



Implementation Team

Minutes

December 1st, 2010
8:30AM – 10:30AM

Attendees: Robert Radujiko-Moore, Kalli Benson, Anita Coen, Cliff Moers, Ami Garry, Angie Lawson, Laura Douglas, Rebecca Herr, Rachael Moore, Jewlya Lynn, Rebecca Kahn, Art House, Laura Douglas, Janet DesGeorges

ACTION ITEMS

- **Action Item:** Summary of Guidelines of Care for Consumers
 - Description: Develop a 2 pager summarizing the guidelines for care, with a link to where you can get the whole set of guidelines.
 - Responsible Party: Standards Work Group
- **Action Item:** Grant Opportunities
 - Description: As anyone finds grants, please send them to the Core Team or CSI. The smaller the grant, the less it is worth the staff time to write the grant, so perhaps nothing less than \$25,000. However, please do send any grants of \$25K or more, even if they are for a focus larger than MH and SA.
 - Responsible Party: Implementation Team Members
- **Action Item:** Sustainability Plan
 - Description: The Core Team will bring a rough draft of the Sustainability Plan to the Implementation Team when it is ready.
 - Responsible Party: Core Team

1. Welcome and Introductions

2. Completed CAC Curriculum & Training WG ~ Next Steps

- a. We have recently come to the end of a three and a half month intense period of working on the DBH contract deliverables. There were two big deliverables:
 - i. Complete a curriculum for a class that the Division of Behavioral Health (DBH) could use for the Certified Addiction Counselor (CAC) training, and for continuing education for mental health and substance abuse providers under the new licensure requirements. Our short title for this is the CAC Endorsement Training.
 - ii. Complete the Guidelines for Care. We will discuss the guidelines for care further in the next agenda item (Item 3).

- b. Angie, Mary, Maria, Ami, Rachael, Monica Braden, Rebecca Herr and others worked on this training. The curriculum is intended to be comprehensive two-day training, including some building of clinical skills. It starts with a general overview of what deafness is, what hard of hearing means, what the cultural models are. Then there is more about deaf culture, the hoh experience, and hearing assistive technologies (hat, HAT). Then it discusses clinical skills – how to get the right info from the client, psychosocial interviewing, different kinds of techniques used with dhoh clients, ethics, and special considerations. The latter has to do with trauma and other issues. There is also a big section on mental health interpreting, and how to work with mental health interpreters, and defining what mental health interpreters are, and their code of ethics.
- c. Core competencies for the course include, among others:
 - i. The ability to articulate a working knowledge of the diff perspectives related to hearing loss,
 - ii. The ability to demonstrate the clinical ways of working with an interpreter,
 - iii. The ability to recognize their own biases,
 - iv. The ability to identify the appropriate HAT based on a person’s needs,
 - v. The ability to identify appropriate resources outside of clinical care.
- d. Materials include a PowerPoint presentation, a set of handouts, an agenda for the course, some interactive activities, the core competencies, and the exam.
- e. At this point the entire curriculum is drafted, but it needs further work. Additional steps needed are:
 - i. To continue to improve the overall quality and content,
 - ii. To pilot the training,
 - iii. Through work with the early adopters and elsewhere, to have it formally adopted by DBH.
- f. Question: What is the deadline for DBH to get the deliverables?
 - i. Answer: The deadline is passed – it was October 31st. The draft version was submitted. There is no deadline other than Daylight Project’s grant deadline for the final version.
- g. There is interest in having the training posted on the Daylight Project Website so that people may download and read it.
 - i. **Action Item:** Rebecca Kahn will post the curriculum on the website.
 - ii. **Post-Meeting Addendum:** At the request of members of the Core Team, the curriculum will not be posted on the website until it is further along.
- h. Demographics and the population issue for the hard of hearing. Nationally, all the government agencies go with around 17% hard of hearing in the general population. The Daylight Project is using the same figures that the Commission uses, but those are from 1992. Right now we’re saying that there are about 450,000 hard of hearing in Colorado, but the new numbers say that there are more like 842,000. Counting the deaf population is more difficult. In the final version of the curriculum, can we put in a discussion point about the different estimates out there and say that the numbers vary?
 - i. For now we are using the Commission numbers, although Rob in Cliff’s office took a look at the numbers, and found that they really conflict. He is looking into the numbers and we will bring his result to the group.
- i. It would be a good idea to have a discussion about the definition of deaf and the definition of hard of hearing. There is all sorts of data collected through CCAR and DACODs, but one of the problems we have is that dhoh is one category. Arapahoe House has just split this category internally so they can track the deaf separate from the

hard of hearing, but one of the problems is that when people are left to their own devices in identifying the deaf versus the severely hard of hearing, the results are very inconsistent. We need to find a way to make sure everyone is talking about the same thing when they say severely hoh, hoh, and deaf.

- i. Anita will be working with all the early adopters to implement some data collection – we can talk to her about how to make sure everyone is using the same definitions.
 - ii. It needs to be something concise and brief, like a drop down menu, so that you get consistency even when you get staff turnover.
 - iii. Arapahoe House collects a huge amount of data, and then that data gets collected and aggregated by DBH, but there is no inner reliability system.
 - iv. Anita will probably go a little beyond just deaf and hard of hearing to categories like late deafened.
 - v. It would be nice for a couple of the people on the service delivery side to participate in Anita's process, to make sure any new ways of collecting are concise and usable. That will be part of the Learning Collaborative effort.
- j. Rebecca Herr has a couple of charts that talk about the different categories of dhoh, from the perspective of employers accommodating different kinds of people—it is a very user friendly chart and deals with functional groups. R Herr can send it to Anita. Having a one pager of the possibilities is a good idea.
- k. We already have a definition of deaf and hoh in our action plan, so we can refer to that as well.

3. Completed Guidelines for Care & Standards WG ~ Next Steps

- a. This is the second deliverable for the DBH contract. The intent of these is not for clinical providers but actually for organizations, to lay out the context the clinical provider would be working in, to make sure the provider can meet the clinical standards. To develop these guidelines of care, many steps were used. A very large number of articles and reports and books were brought to the standards WG and reviewed, and then guidelines drafted and revised through the WG and in one-on-one conversations with experts. The last step is that we sent a draft of the guidelines to 4 experts: Neil Glickman, Deb Guthmann, Steve Hammerdinger in Alabama, and Roger Williams in South Carolina. They provided a wealth of feedback.
- b. For each standard, there is an endnote that pulls out the quotation or quotations from which we got the standards, and a brief summary of the discussion behind the development of the standard. The point of the very thorough citation and background is to make sure people understand why to implement each standard.
- c. Next Steps:
 - i. Create a document that explains HOW to implement each standard. We need to make sure the organizations have the materials needed to education their interpreters.
 - ii. Train administrators.
 - iii. We refer regularly in the guidelines to a communication profile – that needs to be created. The technology WG is working on this.
 - iv. Define the difference between the ideal and the minimum standard.
- d. So there is a lot of work left to move the standards from a well documented set of standard to something that can change the quality of services in Colorado.

- e. Discussion:
 - i. Often guidelines need the will of the consumer to get them implemented. We need to get the guidelines into the hands of the consumers, who can be a force for encouraging the guidelines to be implemented.
 - **Action Item:** Develop a 2 pager summarizing the guidelines for care, with a link to where you can get the whole set of guidelines.
 - ii. We have one center that we know right now is going to follow the Guidelines for Care.
 - iii. Communication profile – that is something that would be helpful for consumers to bring with them every time they go the doctor. We should keep in mind the consumer perspective – and put in some materials that would be useful to consumers.
 - iv. In Colorado we have quality standards of deaf education. Parents don't take all the standards into an IEP meeting, but they might pull out the issue they are dealing with. So although a consumer might not use all of a 40 page booklet, they might find it very useful to have it, so they can pull out the items of most interest to them.
 - v. The Learning Collaborative is going to be a sort of feedback process.
 - vi. The very 1st standard is that organizations shall integrate the dhoh standards in this document into their organizational policies. The idea is that these standards don't just sit on a shelf. To that end, they were written to integrate with existing regulations on such things as seclusion and restraint. It would be interesting to map these against the existing policies at one or two of the organizations, to see how they fit.
 - vii. The issue about ideal and minimum standards: sometimes minimum standards become maximum standards. We need to look at how to incentivize people to do them. We should explicitly talk about how to meet any set of standards – physical plant, personnel, clinical, etc. This may lend itself to a checklist or inventory of how well you are fulfilling the standards. We should generate through implementation a checklist or inventory, to become part of the guidance document.

4. Viewing: RMPBS Video Clip

- a. The Implementation team viewed the 30 second Rocky Mountain PBS clip.
- b. General comments that the clip is very good.

5. Learning Collaborative

- a. Ric and Mary can talk more about this at the next meeting.
- b. There are eight organizations that we have chosen to be early adopters (EAs):
 - i. Arapahoe House,
 - ii. The Mental Health Center of Denver,
 - iii. Addictions Research and Treatment Services (ARTS),
 - iv. Aspen Pointe,
 - v. Larimer Mental Health Center,
 - vi. Centennial Mental Health Center,

- vii. Colorado West Regional Mental Health Center,
- viii. North Range Behavioral Health
- c. We have completed our draft of a Memorandum of Understanding, and have sent them out to each EA a couple of weeks ago. The agencies are in the process of reading through the MOUs and making changes or adjustments. Then we will have an orientation for the EAs. At that orientation we will discuss the MOU and make sure the points are agreed to by all.
- d. In the MOU we expect the EAs to participate in 5 meetings every other month, called Learning Collaboratives (LC), until the end of the Daylight Project. These will be 2 hour meetings, some in person or by teleconference. We also want to talk about sharing services – we will ask them to commit to sharing services and resources to each other.
- e. At our last Core Team meeting, we discussed the first meeting of the collaborative occurring in December, and then kicking off training and the guidelines for care in the new year.
- f. Data collection – we will establish some data collection guidelines for the learning collaborative group, so that during the time they are in the project with us they collect good data we can use.
- g. In some ways the LC is the culmination of all the different things we’ve been working on – what we’ve learned and developed so far – an opportunity to put it into practice.
- h. We will put the LC on the agenda again for next month so that Ric and Mary can get what they needed input on.
- i. Question: Is there a requirement in the MOU for who participates from the LC from each organization?
 - i. Answer: There is a requirement for who receives the different types of information from the LC, different people for different things. The MOU is still getting feedback, so this may change.
- j. Art from Arapahoe House has been working with the Network for the Improvement of Addiction Treatment, which is focused on a change model that requires that the executive of the organization empower someone as the executive sponsor. The model requires a change leader who is specifically focused on producing the change. They have used this change model in a variety of health and mental health settings. It is a model with some structural pieces that increase the possibility of actual change. Is there a way to incorporate some of the principles of this model into the LC by identifying WHO is going to carry forward the change in each organization? Art will send the link to CSI.
 - i. It is really important to have a change agent in each organization to accomplish anything. The Core Team hasn’t talked about a change agent (they have talked about a main contact), but a change agent is an even better idea.
- k. If there is ever a time when we need consumer perspectives in the learning collaborative, the Consumer and Family Work Group would be happy to send someone.

6. Update: Capacity Building at Arapahoe House

- a. This is another aspect of the DBH grant. Art from Arapahoe House will brief us on his work.
- b. Arapahoe House has been recruiting for 2 providers, and have hired one so far. The new hire has a CAC 3 and is bilingual and severely hearing impaired herself. Arapahoe

House has the person set up with an i-phone with the capacity for video conferencing. She has a couple of different office locations, where we have the highest demographic distribution of dhoh people.

- c. Arapahoe House had also recruited someone else who is deaf and also fluent in written English and ASL, but that person had a family emergency, so they have reopened the position.
- d. Arapahoe House is separating deaf from hoh in their tracking system, as was mentioned earlier. They believe that they under-report right now, and would like better numbers. Our target is to have capacity by January of 2011. The current data says they have had 19 admissions. 16 of those have been in detox, 6 have been in treatment, and 4 of the people in treatment are deaf and 2 are severely hard of hearing.
- e. Question: What are the overall numbers at Arapahoe House?
 - i. Answer: About 20,000 admissions. For unduplicated admissions, it is around 15,000 admissions. The largest volume is in detox.
- f. If you look at the DBH numbers for the deaf and hard of hearing who have sought services statewide, it was 65 people, and most of those people were served through Arapahoe House. Unduplicated, the number was about 590, so there is huge under-reporting.
- g. Question: What is the minimum age you serve?
 - i. Answer: zero. We have detox mostly with adults and some adolescents, a program for pregnant women and postpartum women, women and children's program where the kids range up to about age 12, also adolescent outpatient program. The minimum age for the adolescent program is about 12 or 13.
- h. The person Arapahoe House has hired is hard of hearing, and she will work closely with both deaf and hard of hearing consumers. The second position will work with deaf consumers also. Our hope is that they can work together and be a team. The problem is that Arapahoe House operates 24 hrs a day 7 days a week, so they need to be able to switch off.

7. Updates and discussion from work groups

- a. Consumer & Family – Training Modules. Rebecca Herr.
 - i. On November when the group met, we had the 1st look at our 3 modules. One is for consumers in dhoh communities, and one is on mental health and substance abuse issues, and one on personal and community advocacy.
 - ii. Ann Tinkham, the instructional designer, joined the meeting, and since then she has met with 2 of the 3 module leads, and taken over those modules. We are in the process of getting input from her.
 - iii. Next steps:
 - Revise the modules and have them all ready by 12/31.
 - Develop the supportive materials – handouts, resources, things that go with the trainings.
 - iv. Coordination with the other Work Groups. We need to gear up for the training process and need interaction with the other Work Groups. We would like to work with Anita and the Assessment Work Group on the pre and post test, as well as have input into the Training WG.

- v. It would be nice to standardize – to have consistent look and wording across all the modules and products. Perhaps there needs to be a finishing step to make all the products consistent.
- vi. Developing consumer advocates. We need some short materials explaining what we're doing.
- vii. Use of consumer advocates in the CAC Endorsement Training. We'd like to have as a goal to use the advocates in the trainings. It is very empowering to have any impact on a group. Build opportunities for action into the training opportunities.
- viii. Re the Sustainability WG – R Herr reviewed the goals of the work plan – we are supposed to develop a statewide network of advocates. Developing advocates is an ongoing process that requires some resources to keep doing trainings and paying for expenses like communication access. Once the grant runs out, that is an issue. The Sustainability WG needs to talk about how to sustain this effort. There are lots of grant opportunities for improving access to health services – there is a whole category of access to health services on the ARRA. Verizon has a community grant re access to Health Care, and CIGNA and Walmart also have grants.
- ix. Can the Consumer and Family WG can think about providing training about DLP to organizational members? Yes! Doing presentations to consumer groups is very important. It is really tough to training people to become advocates – you've got to have the ability inside of you to be an advocate. DHOH people already have identity problems – they need to work through that before they can become advocates. It is a big challenge.
- x. Our work plan leaves it open what the consumer advocates will work on – which is great for future grants – we can tailor the outcome to the funding priority of a grantor.
- xi. We are coming close to the time to task to core team about the “Where” of the trainings. We are a statewide project – we need to brainstorm about where to start. The Core Team is meeting next week on 12/9 – we can begin discussing the where. Ami can pass along the information to the core team.
- xii. Thank you Rebecca Herr for all the work you've been doing!

b. Sustainability

- i. The Core Team was delegated the responsibility for developing a Sustainability WP – is that ok with everyone? Yes.
 - **Action Item:** The Core Team will bring a rough draft of the Sustainability Plan to the Implementation Team when it is ready.
- ii. Right now Mary and Ric are overwhelmed, but the Core Team will be ready to develop the Sustainability Plan in January. CSI is helping with this. Quinn is gathering information from out of state organizations and will bring that to the Core Team.
- iii. Rebecca Herr is willing to help with chasing down grants. We are in the meat of all of our project work right now, but these grants have a lag time with applying. There is a fear of running out of money just as we get momentum going. What do we do about this? Got to keep an eye on some of these deadlines! If an opportunity shows itself, we should take advantage of it. We do think we need

a clear plan for sustainability before we move forward. We also need to define our education and Technical Assistance center.

- iv. Simple sustainability of the grant activities and products – to continue to engage the advocates, to continue to have a network of providers and EAs, continue to provide the trainings developed through the project. There is also more to it – the action plan says that although at the moment we are working on MH and SA in MH and SA settings, the action plan is about MH and SA in all settings - primary care, JJ, criminal justice, etc. This is a very different set of funding. The RWJ grant is really more about implementing the action plan, not just daylight. There is a chunk of the next core team dedicated to discussing how to implement the remaining portion of the action plan.

- **Action Item:** As anyone finds grants, please send them to the Core Team or CSI. The smaller the grant, the less it is worth the staff time to write the grant, so perhaps nothing less than \$25,000. However, please do send any grants of \$25K or more, even if they are for a focus larger than MH and SA.

- v. RWJ Proposal

- One of the grant opportunities CSI identified last week in an RWJ foundation request for proposal. RWJ has a short proposal due Dec 14th (5 pages), for a very interesting program. The call is for the new consumer engagement key to quality health care. There are two levels of consumer engagements:
 - a. Individual level of consumer engagement to show the grant would evaluate and implement how consumers would have more of a voice. The voice could be initiated by either provider or consumer.
 - b. Community level of consumer engagement – strategies for consumers to be leaders.
- RWJ has a very high level of commitment to breaking down language barriers.
- RWJ grants are very competitive and it is very tight timeline. The proposal is specifically about implementing existing tools, so we'd have to finish the tools within Daylight.
- Does the whole Implementation Team want to see the draft? More input is better!
- Is there a way to include some connection to primary care clinic systems – a pilot with primary care in the grant? One of the populations with the greatest difficulty accessing primary care is people who are chronically ill. It is a 3 year project. What about proposing in the third year to expand beyond MH and SA to primary care? Individual level – use of technology, text messaging, etc. Jewlya and Art will follow up to discuss this.

- c. Evaluation

- i. There is an Evaluation WG meeting next Wednesday, and we are looking for consumers or family members to participate. The person we had who was a consumer is out of state and not able to commit regularly. If you can think of

anyone who might be interested, please give them Anita's contact information:
focuseval@comcast.net!

- ii. Other things the Evaluation WG has been working on: a lot of reports, key informant interviews. We will continue to interview if names appear to us.
- iii. The Evaluation WG is also working on the Consumer & Family interview report. They will send it to the Core Team and then present some findings in January to the Implementation Team.
- iv. The Core Team will be having its site visit with Kelli from SSUF next Tuesday. Wish us luck!

8. Announcements:

- a. Hands and Voices is part of a new coalition looking at dual diagnosis of autism and deafness. As a result, the CDE is created an advisory board on dual diagnosis – they want to ask if there is an expert interested in serving on that board?
- b. We will be having an Implementation Team Meeting in January, on the 1st Wednesday.