

FINAL REPORT

The New Hampshire MATCH Learning Collaborative



Founded in 1917, Judge Baker Children's Center (JBCC) is dedicated to improving the lives of children and adolescents whose mental health problems threaten to limit their potential. JBCC was named in honor of the Boston Juvenile Court's first judge, Harvey Humphrey Baker, a visionary in child welfare. Harvey Baker was among the first to advocate a system based on understanding and treatment to help troubled youth, rather than one using punishment or incarceration. The mission of JBCC is to promote the best possible mental health of children through the integration of research, intervention, training, and advocacy. JBCC carries out its mission through:

- Research that identifies best practices;
- Intervention that brings those practices to children and families of diverse communities;
- Training that disseminates skills in research and quality care; and
- Advocacy using scientific knowledge to expand public awareness and inform public policy.

Judge Baker Children's Center's Quality Care Initiative is comprised of a range of programs focused on bridging the gap between science and practice in children's mental health by implementing best practices in real world settings through the utilization of proven strategies supported by implementation science.

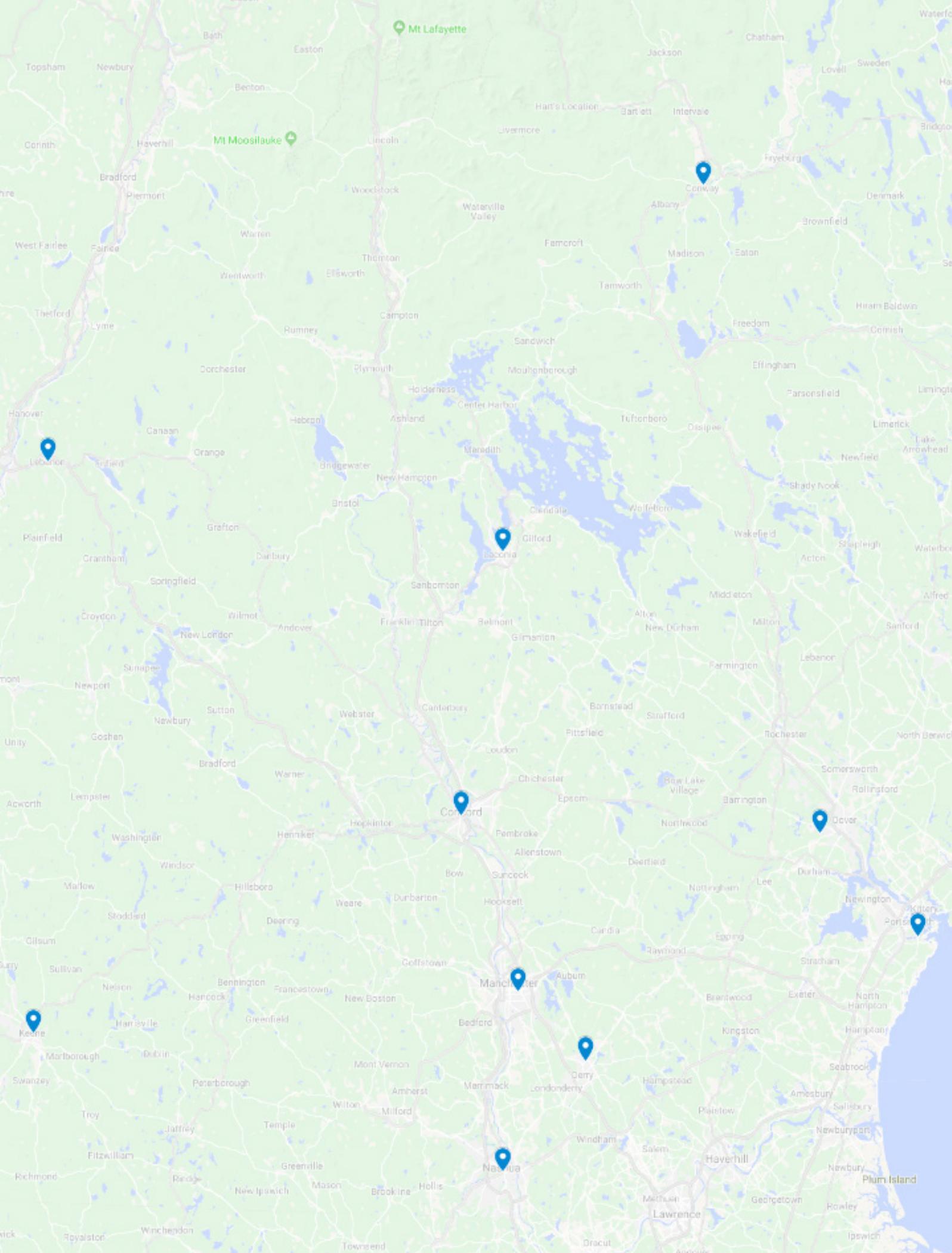
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The New Hampshire MATCH Learning Collaborative
Final Report
Fiscal Years 2017 - 2020

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Mt Lafayette

Mt Moosilauke

Conway

Laconia

Concord

Manchester

Nashua

Dover

Portsmouth

Keene

Derry

Plum Island

About the New Hampshire MATCH Learning Collaborative Initiative

The MATCH Learning Collaborative (Learning Collaborative) was a three and a half year initiative funded by the Children’s Bureau of the New Hampshire Department of Health and Human Services, Division for Behavioral Health to disseminate the Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems (MATCH) to community mental health centers (CMHCs) across the state. Judge Baker Children’s Center (JBCC) partnered with the Children’s Bureau to provide clinical training and consultation in MATCH, as well as provide implementation and continuous quality improvement support to facilitate adoption and sustainability of the model. JBCC faculty worked closely with state personnel, including a mental health block grant planner, the children’s behavioral health director, and the children’s behavioral health administrator. Regular communication between state authorities and JBCC faculty allowed for system-level supports for implementation and sustainability of MATCH.

MATCH is a treatment protocol for children aged 6-15. Unlike most evidence-based practices (EBPs), which focus on single disorder categories (e.g., anxiety only), MATCH is designed for multiple disorders encompassing anxiety, depression, post-traumatic stress, and disruptive behavior, including the conduct problems associated with ADHD. These four clinical categories represent approximately 80% of clinical caseloads in public practice clinics.

The MATCH protocol is composed of 33 modules with specific treatment procedures derived from well established EBPs. It has been developed specifically to address many of the issues that impede the widespread implementation of EBPs. MATCH includes a detailed decision tree, giving therapists the flexibility to move between different treatment modules.

MATCH is accompanied by TRAC, an inexpensive, user friendly web-based monitoring system, which tracks clinical interventions and symptoms on a weekly basis. It enables therapists to continually adjust and refine their treatment in real time, in response to outcome data for each individual youngster. MATCH, combined with TRAC, has been researched

in outpatient community mental health settings in Massachusetts, Maine, Hawaii, and California. In the multisite randomized effectiveness trial of MATCH carried out in Massachusetts and Hawaii (Weisz et al.,

Many trials of evidence-based practices (EBPs) are done in university settings, and studies suggest that EBPs lose much of their effectiveness when research moves from the laboratory to real world clinical practice.

2012), MATCH showed markedly better outcomes than usual clinical care, with shorter treatment duration, greater reduction in number of problem areas, and higher therapist satisfaction. The use of MATCH led to a 37% reduction in number of treatment sessions, compared to usual care. MATCH provides a substantial cost savings per treatment episode by reducing service utilization both during and after treatment, reducing psychotropic medication usage, and enhanced access to care by shortening waiting lists. Randomized trials supporting MATCH are available in the Archives of General Psychiatry (Weisz et al., 2012), and the Journal of Consulting and Clinical Psychology (Chorpita et al., 2013; Chorpita et al., 2017).

What is a Learning Collaborative and How Does it Improve Implementation?

A Learning Collaborative differs from standard “standalone” training in important ways – it is an ongoing process conducted over approximately 18 months and involves stakeholders at several levels of the mental health system, such as state partners, whole mental health organizations, and community partners (e.g., youth advocacy groups), in addition to therapists.

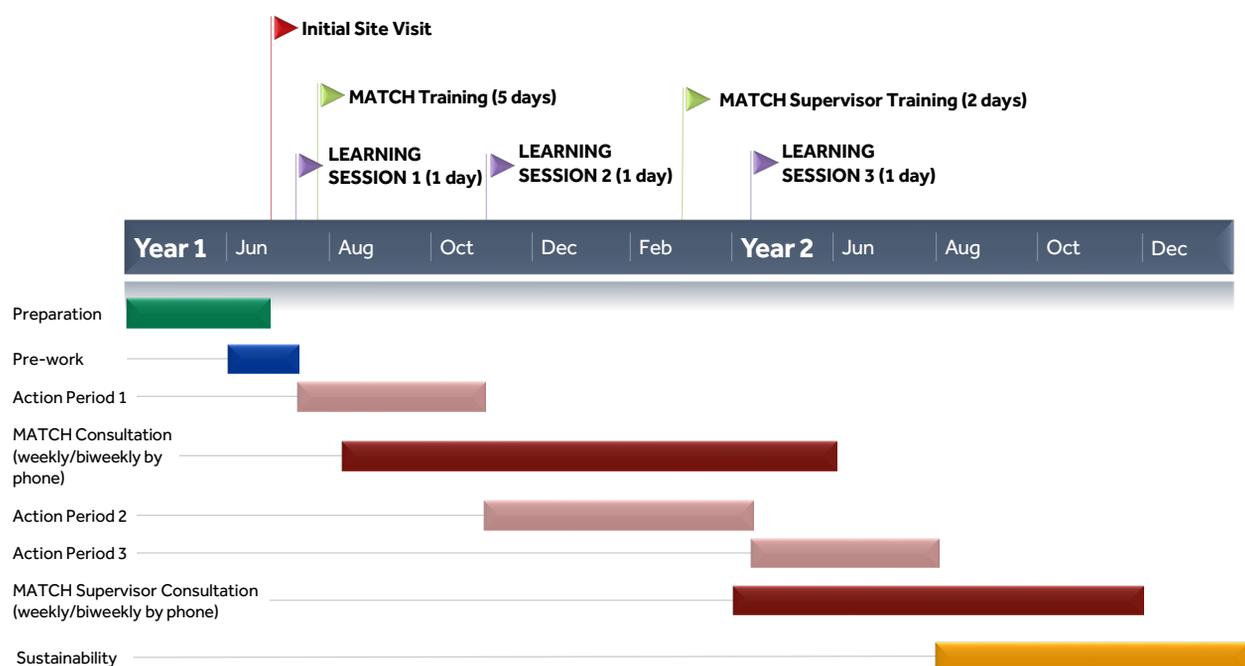
A Learning Collaborative encompasses all of the activities needed to implement a practice well, including:

- “Pre-work” to assess strengths and needs for implementation;
- Learning Sessions with other participating organizations, so that organization implementation teams can learn from and support one another during the Collaborative (and hopefully beyond!);
- Implementation team action periods to address barriers to successful practice (e.g., “Plan-Do-Study-Act” cycles); and
- Consultation, including clinical consultation to address issues in practice, organization implementation team coordinator calls to help implement continuous quality improvement, supervisor training and consultation so the practice can be sustained, and “senior leader” calls to help leaders ensure that staff have what they need to do MATCH well, now and in the future.

Learning Collaborative Goals and Timeline

The goal of the MATCH Learning Collaborative, beyond simply getting staff trained in the Modular Approach to Therapy with Children (MATCH), is to provide all of the supports needed to successfully implement and sustain MATCH by:

- Building CMHCs’ readiness and capacity to implement MATCH;
- Developing the MATCH clinical competencies of participating therapists;
- Supporting the active engagement of youth and families in the implementation process.



Key Partnerships and Personnel

FACULTY AND PLANNING TEAM

A Learning Collaborative typically includes several faculty members who develop and provide training in clinical competencies and implementation and monitor progress of the Collaborative. The JBCC faculty of the New Hampshire MATCH Learning Collaborative are listed below:

Robert Franks, Ph.D. is the President and CEO of Judge Baker Children’s Center and was the Project Director for the New Hampshire MATCH Learning Collaborative. He oversaw the initiative and facilitated the senior leader Affinity Group as well as the senior leader call series.

Dan Cheron, Ph.D., ABPP is the Director of Training and Implementation at Judge Baker Children’s Center and was the Training Director for the New Hampshire MATCH Learning Collaborative. He oversaw all MATCH and TRAC training and consultation activities.

Charlotte Vieira, M.P.H. was the Implementation and Quality Improvement Associate at Judge Baker Children’s Center and was the Project Coordinator for the New Hampshire MATCH Learning Collaborative. She helped manage Learning Collaborative activities and acted as a liaison to participating CMHCs.

Rachel Kim, Ph.D. is the Implementation Associate and a MATCH Trainer at Judge Baker Children’s Center and supported the New Hampshire MATCH Learning Collaborative by facilitating both implementation support and clinical training and consultation to ensure the success of participating CMHCs.

PARTICIPATING COMMUNITY MENTAL HEALTH CENTERS

All ten CMHCs in the state participated in the Learning Collaborative, divided into two cohorts: Cohort 1 timeline: April 2017-October 2018; and Cohort 2 timeline: April 2018-December 2019. Each CMHC implementation team includes representation of senior leadership (e.g., children’s directors), organizational systems (e.g., quality assurance directors, information technology directors), clinical supervisors and/or team leads, therapists, and community liaisons or family partners.

Cohort 1

CMHCs that participated in the first cohort of the Learning Collaborative were Center for Life Management, Mental Health Center of Greater Manchester, Northern Human Services, and Seacoast Mental Health Center.

Cohort 2

CMHCs that participated in the second cohort of the Learning Collaborative included Community Partners, Greater Nashua Mental Health Center, Lakes Region Mental Health Center, Monadnock Family Services, Riverbend Community Mental Health, and West Central Behavioral Health.

MULTIDISCIPLINARY INTERAGENCY STEERING COMMITTEE

The Learning Collaborative also hosted a multidisciplinary interagency steering committee which consisted of representatives from JBCC, the state, participating CMHCs, consumer representatives, and liaisons from other community agencies (e.g., Department of Children, Youth, and Families).

Project Deliverables

Over the course of the initiative (Fiscal Years 2017 through 2020), JBCC collaborated with the Children's Bureau to develop the following project deliverables.

YEAR 1 (FY17)

1. Produce and release Program Announcement and Requirements to all ten CMHCs in New Hampshire.
2. Establish the Multidisciplinary Interagency Steering Team and help plan a process for convening the team and soliciting and implementing guidance and feedback.
3. Plan and facilitate in-person applicant meeting and conference calls, as well as an in-person meeting with State.
4. Develop and distribute a Welcome Packet, introducing the Learning Collaborative to implementation teams at participating CMHCs (Cohort 1).
5. Develop and distribute an Enhanced Change Package to CMHCs to facilitate assessments of their organizational readiness to implement MATCH (Cohort 1).
6. Complete informational and outreach site visits to all four participating CMHCs.
7. Analyze and report findings of the pre-work Enhanced Change Package baseline administration with participating CMHCs and the Bureau (Cohort 1).
8. Support the development of CMHC implementation teams and help these teams develop implementation work plans (Cohort 1).
9. Adapt the professional development portfolio/curriculum items to meet the specific needs of the participating CMHCs and the Bureau.
10. Adapt training materials to meet the cultural and linguistic needs of the communities served by the participating CMHCs.
11. Modify the TRAC system and additional data collection tools to address data and measurement needs specific to the agencies and communities served, as identified by the JBCC faculty, participating CMHCs, and the Bureau.
12. Collaborate with the state and participating CMHCs to develop and implement tailored strategies to address relative strengths and weaknesses identified by the Enhanced Change Package (Cohort 1).
13. Work with participating CMHCs to plan the collection of additional implementation data (i.e., beyond those included in the TRAC system) to be shared with the Bureau (Cohort 1).
14. Prepare and deliver the first of three Learning Sessions for the first yearly cohort of Learning Collaborative CMHCs (Cohort 1).

15. Provide 35 or more hours of initial MATCH training over 5 days and necessary supplies (Cohort 1).
16. Develop and provide monthly implementation and quarterly performance reports (Cohort 1).

YEAR 2 (FY18)

17. Produce and release Program Announcement & Requirements (Cohort 2)
18. Plan and facilitate applicant conference call (Cohort 2)
19. Distribute Welcome Packet and complete Site Informational & Outreach Visits (Cohort 2)
20. Develop local work groups & assist groups with developing work plans (Cohort 2)
21. Distribute Enhanced Change Package on a quarterly basis to assess organizational readiness, monitor completion and data quality, and analyze Enhanced Change Package Data (Cohorts 1 & 2)
22. Provide assistance to local work groups in adapting and revising work plans to guide and track implementation and long term success (Cohorts 1 & 2)
23. Convene semi-monthly coordinator calls with work group liaisons (“Implementation Team Coordinators”) at each participating CMHC; Conduct video-based and in-person consultation visits with CMHCs to review quarterly progress and inform implementation process (Cohorts 1 & 2)
24. Host a senior leader call series to foster leadership at participating CMHCs and promote ongoing sustainability of MATCH (Cohort 1)
25. Provide a minimum of 25 clinical consultation calls over 12 months to clinicians who have completed MATCH training and are currently using MATCH in active cases (Cohort 1)
26. Collaborate with CMHCs to develop additional data collection and documentation tools and modify TRAC as needed to address identified data needs (Cohorts 1 & 2)
27. Monitor and provide feedback to CMHC work groups on the use of the TRAC system to collect clinical outcome and implementation data (Cohort 1)
28. Certify clinicians who have completed MATCH training and are currently using MATCH in active cases (Cohort 1)
29. Prepare & Deliver Learning Collaborative Session 2 (Cohort 1)
30. Prepare & Deliver Learning Collaborative Session 3 (Cohort 1)
31. Prepare & Deliver Learning Collaborative Session 1 (Cohort 2)
32. Provide a minimum of 35 hours of initial training over 5 days (including educational supplies) (Cohort 2)
33. Provide specialized MATCH supervisor training (Cohort 1)
34. Facilitate and implement CQI process and establish tools to support CMHCs in developing CQI capacity (Cohorts 1 & 2)
35. Collaborate with State partners (e.g. Quality Assurance, Improvement) to obtain out-of-home placement, education, substance use, and juvenile justice outcomes data. (Cohorts 1 & 2)
36. Develop and provide monthly implementation status reports (Cohort 1)
37. Develop and provide quarterly performance assessment reports (Cohorts 1 & 2)
38. Develop and provide annual implementation and performance reports (Cohorts 1 & 2)

YEAR 3 (FY19)

39. Distribute Enhanced Change Package on a quarterly basis to assess organizational readiness, monitor completion and data quality, and analyze Enhanced Change Package data (Cohort 2)
40. Provide assistance to local work groups in adapting and revising work plans to guide and track implementation and long term success (Cohort 2)
41. Convene semi-monthly coordinator calls with MATCH coordinators at each participating CMHC; Conduct consultation with CMHCs to review quarterly progress and inform implementation process (Cohort 2)
42. Host a senior leader call series to foster leadership at participating CMHCs and promote ongoing sustainability of MATCH (Cohort 2)
43. Provide a minimum of 25 clinical consultation calls over 12 months to therapists who have completed MATCH training and are currently using MATCH with active cases (Cohort 2)
44. Collaborate with CMHCs to develop additional data collection and documentation tools and modify TRAC as needed to address identified data needs (Cohort 2)
45. Monitor and provide feedback to CMHC work groups on the use of the TRAC system to collect clinical outcome and implementation data (Cohort 2)
46. Certify therapists who have completed MATCH training and have met MATCH certification requirements (Cohort 2)
47. Prepare & deliver Learning Collaborative Session 2 (Cohort 2)
48. Prepare & deliver Learning Collaborative Session 3 (Cohort 2)
49. Provide specialized MATCH supervisor training (Cohort 2)
50. Provide ongoing supervisor training and consultation to ensure MATCH supervisors have the capacity to independently provide consultation and training in MATCH (Cohorts 1 & 2)
51. Facilitate and implement CQI process and establish tools to support CMHCs in developing CQI capacity (Cohorts 2)
52. Develop recommendations on use of out-of-home placement, education, substance use, and juvenile justice outcomes data to inform implementation and provide consultation to State partners on options for implementing recommendations to support sustainability (Cohorts 1 & 2)
53. Develop and provide monthly implementation status reports (Cohorts 1 & 2)
54. Develop and provide quarterly performance assessment reports (Cohort 2)
55. Develop and provide annual implementation and performance report (Cohorts 1 & 2)

YEAR 4 (FY20)

56. Provide ongoing supervisor training and consultation to ensure MATCH supervisors have the capacity to independently provide consultation and training in the MATCH protocol (Cohort 2).
57. Provide ongoing supervisor training and consultation to ensure MATCH supervisors have the capacity to independently provide consultation and training in the MATCH protocol (Cohort 2).
58. Develop and provide final implementation and performance report (Cohorts 1 & 2).

Structure of the Learning Collaborative

The structure and activities of the Learning Collaborative are strategically designed to maximize the development of clinical skills and the sustainability of practice within organizations and broader systems. It is divided into I) preparation, II) pre-work, III) active implementation, and IV) sustainability phases. Each phase is tailored toward the unique needs that arise as organizations and systems are implementing new practices. As organizations and systems move through each phase, the themes and tools from the previous phase become building blocks towards independent sustainability.



Phase I

> PREPARATION

The Learning Collaborative begins with the preparation phase to engage the sponsoring agency in planning. Goals for the Learning Collaborative are developed and potential participating organizations are identified. The requirements for participation are communicated to potential participants and selection and commitment of organizations is finalized.



Phase II

> PRE-WORK

Once the preparation phase is complete, the pre-work phase begins. The focus of this phase is on assessing organizational factors that might serve as opportunities or barriers to MATCH implementation. This phase also includes the design and installation of structural supports for implementation.



Phase III

> ACTIVE IMPLEMENTATION

The active implementation phase includes the installation of the MATCH treatment program into the participating organizations and the initial implementation of MATCH services. Participants engage in a number of structured and self-guided learning activities to deliver MATCH with high integrity.



Phase IV

> SUSTAINABILITY

To ensure ongoing success of the MATCH program, the sustainability phase facilitates organization independence in the MATCH program through activities designed to eliminate barriers to practice utilization and create flexible plans for adapting to new challenges.

PREPARATION

The Learning Collaborative began with a preparation phase to engage the Children's Bureau in the Learning Collaborative process. A Program Announcement and Request for Qualifications (RFQ) was developed in collaboration with the Children's Bureau so that it met all state sponsor objectives and was consistent with all established policies and procedures. The preparation phase also focused on identifying the potential pool of participating CMHCs. The RFQ was then released to potential partner CMHCs to provide an overview of MATCH and the Learning Collaborative structure. It also detailed the requirements of participating CMHCs and selection criteria of JBCC. Interested CMHCs then participated in a Q & A meeting with Learning Collaborative Faculty and state liaisons to obtain any additional information and clarify expectations. Following the Q & A meeting, interested CMHCs submitted a letter of commitment and a participation form. The Learning Collaborative Faculty and state sponsor collaboratively verified the qualifications of the applicant organizations.

PRE-WORK

Once CMHCs were enrolled in the Learning Collaborative, the pre-work phase began. The emphasis of the pre-work phase centered on assessing organizational factors (e.g., capacity, readiness, attitudes towards EBTs) that might impact MATCH implementation and sustainability, as well as engaging relevant therapists, staff, administrators, and community partners in the Learning Collaborative process. This phase also included building structural supports for implementation, such as planning for staff time to attend the MATCH clinical training.

WELCOME PACKET

The Welcome Packet was the first document released to CMHCs once they had been enrolled in the Learning Collaborative. It contained information regarding the Learning Collaborative timeline, faculty roster and contact information, descriptions of pre-work activities, descriptions of Learning Collaborative activities, a consultation call schedule, description of measures and metrics to be collected and utilized throughout the Learning Collaborative, and instructions for the Enhanced Change Package assessment and the Organizational Storyboard, both of which were to be completed during this phase.

ENHANCED CHANGE PACKAGE ASSESSMENT

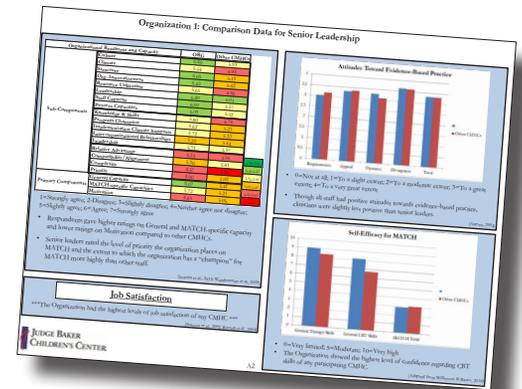
The Enhanced Change Package (ECP) was a tool to assess progress towards the Learning Collaborative mission of implementation and sustainability of MATCH through collaboration across levels of engagement, regular monitoring, and clinical training. It included indicators of organizational readiness and capacity, clinically competent practice of MATCH, and effective youth and family engagement.

Additionally, the ECP allowed for measurement of specific objectives and benchmarks through the Learning Collaborative process (e.g., screening for eligible clients, therapist fidelity to the MATCH model). The ECP was administered four times throughout each cohort of the Learning Collaborative, beginning during the pre-work phase and following the final Learning Session. It was divided into two parts, the team self-assessment and individual self-assessment. The Enhanced Change Package helped to:

- Provide a framework for the organizations' MATCH implementation;
- Foster discussion among organization's team members about strengths and challenges; and
- Assess progress over time by measuring how each organization is advancing the mission, goals, and objectives of the Learning Collaborative at multiple intervals.

TEAM SELF-ASSESSMENT

The purpose of the team portion of the ECP was to foster discussion and reflection among members of each organization's implementation team about their agency's capacity to implement MATCH, specific objectives and benchmarks for improving their capacity, and progress towards these objectives and benchmarks through the Learning Collaborative. Given their various roles and experiences, each team member's perspective was especially valuable. Thus, this portion of the ECP was completed by all members of the team.



INDIVIDUAL SELF-ASSESSMENT

The individual portion of the ECP assessed team members' attitudes toward evidence-based practices and perspectives on their organization's readiness to implement MATCH. This assessment was completed by each team member individually to understand their unique perspectives. Reports detailing results and interpretation of the team and individual self-assessments were shared with CMHCs following each administration.

INITIAL SITE VISITS

During the pre-work phase, members of the JBCC faculty visited with each organization to share findings of the first administration of the Enhanced Change Package as a way to begin planning for implementation work that would occur throughout the Learning Collaborative.

ORGANIZATIONAL STORYBOARD

The Storyboard was used to help teams at each organization learn to work together as a cohesive group and assist teams in thinking about how they would use their unique set of strengths, skills, and experiences to work towards their implementation goals and benchmarks. The Storyboard was then shared with the entire cohort at Learning Session 1 to introduce the team to the faculty and other participants.

ACTIVE IMPLEMENTATION

After preparing CMHCs for the Learning Collaborative implementation, the active implementation phase began. This phase included both the initial installation of the MATCH treatment program as well as initial implementation efforts. The central focus of this phase was on developing the competency of providers, enhancing the capacity of the organizations, and improving the commitment of the leadership at all participating organizations. These objectives were accomplished through four specific types of activities:

- Learning Sessions and Action Periods;
- Clinical Training and Consultation;
- Implementation Consultation; and
- Progress Monitoring

LEARNING SESSIONS AND ACTION PERIODS

Learning Session 1

Learning Session 1 was the first meeting of all participating organizations, the sponsoring agency, and JBCC faculty in each cohort. The primary objective of Learning Session 1 was to foster engagement and buy-in among teams to support successful implementation of MATCH. In this Learning Session, JBCC faculty encouraged group cohesion within teams and across organizations, introduced the Learning Collaborative objectives and structure, and introduced MATCH and TRAC. A key feature of the Learning Collaborative were the Affinity Groups, which began in Learning Session 1. Affinity groups were composed of team members from across organizations that were in a similar role (e.g., therapists, senior leaders). These groups provided team members from different organizations the opportunity to share role-specific experiences and problem-solve collectively.

Action Period 1

An Action Period was the time between Learning Session in which participants engaged in the implementation process. The primary objectives of each Action Period built on the themes from the prior Learning Session. In the first Action Period, organizations were encouraged to continue building the necessary supports to begin the implementation of MATCH. During this period, select staff (e.g., therapists, senior leaders) met weekly as an implementation team and discussed topics related to the implementation at their organization specifically. The five-day MATCH therapist training also took place during this time.

JUDGE BAKER CHILDREN'S CENTER
Plan-Do-Study-Act (PDSA) Worksheet

Describe Change
 Initial
 Adapt
 Scale up
 Describe desired change (e.g., improve family engagement in MATCH):
Inform other staff members about MATCH to increase internal referrals

PLAN
 WHAT are we going to do? *Do brief presentations of MATCH modules*
 WHEN will it be done? *During weekly staff meetings*
 WHO will do it? *Each MATCH trained clinician will take a turn*
 HOW will we do it? *Provide staff with a brief summary of module and how the skills is applied.*

DO
 WHEN was the test done? *During meetings from October to December*
 DID we collect data? *Number of internal referrals before starting presentations and after*
 WAS test done as planned? *Some difficulty getting time during staff meetings*

ACT
 ABANDON
 ADAPT
 ADAPT
 SCALE UP
 Should the adaptation or scale up (yes, 2 people to which team):
 1. MATCH clinicians will present on how to talk about MATCH with families in next staff meeting.
 2. MATCH clinicians will offer to meet with families to answer questions when available.

STUDY
 WAS there an improvement? *Slight increase in number of internal referrals to MATCH*
 WHAT feedback did we receive? *Though staff felt MATCH could be useful, unsure of how to talk to their clients about MATCH*
 WHAT were the lessons learned? *Staff need support to increase conversations about MATCH with families*

Learning Session 2

As organizations begin using the MATCH model with clients, they naturally face challenges and barriers to implementation. The focus of Learning Session 2 was on strategies that the agencies and the broader Learning Collaborative could utilize to address initial barriers and engage in a continuous quality improvement (CQI) process. Topics included clinically-related issues such as tailoring MATCH to fit diverse populations, and organization-level challenges such as developing a screening process to determine MATCH client eligibility. One CQI tool that was utilized at this stage was the Plan-Do-Study-Act (PDSA) Cycle. The PDSA Cycle was a structured method of identifying a problem, making a plan for how to address the issue, using data to evaluate the success of the solution, and determining how to move forward based off that success. CMHC teams engaged in use of the PDSA Cycle during the Learning Session with facilitation by JBCC faculty. At Learning Session 2, participants again had an opportunity to meet with their Affinity Groups for collaborative learning and problem-solving.

Action Period 2

The emphasis of the second Action Period was on addressing the initial barriers that had arisen using CQI strategies that were shared in Learning Session 2. Organizations were encouraged to consider how they could utilize data to determine CQI needs and benchmarks. The MATCH Agency Supervisor training took place during this time as another way to equip organizations to build capacity for sustainability.

What participants said about Learning Sessions:

“I am excited to learn more about what MATCH is and to be able to use it with clients. I do like the data collection and review idea because I’m a strong believer that we should be continuously collecting actual data and using it to determine if our work and programs on individual and organizational levels are effective.”

“Looking forward to the training. This is a great program and will improve the delivery of mental health services for kids in our state by honing our skills and giving us tools to improve our treatment interventions. I am confident in that.”

“This learning session has reinforced how much I feel supported by my agency and their investment in making MATCH a sustainable endeavor.”

“Breaking into groups of folks who had similar roles was great, it both validated the challenges experienced as well as presented a forum for learning about strategies others had used.”

Learning Session 3

At the final Learning Session, the objective was to highlight progress organizations had made in implementing MATCH through the Learning Collaborative and efforts they were making to sustain the practice of MATCH. Teams had the opportunity to share about successful clinical cases and implementation achievements. Teams also shared sustainability plans that included measures they had already implemented and those they would be implementing moving forward. Participants had a final opportunity to meet as affinity groups to discuss upcoming challenges in their specific roles.

Action Period 3

During the final Action Period, organizations continued to move towards increasingly independent sustainability. More advanced clinical skills were reinforced, specifically related to maintaining integrity to MATCH clinical skills without the support of Learning Collaborative faculty. Additionally, individual organizations worked towards implementing their sustainability plan and addressing barriers with the JBCC faculty. Therapists and supervisors received advanced instruction in maintaining MATCH integrity as Learning Collaborative supports reduced.

CLINICAL TRAINING & CONSULTATION

Therapist Training and Consultation

At the core of the Learning Collaborative was the MATCH Therapist Training and Consultation series. Training faculty guided each cohort of MATCH Trainees through 35 hours of didactic presentations over 5 days. Learning was organized into a professional development curriculum that covered each of the MATCH modules in detail, as well as core competencies in evidence-based practices. To enhance understanding and retention, training utilized adult learning principles including didactic training, audio and video presentations of case vignettes that illustrated the training concepts, direct modeling by trainers, and assisted role-plays that allowed trainees to practice skills with immediate expert feedback. In addition, trainees were given tasks to complete between training sessions (i.e., “action periods”) that reinforced important concepts presented during the training day.

“I learned a lot about using progressions in a systematic way to treat. This will give my treatment more intention and direction.”

-MATCH Therapist

At the start of the training, attendees also received a MATCH Professional Development Portfolio that included a syllabus of the Concepts, Resources, and Applications used in the MATCH program. The trainee used this portfolio to track their developing expertise throughout the active learning phase. The participating therapists immediately applied the in-person training they received with clients on their caseload and were provided with ongoing, case-specific consultation from the MATCH trainers. Model fidelity was enhanced by training therapists on the use of assessment and treatment procedures, as well as MATCH’s

continuous measurement feedback system, the TRAC System. Utilized in tandem with MATCH, TRAC collected outcome data and monitors progress to inform clinical decision-making by helping therapists understand whether children are responding to treatment, whether and when changes in treatment strategy are needed, which changes are effective, and when treatment gains have been achieved and treatment can end.

Immediately following the training, therapists began the transfer of learning period to facilitate active implementation, during which they started using MATCH with their active cases. Trainees received ongoing clinical consultation with MATCH experts on how to apply what they learned in the training to their work with children and families. Over the course of approximately 10 months for each cohort, there were 25 consultation calls per trainee consult group. This consultation afforded therapists the opportunity to receive input and guidance on how to apply their newly learned assessment and clinical skills to treat children and families using the MATCH protocol. Calls occurred in a phased manner (i.e., weekly consultation calls for 15 weeks and

“I like the idea of having a program that allows the pivoting necessary to effectively work with our families.”

-MATCH Therapist

Clinical Consultation

Therapists directly providing MATCH services participated in web-based videoconferencing calls shortly after the MATCH 5-day clinical training. These calls lasted one hour and continued for approximately 10 months. Initially, the calls were held on a weekly basis to help therapists learn the necessary skills to practice MATCH. By the end of the consultation call period, calls were every two weeks.

Supervisor Consultation

Therapists who completed the basic MATCH training and received additional training in MATCH supervisory techniques participated in web-based videoconferencing calls shortly after the MATCH 2-day supervisor training. As with clinical consultation calls, supervisor consultation calls were initially held on a weekly basis, and then decreased in frequency to every other week.

Implementation Coordinator Consultation

Coordinators who had been designated to coordinate implementation team activities at their organization participated in biweekly phone calls with a JBCC faculty member. The goal of these calls was to assist organizations in keeping implementation on track and address organization specific issues that were emerging.

Senior Leader Consultation

Senior leaders from each organization joined with state liaisons and Learning Collaborative faculty each month to address topics to facilitate organizational and systems change. The consultation offered senior leaders the opportunity to learn from the experiences of other leaders at fellow organizations.

Monitoring Progress in MATCH: The TRAC System

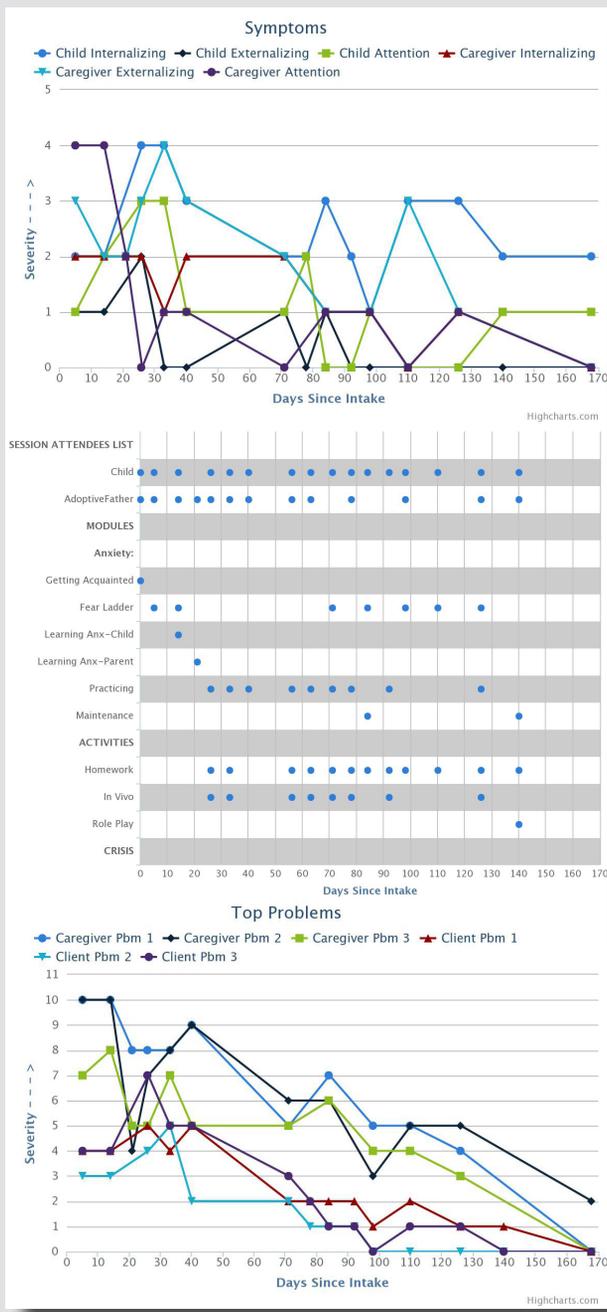
The Treatment Response Assessment for Children (TRAC) System is a web-based progress monitoring and feedback system. Utilized in tandem with MATCH, TRAC collects outcome and implementation data and monitors progress to inform decision-making. Children and caregivers independently respond to surveys weekly, providing a quantitative self-report of both standardized outcome data as well as idiographic, family-identified challenges. Therapists also submit information about each session, providing data on family engagement as well as utilization of therapeutic techniques and activities.

Clinical Progress Monitoring

By using TRAC, therapists can understand whether children are responding to treatment, whether and when changes in treatment strategy are needed, which changes are effective, and when treatment gains have been achieved and treatment can end. Research increasingly supports the efficacy of providing therapists ongoing feedback on their clients' treatment response. Providing feedback to therapists can improve outcomes and reduce rates of treatment failure. Giving therapists feedback on their clients has been shown to double the success rate of therapy, reduce deterioration in client functioning, reduce treatment duration for positive responders, and lead to longer-lasting treatment effects.

Implementation Progress Monitoring

TRAC also provides important information that can assist agency administrators in effective implementation. Understanding the organizational enrollment in MATCH services, frequency of MATCH content delivery, and degree of family engagement in relation to quantitative clinical outcomes may help identify and sustain successful organizational activities and leadership. TRAC data may also help organizations leverage successful outcomes to procure more financial and policy support for evidence-based practices.



then biweekly). The phased approach was designed to help with the uptake and use of the MATCH core competencies. The number of trainees per call was set at 8 to maximize the opportunity for shared learning amongst colleagues while also providing individualized attention to cases.

During the consultation calls, consultants covered a range of themes to assure that trainees received a structured educational experience. Call themes included how to get the most out of consultation, co-creating supplemental material, understanding how to use the TRAC system to plan treatment, selecting appropriate intervention modules for cases, managing crises in MATCH treatment, using session agendas to stay on track, and other trainee-requested themes. Consultation calls were conducted via web-based videoconferencing software to enable consultants to share documents and visual materials in real time with trainees. Participants were also logged into the TRAC system during consultation calls in order to view case-by-case progress.

Supervisor Training and Consultation

Midway through each cohort of the Learning Collaborative, selected MATCH therapists from each organization participated in a MATCH Supervisor training and consultation series. To assure the sustainability of the MATCH program and accommodate staff turnover, these therapists were trained to become MATCH Supervisors in subsequent years using a Train-the-Trainer model. Once certified, MATCH Supervisors had the capacity to both independently provide ongoing consultation to MATCH Therapists and to train new therapists in the didactic components of the MATCH protocol within their organization so they could begin their therapist certification process. The ability to internally train new therapists in MATCH is vital to sustainability and enables a certified MATCH Supervisor to continually train new MATCH Therapists at their organization without the need to receive further training from JBCC faculty.

“I learned a lot about supervisory strategies and ways to support my therapists. This will help guide me in this major change in position as I start supervising others.”

-MATCH Supervisor

The MATCH Supervisor training was a 2-day (14-hour) program for up to 12 MATCH Supervisors that focused on advanced MATCH topics, as well as supervisory strategies and techniques. The training included presentations of case examples that illustrate the training concepts. Instructors provided vignettes and modeled skills directly for supervisors and assisted supervisors in individual role plays to practice skills. Supervisors were assigned homework tasks to complete during the evening between training sessions to solidify important concepts presented that day. Example material covered during MATCH Supervisor training included: clarifying the MATCH supervisory role, understanding trainee phases of expertise, using guided reasoning models in supervision, maintaining model integrity, managing MATCH Therapists, and managing the organizational climate and culture.

After completing the MATCH Supervisor training, supervisors-in-training began receiving MATCH Supervisor consultation from experts at Judge Baker. Supervisors helped co-lead 3 months of MATCH Therapist consultation calls with a Judge Baker expert. Gradually, supervisors were encouraged to take over leading these consultation calls. Concurrent with these co-led calls, supervisors received group-based supervisor-only consultation from Judge Baker experts. These groups included other supervisors-in-training in a maximum group size of 6 individuals. A total of 25 calls per supervisor group, spanning approximately 10 months, were provided to supervisors-in-training. Themes included managing therapist learning, reviewing professional development portfolios, creating role plays and models for trainees, using a road map to solve clinical problems, maintaining fidelity to MATCH, and advanced use of TRAC system data in supervision.

Implementation Consultation

Throughout the Learning Collaborative, JBCC faculty also provided comprehensive implementation consultation at multiple levels. On the organizational level, implementation teams were formed, consisting of therapists, supervisors, organizational administrators, and senior leaders. Weekly team meetings were scheduled to facilitate installation of MATCH and plan for sustainability. JBCC faculty consulted to the implementation teams throughout the active implementation phase. This implementation consultation was provided during some co-facilitated site-based implementation team meetings, and also scheduled as needed. Additionally, the faculty provided consultation to the state sponsoring agency in order to address systems and policy issues that could help facilitate MATCH implementation.

SUSTAINABILITY

In the sustainability phase of the Learning Collaborative, faculty assisted both the organizations and the sponsoring agency in developing and implementing plans to sustain the MATCH program indefinitely. Although the sustainability phase were listed as the final phase of the Learning Collaborative, sustainability was really built into the activities from the very start. The provision of data systems monitoring and feedback, consultation, and broader systems engagement all helped to facilitate long-term use of the MATCH intervention.

Continuous Quality Improvement

Continuous quality improvement (CQI) was a key component of a Learning Collaborative – in fact the Learning Collaborative model was developed as a means of driving improvements in quality of care. Strategies to support improvement efforts began early and were integrated throughout the Learning Collaborative. Pre-work activities focused on identifying quality assurance and improvement

representatives to participate in and support the implementation process. Activities during the active implementation phase focused on introducing CQI tools and processes, as well as modeling CQI principles and supporting agency process development through consultation and technical assistance. Data were used throughout the Learning Collaborative to drive CQI and inform collaborative problem solving efforts. Agencies were also supported to develop their own data collection and review processes to monitor and sustain progress in the future. In the final phase of the Learning Collaborative, agencies were led by their senior leadership to develop and implement a sustainability plan, integrating CQI within existing organizational supports to sustain the practice long-term.

Monthly Implementation Metrics Reporting

The Monthly Implementation Metrics Report was a tool that the faculty used to facilitate much of the Learning Collaborative consultation. The report integrated data on implementation milestones, client enrollment, process and fidelity metrics, and client outcomes. These data were used to identify implementation patterns and continuous quality improvement targets and foster collaborative brainstorming during the senior leader calls.

CROSS-SITE IMPLEMENTATION METRICS REPORT

SECTION I: STAFF TRAINING & CONSULTATION

STAFF TRAINING & CONSULTATION		Org 1	Org 2	Org 3	Org 4
1	% of clinician trainees that have seen MATCH clients	100%	100%	100%	100%
2	Average % of those trained participating in consultation calls	90%	93%	92%	85%

SECTION II: IMPLEMENTATION MILESTONES

IMPLEMENTATION MILESTONES		Org 1	Org 2	Org 3	Org 4
1	Regular implementation meetings scheduled	Yes	Yes	Yes	Yes
2	Submission of implementation plan for Objective #1	Yes	Yes	Yes	Yes
3	Target MATCH population identified	Yes	Yes	Yes	Yes
4	Standardized MATCH screening process implemented	Yes	Yes	Yes	Yes
5	PDSAs initiated	Yes	Yes	Yes	Yes
6	Submission of implementation plan for Objective #2	Yes	Yes	No	Yes
7	Submission of implementation plan for Objective #3	Yes	Yes	No	Yes

SECTION III: CLIENT METRICS

CLIENT METRICS		Org 1	Org 2	Org 3	Org 4
1	# new clients enrolled in TRAC for most recent month	4	5	7	3
2	# total clients enrolled	100	55	66	72
3	Average # clients per clinician	10.13	4.75	10.20	6.29
4	# completed sessions	551	559	327	523
5	Average # sessions completed per client	5.51	10.16	4.95	7.26
6	# inactive clients	19	17	15	28
Reasons Inactive					
7	Treatment completed – all goals met	0% (0)	0% (0)	0% (0)	0% (0)
8	Treatment completed – some goals met	0% (0)	0% (0)	7% (1)	0% (0)
9	Treatment incomplete – family withdrew from services	0% (0)	0% (0)	0% (0)	0% (0)
10	Treatment incomplete – lost contact with family	0% (0)	6% (1)	7% (1)	0% (0)
11	Treatment incomplete – therapist left or transferred	5% (1)	0% (0)	7% (1)	0% (0)
12	Higher level of care needed	0% (0)	0% (0)	0% (0)	0% (0)
13	Other	0% (0)	0% (0)	0% (0)	0% (0)

- Reports were generated on a variety of levels (e.g., therapist, organization, and multi-organization) to help to determine specific areas of implementation strengths and challenges.
- The report also helped in developing procedures for ongoing training in MATCH that both comply with minimum standards and are feasible within the agency.
- By using the data from the report, organizational leaders could integrate CQI strategies for MATCH learned in the Learning Collaborative into the agency's existing processes.

State Sustainability Consultation

Learning Collaborative faculty maintained regular contact with state liaisons, including monthly phone calls. Calls were tailored toward facilitating implementation and sustainability at the state-level. A variety of topics were addressed during this state-level consultation that focus on supporting organizations implementing MATCH, including:

- Facilitating the allocation of training funds to participating organizations to offset lost therapist productivity;
- Identifying opportunities to access and develop state-level data to evaluate the impact of MATCH and monitor outcomes long-term; and
- Developing a state-level therapist registry aimed at helping build awareness and connect consumers interested in finding local MATCH services to qualified therapists.

Multidisciplinary Interagency Steering Committee

To ensure ongoing success of the MATCH implementation, JBCC faculty and state liaisons collaborated to facilitate a multidisciplinary interagency steering team consisting of diverse community stakeholders, including state liaisons, provider organizations, consumer representatives, and Learning Collaborative faculty. The MATCH Steering Committee met quarterly throughout the course of the Learning Collaborative to discuss implementation progress, barriers, and successes, including:

- Identifying opportunities and avenues for advocacy at the state-level to support MATCH;
- Informing workforce development and retention of MATCH-trained clinical staff;
- Brainstorming opportunities for building awareness of MATCH for consumers; and
- Developing family champions among those that have benefited from the MATCH treatment.

“This was one of the best investments that state dollars were ever used for!”

-Steering Committee Member

The Steering Committee was successful in developing a number of tools and materials to facilitate the broad-scale implementation of MATCH across the state, including:

- Advocacy flyers that introduce MATCH;
- Handouts describing the clinical outcomes and cost effectiveness of MATCH;
- Presentation slides for use with other collaborating professionals from across the state; and
- Interview guides for eliciting family testimonies of the MATCH program.

As the initiative was drawing to a close, the Steering Committee focused on setting priorities for future directions of the Committee and developing a mandate and governance structure to support the sustainability of the Committee past the close of the Learning Collaborative. This transition planning was critical to building buy-in and engagement amongst representatives and in identifying champions and partnerships to lead the effort to sustain MATCH at the state-level. Leadership of the Steering Committee transitioned to CMHC Children's Directors from Seacoast Mental Health Center and Northern Human Services. The MATCH Steering Committee would also be coordinating with the NH Children's Behavioral Health Collaborative's Workforce Development Network.

Components of the MATCH Learning Collaborative



Innovations



Stages



Drivers



Teams



Improvement
Cycles

Progress Monitoring

Using the TRAC Progress Monitoring and Feedback System, surveys were collected from children and caregivers throughout their active engagement in MATCH services. TRAC utilizes very brief measures to reduce the measurement burden that can prevent frequent use and focuses on responsive and useful feedback to enhance motivation for utilization. Caregivers, youths, therapists, and clinic administrators are more likely to use TRAC if it is convenient, takes little time, and addresses their needs.

In addition to having a brief and useful survey, the psychometric integrity of the survey is essential if TRAC is to have genuine value as a form of evidence-based assessment. To meet these goals, TRAC uses 2 measures to complement one another:

1) The Brief Problem Monitor (BPM; Achenbach et al., 2011) provides standardized assessment of well-established common dimensions of youth psychopathology (internalizing, externalizing, and attention problems). The BPM is 19-items long and has excellent psychometric strength and significantly predicts change in child symptoms during treatment.

2) The Top Problems Assessment (TPA; Weisz et al., 2011) provides idiographic assessment of the 3 specific problems youths and caregivers (separately) identify at pre-treatment as their most important concerns that need attention in treatment. Their severity ratings on those problems are obtained throughout treatment. The measure is very strong psychometrically, with good test-retest reliability, convergent and discriminant validity.

Date: Date must be in mm-dd-yyyy format!

Section 1:

Here are the things you told us you would like to work on when you started therapy. Please rate how much of a problem each one has been for you over the **past week** on the scale of 0-10. "0" means that it was not a problem at all for the past week, and "10" means that it was a huge problem.

	Not a problem	Huge problem
I am shy with kids my age.	0 1 2 3 4 5 6 7 8 9 10	
I am nervous to talk to the mail lady.	0 1 2 3 4 5 6 7 8 9 10	
I have a hard time saying thank you to people I don't know well.	0 1 2 3 4 5 6 7 8 9 10	

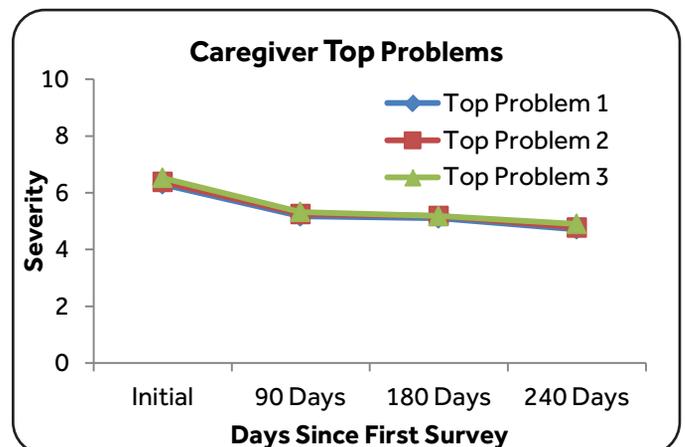
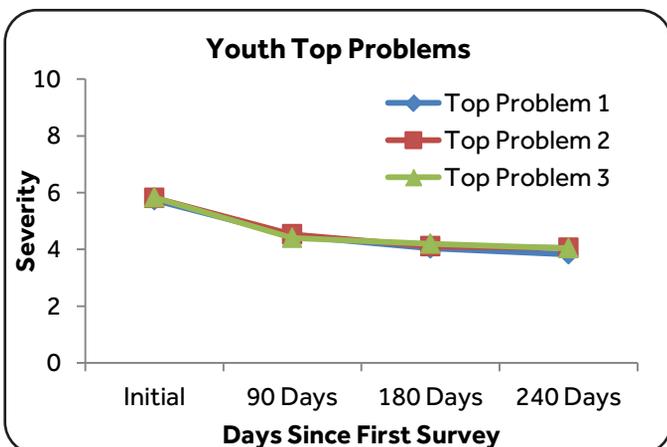
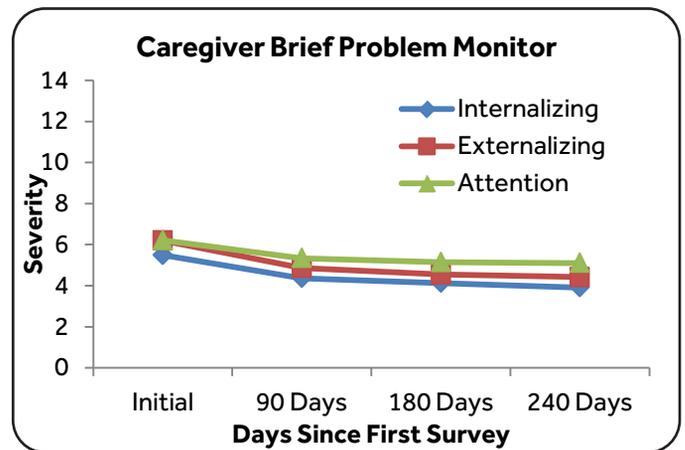
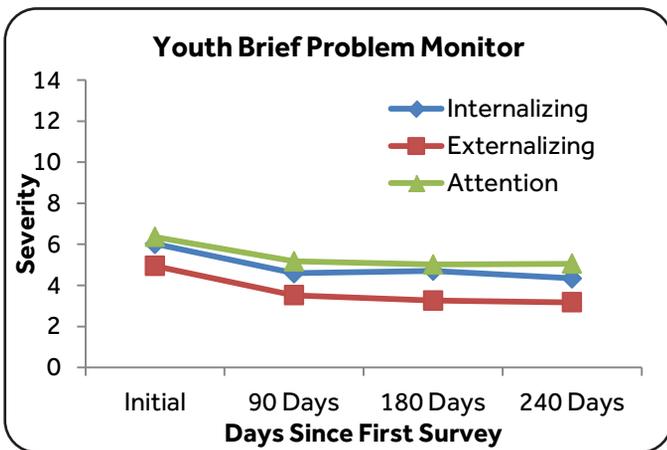
Section 2:

Here is a list of things that kids sometimes have trouble with. For each one, please tell us how true it has been of you over the **past week**.

1. I act too young for my age	Not True	Somewhat True	Very True
2. I argue a lot	Not True	Somewhat True	Very True
3. I fail to finish things I start	Not True	Somewhat True	Very True
4. I have trouble concentrating or paying attention	Not True	Somewhat True	Very True
5. I have trouble sitting still	Not True	Somewhat True	Very True
6. I destroy things belonging to others	Not True	Somewhat True	Very True
7. I disobey my parents	Not True	Somewhat True	Very True
8. I disobey at school	Not True	Somewhat True	Very True
9. I feel worthless or inferior	Not True	Somewhat True	Very True
10. I act without stopping to think	Not True	Somewhat True	Very True
11. I am too fearful or anxious	Not True	Somewhat True	Very True
12. I feel too guilty	Not True	Somewhat True	Very True
13. I am self-conscious or easily embarrassed	Not True	Somewhat True	Very True
14. I am inattentive or easily distracted	Not True	Somewhat True	Very True
15. I am stubborn	Not True	Somewhat True	Very True
16. I have a hot temper	Not True	Somewhat True	Very True
17. I threaten to hurt people	Not True	Somewhat True	Very True
18. I am unhappy, sad, or depressed	Not True	Somewhat True	Very True
19. I worry a lot	Not True	Somewhat True	Very True

Clinical Outcomes

Clinical outcome data are reported for both Cohorts 1 and 2 from the start of the initiative through December 30, 2019. Children and youth who have been enrolled in MATCH for at least 90 days have improved across internalizing, externalizing, and attention scales of the Brief Problem Monitor by youth and caregiver reports, as well as youth- and caregiver- identified Top Problems. Internalizing (e.g., anxiety and depression) and externalizing (e.g., disruptive behavior) problems were most positively impacted by MATCH, and though attention problems also improved, they did so to a lesser degree. Because MATCH was specifically designed to address anxiety, depression, and conduct problems, and does not specifically target inattention, this pattern of improvement is expected. Notable improvement across Top Problems shared by youth and caregivers suggests that while MATCH addresses broad areas of anxiety, depression, conduct, and traumatic stress, it also positively impacts specific challenges that are reported by families. Clinical outcomes improved from initial survey to 90 day survey in all areas of the Brief Problem Monitor and Top Problem measures and continued to incrementally improve through 240 day survey measure. Overall, gains across areas of common youth psychopathology and in families' own top problems demonstrate the promise of the effectiveness of the MATCH approach to address child and youth mental health challenges in community mental health settings in NH.



Implementation Outcomes

IMPLEMENTATION OBJECTIVES

Implementation outcomes are organized in accordance with the five objective areas of the Learning Collaborative, which are:

1. Screening for MATCH eligibility;
2. Basic clinical training in MATCH;
3. Ongoing training and supervision in MATCH;
4. Fidelity to MATCH; and
5. Assessment of progress.

Primary implementation outcome data were collected using monthly metrics and the team assessment portion of the Enhanced Change Package.

Objective 1: Screening for MATCH Eligibility

Cohorts 1 and 2 collectively enrolled a total of 1553 clients in MATCH services over the course of the initiative. Conduct, anxiety, and depression were most frequently identified as treatment foci among clients enrolled. Fewer clients were enrolled in the trauma protocol. This may be due to previous training in Trauma-Focused CBT and Child-Parent Psychotherapy across the CMHCs or the fact that post-traumatic stress disorder occurs at a substantially lower rate in youth than the other three diagnostic areas. As part of the enrollment process, therapists consistently, where appropriate, engaged caregivers and youth in identifying Top Problems, which are helpful in decision-making throughout treatment. Identification of Top Problems may not occur in cases where children are not developmentally appropriate (e.g., younger than age 8). All agencies endorsed substantial increases in screening competencies on the team assessment of the Enhanced Change Package over the course of the Learning Collaborative for their cohort. Screening competencies included the development and integration of standardized MATCH screening protocols and the training and orientation of staff involved in assessment of potential MATCH cases.



By the numbers

1553

number of children and their families enrolled.

13917

number of sessions delivered.

4.35

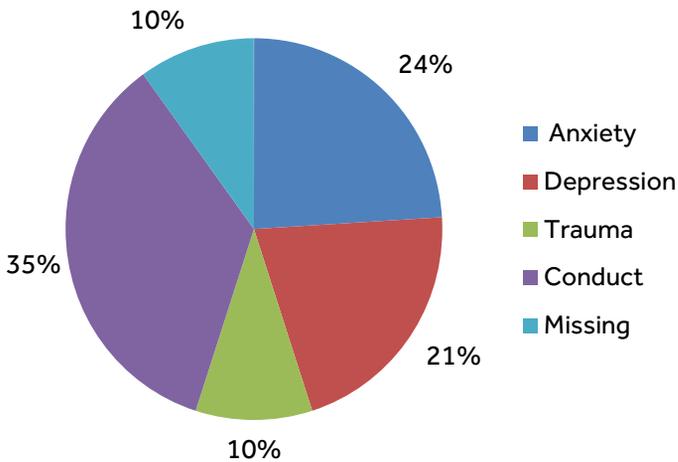
number of clients per active clinician.

8.96

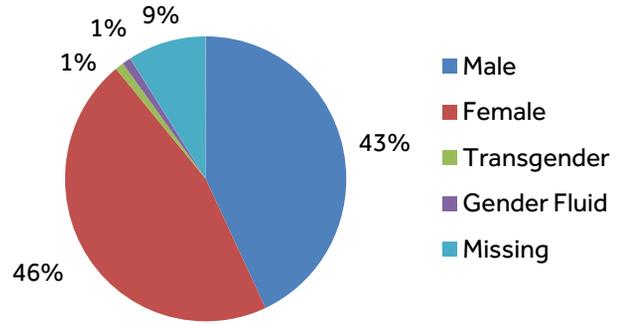
number of sessions per client.

Client Demographics

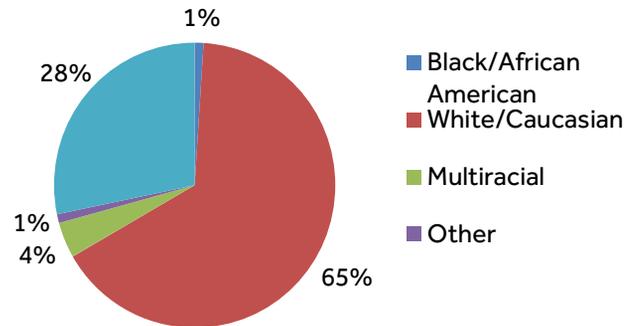
Treatment Focus



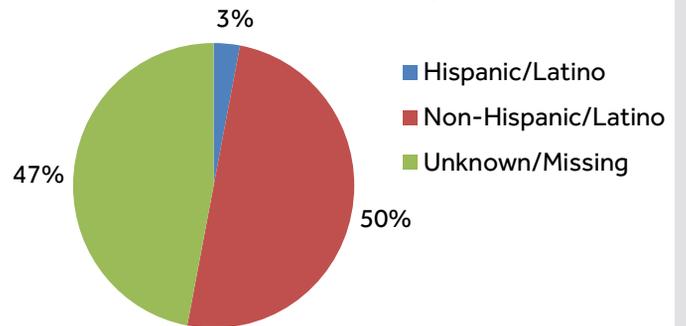
Client Gender



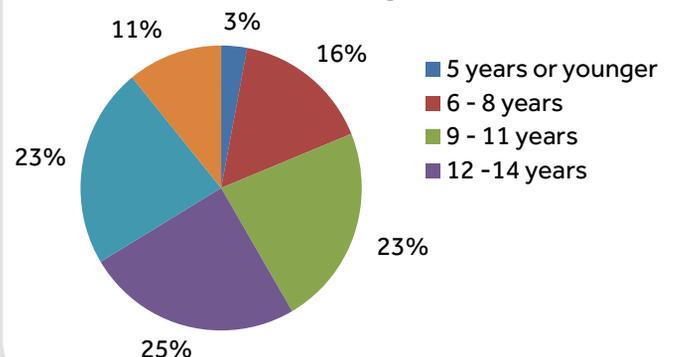
Client Race



Client Ethnicity



Client Age



Objective 2: Basic Clinical Training in MATCH

JBCC provided two MATCH therapist trainings, training 63 therapists in MATCH across all 10 CMHCs since the start of the initiative. Overall, therapists reported finding the five-day training in MATCH to be helpful and MATCH capacity increased following the initial training. All 10 CMHCs had conducted at least one internal MATCH training by the close of the initiative and continue to build overall MATCH capacity. All agencies endorsed substantial increases in basic training competencies on the team assessment of the Enhanced Change Package over the course of the Learning Collaborative. Basic training competencies included the completion of MATCH 5-day training and the development of processes to continue MATCH training. High levels of senior leadership support, as well as participation of a program champion, may have contributed to the attainment of basic training benchmarks.

Objective 3: Ongoing Supervision and Consultation in MATCH

All JBCC-trained therapists had delivered MATCH services during the course of the Learning Collaborative. There was high clinician engagement in the JBCC-led MATCH clinical consultation series throughout the year. Therapists from both cohorts continue to pursue certification in MATCH, as well as therapists trained internally in MATCH. Sixty-three clinicians had been certified by the close of the initiative. All agencies endorsed substantial increases in ongoing training and supervision competencies on the team assessment of the Enhanced Change Package. Ongoing training and supervision competencies included the participation in ongoing clinical consultation, progress toward achievement of certification requirements, and the allocation of resources to support ongoing MATCH training within the agency. Achievement of ongoing training and supervision benchmarks may be supported by the high level of senior leadership and program champion involvement.

Objective 4: Fidelity to MATCH

Clinicians used MATCH modules in the majority of their sessions, even in the face of interference (e.g., comorbidity, emergent life stressors, or engagement challenges). Of note, MATCH was designed as a weekly therapy model, and clients are being seen, on average, every 12.0 days. However, less than a third

Clinicians by the numbers

63

number of therapists trained by JBCC.

80

number of therapists trained by CMHCs.

63

number of therapists certified.

100

percent of therapists trained who have implemented MATCH with clients.

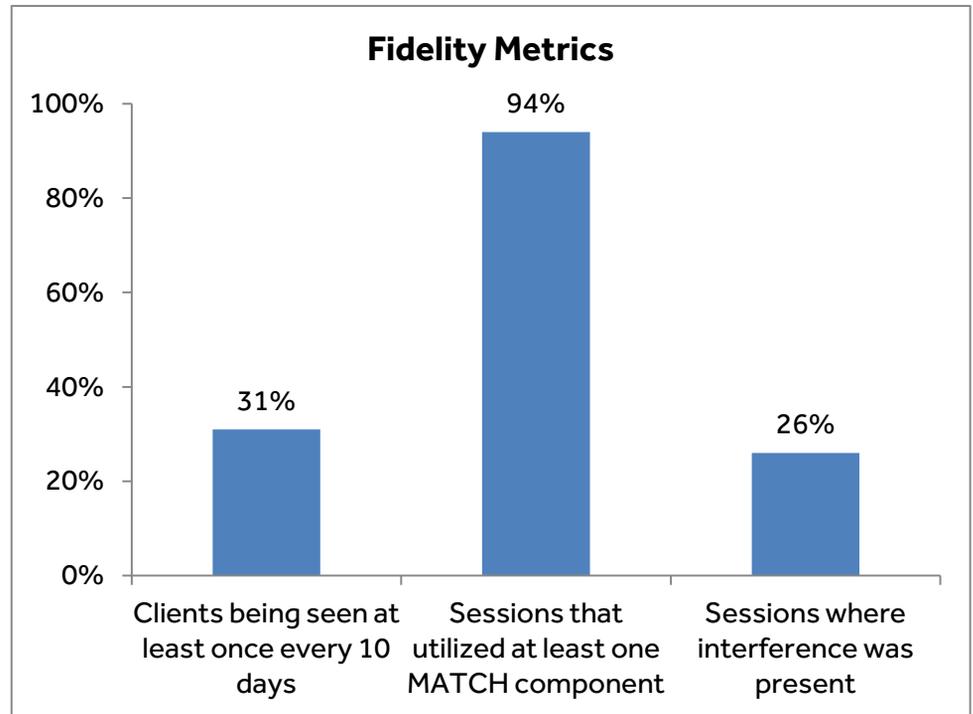
24

number of supervisors trained.

15

number of MATCH therapist who have left CMHCs

of families enrolled in MATCH had sessions at a 10-day interval. Despite challenges to weekly delivery of MATCH services, most agencies endorsed substantial increases in fidelity competencies on the team assessment of the Enhanced Change Package over the course of the Collaborative. Fidelity competencies included the measurement of clinical competence, the documentation of intervention components utilized, and the ability to adapt and flexibly apply MATCH skills.



Objective 5: Assessment of Progress

Through the MATCH initiative, CMHCs have been able to integrate more standardized assessment into their routine practice. Regular use of standardized assessments is crucial to identifying success of an implementation, as well as identification of quality improvement targets through the implementation and sustainability process. However, though clinicians are highly successful at obtaining caregiver and youth Top Problems, only about 44% of caregivers and 27% of youth are completing surveys at least every 14 days. Regular assessment using Top Problems and the Brief Problem Monitor are key factors in real-time clinical decision-making, specifically in terms of selecting which modules to use and determining whether specific modules have been helpful or if they warrant additional coverage in session. Because progress monitoring is essential to the MATCH model and fidelity to it, more attention to supporting this area is warranted.

Despite challenges to biweekly collection of surveys, most agencies endorsed substantial increases in assessment of progress competencies on the team assessment of the Enhanced Change Package over the course of the Collaborative.

“Thank you for sparking continued excitement for learning. I appreciate the Collaborative mirroring the learning MATCH process.”

-MATCH Clinician

Assessment of progress competencies included development of infrastructure to support use of standardized measures and the regular review of assessment findings with youth and caregivers.

IMPLEMENTATION AND CONTINUOUS QUALITY IMPROVEMENT SUPPORT

Organizational Readiness and Capacity for MATCH Implementation

Overall, there was growth in the CHMCs general capacities over the duration of the Learning Collaborative as measured by the Readiness Monitoring Tool administered as part of the individual assessment portion of the Enhanced Change Package. Areas of leadership and culture improved at several of the CMHCs. In addition, growth was endorsed in structure (e.g., processes that affect how well an organization functions on a day-to-day basis) and process capacities (e.g., organizational ability to strategize, implement, evaluate, and improve) at several agencies.

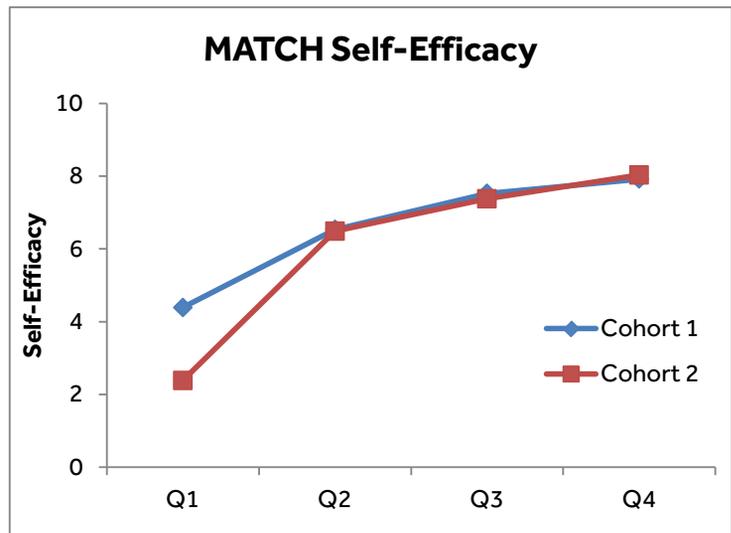
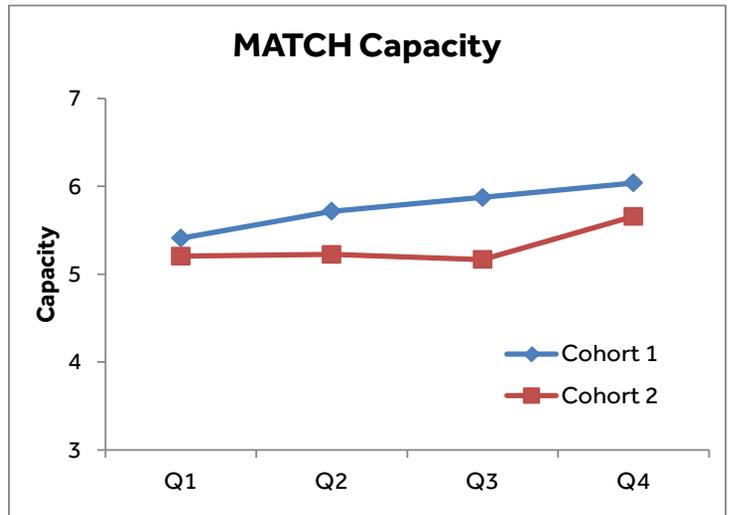
These findings support the use of the Learning Collaborative as a methodology for developing the agencies capacity for change and competency to support implementation of a new initiative. Particular examples include the promotion of team time at both the Learning Sessions and as a standing internal activity, as well as regular review of metric data, implementation outcomes, and barriers to service delivery as a way to engage teams in shared learning and problem-solving.

Clinician Self-Efficacy

Findings on the Self-Efficacy for MATCH Scale support basic training and ongoing training and supervision outcomes outlined previously with therapists endorsing substantial gains in overall clinical self-efficacy and, most notably, MATCH skills over the course of the Learning Collaborative.

Attitudes Towards Evidence-Based Practice

Evidence-Based Practice Attitude Scale results suggest that participant attitudes towards evidence-based



practice improved over the course of the initiative. Particular areas of growth included appeal, openness, and requirements, suggesting that participants felt more positively toward the use of evidence-based practice, and that use of evidence-based practice was prioritized at a higher level within the agency following the initiative.

Job Satisfaction

Finally, participants' overall job satisfaction as reported on the Abridged Job in General and Job Descriptive Index was relatively stable throughout the initiative, though with high scores at the start of the initiative, there was limited room for growth.

Learning Collaborative Engagement

Participation in Learning Sessions was high, averaging about 87% per session across cohorts. Therapists attended 89 % of all scheduled clinical consultation calls.

Engagement in monthly cross-agency senior leader consultation calls may have also contributed to shared learning at a management level that then supported

clinicians' training and development. On average, 86% of senior leader calls were attended by at least one representative from each organization. Involvement of the multidisciplinary interagency steering committee has also supported the sustainability of MATCH in the state through broad outreach efforts.

“I so appreciated the opportunity to learn from and work together with you all. I think MATCH has infused some much needed positivity into our work and we have the tools we need to go forward and implement it.”

-MATCH Supervisor

Full implementation outcomes are presented for both Cohorts 1 and 2 in the Appendix starting on page 29.

Summary and Conclusions

Overall, clinical and implementation outcomes from both cohorts of the Learning Collaborative provide support for the success of the MATCH initiative in New Hampshire. As a group, clients who received MATCH showed symptom improvements across problem areas by both youth and caregiver report. Therapists demonstrated regular use of MATCH modules in sessions, an indicator of treatment fidelity. Therapists are encouraged to continue to engage youth and caregivers in regular progress monitoring to inform clinical decision-making, and to see clients regularly, in service of continued clinical benefit from MATCH. Beyond clinical improvement, following MATCH clinical training and consultation, therapists have expressed increased confidence in their ability to utilize the MATCH model. Therapists and supervisors continue to participate in internal MATCH clinical consultation and to seek MATCH

Therapist and Supervisor Certification as ways to maintain integrity to the model. Additionally, the state's commitment to continued financial support of the TRAC system will also facilitate routine progress monitoring and feedback to guide clinical decision-making and treatment integrity.

Positive implementation outcomes, such as continued client enrollment and internal training of new MATCH therapists, suggest sustainability of the model within the state moving forward. Through the Learning Collaborative, CMHCs and the state have participated in numerous activities, such as Learning Sessions and consultation, to provide concrete support for the initiative at multiple levels of engagement (i.e., senior leadership, supervisors, clinicians, community liaisons, and state representatives). Individually, CMHCs have been encouraged to continue to regularly convene MATCH implementation team meetings and to review implementation metrics data through the TRAC administrative dashboard. Beyond MATCH therapists trained by JBCC during the Learning Collaborative, we expect that CMHCs ability to continue to train more therapists as individual agencies and collaboratively will contribute to continued growth in capacity to serve more youth and families using MATCH. At a cross-organization level, CMHC Children's Directors have taken over leadership of the MATCH Steering Committee and, in collaboration with stakeholders from other child-serving organizations in the state, have planned for continued support of MATCH within the state. Overall, the high levels of buy-in, support, and collaboration from diverse stakeholders within the system have contributed to continued growth in capacity and motivation through the MATCH initiative and have built a solid foundation for sustainability of the MATCH model moving into the future.

APPENDIX

Implementation Outcomes (January 18, 2017 to December 31, 2019)

Objective 1: Screening

Screening and Enrollment Metrics	Cohort 1				Cohort 2						All CMHCs
	CLM	MHCGM	NHS	SMHC	CP	GNMH	LRMHC	MFS	RCMH	WCBH	
# total clients enrolled	318	153	135	134	165	95	96	147	101	209	1553
Average # clients per active therapist	6.27	0.82	2.09	2.67	5.63	2.58	4.63	4.94	5.27	11.63	4.35
# sessions delivered	2253	2277	933	1236	1807	643	567	1107	1000	2094	13917
Average # sessions delivered per active client	7.08	14.88	6.91	9.22	10.95	6.77	5.91	7.53	9.90	10.02	8.96
# clients made inactive	249	139	112	110	75	64	59	68	43	116	1035
Reasons Inactive											
Treatment completed – all goals met	3% (7)	12% (17)	8% (9)	18% (20)	23% (17)	6% (4)	10% (6)	13% (9)	7% (3)	15% (17)	11% (109)
Treatment completed – some goals met	1% (3)	16% (22)	16% (18)	11% (12)	15% (11)	13% (8)	17% (10)	4% (3)	14% (6)	12% (14)	10% (107)
Treatment incomplete – family withdrew	9% (22)	8% (11)	22% (25)	9% (10)	27% (20)	14% (9)	17% (10)	10% (7)	12% (5)	22% (25)	14% (144)
Treatment incomplete – lost contact	4% (10)	14% (20)	11% (12)	9% (10)	9% (7)	8% (5)	15% (9)	26% (18)	5% (2)	20% (23)	11% (116)
Treatment incomplete – therapist left	24% (61)	9% (13)	10% (11)	5% (5)	8% (6)	9% (6)	5% (3)	10% (7)	26% (11)	9% (11)	13% (134)
Higher level of care needed	2% (5)	5% (7)	1% (1)	9% (10)	4% (3)	9% (6)	0% (0)	3% (2)	5% (2)	1% (1)	4% (37)
Other	41% (103)	32% (44)	14% (16)	8% (9)	12% (9)	28% (18)	15% (9)	16% (11)	12% (5)	10% (12)	23% (236)
Missing	15% (38)	4% (5)	18% (20)	31% (34)	3% (2)	13% (8)	20% (12)	16% (11)	21% (9)	11% (13)	15% (152)
Top Problems Entered at Intake											
Caregiver											
% of caregiver Top Problem 1	86% (273)	95% (146)	93% (126)	97% (130)	91% (150)	81% (77)	92% (88)	82% (121)	92% (93)	80% (167)	88% (1371)
% of caregiver Top Problem 2	84% (268)	95% (145)	87% (118)	96% (129)	90% (148)	80% (76)	91% (87)	82% (121)	90% (91)	79% (166)	87% (1349)
% of caregiver Top Problem 3	79% (252)	82% (126)	67% (91)	92% (123)	81% (134)	74% (70)	88% (84)	80% (117)	79% (80)	77% (161)	80% (1238)
Child											
% of child Top Problem 1	77% (244)	65% (99)	74% (100)	74% (99)	53% (87)	78% (74)	65% (62)	80% (118)	70% (71)	68% (143)	71% (1097)
% of child Top Problem 2	73% (232)	60% (92)	67% (91)	72% (96)	53% (87)	73% (69)	64% (61)	78% (115)	68% (69)	67% (141)	68% (1053)
% of child Top Problem 3	64% (203)	47% (72)	53% (72)	69% (93)	45% (75)	64% (61)	58% (56)	69% (101)	55% (56)	66% (137)	60% (926)

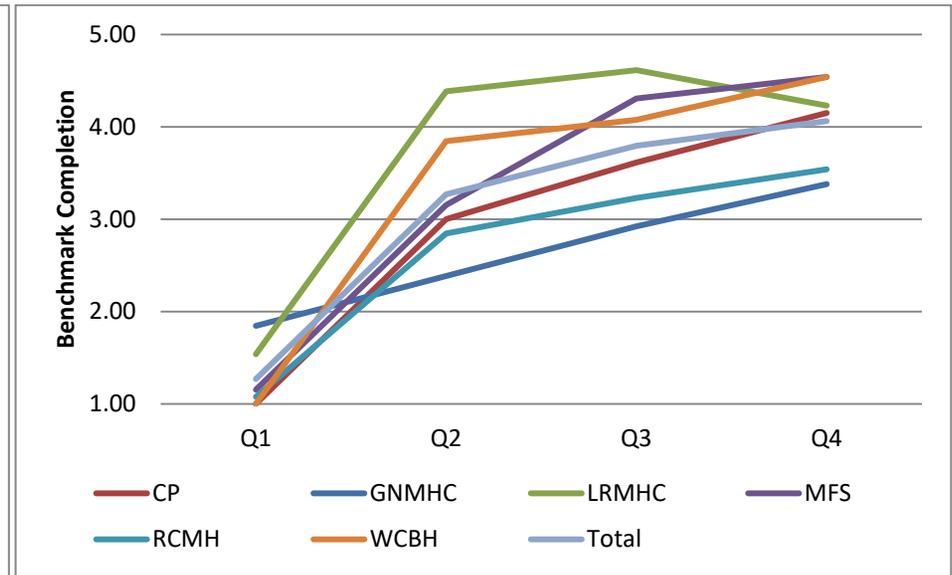
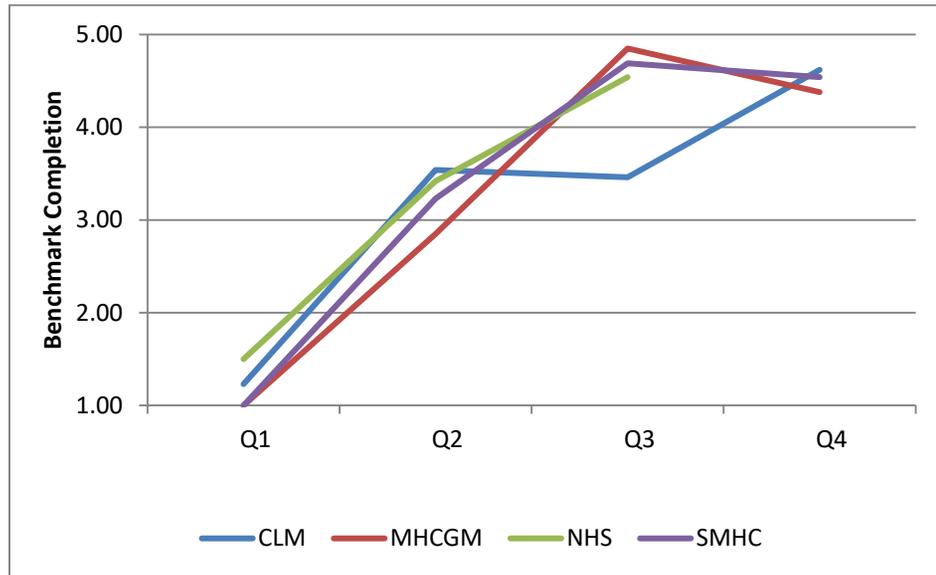
Objective 1: Screening – continued

Screening and Enrollment Metrics	Cohort 1				Cohort 2						All CMHCs
	CLM	MHCGM	NHS	SMHC	CP	GNMH	LRMHC	MFS	RCMH	WCBH	
Race											
% American Indian or Alaska Native	0% (0)	1% (2)	0% (0)	0% (0)	0% (0)	0% (0)	1% (1)	0% (0)	0% (0)	0% (0)	0% (3)
% Asian	1% (2)	0% (0)	0% (0)	1% (1)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (3)
% Black or African American	0% (0)	3% (5)	0% (0)	1% (1)	2% (3)	4% (4)	0% (0)	2% (3)	0% (0)	0% (1)	1% (17)
% Native Hawaiian or Pacific Islander	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)
% White or Caucasian	70% (224)	73% (112)	84% (114)	75% (101)	71% (117)	72% (68)	51% (49)	19% (28)	66% (67)	62% (129)	65% (1009)
% Multiracial	4% (13)	17% (26)	4% (6)	3% (4)	4% (6)	7% (7)	1% (1)	2% (3)	2% (2)	0% (1)	4% (69)
% Other	1% (4)	3% (5)	0% (0)	1% (1)	1% (2)	2% (2)	0% (0)	0% (0)	1% (1)	1% (3)	1% (18)
% Missing	24% (75)	2% (3)	11% (15)	19% (26)	22% (37)	15% (14)	47% (45)	77% (113)	31% (31)	36% (75)	28% (434)
Ethnicity											
% Hispanic/Latino	3% (9)	14% (22)	1% (1)	1% (1)	2% (3)	7% (7)	0% (0)	2% (3)	2% (2)	2% (5)	3% (53)
% Non-Hispanic/Latino	68% (217)	59% (90)	67% (91)	63% (84)	58% (96)	49% (47)	18% (17)	2% (3)	22% (22)	51% (107)	50% (774)
% Unknown/Missing	29% (92)	27% (41)	32% (43)	37% (49)	40% (66)	43% (41)	82% (79)	96% (141)	76% (77)	46% (97)	47% (726)

Objective 1: Screening – continued

Change Packet Results: Agency Self-Assessment of Implementation Objectives												
	Cohort 1					Cohort 2						
	CLM	MHCGM	NHS	SMHC	Cohort 1 Total	CP	GNMH	LRMHC	MFS	RCMH	WCBH	Cohort 2 Total
Screening												
Q1	1.23	1.00	1.50	1.00	1.17	1.00	1.85	1.54	1.15	1.08	1.00	1.27
Q2	3.54	2.85	3.42	3.23	3.26	3.00	2.38	4.38	3.15	2.85	3.85	3.27
Q3	3.46	4.85	4.54	4.69	4.38	3.62	2.92	4.62	4.31	3.23	4.08	3.79
Q4	4.62	4.38	--*	4.54	4.51	4.15	3.38	4.23	4.54	3.54	4.54	4.06

*Did not submit Q4 ECP



Objective 2: Basic Training

Training Metrics	Cohort 1				Cohort 2						All CMHCs
	CLM	MHCGM	NHS	SMHC	CP	GNMH	LRMHC	MFS	RCMH	WCBH	
# therapists trained in MATCH by JBCC	8 ⁱ	8 ⁱ	8 ⁱ	9 ⁱ	5 ⁱ	5 ⁱ	5 ⁱ	5 ⁱ	5 ⁱ	5 ⁱ	63 ⁱ
# therapists trained in MATCH by CMHCs	11	7	7	4	8	9	9	14	8	3	80
# MATCH trained therapists who have left agency	2	2	3	2 ⁱⁱ	0	2	1	1	2	0	15

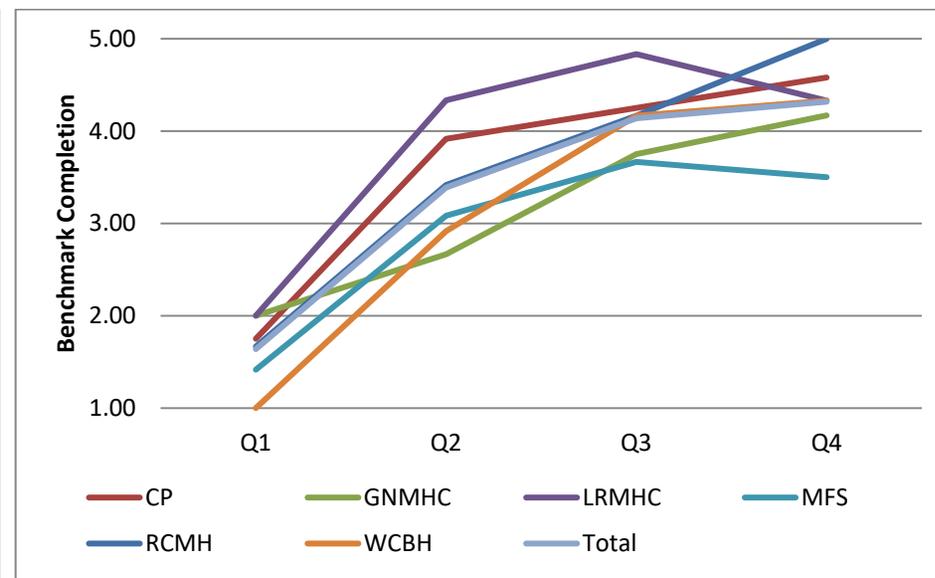
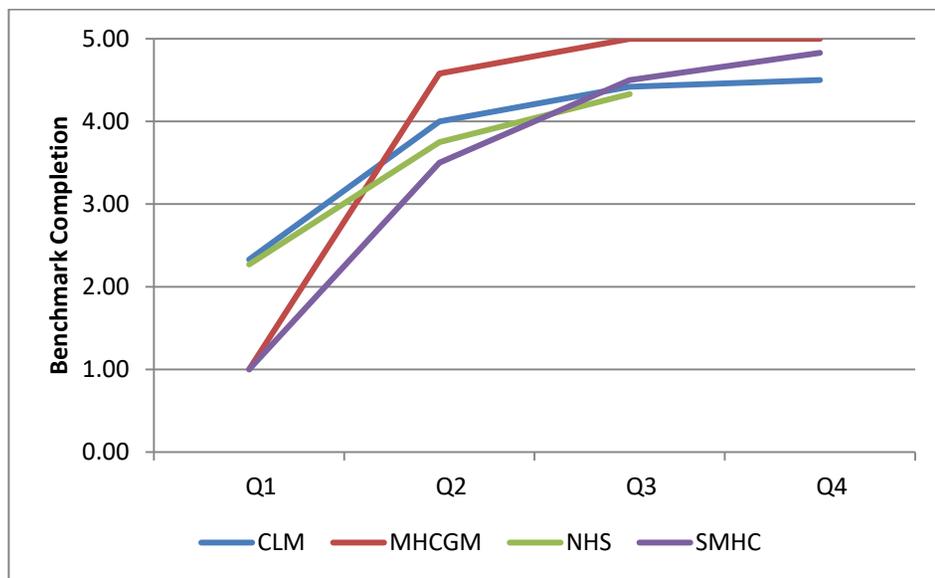
i) Conducted during Years 1 and 2

ii) One clinician transferred to an agency in Cohort 2

All training data as of July 31, 2019

Objective 2: Basic Training - continued

Change Packet Results: Agency Self-Assessment of Implementation Objectives												
	Cohort 1					Cohort 2						
	CLM	MHCGM	NHS	SMHC	Cohort 1 Total	CP	GNMH	LRMHC	MFS	RCMH	WCBH	Total
Basic Training												
Q1	2.33	1.00	2.27	1.00	1.63	1.75	2.00	2.00	1.42	1.67	1.00	1.64
Q2	4.00	4.58	3.75	3.50	3.98	3.92	2.67	4.33	3.08	3.42	2.92	3.39
Q3	4.42	5.00	4.33	4.50	4.56	4.25	3.75	4.83	3.67	4.17	4.17	4.14
Q4	4.50	5.00	--	4.83	4.78	4.58	4.17	4.33	3.50	5.00	4.33	4.32

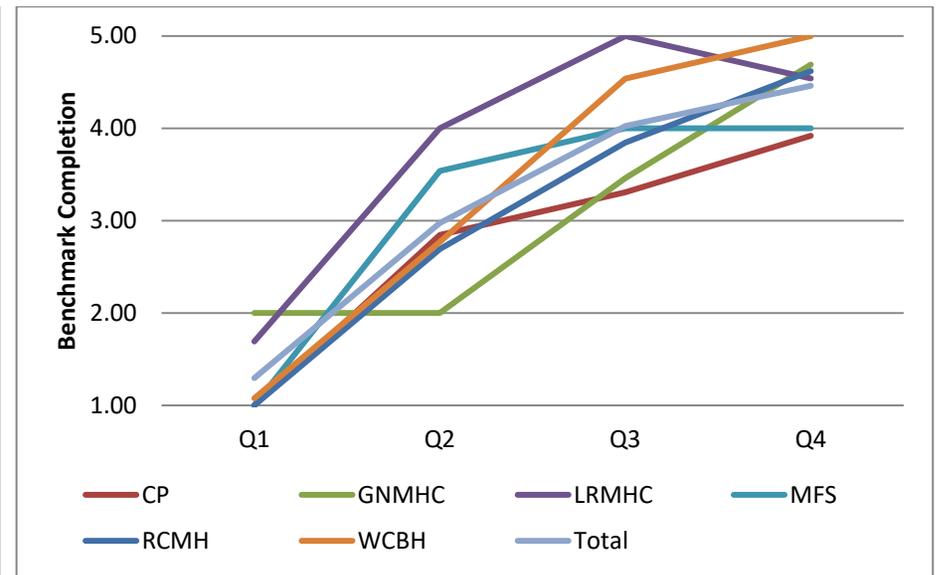
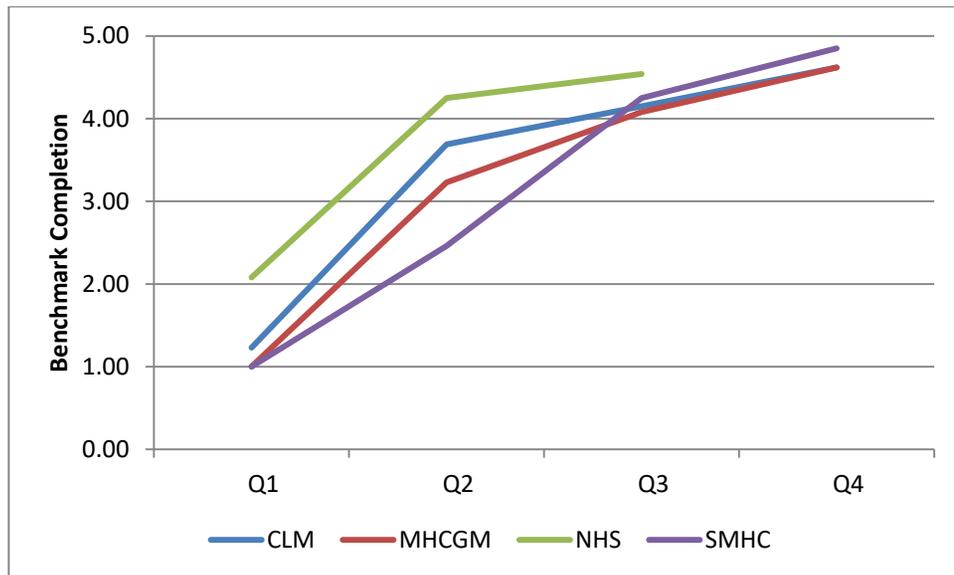


Objective 3: Ongoing Training & Supervision

Supervision and Certification Metrics	Cohort 1				Cohort 2						All CMHCs
	CLM	MHCGM	NHS	SMHC	CP	GNMH	LRMHC	MFS	RCMH	WCBH	
<i>% of JBCC-trained therapists that have seen MATCH clients</i>	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
<i>Average % of therapist participation in JBCC-led clinical consultation</i>	89%	92%	91%	85%	92%	81%	87%	91%	83%	94%	89%
<i># therapists certified in MATCH</i>	4	7	5	7	3	3	2	2	2	3	63

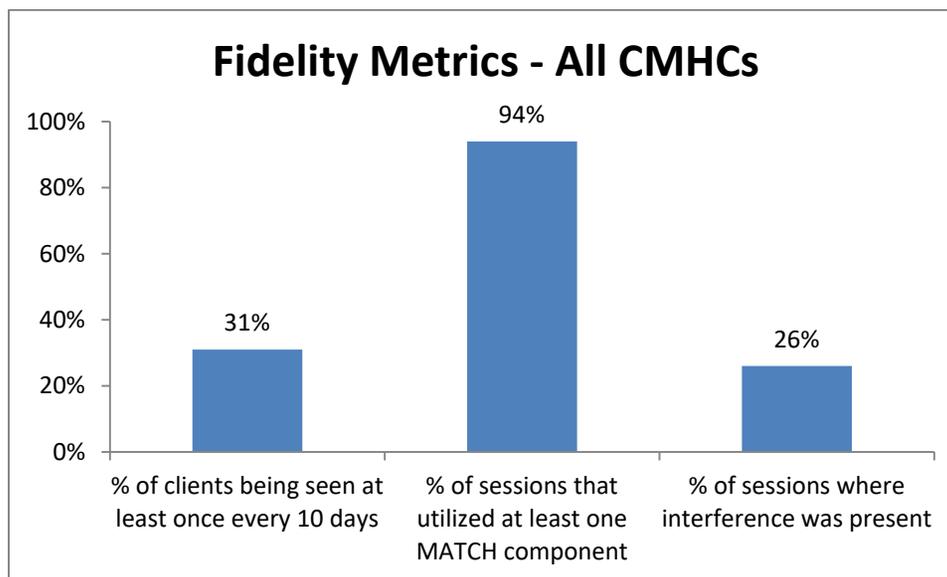
Objective 3: Ongoing Training & Supervision - continued

Change Packet Results: Agency Self-Assessment of Implementation Objectives												
	Cohort 1					Cohort 2						
	CLM	MHCGM	NHS	SMHC	Cohort 1 Total	CP	GNMH	LRMHC	MFS	RCMH	WCBH	Cohort 2 Total Total
Training & Supervision												
Q1	1.23	1.00	2.08	1.00	1.33	1.00	2.00	1.69	1.00	1.00	1.08	1.29
Q2	3.69	3.23	4.25	2.46	3.39	2.85	2.00	4.00	3.54	2.69	2.77	2.97
Q3	4.15	4.08	4.54	4.25	4.21	3.31	3.46	5.00	4.00	3.85	4.54	4.03
Q4	4.62	4.62	--	4.85	4.7	3.92	4.69	4.54	4.00	4.62	5.00	4.46



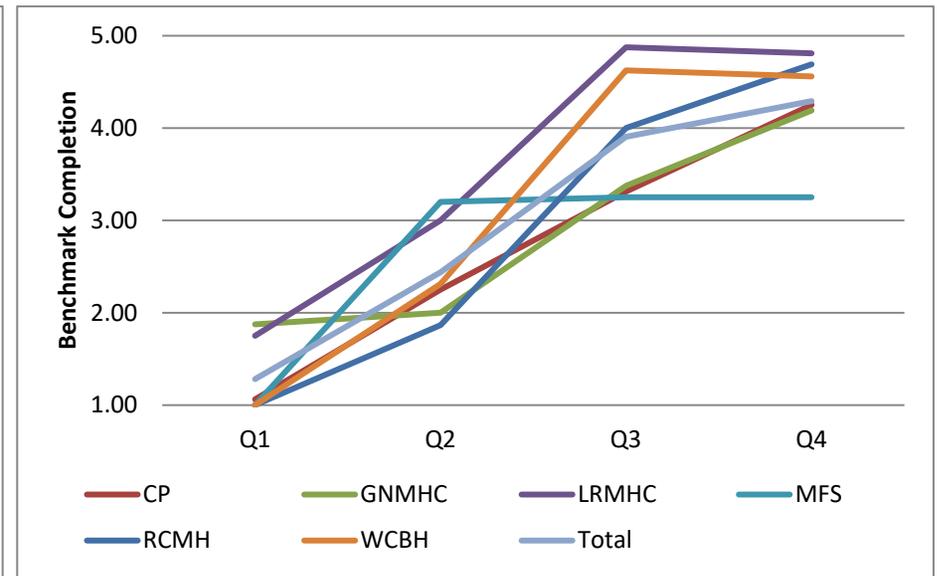
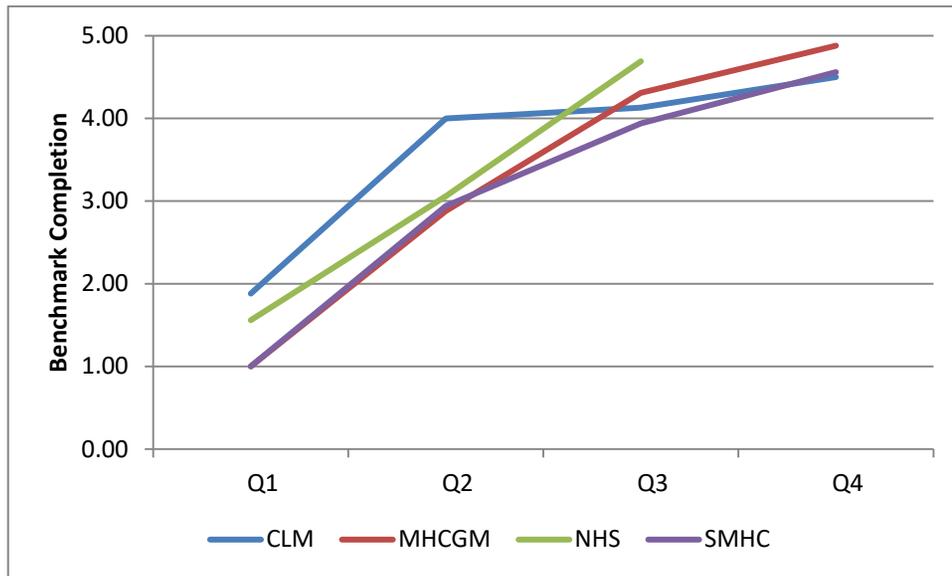
Objective 4: Fidelity

Fidelity Metrics	Cohort 1				Cohort 2						All CMHCs
	CLM	MHCGM	NHS	SMHC	CP	GNMH	LRMHC	MFS	RCMH	WCBH	
Average # days between session	13.7	10.5	14.9	12.5	9.6	10.8	10.6	13.8	8.8	11.7	12.0
% of clients seen at least once every 10 days	23%	47%	20%	24%	49%	25%	22%	28%	38%	32%	31%
% of sessions that utilized at least one MATCH component	91%	95%	95%	93%	91%	96%	97%	90%	96%	97%	94%
% of sessions where interference was present	38%	22%	26%	29%	29%	24%	21%	22%	39%	12%	26%



Objective 4: Fidelity – continued

Change Packet Results: Agency Self-Assessment of Implementation Objectives												
	Cohort 1					Cohort 2						
	CLM	MHCGM	NHS	SMHC	Cohort 1 Total	CP	GNMH	LRMHC	MFS	RCMH	WCBH	Total
Fidelity												
Q1	1.88	1.00	1.56	1.00	1.34	1.06	1.88	1.75	1.00	1.00	1.00	1.28
Q2	4.00	2.88	3.06	2.94	3.22	2.25	2.00	3.00	3.20	1.87	2.31	2.44
Q3	4.13	4.31	4.69	3.94	4.25	3.31	3.38	4.88	3.25	4.00	4.63	3.91
Q4	4.50	4.88	--	4.56	4.65	4.25	4.19	4.81	3.25	4.69	4.56	4.29

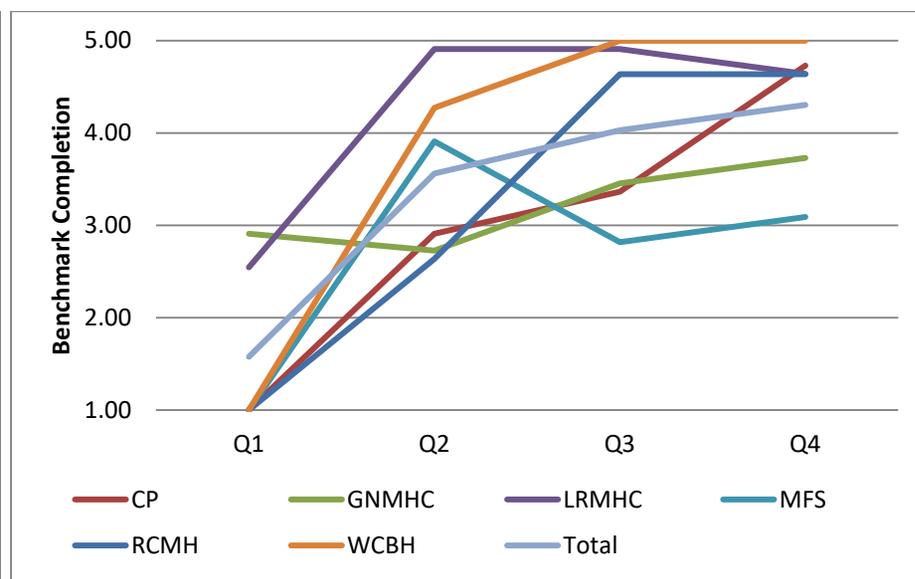
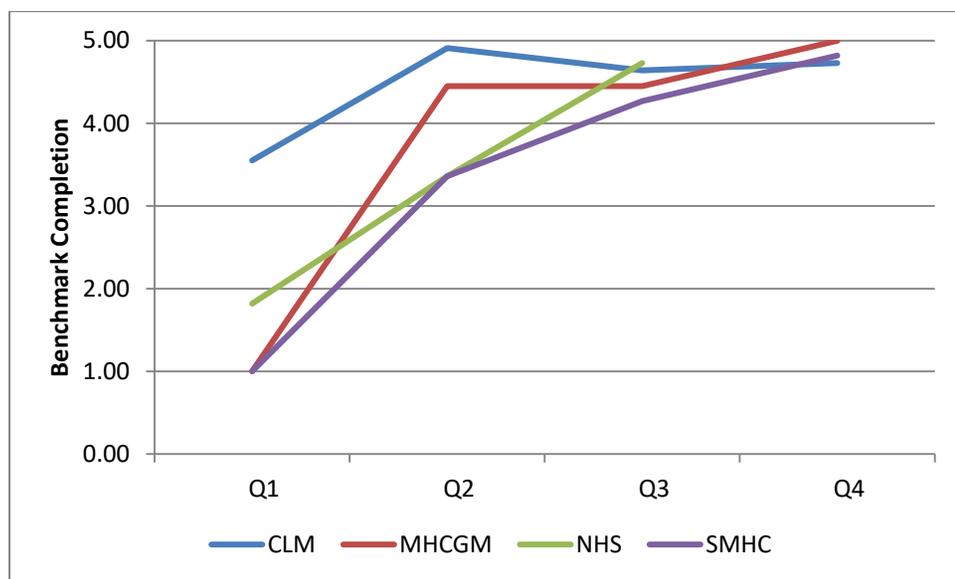


Objective 5: Assessment of Progress

Assessment of Progress Metrics	Cohort 1				Cohort 2						All CMHCs
	CLM	MHCGM	NHS	SMHC	CP	GNMH	LRMHC	MFS	RCMH	WCBH	
<i>% of caregivers completing surveys at least once every 14 days</i>	40%	46%	47%	49%	57%	33%	51%	24%	50%	43%	44%
<i>% of children completing surveys at least once every 14 days</i>	23%	30%	21%	28%	31%	29%	27%	20%	34%	34%	27%

Objective 5: Assessment of Progress - continued

Change Packet Results: Agency Self-Assessment of Implementation Objectives											
	Cohort 1					Cohort 2					
	CLM	MHCGM	NHS	SMHC	Cohort 1 Total	GNMH	LRMHC	MFS	RCMH	WCBH	Total
Assessment of Progress											
Q1	3.55	1.00	1.82	1.00	1.84	2.91	2.55	1.00	1.00	1.00	1.58
Q2	4.91	4.45	3.36	3.36	4.05	2.73	4.91	3.91	2.64	4.27	3.56
Q3	4.64	4.45	4.73	4.27	4.52	3.45	4.91	2.82	4.64	5.00	4.03
Q4	4.73	5.00	--	4.82	4.85	3.73	4.64	3.09	4.64	5.00	4.30



Implementation and CQI Supports: Organizational Readiness & Capacity

Readiness Monitoring Tool Results												
	CLM	MHCGM	NHS	SMHC	Cohort 1 Total	CP	GNMH	LRMHC	MFS	RCMH	WCBH	Cohort 2 Total
General Capacity												
Q1	6.14	5.86	5.31	5.30	5.68	5.21	4.97	5.56	5.09	5.66	5.48	5.33
Q2	6.17	5.77	5.50	5.26	5.71	5.19	5.29	5.36	5.21	5.62	5.21	5.30
Q3	6.03	5.90	5.57	5.58	5.82	5.11	5.47	4.99	4.94	5.32	5.20	5.19
Q4	5.63	5.95	5.86	5.87	5.85	5.42	5.65	5.22	5.40	5.73	5.24	5.42
MATCH Capacity												
Q1	5.81	4.88	5.50	5.52	5.41	5.30	4.48	5.65	4.98	5.16	5.34	5.20
Q2	6.20	5.77	5.28	5.40	5.72	5.12	4.97	5.71	4.86	5.17	5.39	5.23
Q3	6.14	5.90	5.37	5.82	5.87	5.05	5.12	5.28	4.77	5.32	5.57	5.17
Q4	5.44	6.12	6.20	6.17	6.04	5.67	5.71	5.58	5.26	5.84	5.84	5.66
Motivation												
Q1	4.80	4.87	5.35	5.03	4.98	4.73	4.24	5.23	4.71	4.24	4.73	4.69
Q2	5.21	5.01	5.21	4.81	5.06	4.56	4.25	4.86	4.48	4.81	5.19	4.69
Q3	5.46	5.19	5.26	5.09	5.25	4.76	4.72	4.82	4.66	5.25	5.17	4.87
Q4	5.36	5.65	5.57	5.41	5.51	5.29	4.49	5.00	4.70	5.19	5.50	5.11

Implementation and CQI Supports: Organizational Readiness & Capacity
 – continued

6.00-7.00	Agree to Strongly Agree
5.00-5.99	Slightly Agree
4.00-4.99	Neither Agree nor Disagree
1.00-3.99	Slightly Disagree to Strongly Disagree

CLM					
Primary Component	Sub-component	Q1	Q2	Q3	Q4
General Capacity	Culture	6.40	6.60	6.40	6.14
	Climate	6.00	6.10	5.82	5.03
	Structure	6.00	6.20	6.07	5.48
	Org. Innovativeness	6.50	6.40	6.28	5.74
	Resource Utilization	5.80	5.40	5.21	5.64
	Leadership	6.50	6.10	6.23	5.71
	Staff Capacity	6.10	6.20	6.14	5.43
	Process Capacities	6.20	6.30	6.10	5.88
MATCH Capacity	Knowledge & Skills	5.90	6.30	6.21	6.43
	Program Champion	5.70	6.40	6.63	6.20
	Implementation Climate				
	Supports	5.80	6.40	6.25	5.34
	Inter-organizational Relationships	5.30	6.00	5.58	5.86
	Structure	--***	6.50	6.25	5.14
	Resource Utilization	--***	5.50	5.58	3.86
Leadership	5.50	6.30	6.45	5.25	
Motivation	Relative Advantage	4.40	4.60	5.06	6.10
	Compatibility/Alignment	5.30	6.20	6.03	6.39
	Complexity	4.60	4.90	5.00	4.76
	Trialability	--***	5.60	6.10	5.75
	Observability	--***	5.00	5.04	4.43
	Priority	4.90	5.50	5.50	4.71

MHCGM					
Primary Component	Sub-component	Q1	Q2	Q3	Q4
General Capacity	Culture	6.20	6.10	6.29	6.38
	Climate	5.20	5.20	5.41	5.57
	Structure	5.70	5.90	6.08	6.11
	Org. Innovativeness	6.00	5.90	6.06	6.09
	Resource Utilization	5.70	5.20	5.29	5.14
	Leadership	6.30	6.40	6.43	6.27
	Staff Capacity	5.60	5.40	5.50	6.03
	Process Capacities	6.20	6.20	6.17	6.04
MATCH Capacity	Knowledge & Skills	4.00	6.00	6.07	6.55
	Program Champion	4.80	5.60	5.94	6.62
	Implementation Climate				
	Supports	5.30	6.10	6.17	6.31
	Inter-organizational Relationships	4.50	4.60	5.14	5.73
	Structure	--***	6.40	6.36	6.18
	Resource Utilization	--***	5.20	5.29	5.09
Leadership	5.70	6.40	6.36	6.40	
Motivation	Relative Advantage	4.50	5.00	4.86	5.55
	Compatibility/Alignment	5.60	5.90	5.93	6.14
	Complexity	4.30	4.30	4.38	5.27
	Trialability	--***	5.20	5.70	5.82
	Observability	--***	4.20	4.77	5.45
	Priority	5.20	5.50	5.52	5.70

Implementation and CQI Supports: Organizational Readiness & Capacity
 – continued

6.00-7.00	Agree to Strongly Agree
5.00-5.99	Slightly Agree
4.00-4.99	Neither Agree nor Disagree
1.00-3.99	Slightly Disagree to Strongly Disagree

NHS					
Primary Component	Sub-component	Q1	Q2	Q3	Q4
General Capacity	Culture	6.00	6.10	6.17	6.28
	Climate	5.10	5.10	4.93	4.89
	Structure	5.20	5.50	5.61	5.90
	Org. Innovativeness	5.10	5.80	5.67	5.94
	Resource Utilization	4.80	5.10	5.33	5.60
	Leadership	6.10	5.80	6.20	6.44
	Staff Capacity	5.30	5.00	5.11	5.63
	Process Capacities	4.90	5.60	5.55	6.19
MATCH Capacity	Knowledge & Skills	5.10	5.80	5.67	6.70
	Program Champion	5.60	5.60	5.50	6.72
	Implementation Climate	5.30	5.80	5.43	6.16
	Supports	6.30	4.00	4.17	5.90
	Inter-organizational Relationships	--***	5.50	5.80	6.30
	Structure	--***	4.40	5.33	5.30
	Resource Utilization	5.80	5.90	5.90	6.33
	Leadership	5.80	5.90	5.90	6.33
Motivation	Relative Advantage	5.80	5.90	5.89	5.53
	Compatibility/Alignment	6.20	6.30	5.83	6.13
	Complexity	4.30	4.40	4.22	5.53
	Trialability	--***	4.90	5.75	5.58
	Observability	--***	4.50	4.67	5.03
	Priority	5.10	5.30	5.22	5.63

SMHC					
Primary Component	Sub-component	Q1	Q2	Q3	Q4
General Capacity	Culture	5.90	6.00	6.16	6.30
	Climate	4.70	4.60	4.97	5.20
	Structure	5.00	5.20	5.78	6.06
	Org. Innovativeness	5.30	5.20	5.78	6.08
	Resource Utilization	5.10	4.70	4.85	5.33
	Leadership	5.70	5.60	5.82	6.43
	Staff Capacity	5.30	5.20	5.47	5.28
	Process Capacities	5.60	5.60	6.08	6.27
MATCH Capacity	Knowledge & Skills	5.00	5.80	6.35	6.42
	Program Champion	5.90	6.10	6.40	6.48
	Implementation Climate	5.50	5.50	5.75	6.27
	Supports	5.30	4.50	5.20	5.67
	Inter-organizational Relationships	--***	5.40	6.10	6.50
	Structure	--***	5.00	5.00	5.42
	Resource Utilization	5.60	5.60	5.93	6.45
	Leadership	5.60	5.60	5.93	6.45
Motivation	Relative Advantage	4.80	4.90	5.03	5.17
	Compatibility/Alignment	5.70	5.70	5.75	6.02
	Complexity	4.60	4.50	4.77	4.53
	Trialability	--***	4.40	5.23	5.92
	Observability	--***	4.30	4.53	5.02
	Priority	5.10	5.10	5.27	5.78

Implementation and CQI Supports: Organizational Readiness & Capacity
 – continued

6.00-7.00	Agree to Strongly Agree
5.00-5.99	Slightly Agree
4.00-4.99	Neither Agree nor Disagree
1.00-3.99	Slightly Disagree to Strongly Disagree

CP					
Primary Component	Sub-component	Q1	Q2	Q3	Q4
General Capacity	Culture	5.97	5.93	6.10	6.06
	Climate	4.91	4.93	5.03	5.09
	Structure	5.01	4.89	4.93	5.17
	Org. Innovativeness	5.24	5.41	5.21	5.57
	Resource Utilization	4.13	4.27	4.00	4.60
	Leadership	5.53	5.87	5.64	6.10
	Staff Capacity	5.72	4.85	4.83	5.07
	Process Capacities	5.18	5.36	5.16	5.72
MATCH Capacity	Knowledge & Skills	5.04	5.64	5.50	6.30
	Program Champion	5.73	5.64	5.90	6.54
	Implementation Climate	4.85	5.26	4.90	5.86
	Inter-organizational Relationships	6.33	3.40	4.80	4.90
	Structure	--***	5.50	5.40	5.60
	Resource Utilization	--***	3.40	3.20	4.50
	Leadership	5.72	5.81	5.64	5.96
Motivation	Relative Advantage	4.61	4.60	4.83	5.50
	Compatibility/Alignment	5.20	5.25	5.48	6.13
	Complexity	4.36	4.20	4.43	4.63
	Trialability	--***	5.20	5.33	5.95
	Observability	--***	3.45	3.85	4.33
	Priority	4.76	4.67	4.67	5.20

GNMH					
Primary Component	Sub-component	Q1	Q2	Q3	Q4
General Capacity	Culture	5.72	5.90	6.20	6.47
	Climate	4.60	4.89	5.22	5.89
	Structure	5.20	5.31	5.25	4.78
	Org. Innovativeness	5.20	5.54	5.47	6.06
	Resource Utilization	3.90	4.08	4.55	4.67
	Leadership	5.52	5.93	6.28	6.27
	Staff Capacity	4.80	5.28	5.47	5.78
	Process Capacities	4.85	5.39	5.29	5.27
MATCH Capacity	Knowledge & Skills	4.40	5.42	5.85	6.50
	Program Champion	4.44	5.03	5.50	5.73
	Implementation Climate	4.12	5.23	5.18	5.47
	Inter-organizational Relationships	5.00	4.50	4.50	5.67
	Structure	--***	5.50	5.20	6.00
	Resource Utilization	--***	3.80	4.00	4.67
	Leadership	4.80	5.13	5.55	5.96
Motivation	Relative Advantage	4.20	4.72	4.83	4.11
	Compatibility/Alignment	4.35	5.50	5.60	5.67
	Complexity	3.53	3.14	4.30	3.22
	Trialability	--***	4.54	4.93	5.25
	Observability	--***	3.13	3.93	3.67
	Priority	4.87	4.44	4.72	5.00

Implementation and CQI Supports: Organizational Readiness & Capacity
 – continued

6.00-7.00	Agree to Strongly Agree
5.00-5.99	Slightly Agree
4.00-4.99	Neither Agree nor Disagree
1.00-3.99	Slightly Disagree to Strongly Disagree

LRMHC					
Primary Component	Sub-component	Q1	Q2	Q3	Q4
General Capacity	Culture	6.03	6.05	5.30	5.67
	Climate	5.15	5.14	4.37	4.56
	Structure	5.06	4.54	4.11	4.83
	Org. Innovativeness	5.60	5.21	4.89	5.11
	Resource Utilization	4.69	4.50	4.33	4.58
	Leadership	5.94	5.38	5.23	5.40
	Staff Capacity	6.29	6.29	5.78	5.72
	Process Capacities	5.74	5.79	5.88	5.92
MATCH Capacity	Knowledge & Skills	5.44	6.31	6.42	6.83
	Program Champion	5.53	5.83	5.90	5.77
	Implementation Climate	5.45	5.80	5.40	5.63
	Supports				
	Inter-organizational Relationships	6.50	5.38	4.67	5.17
	Structure	--***	6.00	5.83	5.33
	Resource Utilization	--***	4.63	3.33	4.67
	Leadership	6.29	6.02	5.40	5.67
Motivation	Relative Advantage	4.88	4.29	4.39	4.56
	Compatibility/Alignment	6.00	5.75	5.38	6.08
	Complexity	4.54	4.71	5.00	5.33
	Trialability	--***	4.94	5.17	4.88
	Observability	--***	4.03	4.04	4.29
	Priority	5.50	5.46	4.94	4.83

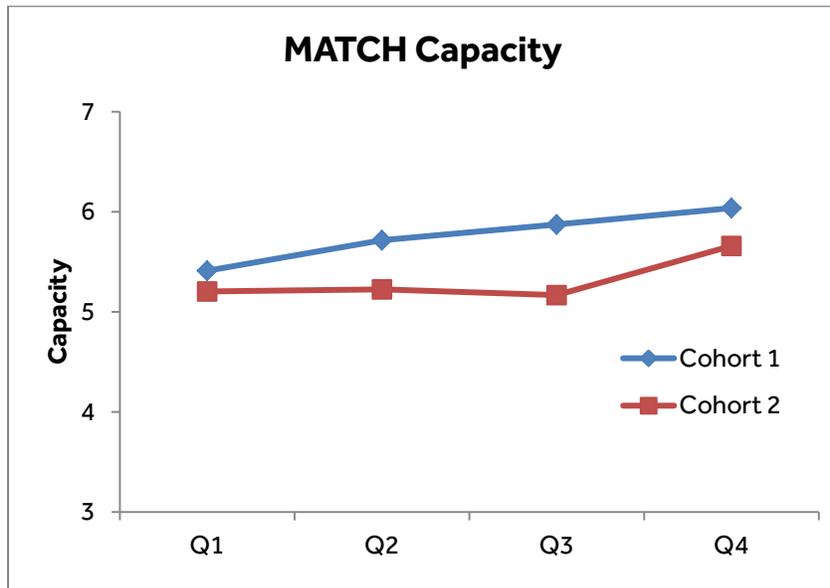
MFS					
Primary Component	Sub-component	Q1	Q2	Q3	Q4
General Capacity	Culture	6.03	6.32	6.00	6.28
	Climate	4.77	5.09	4.94	5.03
	Structure	5.14	4.93	4.56	5.23
	Org. Innovativeness	5.03	5.13	4.83	5.27
	Resource Utilization	4.50	4.20	4.08	5.00
	Leadership	5.46	5.28	5.30	5.48
	Staff Capacity	4.90	5.47	5.11	5.87
	Process Capacities	4.92	5.24	4.71	5.00
	MATCH Capacity	Knowledge & Skills	5.14	5.80	6.00
Program Champion		5.03	5.08	5.46	5.90
Implementation Climate		4.80	5.00	4.60	5.35
Supports					
Inter-organizational Relationships		5.00	4.40	4.67	5.00
Structure		--***	4.60	4.50	4.75
Resource Utilization		--***	4.40	3.50	4.25
Leadership		4.90	4.73	4.67	5.22
Motivation	Relative Advantage	4.71	4.60	4.56	4.83
	Compatibility/Alignment	5.29	5.60	5.42	5.75
	Complexity	3.95	3.87	4.06	4.21
	Trialability	--***	4.50	4.75	4.31
	Observability	--***	3.85	4.33	4.13
	Priority	4.90	4.47	4.83	5.00

Implementation and CQI Supports: Organizational Readiness & Capacity
 – continued

6.00-7.00	Agree to Strongly Agree
5.00-5.99	Slightly Agree
4.00-4.99	Neither Agree nor Disagree
1.00-3.99	Slightly Disagree to Strongly Disagree

RCMH					
Primary Component	Sub-component	Q1	Q2	Q3	Q4
General Capacity	Culture	6.17	6.08	6.10	6.12
	Climate	5.03	5.00	4.87	5.11
	Structure	5.81	5.70	4.97	5.87
	Org. Innovativeness	5.90	5.87	5.31	5.83
	Resource Utilization	4.86	5.20	5.00	5.30
	Leadership	6.03	5.96	5.57	6.08
	Staff Capacity	5.76	5.40	5.06	5.47
	Process Capacities	5.74	5.73	5.65	6.05
MATCH Capacity	Knowledge & Skills	4.86	6.00	5.92	6.50
	Program Champion	5.34	5.36	6.03	5.92
	Implementation Climate	5.06	5.72	5.43	5.84
	Supports				
	Inter-organizational Relationships	5.25	4.40	4.83	5.80
	Structure	--***	5.40	5.67	6.00
	Resource Utilization	--***	3.60	3.67	4.80
	Leadership	5.76	5.70	5.71	6.03
Motivation	Relative Advantage	4.10	4.60	5.06	4.40
	Compatibility/Alignment	4.86	6.00	5.88	5.80
	Complexity	3.67	4.87	5.67	5.60
	Trialability	--***	4.78	5.21	5.80
	Observability	--***	3.95	4.83	4.85
	Priority	4.36	4.67	4.83	4.67

WCBH					
Primary Component	Sub-component	Q1	Q2	Q3	Q4
General Capacity	Culture	5.87	6.03	5.83	5.96
	Climate	5.33	5.00	4.83	4.95
	Structure	5.53	5.28	5.18	5.00
	Org. Innovativeness	5.83	5.25	5.17	5.40
	Resource Utilization	4.58	4.08	4.50	4.70
	Leadership	5.63	5.40	5.48	5.52
	Staff Capacity	5.56	5.00	5.06	4.80
	Process Capacities	5.50	5.67	5.54	5.55
MATCH Capacity	Knowledge & Skills	4.50	6.00	6.25	6.10
	Program Champion	5.30	5.40	5.57	5.76
	Implementation Climate	5.60	5.70	5.87	5.84
	Supports				
	Inter-organizational Relationships	6.00	4.67	4.83	5.80
	Structure	--***	5.50	6.00	6.20
	Resource Utilization	--***	4.83	4.67	5.00
	Leadership	5.56	5.60	5.79	6.15
Motivation	Relative Advantage	4.61	5.67	5.72	6.00
	Compatibility/Alignment	5.29	6.00	5.71	5.90
	Complexity	3.89	5.17	4.50	3.87
	Trialability	--***	5.21	5.38	5.90
	Observability	--***	3.88	4.50	5.40
	Priority	5.11	5.22	5.22	5.93

Implementation and CQI Supports: Organizational Readiness & Capacity – continued

Readiness Monitoring Tool Key

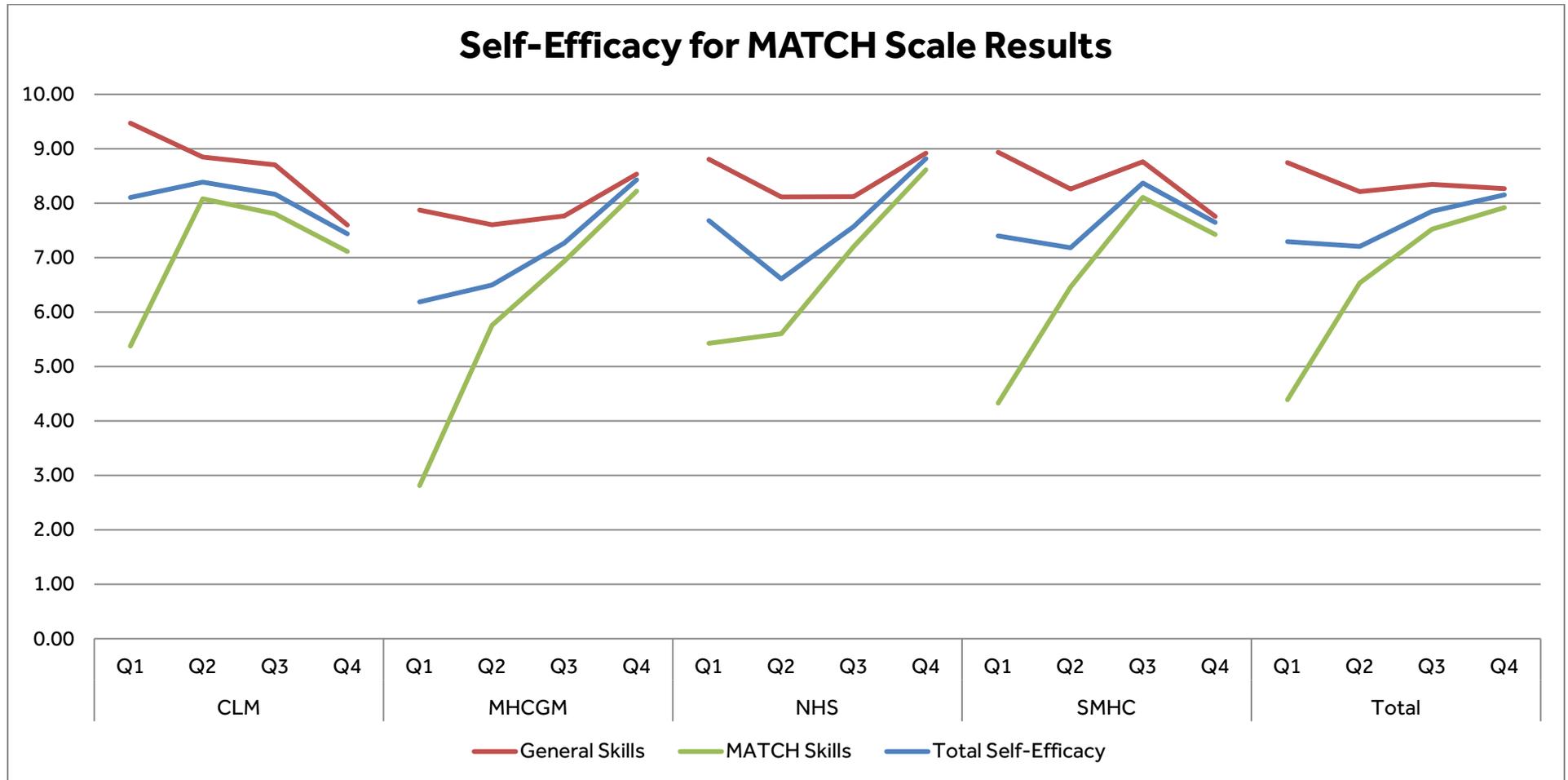
General Capacity	
Culture	Expectations about how things are done in an organization; how the organization functions <ul style="list-style-type: none"> Members of our organization share the same values. We have good relationships with people inside our organization.
Climate	How employees collectively perceive, appraise, and feel about their current working environment <ul style="list-style-type: none"> People are enthusiastic about their work. General staff morale is positive in our organization.
Organizational Innovativeness	General receptiveness toward change (i.e., an organizational learning environment) <ul style="list-style-type: none"> Our organization introduces innovations and adapts to change well.
Resource Utilization	How discretionary and uncommitted resources are devoted to innovations <ul style="list-style-type: none"> There is a clear process by which the organization prioritizes and distributes resources that we acquire.
Leadership	Whether power authorities articulate and support organizational activities <ul style="list-style-type: none"> We have clear leadership in our organization. Our leadership is supportive of ongoing initiatives.
Structure	Processes that affect how well an organization functions on a day-to-day basis <ul style="list-style-type: none"> We are able to communicate openly within our organization. We have a well-defined method to resolve internal problems.
Staff Capacity	General skills, education, and expertise that the staff possesses <ul style="list-style-type: none"> Staff in our organization currently have sufficient knowledge to carry out behavioral health services for children in our clinic.
Process Capacity	Organizational ability to strategize, implement, evaluate, and improve <ul style="list-style-type: none"> We are able to develop appropriate goals for our organization. We know how to evaluate our initiatives.
MATCH Capacity	
MATCHKSAs	Knowledge, skills, and abilities needs for the innovation <ul style="list-style-type: none"> We have the knowledge we need to implement MATCH.
Program Champion	Individual(s) who put charismatic support behind an innovation through connections, expertise, and social influence <ul style="list-style-type: none"> There is a clear champion (or champions) for MATCH in our organization.
Implementation Climate Supports	Extent to which the innovation is supported; presence of strong, convincing, informed, and demonstrable management support <ul style="list-style-type: none"> We have tangible support from our organization to implement MATCH. There is a system in place to monitor the quality of implementation of MATCH.
Interorganizational Relationships	Relationships between providers and supports systems and between different providers organizations that are used to facilitate implementation <ul style="list-style-type: none"> We effectively communicate with other organizations that are implementing similar projects.
Leadership	Whether power authorities articulate and support organizational activities specific to the innovation <ul style="list-style-type: none"> Our leadership has removed obstacles to the implementation of MATCH. Our leadership recognizes and appreciates staff efforts toward successful implementation of MATCH.
Motivation	
Relative Advantage	Degree to which a particular innovation is perceived as being better than what it is being compared against <ul style="list-style-type: none"> MATCH is better for our clinic than what we are currently doing.
Compatibility/Alignment	Degree to which an innovation is perceived as being consistent with existing values, cultural norms, experiences, and needs of potential users <ul style="list-style-type: none"> MATCH fits well with other interventions implemented by our organization. MATCH helps us meet the needs of our community.
Complexity	Degree to which an innovation is perceived as relatively difficult to understand and use <ul style="list-style-type: none"> MATCH is simple and easy to implement.
Trialability	Degree to which an innovation can be tested and experimented with <ul style="list-style-type: none"> We see small changes along the way that show the MATCH initiative is working.
Observability	Degree to which outcomes that result from the innovation are visible to others <ul style="list-style-type: none"> We can see positive changes in our community that may lead to improvements in children's behavioral health.
Priority	Degree to which the innovation is considered important to an organization <ul style="list-style-type: none"> MATCH is one of the top three priorities of our organization.

Scaccia, J. P., Cook, B. S., Lamont, A., Wandersman, A., Castellow, J., Katz, J., & Beidas, R. S. (2015). A practical implementation science heuristic for organizational readiness: R=MC. *Journal of Community Psychology, 43*(4), 484-501.

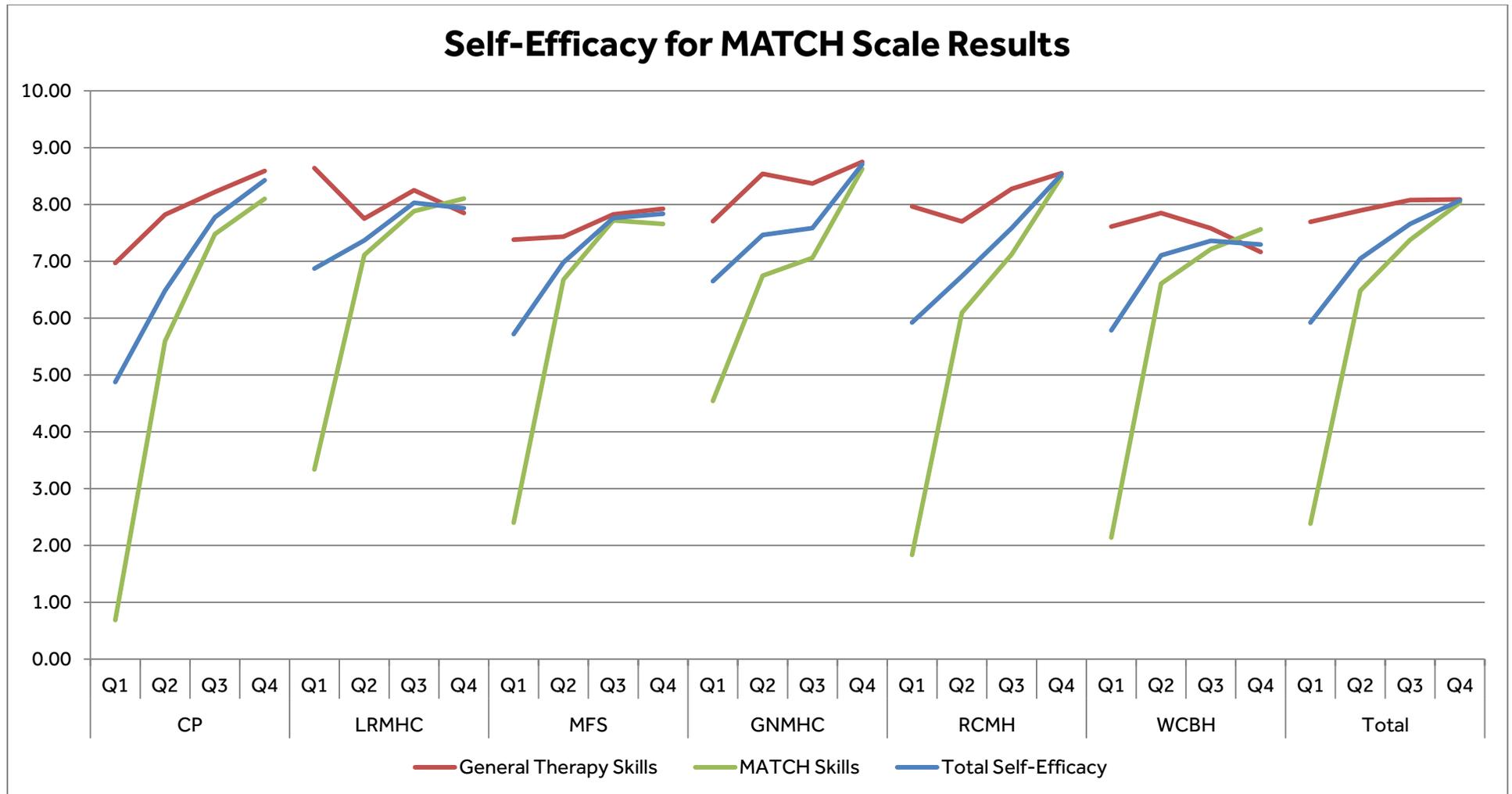
Implementation and CQI Supports: Clinician Self-Efficacy

Self-Efficacy for MATCH Scale Results												
	CLM	MHCGM	NHS	SMHC	Cohort 1 Total	CP	GNMH	LRMHC	MFS	RCMH	WCBH	Cohort 2 Total
General Skills												
Q1	9.47	7.88	8.81	8.94	8.75	6.97	7.71	8.64	7.38	7.97	7.61	7.69
Q2	8.85	7.61	8.12	8.26	8.22	7.82	8.54	7.75	7.43	7.70	7.85	7.89
Q3	8.71	7.77	8.12	8.76	8.35	8.22	8.37	8.25	7.83	8.28	7.58	8.08
Q4	7.6	8.54	8.92	7.76	8.27	8.59	8.75	7.85	7.93	8.55	7.16	8.09
MATCH Skills												
Q1	5.38	2.81	5.43	4.33	4.39	0.69	4.54	3.34	2.40	1.83	2.14	2.38
Q2	8.08	5.76	5.60	6.46	6.53	5.59	6.75	7.11	6.68	6.10	6.61	6.49
Q3	7.81	6.93	7.20	8.11	7.53	7.48	7.06	7.88	7.72	7.12	7.21	7.38
Q4	7.11	8.22	8.62	7.43	7.92	8.10	8.63	8.10	7.66	8.49	7.56	8.03
Total Self-Efficacy												
Q1	8.11	6.19	7.68	7.40	7.29	4.88	6.65	6.87	5.72	5.92	5.79	5.92
Q2	8.39	6.50	6.61	7.18	7.21	6.48	7.46	7.37	6.98	6.74	7.10	7.05
Q3	8.17	7.27	7.57	8.37	7.85	7.78	7.58	8.03	7.76	7.58	7.36	7.66
Q4	7.44	8.43	8.82	7.65	8.15	8.43	8.71	7.93	7.84	8.53	7.30	8.07

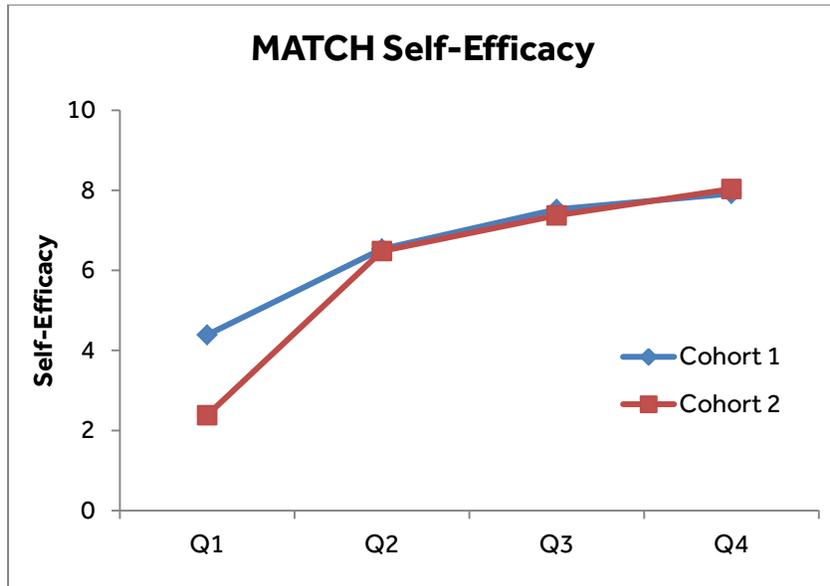
Implementation and CQI Supports: Clinician Self-Efficacy – continued



Implementation and CQI Supports: Clinician Self-Efficacy – continued



Implementation and CQI Supports: Clinician Self-Efficacy – continued



Self-Efficacy for MATCH Scale Key

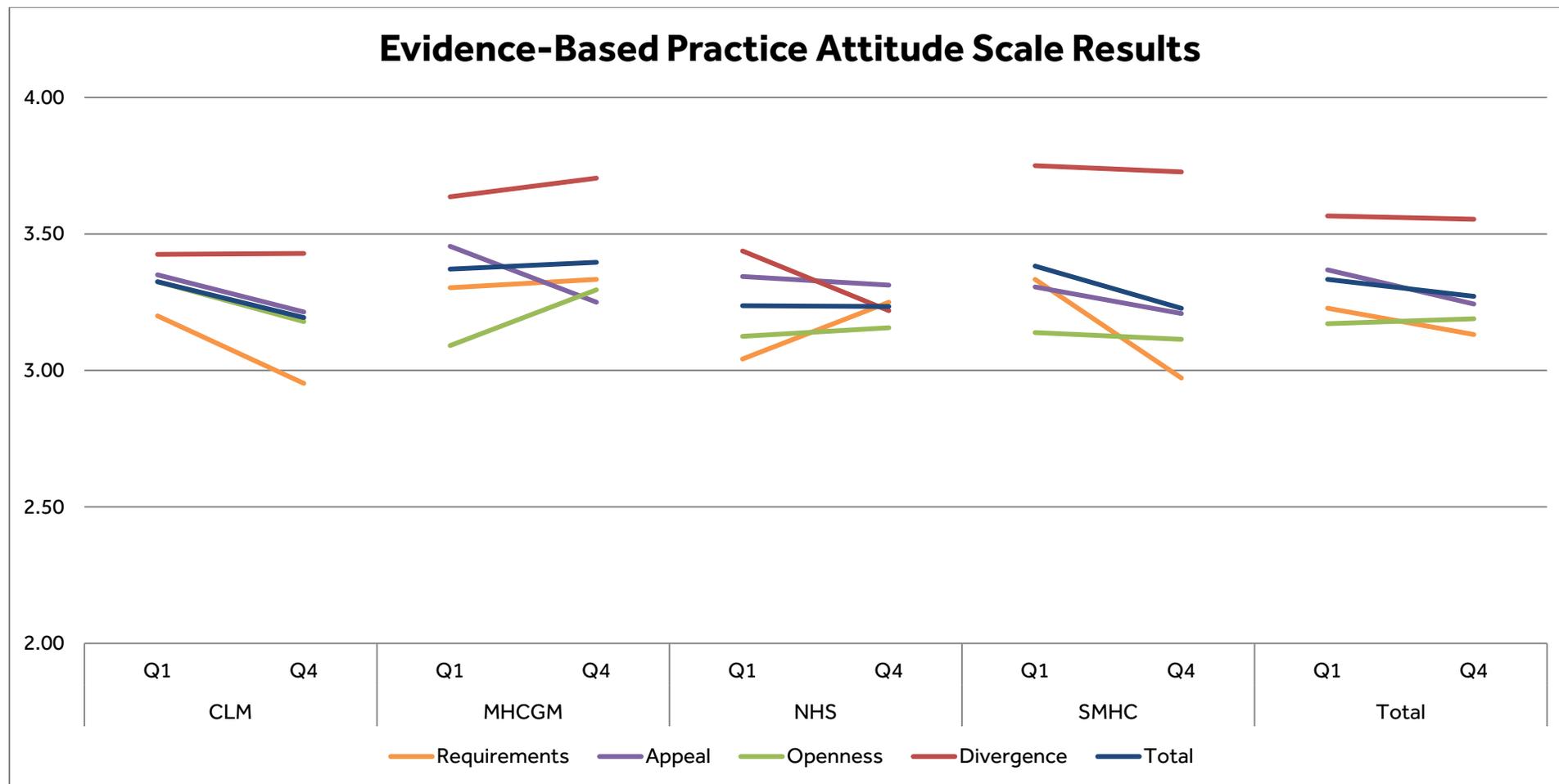
General Skills	The extent to which the clinician feels confident in their general therapy and cognitive behavioral skills <ul style="list-style-type: none"> • How would you rate your capacity for developing a positive therapeutic alliance with families? • How would you rate your capacity for teaching skills to children and caregivers?
MATCH Skills	The extent to which the clinician feels confident in their general therapy and cognitive behavioral skills <ul style="list-style-type: none"> • How would you rate your capacity for identifying and assessing Top Problems with children and families? • How would you rate your capacity for using MATCH to treat common mental health problems among children at your clinic?
Total Self-Efficacy	Global perception of clinical confidence and self-efficacy

Adapted from Wilkerson, A., & Basco, M.R. (2014). Therapists' self-efficacy for CBT dissemination: Is supervision the key? *Psychology & Psychotherapy*, 4, 3.

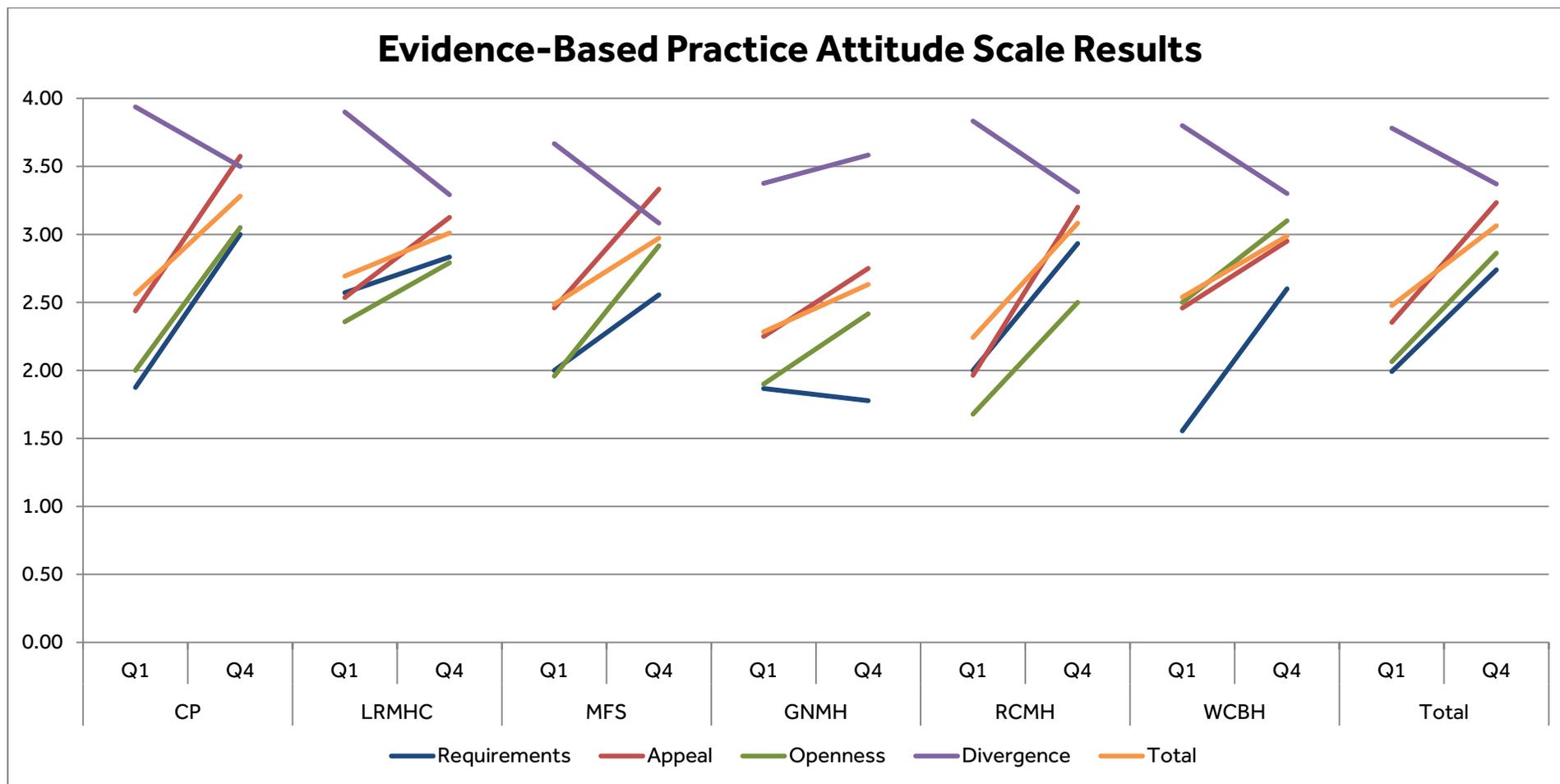
Implementation and CQI Supports: Attitudes Toward Evidence-Based Practice

Evidence-Based Practice Attitude Scale Results												
	CLM	MHCGM	NHS	SMHC	Cohort 1 Total	CP	GNMH	LRMHC	MFS	RCMH	WCBH	Cohort 2 Total
Requirements												
Q1	3.20	3.30	3.04	3.33	3.23	1.88	1.87	2.57	2.00	2.00	1.56	1.99
Q4	2.95	3.33	3.25	2.97	3.13	3.00	1.78	2.83	2.56	2.93	2.60	2.74
Appeal												
Q1	3.35	3.45	3.34	3.31	3.37	2.44	2.25	2.54	2.46	1.96	2.46	2.35
Q4	3.21	3.25	3.31	3.21	3.24	3.58	2.75	3.13	3.33	3.20	2.95	3.23
Openness												
Q1	3.33	3.09	3.13	3.14	3.17	2.00	1.90	2.36	1.96	1.68	2.50	2.06
Q4	3.18	3.30	3.16	3.11	3.19	3.05	2.42	2.79	2.92	2.50	3.10	2.86
Divergence												
Q1	3.43	3.64	3.44	3.75	3.57	3.94	3.38	3.90	3.67	3.83	3.80	3.78
Q4	3.43	3.70	3.22	3.73	3.55	3.50	3.58	3.29	3.08	3.31	3.30	3.37
Total												
Q1	3.33	3.37	3.24	3.38	3.33	2.56	2.28	2.69	2.49	2.24	2.54	2.48
Q4	3.19	3.40	3.23	3.23	3.27	3.28	2.63	3.01	2.97	3.08	2.99	3.06

Implementation and CQI Supports: Attitudes Toward Evidence-Based Practice – continued



Implementation and CQI Supports: Attitudes Toward Evidence-Based Practice – continued



Implementation and CQI Supports: Attitudes Toward Evidence-Based Practice – continued**Evidence-Based Practice Attitude Scale Key**

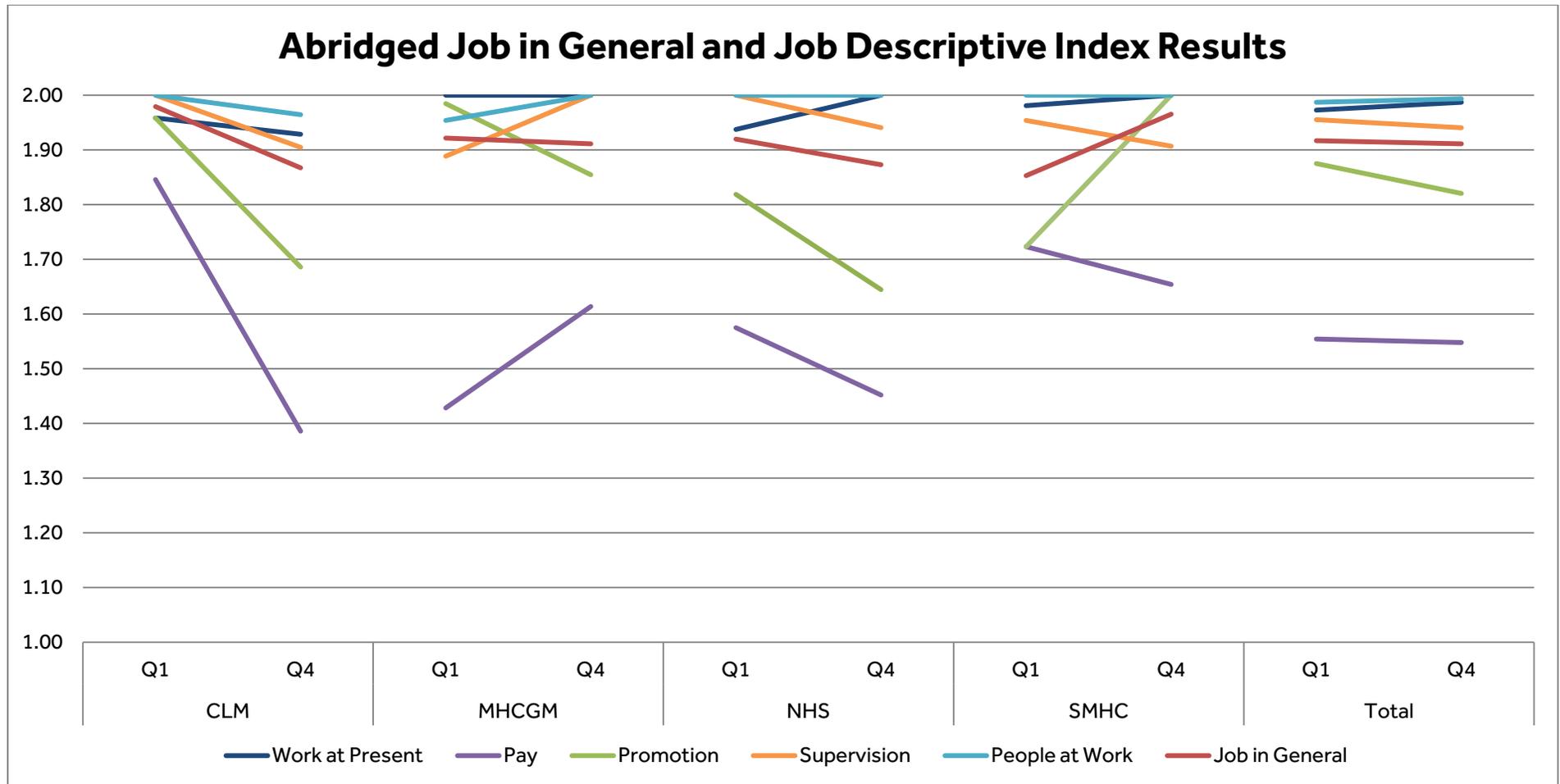
Requirements	<p>The extent to which the provider would adopt an EBP if it were required by the supervisor, agency, or state</p> <ul style="list-style-type: none"> If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if it was required by your agency?
Appeal	<p>The extent to which the provider would adopt an EBP if it were intuitively appealing, could be used correctly, or was being used by colleagues who were happy with it</p> <ul style="list-style-type: none"> If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if it “made sense” to you?
Openness	<p>The extent to which the provider is generally open to trying new interventions and would be willing to try or use EBPs</p> <ul style="list-style-type: none"> I would try a new therapy/intervention even if it were very different from what I am used to doing.
Divergence	<p>The extent to which the provider perceives EBPs as not clinically useful and less important than clinical experience</p> <ul style="list-style-type: none"> Research based treatments/interventions are not clinically useful.
Total	Global attitude toward adoption of EBP

Aarons, G. A. (2004). Mental health provider attitudes toward adoption of evidence-based practice: The Evidence-Based Practice Attitude Scale (EBPAS). *Mental Health Services Research, 6*(2), 61-74.

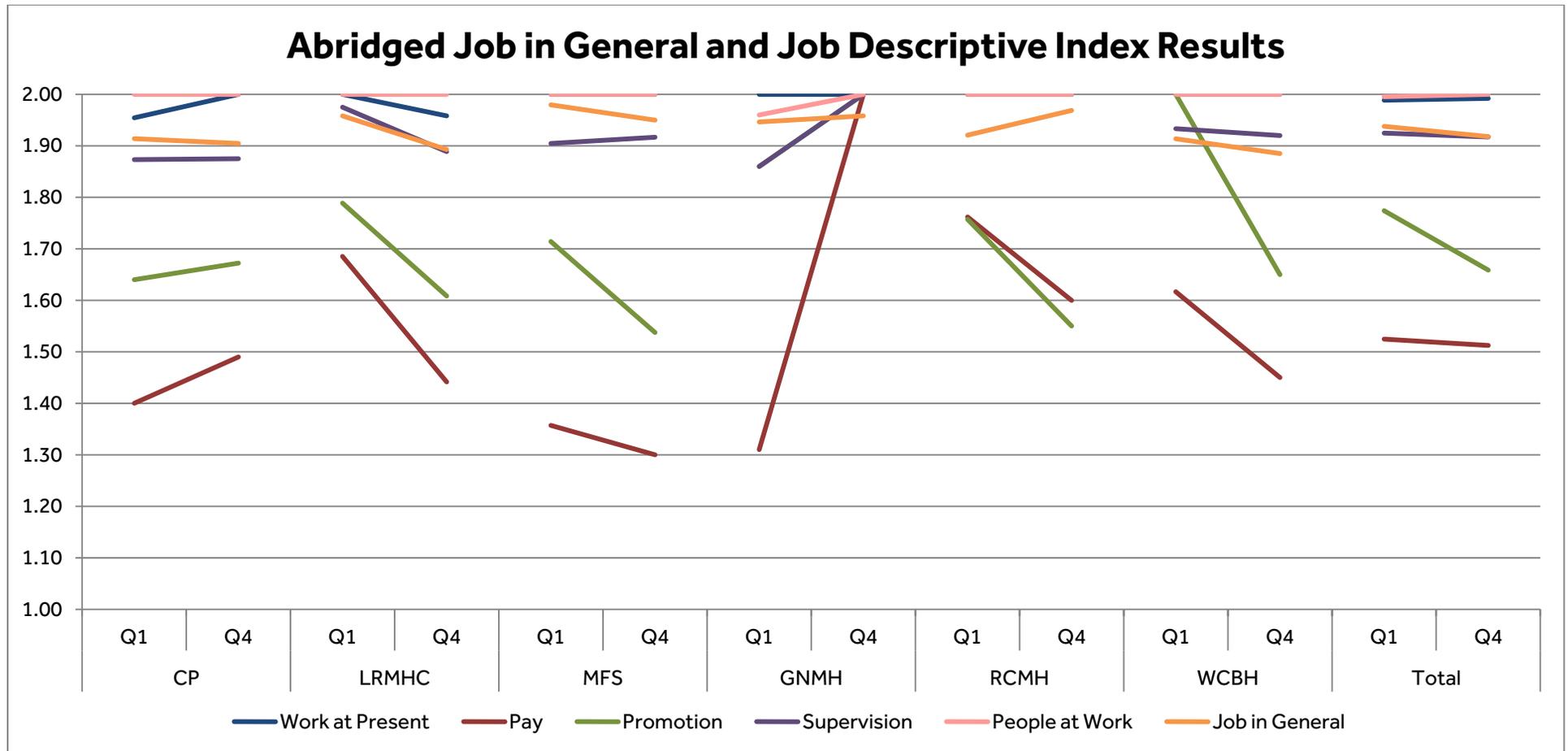
Implementation and CQI Supports: Job Satisfaction

Abridged Job in General and Job Descriptive Index Results												
	CLM	MHCGM	NHS	SMHC	Cohort 1 Total	CP	GNMH	LRMHC	MFS	RCMH	WCBH	Cohort 2 Total
Work at Present												
Q1	1.96	2.00	1.94	1.98	1.97	1.95	2.00	2.00	2.00	2.00	2.00	1.99
Q4	1.93	2.00	2.00	2.00	1.99	2.00	2.00	1.96	2.00	2.00	2.00	1.99
Pay												
Q1	1.85	1.43	1.58	1.72	1.55	1.40	1.31	1.69	1.36	1.76	1.62	1.52
Q4	1.39	1.61	1.45	1.65	1.55	1.49	2.00	1.44	1.30	1.60	1.45	1.51
Promotion												
Q1	1.96	1.98	1.82	1.72	1.88	1.64	1.86	1.79	1.71	1.76	2.00	1.77
Q4	1.69	1.85	1.64	2.00	1.82	1.67	2.00	1.61	1.54	1.55	1.65	1.66
Supervision												
Q1	2.00	1.89	2.00	1.95	1.96	1.87	1.86	1.98	1.90	2.00	1.93	1.92
Q4	1.90	2.00	1.94	1.91	1.94	1.88	2.00	1.89	1.92	2.00	1.92	1.92
People at Work												
Q1	2.00	1.95	2.00	2.00	1.99	2.00	1.96	2.00	2.00	2.00	2.00	2.00
Q4	1.96	2.00	2.00	2.00	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00
Job in General												
Q1	1.98	1.92	1.92	1.85	1.92	1.91	1.95	1.96	1.98	1.92	1.91	1.94
Q4	1.87	1.91	1.87	1.97	1.91	1.90	1.96	1.89	1.95	1.97	1.89	1.92

Implementation and CQI Supports: Job Satisfaction – continued



Implementation and CQI Supports: Job Satisfaction - continued



Implementation and CQI Supports: Job Satisfaction - continued

Abridged Job in General and Job Descriptive Index Key

Work at Present	The extent to which the respondent associates the follow words or phrases with their work at present <ul style="list-style-type: none"> Satisfying, gives sense of accomplishment, challenging, dull
Pay	The extent to which the respondent associates the follow words or phrases with their present pay <ul style="list-style-type: none"> Income adequate for normal expenses, fair, well paid
Promotion	The extent to which the respondent associates the follow words or phrases with their opportunities for promotion <ul style="list-style-type: none"> Good opportunities for promotion, promotion on ability, unfair promotion policy
Supervision	The extent to which the respondent associates the follow words or phrases with their supervision <ul style="list-style-type: none"> Tactful, praises good work, up-to-date
People at Work	The extent to which the respondent associates the follow words or phrases with the people at work <ul style="list-style-type: none"> Helpful, responsible, intelligent
Job in General	The extent to which the respondent associates the follow words or phrases with their job in general <ul style="list-style-type: none"> Good, better than most, makes me content, enjoyable

Adapted from Stanton, J. M., Sinar, E. F., Balzer, W. K., Julian, A. L., Thoresen, P., Aziz, S., ... & Smith, P. C. (2002). Development of a compact measure of job satisfaction: The abridged Job Descriptive Index. *Educational and Psychological Measurement, 62*(1), 173-191.

Adapted from Russell, S. S., Spitzmüller, C., Lin, L. F., Stanton, J. M., Smith, P. C., & Ironson, G. H. (2004). Shorter can also be better: The Abridged Job in General Scale. *Educational and Psychological Measurement, 64*(5), 878-893.



This report summarizes the three-year Learning Collaborative to implement the MATCH Treatment Program in New Hampshire's statewide system of behavioral healthcare. If you would like more information about the results of this MATCH Learning Collaborative or are interested in MATCH implementation options, please contact:

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