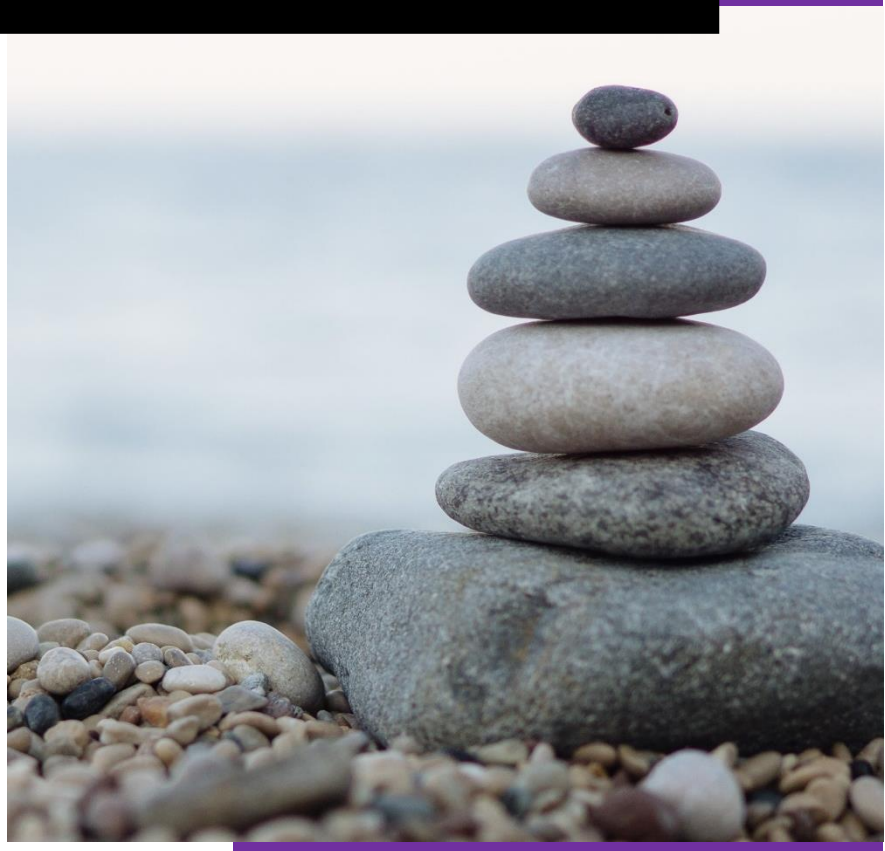

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Contents

Main Messages

Ontario is involved in major health system reform, one aim being to provide consistent, high quality delivery of evidence-based care across the health care system, including for mental health and addictions treatment. Intermediary organizations have emerged in recent years as a major strategy to bridge the research-to-practice gap and support delivery of evidence-based practices (EBPs) within systems of care.

This report profiles four intermediary organizations, selected to be relevant to Ontario efforts to implement structures and processes to support high-quality delivery of EBPs in mental health and addictions treatment.

Based on this review, the following considerations were identified for Ontario:

- An intermediary organization can play a key role in supporting high quality implementation and spread of EBPs in the Ontario mental health and addictions system through a centralized strategy of data collection, integration and reporting to support a learning health care system.
- All aspects of the work of the intermediary should be guided by the standards of care/practice expected for Ontario programs (the core services).
- There can be value in the intermediary being arms-length from government to gain the trust and participation of programs.
- The intermediary is an important source of information about the quality of care in the system and can identify where policy changes or more support are needed to enable programs to deliver high quality care. As such, ongoing communication/ collaboration between the intermediary and the funder is key.
- An intermediary organization may be dedicated to the delivery of one EBP or oversee delivery of multiple EBPs. Regardless, methods and resources should be shared/leveraged, where possible, to increase efficiencies and share learning.
- Ensuring adequate funding for the intermediary is important to enable it to perform its work. The search for additional funds, which was evident in some of the intermediaries reviewed, required time, created stress and limited the scope of work.
- Incentives are an effective strategy to increase program participation in the monitoring and support activities of the intermediary. These incentives can be

financial (e.g., funding enhancements conditional on program fidelity performance or staff training completion/certification) or non-financial (e.g., performance profiling and public commendations). While the reviewed jurisdictions commonly tied funding incentives to performance, programs received support to improve their performance and rarely did quality problems need to be escalated to the funder for review/further action.

- Positive relationships between the intermediary and programs are fundamental to the success of the work. These can be developed through routine contact with programs, employing some staff with clinical experience to enhance credibility, and regular feedback to demonstrate the value of the collected data and inform local improvement work.
- Four core pillars of intermediary work include:
  - Fidelity assessments to measure service delivery in relation to practice expectations and inform program and system level improvement efforts.
  - Centralized training to build and sustain a skilled work force that is equipped to provide a standardized approach to care across programs in the face of staff turnover and evolving evidence.
  - Outcome measurement to measure client outcomes, assess the impact of care and build evidence on treatment effectiveness.
  - Quality improvement/implementation to support programs on the use of fidelity and outcome data to improve quality of services.
- Integrating scientific expertise into the work of the intermediary is key to conducting these core activities with quality and rigour..
- Capacity is needed at the program level to support routine, high quality data collection. Lack of necessary infrastructure and resources for routine data collection was a common barrier across the reviewed intermediaries.
- Stakeholders (including existing EBP networks and organizations, clients and families) should be routinely and meaningfully engaged in intermediary activities.
- Intermediaries are well positioned to conduct practice-based research, which is integral to a learning health care system. However, intentional support for this work needs to be built into the organizational model (e.g., employing clinician researchers, providing protected time). Research can help position the intermediary as a leader in its field.

Background

Ontario is currently undergoing major health system reform that includes the aim of consistent, high quality delivery of evidence-based practices (EPBs) across the province. This is especially relevant to the community mental health and addictions sector, which has lagged behind other Ontario health sectors in supporting EBP practice delivery and improvement. Ontario is not unique in this. Delivery of evidence-based psychosocial community interventions is an international challenge.[1]

The Ontario Mental Health and Addictions Centre of Excellence was recently formed with a mandate to improve consistency and quality of service delivery across the province in line with best practice evidence.[2] The Centre recognizes that concrete mechanisms are needed to implement and scale scientifically supported treatments and interventions to community-based settings. A number of stakeholder networks have formed to support spread of EBPs in Ontario (e.g., Early Psychosis Intervention [EPI]; Assertive Community Treatment [ACT]; Housing First [HF]) but they operate with limited funding that narrows the range of activities, scale and continuity of their work.[3]

In recent years, intermediary organizations have emerged as a major strategy to bridge the research-to-practice gap.[1] They help to develop, implement and support delivery of EBPs within systems of care, building agency and system capacity to implement and sustain such practices with fidelity and to good effect.[1,4] They achieve these aims through various strategies, such as training, fidelity assessments, outcome monitoring and quality improvement/implementation support. Intermediary organizations are considered to serve a vital role in improving the quality of health care and have grown considerably in number in recent decades.[5] They vary widely in their activities, funding models and structures.[1,4,6]

To inform Ontario efforts to build structures and processes to support delivery of high quality care in the mental health and addictions sector, our team reviewed four diverse intermediary organizations in Canada and the US. This report provides an overview of how each intermediary organization operates and identifies successful strategies that may be relevant to Ontario.

Approach

Sample selection

An initial list of intermediary organizations that support delivery of mental health and addictions services was compiled through a web search, suggestions from experts and a review of key papers on the topic. The initial list was investigated further to identify those organizations that met the criteria below:

- Mature organization (i.e., in operation longer than 5 years)
- System-wide, ongoing mandate
- Provided a range of implementation supports (e.g., training, fidelity monitoring, outcome measurement, coaching).

The final sample of four intermediaries was selected based on variation in organizational structure, the number of EBPs supported and developmental history.

Acronyms

EBP: Evidence-based practice

CPI: Centre for Practice Innovations

CEBP: Centre for Evidence-Based Practices

EASA: Early Assessment & Support Alliance Center for Excellence

CNESM: National Centre for Excellence in Mental Health

ACT: Assertive Community Treatment

EPI: Early Psychosis Intervention

IPS: Individual Placement and Support

FACT: Flexible Assertive Community Treatment

ICM: Intensive Case Management

Review method

Information about each intermediary organization was summarized using a standardized template based on a US survey of intermediary organizations.[4] The summarized information included the mandate, sources of funding, development history, relationship to government/policymakers, relationship to academia, EBPs supported, implementation supports (e.g., fidelity monitoring, training, outcome measurement, quality improvement support, etc.), participation incentives/accountabilities, strengths and challenges.

An initial profile for each organization was created based on a review of public documents (i.e., published papers, reports and website) and interviews with key informants from the organization. The profile was then shared with the key informant to validate the data and fill in any gaps.

Profiles in brief

Four intermediaries were selected for the review (see Table 1). Three are located in the US: Centre for Practice Innovations (CPI), Centre for Evidence-Based Practices (CEBP), and Early Assessment & Support Alliance (EASA) Center for Excellence. One is located in Canada: the National Centre for Excellence in Mental Health/Centre nationale d'escellence en santé mentale (CNESM). All operate in systems where both the intermediary and the services they support are largely publicly funded. See the appendix for additional information about each of the four intermediaries.

Table 1: Overview of Intermediary Organizations

Intermediary Organization	**Centre for Practice Innovations**	**Centre for Evidence-Based Practices***	**Early Assessment & Support Alliance Center for Excellence**	**National Centre for Excellence in Mental Health**
Jurisdiction	**New York State** (pop = 19.5 M)	**Ohio** (pop = 11.69 M)	**Oregon** (pop = 4.5 M)	**Quebec** (pop = 8.6 M)
Governance and structure				
Mandate	Develop and implement mechanisms to promote adoption of EBPs in catchment area			
Host	University	University	University	Government
Funding	Public, grants	Public, contracts	Public, grants	Public
Relationship to funder	Arms-length but accountable to funder	Arms-length but accountable to funder	Arms-length but accountable to funder	Within government
Relationship to academia	Highly integrated	Somewhat integrated	Moderately integrated	Not integrated
Staffing	Dedicated team per EBP	Dedicated staff per function	Dedicated staff per region	Dedicated staff per EBP
EBPs supported				
EBPs	ACT, EPI, IPS, four others**	ACT	EPI	ACT, FACT, EPI, ICM

Participation incentives for system agencies				
Incentives	Financial & non-financial	Financial & non-financial	Financial & non-financial	Non- financial
Implementation supports				
Fidelity assessments	- Routinely conducted for some EBPs - Mandatory for some EBPs	- Routinely conducted - Mandatory	- Routinely conducted - Mandatory	- Routinely conducted - Mandatory for some EBPs
Training	- Centrally delivered - Mandatory for some EBPs	- Centrally delivered - Voluntary	- Centrally delivered - Mandatory	- Centrally delivered - Voluntary
Quality improvement support	- Data driven - Provided routinely	- Data driven - Provided routinely	- Data driven - Provided routinely	- Data driven - Provided on request
Outcome measurement & monitoring	- Routine collection for some EBPs - Routine reporting to programs	Not present	- Routine collection - Routine reporting to programs	Not present

*CEBP provides services outside of Ohio supporting a range of EBPs in different jurisdictions but this review focuses on their work in Ohio.

**Four additional practices: Suicide Prevention-Training, Implementation and Evaluation program; Focus on Integrated Treatment; Wellness Self-Management; Improving Providers' Assessment, Care, Delivery and Treatment of obsessive compulsive disorder (OCD).

Key findings

Intermediary organizations can offer a systematic approach that is informed by implementation science to build a high quality system of EBP delivery. This review examined the structure and operations of four intermediary organizations that support delivery of EBPs in mental health and addictions services in their regions. There are many commonalities and some differences in how they operate. Learning distilled from this review can inform Ontario efforts to establish structures and processes to support high quality delivery of EBPs in mental health and addictions system in the province.

A summary of key findings follows.

Organization structure

***Mandate**:* All four intermediaries have similar mandates to develop and implement mechanisms to promote adoption and high quality delivery of EBPs in their catchment areas.

***Host organization**:* Three of the four intermediaries are located within universities. Some are well integrated into the academic environment through either research or teaching participation, while others have little academic integration. The CNESM in Quebec was previously hosted by a partnership between three academic mental health institutes but was recently relocated to operate within government and the formal academic connection has not continued.

***Sources of funding**:* The key informants for all four intermediaries identified government as a primary funding source, although, with the exception of the CNESM, it is not the only funding source. The intermediaries supplement funding with research grants and fee for service contracts, and by leveraging partnerships with other organizations. Reasons for funding diversity cited by the key informants include government funds being insufficient to support necessary operations and the security achieved from diverse funding sources.

***Relationship to government**:* The intermediaries are typically positioned as independent, arms length organizations that are funded by and accountable to government. The exception is the CNESM in Quebec, which has recently been absorbed to operate within government. The specific nature of the accountability relationships are variable. For the CPI, government provides direction but also relies on expertise and policy advice from the CPI to support/enable the system to provide high quality care.

***Relationship to academia**:* Relationships with academia are variable. At CPI, many program leaders have academic appointments and research is highly integrated into the work of the CPI. AS noted above, CNSEM originally had a scientific advisory group but it was recently dissolved. It is unknown whether it will have any formal academic connection moving forward. EASA collaborates on research studies but internal research capacity is limited. CEBP does not appear to have any research involvement. It should be noted that it is possible to integrate rigour and oversight in program operations without formal academic involvement.

***Staffing**:* The importance of staff having clinical expertise and experience delivering the EBP they support was commonly noted. In the cases where a single intermediary supported multiple EBPs, there are dedicated teams or staff supporting each EBP. The CPI key informant also noted the advantages of having common infrastructure and the ability to share learning across EBP teams.

Organization activities

***EBPs supported**:* Both CPI and CNSEM support multiple EBPs within their jurisdictions. In both cases they started with a small number of EBPs and gradually expanded over time. CEBP historically supported multiple EPBs in Ohio but is currently only funded to support one. The CEBP experience demonstrates how public priorities can shift and funding can be withdrawn. EASA in Oregon is an example of an intermediary that focuses on only one EBP. In Oregon, there are multiple intermediary organizations ("centres for excellence"), each supporting a single EBP. These different intermediaries seem to operate largely independently.

***Agency participation/incentives**:* In all four intermediaries, there are at least some EBPs where funders set expectations for agency participation in quality assurance activities (fidelity assessments and/or training). Three of the four jurisdictions use financial incentives, wherein funding is attached to performance criteria (e.g., staff completed training, fidelity scores above benchmark). Non-financial incentives are also used (e.g., peer performance profiling; public reporting; quality improvement project awards). Where the intermediary supported multiple EBPs, expectations could vary by EBP.

Some key informants noted that their intermediary's role in implementing this accountability structure (e.g., collecting data that is sent to the funder) could interfere with their ability to engage in productive relationships with the programs. CEBP addresses this challenge by ensuring that the same person does not fulfill both the program review and coaching roles. Conversely CPI and EASA key informants noted that there are benefits to having the same staff fulfill both roles as they know the program best. The CNSEM key informants reported that the

impact of staff having dual roles was mitigated to some extent because program participation was only made mandatory years after the program had been implemented, when relationships with agencies were already developed.

***Implementation supports**:* While all intermediaries share a common mandate to support quality, the strategies they use and how they implement those strategies vary. Additionally, in cases where multiple EBPs are supported, the types of supports available tend to vary by EBP. Variation appears to be due to the funding available/funder priorities and the state of the evidence for that EBP. The quality assurance functions performed by the intermediaries can be grouped into the following four categories: fidelity assessments; training; quality improvement; and outcome monitoring.

Fidelity monitoring: Fidelity assessments are routinely conducted by all intermediaries for at least some of the EBPs they support and are a core tool for guiding EBP implementation and quality improvement. Participation is mostly mandatory and, in three of the systems, some program funding is tied to fidelity results. Fidelity assessments are commonly conducted via in-person site visits but in some cases are based on administrative data or self-assessments. All intermediaries developed or refined the fidelity scales to reflect the local context and EBP standards, and to enhance assessment feasibility.

Training: Training is also a core component of the intermediary support strategy. For EASA and some CPI EBPs, participation in training is centrally tracked and mandatory for program funding. For the CNSEM, CEBP and other CPI EBPs, training was centrally offered but participation was optional. Training approaches ranged from online self-learning models to multi-day, in-person events. Of the intermediaries reviewed for this report, EASA has the most comprehensive training model, including exams, assignments and supervised practice. Needs identified from the fidelity reviews inform the training, which is constantly updated.

Quality improvement: All intermediaries provide some form of coaching, implementation or quality improvement support, but often these supports are not well defined. Typically, these supports focus on gaps identified by the program fidelity assessments, especially if funding is contingent on meeting certain benchmarks. In some cases, intermediary staff meet routinely with programs for ongoing improvement work. In other cases, delivery of support is more ad hoc, as requested by programs. CPI supports formal learning collaboratives, which provide opportunities for participants to connect with and support each other. Though specific quality improvement processes were usually not identified, all the key informants emphasized the importance of engaging program and building ongoing relationships to support quality care. CEBP intentionally separated fidelity and support staff to avoid conflict of interest, but other key informants believed that performing the dual role enhanced effectiveness of support.

Outcome monitoring: Only EASA and CPI (for some EBPs) currently conduct any outcome monitoring. In both cases, programs routinely submit client level data to the intermediary, which report the aggregated data back to programs and funders. Both EASA and CPI key informants identified a number of implementation challenges, including staff time to collect data, infrastructure requirements (using a dual system of data entry) and supporting programs to use the data.

Conclusion

Intermediary organizations can be an important strategy to bridge the research to practice gap and support delivery of EBPs within systems of care. This report provides an overview of the structure and operations of four intermediary organizations that support delivery of EBPs in mental health and addiction services in their regions. Although there are some differences in organizational structure, there are many similarities in the central activities of these intermediaries and the strategies used to achieve their aims. Lessons learned from the operations, successes and challenges experienced by these programs could help inform ongoing efforts to support high quality delivery of mental health and addiction services in Ontario.

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Appendix: Detailed profiles

Center for Practice Innovations (CPI)

Overview: Located at Columbia University in New York State, the CPI was created in 2008 by the New York State Office of Mental Health (OMH) to support the implementation of treatment for co-occurring disorders. It now supports seven practice areas, including ACT, EPI and Individual Placement and Support (IPS). The expansion occurred by integrating existing organizations (e.g., ACT Institute) and building new EBP teams (e.g., OnTrackNY). The core source of funding for CPI is the OMH. CPI supplements this with grant funding and by leveraging partnerships with other organizations. CPI actively engages with funders, practice experts, program stakeholders (including persons with lived experience) and policymakers at the state and city level, to identify needs, obtain support, and guide its work.

Relationship to government: CPI is accountable to government. Its primary mandate is to support implementation and spread of EBPs as directed by the OMH. CPI collaborates with the OMH to develop strategies and incentives to enhance quality of care (e.g., fidelity performance, training participation) and may advise on program practice models/standards.

Relationship to academia: EBP teams are led by clinician researchers, many with appointments at Columbia University. CPI conducts practice-based research, for example, examining feasibility and effectiveness of implementation support strategies and refining practice models. Grants are an important income source and staff are highly active in academic publishing, enhancing CPI's reputation as a leader in the field.

Participation/performance incentives: Program participation in training, routine fidelity assessments and routine outcome monitoring are foundational to quality monitoring, improvement and accountability. Incentives to participate in these activities vary by practice area and may be financial or non-financial. In some cases, participation is mandatory. For example, ACT program staff must complete CPI training as a condition of licensing (i.e., to enable programs to bill Medicaid for ACT). Non-financial incentives include peer performance profiling and public commendations.

Staffing: Each EBP is supported by a dedicated team whose size and functions vary depending on sector needs and available resources (some practice areas are better resourced than others). Implementation specialists typically have experience delivering the EPB they support. The teams share some infrastructure supports (e.g., the virtual learning platform and the online assistance unit) and meet regularly to learn from each other.

Implementation supports:

- *Training:* Training is centrally developed and managed for all EBPs through a learning management system (LMS). Training blends in-person and online approaches and is intended to be nimble to respond to emerging issues and needs. The LMS tracks participation, learner satisfaction and learning outcomes. Training results inform program quality improvement work, are linked to incentives for some EBPs (e.g., ACT) and are used to refine training.
- *Fidelity assessment*: Fidelity is routinely assessed for three EBPs: ACT, IPS, and EPI. Assessment methods vary (e.g., site visits, self-report and administrative data) based on resources available and sector needs. That said, reducing use of more intensive strategies (on-site reviews) is being explored. Assessment results inform program improvement and training. Aggregate results may inform policy recommendations. Assessments use standardized scales, which are adapted to the local context.
- *Quality improvement*: Improvement supports are varied. In addition to providing regular site-specific coaching and technical assistance, CPI supports virtual learning collaboratives, where participants review data, develop data-based quality improvement plans, monitor performance and meet to learn and share.
- *Outcome monitoring*: Programs routinely (quarterly) submit team and client level data for three EBPs: ACT, IPS, and EPI. Data are reported regularly to the teams to inform improvement work and are also reported to the state. Results may be linked to incentives. The data are collected using platforms operated by the state — a main one being the New York State OMH Web-based Child and Adult Integrated Reporting System.

Strengths: Extensive engagement with funders, EBP experts, program stakeholders, state and city policymakers is used to identify needs and guide work. Each EBP has an advisory group (e.g., family, youth, community, expert etc.). The large size and scope of the organization creates synergisms for learning, trialing approaches and building knowledge. A dynamic centralized training model is used to build a strong workforce in face of staff turnover and evolving evidence. Active publishing in peer reviewed journals contributes to advancing knowledge in implementation support strategies and models of care.

Challenges: These initiatives are resource intensive and base funding is insufficient to support all CPI activities. Data collection can be burdensome for program staff and clients, in part because they are dealing with fragmented data infrastructure. CPI works with system partners to leverage existing data sources, where possible, and work is currently underway to improve data visualization to support program use of data.

Website: https://practiceinnovations.org/

Center for Evidence-Based Practices (CEBP)

Overview: The CEBP is located at Case Western Reserve University in Ohio. It was originally funded by the Ohio Department of Mental Health in 1999 to provide technical assistance for implementation of Integrated Dual Disorder Treatment (IDDT). Over the years, the scope expanded with funding from the state and other entities to support implementation of more EPBs (e.g., ACT, Motivational Interviewing, IDDT, and IPS). In 2016, the Ohio Department of Mental Health and Addiction Services withdrew its funding support, halting much of CEBP's work in Ohio. However, a new funder emerged as the Ohio Department of Medicaid began funding technical assistance for ACT (based on the notion that higher fidelity programs are associated with a reduction in the use of hospital and other high-cost services and hence lower costs). In addition to their work in Ohio, CEBP provides services to entities in 30 different states. This profile is focused on the services currently delivered in Ohio.

Relationship to government: The CEBP's current accountability for its work in Ohio is to the Department of Medicaid. In this role, the Center has input into policy formation and revision, and provides as needed technical assistance to the state and its designated entities, such as managed care insurance companies that manage Medicaid funding in Ohio.

Relationship to academia: CEBP is housed at Case Western Reserve University and some CEBP staff have adjunct faculty status and participate in professional training to students. However, the CEBP does not prioritize or directly lead research.

Participation/performance incentives: Medicaid funding for Ohio ACT programs is contingent on participating in routine fidelity assessments conducted by the CEBP and achieving a minimum score. Previously, participation was not mandatory and the CEBP conducted extensive outreach to encourage program model uptake and participation in fidelity reviews.

Staffing: CEBP staff roles include evaluators, who are responsible for conducting the fidelity assessments, and account managers, who provide training and ongoing coaching support. This role separation is intended to support a positive, productive relationship between the programs and the account managers and ensure this relationship is not compromised by being seen as state auditors.

Implementation supports:

- *Training:* CEBP offers regular training webinars on a range of topics pertinent to the implementation and sustaining of ACT services. Provider organizations use these trainings as well as team-targeted consultation at their own discretion. The CEBP is charged with ensuring these opportunities are available to any interested organization.

- *Fidelity assessments:* All ACT programs in Ohio participate in annual fidelity assessments using a well-established ACT fidelity scale (Dartmouth Assertive Community Treatment Scale- DACTS) that is adapted to the Ohio context. The assessment is based on a one-day site visit, which follows all of the established DACTS review protocols as detailed in the federally endorsed SAMHSA Toolkit.
- *Quality improvement:* Each program has an account manager who meet with them regularly to provide ongoing coaching support and works with them to implement recommended changes from their fidelity assessments.
- *Outcome monitoring:* Outcome monitoring is not currently conducted for Ohio ACT programs but the possibility of future implementation is being explored by the Ohio Department of Medicaid. The CEBP has offered considerable feedback as to what might inform this process.

Strengths: The CEBP has benefited from 22 years of lessons learned with hundreds of treatment teams in Ohio and other practice/policy environments. Diversified funding has helped CEBP survive, thrive, and expand. CEBP has a staff group consisting entirely of former community behavioural health program managers with experience delivering high fidelity EBPs. Efforts are also supported by a considerable history of relationships built with programs and the communities they reside within. CEBP benefits from a national and international network of resources and topical experts and offers a robust website containing free EBP implementation resources.

Challenges: Organizations do not always commit to the full scope of implementation support. Additionally, CEBP's ability to support quality service delivery can be inhibited by program level challenges, including workforce/staffing shortages, access to competent clinical supervision, commitment of important system partners, and adequate funding for service delivery.

Website: https://case.edu/socialwork/centerforebp/

Early Assessment and Support Alliance (EASA) Center for Excellence

Overview: The EASA Center for Excellence is located at the Oregon Health & Science University-Portland State University School of Public Health. The Centre's mandate is to support high quality delivery of Early Psychosis Intervention services in EASA programs in Oregon. It also provides training, technical assistance and program development supports to other states in the U.S. It was launched in 2013 as part of statewide dissemination, building on a pre-existing Early Assessment and Support Team created in 2001. The Center is funded primarily by the Oregon Health Authority (flowed through the university), supplemented by other state and grant funding. The Center is one of several intermediary organizations in the state of Oregon, each of which supports the implementation of a different EBP. These intermediaries mostly operate independently but partner in some areas (e.g., the ACT and EPI intermediaries collaborate with the Supported Employment intermediary for this element of their work). The Centre primarily operates in Oregon but offers some training and technical assistance to other states.

Relationship to government: The Center is accountable to the Oregon Health Authority and other funders.

Relationship to academia: The Center is located in a university and staff actively participate in research, although it is not a primary mandate and internal research capacity is limited.

Participation/performance incentives: All EASA programs in the state (approximately 26 programs) are required to participate in the quality support initiatives of the Center (i.e., training, data collection, and fidelity review) as part of their contract with the state health authority.

Staffing: The Center has a clinical team and a young adult participation coordinator, who provide implementation supports to programs, as well as an administrative/data management team. Each member of the clinical team is responsible for a region of the state and provides the full complement of implementation supports to programs in their region. This model ensures that each program has a single ongoing point of contact and fosters the development of strong relationships with programs.

Implementation supports:

- *Training*: All EASA program staff are required to complete a central training and certification process, which includes mandatory training, an exam, presentation, and assignment (mock case/treatment plan). The Center tracks the training status of all EASA program staff. The

Center has also created a comprehensive set of program manuals, tools and resources, which are used by all EASA programs.

- *Fidelity assessments*: All EASA programs receive fidelity assessments every two years. Assessments are completed using a locally developed fidelity scale based on a two-day site visit that includes interviews and reviews of client records and administrative data. Programs scoring under 80% are given 90 days to address the areas where they underperformed and receive Center support, if needed, to meet this deadline. Fidelity results are shared with the funder. Ongoing revision to fidelity requirements are based on unique rural/frontier characteristics and needs.
- *Quality improvement:* Centre staff meet with EASA programs monthly to discuss fidelity and program development needs, respond to questions and help troubleshoot any clinical or program challenges that have arisen. Specific monthly forums address the unique roles and needs of program administrators, clinical assessors, occupational therapists, nurses, and other identified areas of need.
- *Outcome monitoring*: All EASA programs regularly complete and submit client level data to the Center via REDCap. Data are submitted for all community education events and new referrals on a quarterly basis and at discharge. The Center also sends quarterly reports to the programs.

Strengths: The Center feels that key to its success is a common program model articulating core expectations, direct links between training/technical assistance/quality improvement systems at the Center for Excellence, the Oregon Health Authority, and the Oregon Health Authority contractors. In addition, the Center aims for strong, ongoing relationships between Centre staff and the programs they support. Staff meet regularly with programs and try to position themselves as a supportive partner rather than a regulator. The program model is population-based and centered within the public mental health system; it establishes core goals and practices but allows for flexible implementation. The Center also engages regularly with stakeholders across the system, including individuals with lived experience, to guide their work.

Challenges: Though they collect a fair amount of detailed client level data, the current system is resource intensive (for programs and Center staff). The Center is also challenged by a limited budget and is required to supplement the core budget with contracts and grants. Current priorities include creating an automated process for data input/extraction and reporting formats that are more user friendly and meaningful for programs. The Center is also focused on ensuring services are equitable and culturally appropriate, with an initiative focusing on indigenous peoples.

Website: https://easacommunity.org/

National Centre for Excellence in Mental Health/ Centre nationale d'escellence en santé mentale (CNESM)

Overview: The CNESM was created in 2008 to support delivery of high quality mental health and addictions services in Quebec. Currently, it is hosted and funded by the Mental Health Directorate of Quebec's Ministère de la Santé et des Services Sociaux. Prior to 2020, the CNESM followed a shared governance/accountability model involving the Mental Health Directorate, three academic mental health institutes/centres across the province and local mental health organizations. The academic partners provided strategic direction, administrative supports (e.g., administrative assistance; budget management; training space) and methodological expertise. Clinicians from the mental health organizations were seconded to work in the CNESM in paid staff positions. In 2020, staff and administration both came under the direct operation of the Mental Health Directorate. The CNESM originally focused on ACT and then expanded to support delivery of FACT, EPI and ICM.

Relationship to government: The CNESM was initially created and funded by the Mental Health Directorate but was implemented through shared governance with practical support from three mental health/academic institutes. Currently, it is governed and managed solely by the MHD.

Relationship to academia: Previously, three scientific advisors from the academic partners worked closely with the CNESM and government representatives, sharing their expertise in fidelity, knowledge translation and specific EBPs. This partnership is no longer central to the CNESM's functioning.

Participation/performance incentives: The majority of mental health programs in Quebec partner with the CNESM. This has happened progressively over time, with an increasing number of organizations participating as the benefits of involvement became evident. Fidelity assessments became mandatory for ICM and ACT programs in 2015. Teams with low fidelity scores develop and submit an action plan and receive another fidelity assessment the same year. Additionally, ACT teams are expected to meet caseload and medical staff criteria. Currently, there are no formal sanctions for programs that do not meet these criteria.

Staffing: Each supported EBP has dedicated a staff with clinical experience in that sector, who provides implementation supports to programs.

Implementation supports:

- *Training:* Central training is offered regularly to all staff. Participation is voluntary but uptake is typically high. Additionally, a virtual library of online tools (e.g., videos; clinical guides) was created in 2015 to provide updated information to service providers. A

knowledge broker supported translating knowledge into simple tools, but the role was discontinued. In 2020, the CNESM received an innovation grant to move the virtual library to a mobile application. However, this initiative was discontinued due to the change in governance structure.

- *Fidelity assessments:* All programs receive regular fidelity assessments. Fidelity assessments are framed as a data source to support improvement efforts rather than for accountability. Standardized fidelity scales are used for ACT. A local measure was developed for ICM.
- *Quality Improvement:* Staff are available to provide support, coaching and guidance to programs on request. Staff may also proactively follow up with programs if needed (e.g., based on their fidelity assessments).
- *Outcomes monitoring:* A small number of outcome measures are collected as part of the fidelity assessment (e.g., # of hospitalizations in last six months; # of people who start working; # of returns to school; # of community activities).

Strengths: A core strength of the CNESM are the strong and longstanding relationships with programs. CNESM staff typically have long histories working in the sectors they support, giving them critical expertise and legitimacy. Though mandatory fidelity assessments have caused some mistrust, this has been mitigated to some extent because participation was only made mandatory years after the program was implemented and relationships with programs were already developed. It has also been important that program mangers see the fidelity assessments as a beneficial exercise to identify strengths and challenges within their teams.

Challenges: Capacity to conduct fidelity assessments has become challenging as more teams were implemented. Additionally, the recent shift of the CNESM to direct government operations has caused some concern and uncertainty, and it is yet to be seen how this move will impact operations and relationships with the community. Without the institutes' involvement, it is unclear how knowledge will be shared between academia and clinicians. Though fidelity assessments are mandatory, this was functionally limited by the lack of clear penalties/consequences.

Website: Not currently available.