>>Good afternoon. I'm Jack Simons. I'm the director of the Children's Behavioral Health Initiative at MassHealth, and I'm here with Kelly English and Susan Maciolek from the Children's Behavioral Health Knowledge Center at DMH; also Bonny Saulnier, who is the principal author and editor and who took the practice profile through many, many revisions in response to feedback.

So this afternoon we're going to talk about what the practice profile is, describe the reasons for developing an in-home therapy practice profile, and then talk about steps that we took to arrive at the current draft and where we expect to go with the practice profiles from here.

[Pause]

>>SLIDE: Thank you. So, as everyone knows in-home therapy, it's a great opportunity to work with families, but it's hard, complex work. And over the many years that we have been doing case reviews, intensive care coordination, and in-home therapy, one of the things that we've seen consistently over the years is a high level of variability in the effectiveness of in-home therapy as we practice it here in the Commonwealth.

We have often heard from providers: "I wasn't really trained to do this; I'm having to improvise." We have heard, "There's guidance but not enough on how to deal with this effectively." And we have also heard from many clinicians and PTNS's they wished there was more training on how to do it.

As we thought about how we could give people what they need, the tools that are really effective in in-home therapy, we had conversations with Dr. Allison Metz at the National Implementation of Research Network and the University of North Carolina. And she led to us understand before we go ahead and do training and other kinds of training and intervention supports, we need to define very carefully exactly what good IHT looks like. And that's why we have a practice profile, is to give us a very detailed description of how to do IHT effectively.

So having briefly described the reason we're doing this, Kelly English is going to talk about what a practice profile is, and then you'll hear about the steps that we've been gone through and preview the work that we're going to do in FY'17. Kelly?

>>Kelly English: All right. Thanks, Jack. So I'm going to talk a little bit about background information in developing the practice profile. So for any program or process to really achieve significant impact, it needs to have goals well specified and defined so that the practitioners who are actually responsible for implementing that intervention know what to do in order to deliver or carry out that service; and so one of the first things you need is a really good description of the program. That includes defining the philosophy, values, and principles that kind of undergird that program, because those are often really clarifying for people that serve as sort of that guiding light, their operational. So having those well defined is important; and for CBH goals, those are well determined. So we kind of led with those.

Another kind of aspect of defining IHT, we are part of the development of medical necessity criteria. For any service you need when you go out there, you need to know who is this service appropriate for, who is included in this service, and who isn't the service for. Development of those goals include exclusion and inclusion criteria. So we have those buckets already well defined for IHT. We have performance specifications written for the service as well.

The next part of defining any kind of service or program is being clear about those essential functions that make up or define that program so that you know what activities that are key features or hallmarks of that program or practice. So you will hear -- my colleagues will talk about this in a few minutes -- about those core components that we arrived at as part of the development of the IHT practice profile.

Then the next step was, once you have defined those core components or activities, you go even further and drill down into what are the operational definitions of those essential functions. So what are those? What do those core activities look like, down to the level of saying and doing. And it's really this operational definition of the essential functions that are really the heart of the practice profile work, and that's really the important key ingredient, is getting down to that level of saying and doing to promote consistency across practitioners at the service delivery level.

Then ultimately what you hope is as the next piece of the puzzle is to -- once you've defined the "what," is to create fidelity measures that can be used to kind of help improve practitioner competency and define where are areas to get better. But ultimately, what we were really trying to do here was create something that could be teachable by a supervisor or a skilled clinical teacher and break it down enough so it was learnable by a new staff person who was coming into the role of doing IHT work, and that they could go out then and do that work with the constituent families that they're serving.

>>[Slide]: So on this slide you will see what are those core features of the practice profile.

So this is a template of what a practice profile would look like. So at the top you have the definition of the core element. So, for example, that would be a definition of a co-activity in this case. One of those activities was engagement, for example. Then below that, we have: How does engagement contribute to an outcome in IHT?

And then, further, further drilling down, what we want to see is, what does that practice look like when it's being done ideally? And we use that term, "ideal," deliberately. So some practice profiles use the term "expected practice." We choose to use the term "ideal," because we thought it was describing the quality and performance of what we were aiming for.

Then, in the middle, we tried to -- we attempted to clarify in a practice profile developmental use and practice. So what is does engagement, for example, look like when it is a developmental or emerging skill for somebody? So something they may do inconsistently or some of the time. When it's a developmental practice, it indicates a need for more supervision that would be happening for somebody, and coaching them to get better so that they can move eventually into that ideal category.

Then finally, what does the core activity look like when it's an unacceptable use and practice? And if you are seeing a lot of the kind of folks that are falling into that unacceptable practice category, it really indicates the need for maybe some more organizational or system strategies to better support individual practitioners. Maybe everyone across the board never learned their skills, so we need to go back and help support our staff in that area. So it really gets you clear about what it looks like when it is well done, when it's an emerging skill, and what does it look like when you don't want somebody to ever practice in that way.

>>[SLIDE]: So why do up a practice profile? What are some of the benefits? So once you are clear with the "what" of the service, it can help programs develop more effective training protocols, tools, fidelity assessments, because you are clear about the "what" you are training to.

It can help you understand areas of improvement. It can help to increase the ability of the program or practice model to be replicated in a new setting with new staff. So it helps to promote consistency across new contexts.

And we know that there's often new staff coming into these programs, many -- unfortunately, a common occurrence. So having something standardized that you can use to train people up to that's clear is another real benefit of having a practice profile.

So another benefit of this is that a well- operationalized intervention can help organizations develop decisions, support systems. We

find there is administrative practices to really -- and develop systems partnerships that are really aligned to support this new way of doing work.

And really, it ultimately can help to ensure that your outcomes are accurately interpreted. So outcomes can be challenging to interpret when there is lack of clarity about the event.

>>[SLIDE]: So this next slide walks us through the development process that you will see that we have started back down this path around September of 2015 when we started doing some of the reviews of some of the existing documents out there. You will see now we have gone through several iterations of work review that you will hear about in a moment.

And now we are about ready to emerge into the summer months here, doing some more focus groups of supervisors and clinicians. We are doing webinars today to get you up to speed about where we are.

So it's been many months in the making here.

>>[SLIDE]: So just to -- I mentioned earlier about one of the core activities of developing a practice profile, is to dig down into some of the foundational documents.

So you see here we have this MassHealth program standards and, you know, the foundational aspects. We used the practice guidelines. We built upon those. And also we did some work looking at the Mass practice review, to try and use that; again, to build from this practice profile.

So we didn't create anything. We used those existing documents that many of you have seen to start down this path. So next up, I will turn it over to my colleague, Susan Maciolek, who will talk you through some of the more ongoing development process.

>>Susan Maciolek: Hi, everyone. It's nice to be with you today. I will talk a little bit about how we launched this work within the IT communities, how we brought it forward. We started in November of 2015 with a kickoff meeting, and Jack started the conversation with Dr. Allison Metz, who is from the National Implementation and Research Network. And in the spirit of wanting to be as transparent in building across this network as we can be, we brought her into a daylong meeting with folks here in Massachusetts, where we spent a day with a group of IHT program directors and supervisors, some representatives from the MCO, the court monitor and ADH's, all joined for us a daylong, really working session.

We wanted to make sure that everyone understood where we were coming from in terms of building on the expertise of the National Implementation Research Network. Some of you may have been on previous Webinars with Dr. Metz and some Children's Behavioral Health Knowledge Centers. There is a lot of information on the knowledge center and website, if you are interested more about that workgroup.

The purpose of the day was really to start to dig into the core components, as Kelly said in the previous slide. We started with the core components, and we drew from those foundational documents to identify what we felt were the core components that emerged from those documents and then asked the group to really test that idea and see if those were, in fact, the right core components, going forward.

So Allison presented the practice profile methodology we proposed. We shared the initial drafts of the core components, and we did some small-group work, which I will show in the next slide.

>>[SLIDE]: So here's where we started with the initial core components. If you were to sit and read, as our wonderful colleague Bonny Saulnier did, the practice guidelines and program standards and some of the results from the case reviews, this is what emerged as the core components as in-home therapy.

We handed this to the small groups, and we asked them please to consider whether those core components, with about a paragraph of a definition, were, in fact, part of what they understood to be in-home therapy as they practiced it and managed it and hired into it. And we asked them if they were the right components, to say that yes, we got it

right, or yes with some modifications, or no, that they really weren't the right way of understanding in-home therapy.

And as a result, we ended up with a more robust list. So we have a revised set of core components that emerged from that meeting. And I think you can see from the way they are articulated on the list, that the conversation identified a more robust and really more compressed way of understanding the work of in-home therapy.

There are some things that remain the same. You can see the beginning and end, the bookends of the program, you know, practicing with cultural relevance, still very important on both lists. "Engaging, exiting" were some of the things that continued.

But you will see in the middle some of the "what's" that we began to unpack, what is at the heart of what IHT practitioners and ICC practitioners do.

So two themes emerged. What we found as a group is the documents that they had been evolving put too much emphasis on the care coordination process and not enough on the actual treatment that goes on in in-home therapy, and that we needed to draw a clear distinction between IHT and ICC.

So if you look at the initial core components compared to the revised, you'll see that we collapsed some of the -- what might be called the ICC-like functions that IHT might do as a hub or even some things you don't do as a hub but is not a good practice in terms of care planning and care coordination.

Then really in the revised section we began to unpack some of the clinical work, some of the risk assessment, basic planning, the intervention planning, and the actual treatment that goes on in in-home therapy.

So this is -- we thought this was a really important and productive day for us. We took these revised core components and began to plan even more detailed working sessions, which begin on the next slide.

>>[SLIDE]: So from January to April, we had ten workgroup sessions. We devoted a half day to each of the core components, except for these two that are mentioned in the second bullet -- practicing with cultural relevance and intensive therapeutic intervention. Those are really -- that is particularly important but rich and complex work, and we devoted a full day to each of those. So you can envision the amount of time that we spent with -- both from the in-home therapy community -- really exploring what the work is of each core component. And as Kelly mentions, what are people saying and doing when they are doing these components out in the field?

For participants, we had a wonderful array of participants. We had a total of 42 participants, drawn from an array of providers.

Twenty-two providers, two MCO's, and court monitors joined us for several of the sessions. Each session had about 7 to 17 participants, and some attended just one session. Some attended all the sessions. On average, they attended three sessions each.

We really wanted to get a variety of perspectives. And it is important to know, these folks were representing not their agency, per se, but representing good, strong IHT practice at a variety of levels and a variety of places in the Commonwealth. So we were very fortunate to have them spend as much time with us as they did.

Also there, Jack alluded to, at the beginning, the project team. So those of you on the phone, we also were joined by Jennifer Hallisey and Laura Conrad, who were not able to join the Webinar today. They were equally important members of the project team. And we really spent a lot of time together, making sure that we structured this project as productively as possible, because we are mindful of the valuable time that we have gathered from everyone who participated. And we wanted to make that time as effective a decision as we could, because as Jack said, this is a really important initiative to MassHealth and the Knowledge Centers

that have invested a lot of resources in it.

We think IHT is an important part of the system. So this project team has really sponsored this forward, and we continue to meet and will continue to meet to do some of the work that we'll talk about later in the Webinar.

>>[Slide]: So the next slide gives you the workgroup schedule. You can see how intensive it was, close to every other week. Wednesdays were our day.

We were very fortunate not to have any snowstorms getting in our way. So we were able to take that last day, April 7th, and really devote it to a more in-depth discussion about practicing with cultural relevance.

And for those of you who have participated in some of the trainings that Dr. Ken Hardy has done, we were very fortunate to have the folks who have been in those sessions to join us. And we were able to really benefit from other projects and other investments in IHT quality improvement work.

>>[SLIDE]: So the next slide is a list of all of the providers who were kind enough to lend us their staff for this initiative. We really give them all a big thank-you.

You will see there were providers of varying sizes, a variety of geographic allocations serving diverse communities. We really -- we can't thank them enough for the effort and the commitment and really the deep engagement in the process. People were really very committed to it, and we would not be as far along as we are without that effort.

I think you will understand what kind of commitment and focus which we describe in more detail, what those looked like. And for that I will hand it off to my colleague, Bonny Saulnier.

>>Bonny: Hi, everybody, and thanks for being here.

>>[SLIDE]: So for each of the work groups, we distributed a copy of the first draft of the elements that the group was working on.

And that first draft included the definition, the contribution to the outcomes, and the -- and a column of ideal elements that fit that component.

The definition, as far as contribution to the outcome, I just want to say, means how this particular component enhances child and family well-being and how it promotes the vision and values of CBHI, which is the overarching frame in which in-home therapy operates.

So we passed those out. The full group then reviewed the definition and the contribution to the outcomes and gave either an "endorse" or thumbs up, a "not endorse," not good, thumbs down, or a "request for clarification" on the definition and the contribution to outcomes.

So there was an opportunity to discuss those further at that time. We then reviewed the activities in the "Ideal Practice" column.

So each -- on the left-hand column of the template, there were rows indicating what activities constituted our first draft and what activities constitute that particular component.

Again, everyone was asked to give an endorse, a request for clarification, or a not-endorse -- which we asked, when people couldn't endorse the item, for them to also make suggestions about the changes that would help, rather them just saying no, that's not good.

We asked for suggestions: Okay, how would you say that? What would be a better way to frame it? What would you add? What would you take out? So forth.

When every participant had voted and the item and everyone was able to endorse with whatever changes had been made, we moved on.

So there was really a consensus-building process at every step of the way.

We then broke up into small groups. And each group -- a randomly occurring group -- were given a set of usually four to six of these items to go into more detail in a small group environment to discuss those.

So the specific task was to fill in the developmental and the

unacceptable columns. However, what we found in doing that was as we looked at the developmental and the unacceptable columns, we also had go back and make some revisions to flesh out the "Ideal" columns.

So again, there was a lot of good thinking and process there that influenced the ideal practice as well.

A note-taker was assigned for each of the small groups. And when their work was completed, each small group reported back to the full group.

Again, there was then discussion or questions about what came up.

And finally, all of the notes that the note-takers took were collected, gathered together, and anyone else who took their own notes was invited to share those. So we gathered all of the notes that people wanted to share from the entire group and took those back, to work on the revision.

The writer -- I can say this with all truth, because I was primarily the writer on this -- I took every single paper that had notes on it and looked at every single comment and every single suggestion to try to make sure that we were really incorporating all the input we got from those very hard-working groups.

So I'm going to show you next a little bit about that process.

>>[SLIDE]: This first slide shows the -- just one of the components, the assessment and clinical understanding. At the top, in italics, is the definition, and there is the contribution to the outcome.

And then there is a blank column for "Ideal," "Developmental," and "Unacceptable."

So you heard about how we revised the top areas, the definition and contributions, the outcome.

And I will say that those revisions kept going throughout this process, which is not finished yet.

>>[SLIDE]: What this slide shows is what they were given at the work subgroups, the definitions at the top and then the column of "Ideal" elements you see on the left-hand side.

>>[SLIDE]: This shows an example of the kinds of revisions that were made. So in red here, you see some suggestions for the outcome. You will see how the "Developmental" and "Unacceptable" columns are filled in, and you will see how that also changes in the "Ideal Practice" column.

Finally, when all of those revisions were incorporated and we felt that we had fully-vetted everything that people suggested --

>>[SLIDE]: -- we took the -- we took the drafts and tried to fit them together, because many of the themes that occurred were actually crossed between components.

So you couldn't exactly say, well, these things only fit in Assessment and Clinical Understanding; they don't fit anywhere else.

So we tried to cross-reference. We tried to make sure that we were referring to the places, to the other components where these definitions would become fuller.

And we also tried to make the rows -- tried to clump together things so that the rows showed sort of topic areas rather than every single individual aspect that we had started out with.

So this gives you an idea of where we are with that. These are also now available on the CBH website, the Knowledge Central website, so you can see obviously much more about them there.

>>[SLIDE]: Some of the insights that we drew from this process were very encouraging insights about the high level of consensus about what constitutes quality IHT.

There were a lot of wonderful suggestions in the group, but there was not a lot of difference about what the actual work is.

There were many great suggestions about how to describe that work. So for example, one of many: Often in the first draft the rows said, "Ask the family about this" or "ask someone about that," and there was a strong sense from the group that we should change that to "explore with the

family," which sharpened, broadened the topic, made it a gentler way of describing it.

So that was a very helpful, a very helpful improvement.

Didn't change what we're doing, but changed the tone of it and made it better.

I have to say that one of the take-aways for it was the second one, which was the benefit of the very knowledgeable and skilled practice leaders in that room.

It was a roomful of great minds and generous hearts that put this together.

We also noticed, as I mentioned already, that the development of the full draft meant cross-checking for repetition, meant cross-referencing among the components, and it meant trying to balance to be enough inclusive and descriptive of the process, while also leaving enough room for the value of every family situation.

We did not want this to be a formula to be applied to every family. It needed to be broad enough to allow the variables for what happened with each family.

The core components and activities are not linear. It's not a to-do list. It's not a substitute for the art of the work.

And obviously, not every item will happen in the order that they're listed in those components. And not every item will apply to every family configuration.

And then finally, we realized we needed to carefully -- in some of the components in particular -- distinguish between how IHT is practiced when it is the hub service and how IHT is practiced when it is working in terms of care coordination.

As a result, or an insight that is not listed here, but one which I think we have marveled at that has gone along, is just the great sense of collaboration among all the people that participated in this.

So I'm going to hand this back to Jack now, to talk about the next stage of the work.

>>Jack Simon: Thank you, Bonny.

So before I go further, I just want to say, from a MassHealth perspective, we're incredibly grateful to the Knowledge Center for the role they played in this collaboration. It's been great, and I also want to echo Susan and Bonny in thanking all the workgroup members who gave us such a high level of expertise in this process.

>>[SLIDE]: So we had an expert consensus, but we also wanted to make sure that the practice profile was consistent with the evidence base and the research literature.

So we had Dr. Joyce Taylor from the Springfield College of Social Work do a literature review.

It's only six pages long, very readable.

It's on the website along with the practice profile components. So you may want to look at it.

And what it does is go through each component and look at how it lines up with what is in the literature, both the peer-reviewed research literature and also expert opinions in textbooks and the like.

And in general, Joyce found that what we are doing in Massachusetts with this practice profile is very consistent with best practices from the literature.

There are a whole lot of areas where the literature is silent on how to do things, and there we have practice-based evidence.

We have the expertise of our practitioners to fill in the gaps.

So I'd real encourage you to go look at that.

>>[SLIDE]: And now to talk about where we are. On this slide, completing the practice profile, it had two parts.

The final review is now done.

We sent out the component to all workgroup participants and asked them

for any further revisions.
They wanted to check once again.
Bonny incorporated some new suggestions, although by this point there was very high level of consensus and agreement on that.
Work was done in the middle of June.
And now we move to the next stage, which is the focus groups.
I think we have done one already, but they will continue during the course of the summer.
People from our team are going to be going out and meeting with IHT practitioners, supervisors, and also clinicians and PTNS's at staff meetings in a series of focus groups to discuss whether the components of the practice profile really makes sense to people, whether they are, in fact, teachable, learnable, and doable.
So we're going to have yet another round of feedback this time from people who are doing the work on a daily basis.
And that's how we roll.
Take us to the end.
>>All right.
>>So those of you who have been on a Knowledge Center Webinar, gone through our website, may be familiar with the Drivers triangle that you see up on the screen from the National Implementation Research Network. But this is going to be orienting our work going forward into FY'17.
So as we spent the last year kind of really getting clear about the "what," now what we're going to be focusing on is the "how," or how are we going to implement what we just created through this very intensive process.
So we have some ideas about what we would be focusing on in this next year, in part driven by what you see in the Drivers triangle.
But also we heard quite a bit during our focus workgroup sessions from folks who were saying, how are we going to train people on this?
Or, this makes me think differently about how I might be hiring people, or what I'm looking for.
I may have go back and do some rethinking about various activities that we have as far as our hiring practices or different things that are just going to emerge from new trainings that occur to them.
So we envision in FY'17, going forward, that we will be having some additional work groups that really are going to be focusing more on the "how" of this work, you know, things like how do you supervise this, those types of things.
But it will be organized by those key implementation drivers that you see up here on the screen. So it may involve creation of fidelity tools and those types of things.
>>[SLIDE]: So you heard these are some of the ideas that emerged from those work groups organized by those drivers.
So on that kind of individual competency side of the triangle, you will see things; work groups suggested things like, it would be really helpful if we had some type of online, on-demand thing that everybody sat through, regardless of what program or what agency that they work for, that everybody had a basic 101 slide deck, or something to refer to.
You know, people brought up, I'm trying to figure out some way to create a self-assessment around some of the cultural relevance items.
Creation of some practical tools or how-to's on how to do things like using a genogram or eco map, safety checklists.
So these were good ideas from those practitioners, people who sat with us through those work groups of things that need to be developed or disseminated to help support the work of the practice profile.
Other things that occurred to people throughout these work groups are more organizational in nature and trying to really align some of the support temperatures.
So things like a cross-walk of billable activities was one that came

up quite frequently as we walked through the different practice elements.

Cross-walking with the management care review tools was another tool that emerged, and going through that list of training environments that are in the program by IHT was another thing that program participants suggested would be a helpful support going forward.

And we know that these types of things often require leadership, and so part of what we're doing here is -- and the Webinar is to really try to engage stakeholders, because we know that's going to be so key to continuing to make the effort successful.

So making sure that we are keeping everybody up to date, that we are including every level of our provider community in doing this work.

And we know also, when this starts to roll out, that there's going to be some work that practice leaders within your agencies are going to need to do to kind of help people understand what this is, and how it can be used, and that kind of thing.

So that's all the work that's going to be going forward. So we really see the practice profile as not the end but the beginning of a next step in development of IHT.

>>[SLIDE]: So for those of you who are interested, we have a practice profile page that's on the Children's Behavioral Health Knowledge Center website.

If you haven't been to it, check it out. It is at www.cbhknowledge.center, and then you can go to the practice profile page, backslash ihtpp.

There, you will find the different matrices, literature review that's up there, and also a PDF version of the slide deck that is available from today is already on the website.

If you are interested, take a look at that.

Jack mentioned we would be doing some focus groups with supervisors and direct care staff throughout July and August, and we will be taking notes about further feedback and incorporating them into another revision.

So what you will see up on the center's website is where we are to date.

We are still working on incorporating some feedback from various folks, and then we will create another iteration of it sometime in the fall.

And then we will be working going forward to create an implementation plan for some of those work groups.

So we will roll this out, because as I said, this is a foundation for what we envision will be a variety of different tools and efforts to really make this usable for folks out in the field.

So you will hear more from us about this as we go forward.

>>[SLIDE]: So at this point, we are interested in any questions that you might have for us.

So you should be able to type into your text box there some questions for us that we will see here.

So if anything comes to mind, let us know, and hopefully we will be able to answer it.

One person is asking about if the slides and Webinar will be e-mailed to the participants.

So we do have the slides already posted up on the Knowledge Center's website. So I will encourage people to go there, because what we want you to see are the slides, but also take a look at the different matrices that are up there.

Just a note to folks -- if for some reason you go and the website looks weird, make sure you go in using Google Chrome. That's the magic for making the website actually look pretty.

[Pause]

So, other folks are asking -- someone just asked: Can a previously uninvolved organization become involved in doing this work? And how would

that be?

I envision that we will have, you know, a variety of opportunities as we go forward to kind of involve folks in building this out and having a -- so I say the first step is kind of familiarize yourself with what we have done to date.

And as we start thinking about our -- we are going to be working on our work plan over the summer months, and at that point then we will figure out a way to start engaging other folks in helping us build out maybe some of the training activities or other fidelity tools, or those types of things we know we are going to need to create.

[Pause.]

Okay. So another question about -- is it too late to become involved in the focus groups?

So we worked with those agendas and organizations that were part of the development of the practice profile, to be a part of the focus groups, because what we really wanted to do was have somebody there who was familiar with the development process, kind of help their staff understand what we were asking them.

As we mentioned earlier, we wanted to have as inclusive a process as we can, going forward, you know, as we've developed training, fidelity tools, other types of things. This won't be the last you'll hear from us with respect to this work.

So someone is asking about the slides for the Webinar.

Again, they're up on our website, so you can go ahead and download those.

There's a question about -- it's a good one -- that we will have to go back and do some thinking about to what extent families involved in this process and how might they be involved in upcoming focus groups.

So that's a good, you know, piece of feedback for us to take back and think about how do we figure out some of the work and how the practice profile kind of has evolved, and get some family perspective on that.

[Pause.]

So are there other questions folks are sending us?

Someone is just asking about will there be a training provided on how to train staff on the practice profile matrices.

So we envision that, definitely, that training path you saw in the Drivers triangle earlier, that training and coaching people on how to use the matrices will be an important piece of that work.

So we hope to have a workgroup that will be specifically focused on training.

If you go ahead and once you go to the website and see the different matrices that are up there, you will see in the preambles to the practice profile work, there is a bit of some language up there about how to use the matrices.

That is intended for some initial guidance, but we know we will have to do more to flesh that out for folks.

[Pause]

So someone is asking about the Web site.

So if you are making sure to use Google Chrome instead of Internet Explorer, if you go in, it is www.CBHknowledge.center. From there, it is backslash ihtpp.

Alternatively, you can find it by going through the menu that is at the top. It is under the Innovation tab, the first page that should come up under the Innovation tab.

>>Someone is asking about why Google Chrome.

I don't know! I think it is in part because we use Squarespace as the Internet host for it, and it only talks to Google Chrome, or Safari. I think you can use Safari too. You just can't use Internet Explorer.

So another question about how will the practice changes affect authorization for services?

So at this point in time, I don't think that the practice profiles are changing how the services are authorized.

It's something in part to offer guidance to practitioners about how to do the work. There isn't guidance -- the practice profile won't be for how to talk to the managed care companies, but it is more about how to work with the kids and families.

It's not a tool that is intended to be kind of how do you deal with the administrative components of doing the work. It is more about the actual clinical aspects of the work.

So someone is asking if the session is being recorded, can we access that recording.

So yes. We have been recording it so that we could share it with others who have not been able to be with us today.

So we will be giving that link up on the Knowledge Center's website and be sending it out afterwards. It may take a few days to get it up on the website, but we will have it up there for folks, and you can share that.

The more people that we -- that are part of this and hear about it, I think, the better the outcome. So share broadly.

[Pause]

Other questions that are occurring to people? Or anyone else have any last thoughts for Jack or Susan before we sign off this afternoon?

>>Jack Simon: I think people may have follow-up questions, and they can direct them to Kelly.

>>Kelly English: Mm-hmm.

>>Jack Simon: If it occurs to you later, don't feel you have missed your chance to ask a question.

>>Kelly English: So you will see here, on the final slide here, there is the contact information for myself and for Jack. If there are additional questions that occur to you along the way, please feel free to reach out.

>>Jack Simon: Yeah, either of us.

>>Kelly English: All right. So I think that's -- we have come to the end of our Webinar this afternoon. I want to thank everybody for taking time out of their day to learn about this process.

We are really excited and hopeful about this next stage in the work for the practice profile.

We think we have gotten it to a place that's really well specified, tons of provider input, that we think we are really hopeful about this next stage of quality improvement for IHT.

So thanks, everybody, for being with us, and we will talk again soon.

>>Jack Simon: Thanks, everyone.

>>Bonny Saulnier: Thanks.