IHT Practice Profile Supervisory Strategies Webinar
Webinar Transcript

>> So welcome to everyone. We are going to get started today. And I know some folks are still dialing in and we can see the phone line growing, but I want to get going, we're mindful of your time. Again this is Susan Maciolek, I will be hosting the webinar today and I'm joined by the project team here, the CBHI team, Jack Simons, Margot Tracy, Jennifer Hallisey, Laura Conrad, and also Kelly English from the Children's Behavioral Health Knowledge Center. We are happy to have you join us on our In-Home Therapy Practice Profile webinar.

>> Just a couple of housekeeping items while we have our colleagues continue to dial in, we will keep the lines muted for those listening in today. And we are going to use the chat function to type in your questions. I'm guessing you are all somewhat experienced webinar participants at this point in your career, so you know where the question function is, feel free to type in your questions, we will take a look at those likely to answer questions towards the end of the webinar.

>> If you have any technical difficulty, use the chat function for that. We have somebody here who is monitoring that space and she can definitely help you resolve any technical problems.

>> So with that, we will go ahead and start.

>> So today we're happy to have another webinar presentation on the In-home Therapy Practice Profile. Our goal for today is to talk with you about the in-home therapy implementation workgroup, which has taken up the practice profile and started to do some really rigorous implementation.

>> Describe the in-home therapy Supervisory Strategies, that they are working with us to implement and test, share the results of the usability test that we have been doing with these providers, and preview some of the work that will come up over this year and next fiscal year to scale up the supervisory strategies in support of scaling up the practice profile. With both the colleagues that were working on the implementation group as well as throughout the IHT community.

>> We are also going to share some resources that are available on the CBH Knowledge Center Website towards the end of this webinar so you all know where you can find the resources that we have been developing.

>> So as a reminder, and I hope this is a reminder and you are all already up to speed on this, we have developed this practice profile that has nine core elements. There are what we call a matrix for each of the core elements that describes the work of in-home therapy. We have described it as a shared practice between a clinician and a TT&S. We have delineated nine core elements but they are not linear. Or separate from each other, they're very much interactive and have themes repeat across each of the core elements. We've got a number of materials up on the CBH knowledge center website already. Many of you have a very lovely binder with printed materials that provide the details and practice profile. So I hope this all looks very familiar to you.

>> We've been out there for the past several months, so for almost a year now. Sharing this product with you and encouraging your use of it. So we are here really today to talk about how we have begun to really focus on some key implementation strategies to help in home therapy programs really take up the practice profile to make it be a successful intervention in their program.

>> So the focus of today's webinar is to talk to you about the implementation workgroup, you can see your colleagues' organizations listed there. We have been working with them since last April. Each

program has set a team of six that we have been meeting with once a month since last April and we just had our last meeting in September. About half the participants are supervisors, the other half are clinicians or TT&S.

>> For about three quarters of the staff, IHT was their entire caseload, or more than half of their caseload, and for some of them their caseload was less than half in-home therapy. So we've had a nice mix of experience, with how to support improving in-home therapy practice using the practice profile and using supervision strategies in particular.

>> We continue to use this approach – I'm sure you recall when we first introduced the practice profile. We talked about the very collaborative processes to develop and to design it. We had met for several months running with what ended up being close to 50 at any given time practice leaders in the IHT community to develop the practice profile and that was an important part of creating it. We have continued that spirit of collaboration and practice of collaboration to develop the supervisory strategies and test them and make them usable from the perspective of front-line clinicians, supervisors, and programs.

>> So here's where we are with this particular implementation set of strategies. We've developed a guide, started with it in April. With a working draft back then, and it's nearly final now. We will tell you where to find that soon. That describes in-home therapy supervisory strategies. There were three in particular that we developed and have been testing. One is using the practice profile in a slightly different form, using it as a self-assessment tool for staff to then take into meetings with the supervisors to guide supervision. And make at least one meeting a month a supervision, a focus on professional development. Informed by the practice profile and the staff's assessment of their own practice using that.

>> A second strategy was behavioral rehearsal. A third strategy was field observations. The scenarios for both of those have come from the practice profile to focus on what supervisors pay attention to in those two strategies, informed by the practice profile. And so this guide, which we have been able to now refine thanks to the pilot of the implementation workgroup, describes the definition and purpose of each of these strategies, describes the outcomes we hope to impact because of each of these strategies. We articulated what we believe the theory of change in the impact is from using each of these. And we have given some guidance about how to prepare and conduct each of these three.

>> And we will really walk you through some of this in the webinar to give you a sense of what the three strategies are, I'm going to introduce each of them and then we've got members from the implementation workgroup, providers that have been testing these, to share with you their experiences.

>> Here is our rough testing approach. We started working in April with this provider implementation workgroup. And here is a series of tests that we did starting in May, we began by testing the self-assessment. And that helped us feed into doing field observations and in turn informed behavioral rehearsals.

>> What we mean by test is that each team agrees to have at its pilot site 10 staff. With a combination of clinicians and TT&S, and each site tested each of these strategies once.

>> So, in each provider agency, 10 people did a test of the self-assessment. They used the tool we created, did a self assessment, met with their supervisor, and began to develop an individual skills

development plan. To see how that tool that we created would inform their own professional development and their attention to where they needed to improve their own practice.

>> Similarly, each of these 10 people was observed once in the field by their supervisor. So we created some guidance and an observation tool. And that was tested 10 times in each pilot site. Following that, the teams did the behavioral rehearsal test. We'll hear more about that in detail later. But in general, people used staff meetings, or similar meanings, to have each of their 10 staff in the pilot, and in some cases additional people, to do behavioral rehearsals using scenarios drawn from the practice profile. And then we asked for feedback from each of those 10 staff people in the pilot to let us know very specific feedback on how that strategy went and we did that with each of the strategies, and collected structured feedback through a survey monkey tool and we used that data to debrief with the project team to explore what we collected and what we were learning about each of the strategies.

>> That was our general approach. We will spend a few minutes walking through the each of the strategies. The first idea is about monthly supervision guided by staff self-assessment. These items that you see on the screen are right from the guide. The guide has a lot more detail than here but this gives you a sense of what we mean by the definition of use of self-assessment in the context of supervision.

>> We know supervision often gets taken up by the need to focus on challenging cases. Difficult situations and the like. And that's important. We felt it was equally important that we carve out some space once a month to focus on the staff professional development and practice development guided by the practice profile.

>> So the purpose that we carved out for that, we believe, is to reflect with the staff about their practice as a mutual assessment about the staff's knowledge, skills, and attitudes, and to support their staff in their practice development progression.

>> So we talked about it as a self-assessment tool and it begins there, as a self-assessment, but staff really bring it to their supervision meeting and get feedback from the supervisor, and the supervisor has the opportunity to also assess their staff using the practice profile, so it really is a mutual assessment. That then can inform an individual's skills plan.

>> And this is what kicked off the test of the pre-strategy, the foundation for how to use other targeted supervisory coaching tools. That we will talk about next.

>> But here's some feedback before we go on, as I said we did some structured survey monkey feedback. As a series of questions we had a survey for the staff. And we had a survey for the supervisor.

>> One of the questions that we asked each of them was to list three adjectives that describes their experience using the strategy.

>> And this was the feedbacks that we got, from the staff. You can see that in general the bigger words are generally the more positive ones, which we were happy to see, that it was informative and helpful. We got some other feedback that has caused us to refine the tools, so you'll see some comments there about it being lengthy and time-consuming.

>> The debrief that we had with the project teams about this feedback sent us back to the drawing board a bit to refine the tools so they can be less lengthy and time-consuming and we hope equally informative and helpful in terms of sparking good conversation.

>> The supervisors had some equally overall positive feedback for us. Helpful, we were pleased to see they found it strength-based, insightful, a good structure, helped them be reflective – all those things we had hoped for when we really designed together the practice profile content, and had hoped people would take it up in the spirit of being reflective and positive with their staff, and we see a lot of that here.

>> The other question we ask was how likely is it that staff, in this case clinicians and TT&S, would recommend completing a self-assessment to a colleague.

>> The idea that they felt positively enough that they would endorse this for colleagues to use, would be a good indicator for us about where they felt on the usefulness of the strategy.

>> And you can see we had a range of responses for that. Mostly ending of the top end, which is strongly recommending the strategy.

>> And so we were pleased to see that people felt that it was, despite its length, which we trimmed back, overall it was a useful tool, a helpful tool to gain insight into their practice talk with their supervisors.

>> Similar question asked of supervisors – would they recommend using a self-assessment as part of their supervision to a colleague, would they recommend that a colleague use the strategy and again we see some range, but must going for the positive strong recommendation that the strategy is indeed helpful to a supervisor.

>> I'm going to turn it over now to Erin Hourahan, who is on the South Shore Mental Health Team. She will share some of her team's experiences with the strategies. And answer some questions that are on the screen there.

>> Erin.

>> Erin, Are you still on mute?

>> Hello everyone, can you hear me?

Yes.

>> Yes, very good. Thank you so much.

>> I am glad to talk today about the self-assessment from the provider perspective, in regards to what our team hopes for, I think that we were hoping initially that the assessment would provide the staff with an opportunity to match what they were doing out in the field. With what the expectations were of the initiative in the first place.

>> We were fearful that the staff would interpret the assessment as a means for active supervisors to figure out what they were doing wrong.

>> Versus a way just to simply enhance the they were already doing so well.

>> Also I think that we were thinking that the tool could also help us better assess how they are utilizing and coordinating care with other collaterals, such as ICCs and in-home behaviorists, and the like.

>> Also, it was a way to measure our successes individually. And also collaboratively as a team. But we were hopeful that it would come out promising, but we were definitely fearful that maybe we were missing something.

>> So the self-assessment tool was wonderful because we were able to then differentiate from what we received after we implemented it. To determine what next steps we can take, not only individually but also as the program.

>> So in regards to how we implemented it, we initially asked our staff if they would be willing to volunteer. And luckily actually each staff member did agree to take the self-assessment.

>> So we implemented the assessment first by each giving the staff person the self-assessment to review on their own. And then we reviewed any questions that they had that they noticed about the assessment. During our supervision which is simply a one-on-one supervision.

>> So that way if they had any real questions or concerns, or they didn't understand something, they felt more comfortable to do so with us, just individually with their supervisor.

>> So then we had them administer the self-assessment. And from there, after that occurred, I would say maybe a week afterward, less than that actually now that I think of it. We had a group meeting to discuss and possibly discuss any critiques that they had, or questions. And to help review the overall outcome.

>> Once that was done we also then went back into supervision one-on-one to talk with them further about how each element within the self-assessment was particularly poised to them and their work, not only in their current clients, the families they server, but just historically to determine where they used to be versus where they think they are now clinically.

>> And that was also very interesting. To note. However, luckily we were able to use all their answers and build off of their answers and their professional goals. And we implemented those professional goals through our yearly performance appraisal. And so now luckily the practice profile language and all core elements are now part of our yearly performance appraisal.

>> Which is been very helpful really. Just because as I'm sure all of you know, doing the yearly performance appraisals aren’t always fun; however, this gave us a nice balance in order to know how to work with the staff person on where they could really improve or where they were doing so well, but maybe didn't realize they were doing so as well as they were.

>> And so I think that our staff really appreciated that. Because it was concrete. And I think that it was helpful to them to know where they stood and that it could be a universal language through the core elements that everybody would be able to start to use.

>> So in regards to what the reactions were of our staff, going back to when we provided them initially with the self-assessment, their initial reaction honestly was that they were a little overwhelmed. Because it was larger than it is now, so it looked a little daunting to them.

>> The staff realized that they were actually doing the work. Through all the core elements. More proficiently and thoroughly than they probably realized they were.

>> And I think it really boosted morale quite a bit because it's one thing to be told that you're doing a great job, but sometimes we don't always know what that means exactly.

>> And so through the self-assessment, they truly were able to mirror what they were doing with the feedback that we could then provide them through supervision and in the general group when we all got together to say hey, everyone is doing a much better job than you may have thought.

>> And by the way your colleagues are also out there doing just as well as you are.

>> And so that was really exciting, and I think it helped our team congeal a little bit more.

>> So people are proud of one another and they were proud of themselves after reviewing their assessment.

>> Also, they were also surprised to see that they all seemed to agree that there were general themes throughout the self-assessment, related to wanting more training.

>> On specific elements.

>> So for instance the first and last elements, were the most popular, I guess, for our staff. So practicing cultural relevance was a really large request.

>> In order to implement further trainings and more in-depth training as it relates to our current population that we serve.

>> As well as then the last element being preparing to exit.

>> And clinically speaking, I think that we, as a team, tend to be more thorough about our treatment plans and making sure that we have our timelines in place and we're building our professional supports around the family as well as the natural support.

>> However, when it’s time to say goodbye and it’s time to celebrate these successes, sometimes we forget to do that.

>> And so the self-assessment shows that a lot of people needed extra help on learning how to better prepare to exit, to say goodbye to a family that they have been working with.

>> So overall I think lessons that we learned were actually more surprising than we thought because, quite frankly we initially were thinking that the self-assessment was going to be just kind of another task. However, it turned out to be much more important, and much more reflective.

>> And we were really excited. Because not only was it something that was being asked of us, but then we were able to use the tool to really review how we are having our conversations with supervision and also thinking about what the goals are for our own staff.

>> We're so concentrated on thinking about what goals and objectives we are keeping in mind for the families we work with, but when it comes to our own professional development, what are our goals and objectives.

>> This self-assessment helped us do that.

>> And we're happy to report that we now are building this into our yearly performance appraisal.

>> And it's a very exciting tool. And I'm very excited to talk about this with everybody today because I think that is definitely something to implement. And so I appreciate your time. If there's any questions, I am happy to take them now.

>> Erin, thank you so much. That was really helpful to hear you reflect on what the experience was like for your team.

>> We will keep an eye on questions and I am going to jump in and talk about field observation while we watch the questions coming in and we will get to them before the end.

>> So our next strategy to talk about is the field observation. So I think we would all say and reflect that this is the one that folks are more anxious about, as much as folks are anxious about the self-assessment and how it might be used, the idea of being observed in the field, for those who don't have that practice yet, and thought it was a little bit nerve-racking. We all agreed it was an important and good practice to try to test to see how it can be used and see how to support it. And so we will go what a field operation is, I'm sure you are all familiar with the idea of it.

>> And the purpose that we had identified and we really strongly encourage you do observations of your staff working families, not just observation of the staff in professional meetings and professional situations, where we have the opportunity to make observations in the office space, but to really get out into the field. And to go to a home visit and see how staff are working with families and kids.

>> And so we developed a scale observation tool that we will also be posting and some guidance. We will spend a good amount of time talking about how to give productive feedback. And so we will be sharing that in the guidance as well as the tools.

>> Some of the feedback that we got in our survey of staff afterwards, you'll see that overall helpful, people felt supported. And found it informative and educational. You see the nerve-racking there and the awkward, those things are real. Every one of the 10 staff was observed once so this is feedback from people who had one observation in programs that largely did not have this kind of practice in place, and so over time we all imagine that as people became comfortable with doing the field operations, that the nerve-racking part of it that might diminish as it becomes a standard practice. And in the beginning with the first one this is where we landed, and in the one-time experience would be the helpfulness, which is encouraging and also really a testament to your supervisors who conducted the observations and they did a wonderful job doing that.

>> The supervisor feedback, also the supervisors responded helpful as well, insightful, they talked a lot about how helpful it was to go out to see what the work is with families and see what their staff are doing every day, and the challenges that they face and found it an important way to gain insight into the challenges that the staff talk about in supervision, and so they really valued a lot being out in the field and doing these observations.

>> In terms of whether folks would endorse this, you see a range -- a little bit warmer range and a stronger anchor at the bottom, but again, seven and above, slightly strongly or strongly endorsing the use of the field observation, these are the staff overall, 10 times 9 sites, so about 90 staff, overall endorsing field observations, which we were pleased to see given some of the anxiety folks had at the beginning.

>> And supervisors had a much stronger endorsement, I think that the supervisors found it very helpful and insightful to spend time with their staff, many of them spent time not just doing the observation but doing the debrief out in the field, and really were able to have the kinds of conversations that they typically would not have had if they had been in the office doing office-based supervision without this kind of feedback from their direct observations of staff, so hearing in an office setting how staff are sharing their experiences with families and how staff are reflecting on their own practice is one thing, being out in the field and observing them and seeing how well they are doing or what they are struggling with and why they might be struggling gave the supervisors a whole level of insight that really helped them advance their own practice as supervisors to help their staff.

>> So quick overview of field observations, and I think you're generally familiar with the idea of it. I wanted to give a chance to hear from Meg List, who is going to share her team's experiences with field observations.

>> Hello everyone. So we will start off with recognizing when this was introduced to us I think everybody in the room was introduced immediately started to panic. Our management team started to panic a little bit. We were just really concerned initially that this would take a lot of time, that it would take us out of the office, could take a lot of time to do. We had a lot of concerns fundamentally logistically how we will pull off having our supervisors out of the fields with our clinicians, for sessions, that could run from an hour to three hours in doing this with all of our clinicians.

>> And we kind of reminded ourselves, we only had a to test 10, and we were able to kind of get to place to really realizing this is going to give us a great opportunity to see our clinicians out in the field.

>> To see what is that they are doing with their families, what are their strengths, one of their areas of development, then we actually got excited about this.

>> When we introduced it to our clinicians, they were all a little bit hesitant, more so what we got from them was they were worried about how the families would take to a supervisor coming in, and sitting in on a session, in our agency this is not a standard practice, so their concerns are what the families would think about this.

>> And before rolling it out, we sat down with our clinicians who had already completed their self-assessment. And we kind of went through the self-assessment and from the self-assessment we created a skill development plan, and we looked at their caseloads and their families that they were seeing and we narrowed it down with each clinician individually in the supervision, what family had some things that were going on that spoke most to their skill development plan and things that they want to work on.

>> So ultimately the decision about what family we were going to go out and observe, was with the clinician to fill a skill development plan that we had created from their self-assessment.

>> Then we talk to our clinicians about how do you talk to families about this. We developed some language that just made it more normal, we talked to the clinicians about how pretty much any industry you're in someone's observing the work that you do, and giving you comments including that feedback in a meaningful way, and it's a great opportunity for us to be able to see the great work they are doing. We had them talk to their clients individually, and mentioned that we were part of this practice profile group and explained a little bit about what it is and the point was not to come out to critique the family,

but to come out and be able to get some view of what the clinicians were doing to offer them more support to be able to help the families.

>> And that actually proved to be one of the better pieces of it. The clinicians having the conversations with the family and that some of us ended up having conversations with the family before going as well. Just really normalize that this is a learning field, and we're possibly evolving and this is a great way to help people to provide more support so that everybody is delivering better care.

>> So then we rolled it out, our supervisors a picked a clinician and a week to go out and do the supervision on – it did and require a little bit of rearranging on our schedule juggling some supervisions to make room for this, so we all went out and try to do one clinician's client a week. I think it ranged from an hour in the home to almost 3, in the shadowing that I did.

>> And it was really really beneficial, while they were happening, the families pretty much forgot who we were, I would say for the most part, and the families that did focus on the fact that a supervisor was there, it didn't seem to hinder what they were working on.

>> After about 20 minutes or so, I think the family and the clinicians kinda went right into their normal vibe and we really were able to just be observers. One family that that I did the field observation for did not get over the fact that a supervisor was there. They really have a lot of questions. And they directed them specifically at me as a supervisor. And we were able to really clarify some confusion they had about how IHT was different from other services. What was really going on here, is this the appropriate thing, and ultimately it really ended up being a great experience.

>> At the end, after the observation, we tried to do a quick debrief with the clinicians to just give them an idea of some of the positives we saw, talk to them a little bit quickly about some of the areas or core elements they had wanted us to focus on.

>> And give them some insight on what we had noticed.

>> After that, we as a supervisors came back and gave ourselves some time to really process, the notes that we had typically written in the session -- and quick debrief with our clinicians and came up with kind of a longer more in depth debrief so that we can point out to them some of the skills that they were actually using that maybe they didn't think they were using, that are within the practical profile, embedded in the different elements.

>> We also then were able to pull out some of the areas that we did have some suggestions for. And able to use that with informing the supervision going forward.

>> Each of the clinicians that we have the opportunity to observe in the field, I would say our supervision is so much more rich. When it comes to that family we observed.

>> It has given me as a supervisor a brief kind of first-hand view of what the family and the dynamics are like, what it's like going into this home. What are the barriers going into this home, what are the strengths going into this home.

>> Understanding our clinicians' frustrations when they describe a certain personality having been able to see it firsthand has really made our clinical conversations about these families much more rich, and they are seeing a lot more progress with them as well.

>> We were able to have much better conversations about their skill development and I think all of my clinicians had areas that they had been pointed out from self-assessment they thought that they were weak on, but after the field observation we were able to give them the feedback they really do have this, that they are much stronger in that area they thought they were -- and we were able to give a much better clinical insight to what they are doing and how things are going so really at the end of the day I think it was probably one of the scarier elements that we talk about testing. But it was probably my favorite that we have done. The quality of supervision and the quality of the practice is much better now that we have been able to go out there and we are rolling this out as something to do more frequently with our clinicians and really picking cases as they come up that make sense for the IAP plan, so if we have a clinician that said I am really concerned about preparing to exit, going out and doing field observations with them with intention, and plan to be giving them the feedback on what it is that they are actually doing.

>> And as all of us know, who've had to try this exercise at one point in school or whatever, when you have to videotape yourself talking to somebody, we are not aware of what we do not know about ourselves and the field observations gave us the ability to give us insight into how did in her nonverbal skills play into their practice. Do they come across as being intentional with their clients? Do they have a plan? Is this a clinician that has a beautiful plan and then it walks in the door and goes out the window? So it was just one of the better helpful things that we did.

>> Meg, thank you so much for that.

>> It was helpful to hear your suspect perspective. The one thing I want to add for folks hearing about this for the first time is during the pilot we allowed for about 6 weeks to do the field observations, and that really did crunch people time wise, and when Meg talked about this being supervisors do maybe one per week, that was really something we asked them to commit to because of the nature of the pilot.

>> We're now at a place where the teams are figuring out what is their realistic pace. The ongoing supervision, and make it meaningful in all the ways that we talked about, but I don't want you to hear about field operation, it's not necessarily something that has to be done once a week, but it's something we really understand needs to be worked out in terms of the context of your programs and we're really undertaking that part of that work now in our second phase.

>> And just actually just add to that, it did not take as much time as any of us thought it was, we were all of my God we would have to be away from our desks, and having the supervisor panic, but I would say it did not take nearly as much time as we had made it up in our heads it would take, and the knowledge that we walked away from on what the clinicians were doing, way outweighed the couple hours you were away from your desk. So it was worth it.

>> Great, thank you.

>> So one more strategy of the 3, behavioral rehearsals. Some people call these role-play. But we don't call them that because we're not really playacting. And it's not an emotive exercise, is to rehearse the behaviors described in the practice profile. They are really opportunities to practice with a realistic scenario, they are more generally done in teams among staff, and so staff would play the role or stand in for the family or somebody that practitioner was practicing on and we will hear a little bit more about

that from Katelyn in a minute, but being part of these behavioral rehearsals are really important parts of any training experience.

>> Those of you who do trainings know that the best practice is to integrate into the presentation style training the opportunity to rehearse the skills and knowledge people are learning about.

>> We also see it as an opportunity to really build a collaborative environment so the teams of people doing these would have a chance to learn from each other and do best practice sharing among peers, among staff. And so we built a behavioral observation tool, very simple, very straightforward, draws from the practice profile core elements. Guidance about how to debrief and how to provide feedback. And giving feedback is itself a skill, and we talked about that throughout the pilot, developing the practice of giving and receiving feedback, and then we have developed some sample scenarios.

>> This is our final strategy at the end of the summer and we get feedback from staff when they were acting or in the role of the practitioner. And again helpful and informative and a little nerve-racking here and there and you see a range of things in terms of it was pleasant and practical, it was great, it was easy, it was stressful, but overall, I think people seemed to have found it to be a helpful way to do some learning about the practice in the practice profile.

>> Here is the staff when they're talking about being observers, so they got the opportunity to observe a colleague of theirs. Practicing their skills and sharing their observations in the form of giving feedback. And that's also an important skill that this opportunity allowed them to develop, and there are a wide range of adjectives to describe that.

>> Mostly along the positive continuum, a few hitting anxiety, a little hard, mostly informative, interesting, helpful, we were encouraged that people saw that as being an observer was also part of the learning process.

>> So supervisors' feedback on behavioral rehearsal. Supervisors actually played a lot of roles in that, they convened and corralled the group's activities. Sometimes they stood in as the family, sometimes observers, and they had a range of roles, and here's their feedback about what their experience was like. We then asked similar questions about if you would recommend behavioral rehearsals to colleagues and staff, and lots of positives here, they would in fact recommend it.

>> And we asked a series of questions of the supervisors.

>> Did the behavioral rehearsal help you bring staff together in a group environment to share. And a lot of very strong endorsements. The behavior helped build a collaborative work environment. And strong endorsements of that as well.

>> Did the behavioral rehearsal help the supervisor support their staff in demonstrating best practices. Again supervisors I think overall really took advantage of this opportunity to really build teamwork or to build off of the teamwork they had already done a good job establishing, and created shared environments to really demonstrate and share best practices. So finally would supervisors recommend behavioral rehearsals to colleagues. So you can see across these 3 strategies that those of you on the call who are supervisors, your peer supervisors from the pilot make a strong recommendation as a part of these 3 strategies to be ways to build practice with their staff.

>> I will turn it over now to Katelyn Gawthrope from Wayside to talk about her team's experience with behavioral rehearsals.

>> Hello, can you hear me?

>> We can.

>> Great. I have to state that my initial understanding of behavioral rehearsals was pretty grim. I really didn't have a lot of hope. We had a lot of fears. I thought it was MassHealth's way to try to check us into doing role-plays. I was kind of concerned it would feel phony and just another thing that we were making people do.

>> I was very wrong. Pleasantly surprised, I very wrong.

>> So what we did was the group of us that went to the practice profile workgroup made up a training exercise. We chose something simple, orienting families to services and the agencies and the core element of engagement. We scheduled it into a staff meeting that was already existing. We prepared intake documents for people to use as props. We instructed folks who were in the role of a parent or person served to kind of just hold the scene. They didn't have to act, there would be no Emmy awards that would be happening. So they just kinda needed to hold the role for the clinician or the youth and family support worker to practice.

>> We had people break into the groups of three or four - a clinician and/or youth or family support worker, the parent or person served, and an observer. We gave them 45 minutes to practice. Some groups rotated roles to give newer employees time to practice on their own. We had groups come back together to debrief the exercise so we could give feedback on the practice profile survey.

>> People liked it so much that we did another one the next month on evaluating full risk and safety concerns and we provided the safety clinic guidelines and the safety planning worksheets as props to facilitate the rehearsal.

>> So pleasantly, our staff really liked these exercises. They asked us to do it again, we did, we have, they said it was more engaging than having me drone on and on to them.

>> They liked that they did not have to put on a show. There was no – they didn't have to make up a character, we provided them with some guidelines. They also liked learning from each other with different styles that they had not thought of or observed before, so seeing how other people do things sort of improving the method that they had already adopted.

>> I think it was really helpful to tell them not to act. Then the responsibility could be on supporting their peer, as opposed to making up some awful scenario to act out.

>> It really took some of the pressure off of me as a clinical director, I am the main trainer in the building, and to put together an engaging curriculum that doesn't leave people checking their email daydreaming is sometimes difficult.

>> So it's something that we can incorporate into our meetings. So that's really helpful.

>> It was also good to do them in peer groups is opposed to supervision. People were more relaxed with each other, it created a collaborative learning environment, as opposed to feeling they were evaluated or judged.

>> The only advice that I could give all of you is to be open to these strategies because they may really change the practices in ways that are easier for you.

>> That's all I have.

>> So great, Katelyn, thank you so much for that.

>> We have been looking at some of the questions that have been coming in so let me turn to where we are going next so I think that will help me with some of the questions in terms of our next phase of work.

>> So we have done phase 1 piloting, that we described, we ended that in September. We are now working with 8 of the providers from that process. To do scale up planning.

>> We had one meeting, November 1, and now we are planning our second in December, and then we will ask them to really begin full implementation.

>> So one of the questions that came in was about billable time and how to understand that, how to allocate that. One of the benefits that we have with the pilots was that you are able to stipend some of the time to pay for people's time to do some very intensive work for us and we knew that it was more intensive than is likely to be the case when we scale up. We are learning in phase 2 what scale up means. It won't mean ten tests at the level of intensity that we just did, so we will be working with folks to understand what real intensity should look like with best practices.

>> Find the best ways of supporting that, we've had the benefit of being able to stipend people to get through this group of the work, that won't obviously continue, so we're learning more about that.

>> One question came up is field observations, and behavior, are they similar to what you might know from wraparound. We did actually look at the TOM measure from wraparound. Which is similar in that it's an observation tool. Could be different in that you go into the family's home and making observations in different contexts, so we did actually draw from some of the practices from wraparound. So those of you who are familiar with some of the wraparound practice of observation might have a leg up in sort of taking in the practices that we've talked about for in-home therapy.

>> In terms of the question of sharing materials, yes, we are definitely going to be sharing materials as we move towards full implementation in the statewide meeting and we're going to make sure everyone has the materials available for them.

>> And Phase 1 we are actually working to get finalized and out sometime this week, we've used the children's behavioral health knowledge center to disseminate materials, so you will there find, in a couple days give us time, the slides from this webinar, the recording of this webinar, and tools that we talked about today across the three strategies, we are revising them based on feedback and we're taking a little bit of time and hope that we are done this week with getting tools on that knowledge center website. So for those of you, for those of you familiar with the website, this is where you can the find in-

home therapy practice profile-- at the top see there's an item called practice profile library. The knowledge center has now done three of these, there are two others under development.

>> You can see the little icon that you see is the in-home therapy practice profile, and we will add an icon there for supervisory strategies and when you link to it you will find all the tools that we've been talking about. So stay tuned there. Or check back towards the end of the week. Or early next week and it will be there.

>> When you click on the practice icon, this is the kind of information you will find, there is a lot of material and supports under each category that are available to folks. And for those who are interested in poking around there, we're still looking forward to hearing and learning from you, some resources needed for these support elements in particular.

>> If any of you know of some resources, either from your searches and your learning, conferences, websites, or you that may have developed yourself, that your program was developed, and you are willing and want to share those with the knowledge center and with your colleagues, we would love to hear from you. The knowledge center has an email and you can email us from that website and share it. And that's where you will find all the resources from today. As I said we are hoping to do another round of statewide meetings in April and you will recall we did a big couple of meetings in March where we handed out the practice profile. We are aiming to do another round in April. To share with you what we are learning about, scaling up, about bringing moving from a pilot with 10 staff to going program-wide, across multiple sites and what the strategy looks, like resources are available. And hear from your colleagues again like you heard from them today. About how to really take up the practice profile to continue to meet the quality by each team.

>> That is coming next spring. And you will all hear more details about that as that approaches.

>> For now though, we do look forward to sharing those resources with you from the website. And happy to take it more questions that you might have today, and we are looking at them in the question box. So the skills assessment that was sent out -- that will be one of the materials that we will share -- the self-assessment tool is was one we had to do the most changes on because it was too time-consuming so we scaled it back. So we will get access to the revised skills assessment along with the materials that we just described.

>> A question about field observations. How did you initially identify families for observations, did you try to avoid the higher acuity families. So, Meg.

>> Meg, are you still with us?

>> Yes, sorry, my mute button got stuck!

>> Did you hear the question?

>> Can you say it again?

>> How did you identify families for field observations, did you try to avoid the higher acuity families.

>> No, we really went with what the clinician's preference was, and what we found was our clinicians did not shy away from the high acuity families, some of them were actually eager to have us come in and see these intenser settings to get the feedback on it.

>> Right, thank you.

>> Any other roll-outs or trainings we can look forward to?

>> At this point we're really focused on those April statewide meetings. If you have more specific requests, we would like to hear from you about what that might be.

>> Who should you contact for training or questions about the IHT practice profile?

>> You can always contact us through the knowledge center website email address.

>> Or your MCE TA Team.

>> Either those website emails or the MCE TA Team person would be a good resource for you depending on your question.

>> So I see no other questions there. And it is 3 o'clock. So we are mindful of our time and your time. We appreciate you joining us today. We are hoping that this sparks some interest among all of you learning more about and exploring the materials. Perhaps talking more with your colleagues and we really appreciate Erin and Meg and Katelyn, really giving life to the work, it's always so helpful to hear and to know that we are really making a positive impact on supporting the clinicians on the front line, that's really what this effort was about. So we really appreciate the three of you joining us today, and we appreciate everyone. One more question. Supervisors cannot bill for the time they spent in the field doing the observation.

>> That was one question that came up and no, we supported it through stipends, because it's not billable and we are now working with programs to figure out how do we make that a reality, how do they make that a reality, how they integrate it into their practice, as a matter of their ongoing work, it's not a separate billable item.

>> It's part of supervision time and that should be covered him as part of supervision, kind of and making it streamlined, make it as streamlined as you can to incorporate the ongoing supervision you're already doing. And recognizing that it is a new strategy in the toolkit.

>> So that was the last question. Seeing no more, I will say goodbye on behalf of the team and thank you once again for joining us and look forward to seeing you next spring.

>> Thank you.

>> [Event concluded]