PRESENTER 1: 1 of 10 regional centers and 6 international HIV-focused ATTCs were funded by SAMHSA, the Substance Abuse and Mental Health Services Administration. As you can see from the slides here, we cover the great states of Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. This is the first webinar in a two-part series on implementation science.

Dr. Molfenter will tell you a little bit about what it is and how it applies to your work. All of these webinars will be recorded, and they'll be available for viewing after the webinar after today's live presentation. A little bit of housekeeping for today-- today's audio i is broadcast through your computer speakers, so make sure that they're turned on and up.

There's no call-in number available for today's recording. You can ask questions using the chat feature that's at the bottom of the screen. And we'll also have a Q&A session after the presentation.

Today's presenter, Dr. Molfenter is, as I mentioned, the director of the Great Lakes ATTC. And he also has-- I'm sorry, also director of NIATx, based at the University of Wisconsin Madison. Dr. Molfenter has more than 20 years of experience in managing research projects and organizational systems change efforts focused on improving the implementation of evidence-based practices. And with that, I'll turn it over to our presenter.

TODD MOLFENTER: Thank you. Thank you. OK, I'll go ahead and get started. This is Todd Molfenter, with the Great Lakes ATTC. And I'm very excited today to talk about a subject. It's really interesting.

It's a subject I've been involved with, as Maureen said, for the past 20 years or so but really have only called it implementation science the last maybe 5 or 10 years because really what I have done in my work is organizational and systems change. And that can be changes to processes, and it can be changes to how people deliver services, clinical or administrative. And what's really come in more vogue, if you will, the last 5 to 10 years is this whole notion of implementation science being a science. And I think that's good because I think it puts research behind it, and it gives us things we can learn from.

So why-- well, first the one I just describe a little bit, a brief description of what implementation science is. And then we can talk about a few other items. But in its basic definition, it's how you go about implementing either a practice or a process. And there's different models for it. There's different approaches.

But really it's about how do you implement something. Or in a more general sense, how do you change something? Because usually you're doing this in an existing system. So why implement-- the loss of sound there. And OK.

So why implementation science? And I think that's about where I was when the sound went out is really how the whole-- the purpose of the whole field is really providing better care. And where the field emerged from was there's this tremendous gap in evidence-based practices that were being generated. And in looking at-- in fact, I was just talking to someone who was at a mental health conference in Maryland, where they're talking about evidence-based practices and penetration rates and how much people are using them. And so really the whole implementation science field really sort of was focused on or has sort have arisen around trying to implement these evidence-based practices.

But I think what sort of attracted me to this whole area is just wanting to provide better care. And I think as someone who is not a clinician, is actually an engineer by training, I appreciate that the clinical care can be improved and also, sort of, the processes that surround it. And we'll talk about that a little bit more here. And with the implementation science, while we do have clinical evidence-based practices, what we don't have is administrative evidence-based practices.

But through the implementation science field, we're starting to get more and more of those. And I'll talk a little bit about things that seemed to have worked and things that aren't working so well later on in my discussion. But really the practical issue is, and the issue I want to talk about today is this whole notion that the implementation science is not very easy. And a lot of folks I talk to out in the field say, wow, this is more difficult than I thought it would be, trying to get these changes in place. And quote unquote, "this is not what we signed up for." And so really what I want to talk about today is what are some of those barriers, and then the ways to overcome them. And so why the gap?

Why are these gaps is it's not easy. And if you're a person that's like, well, really, in our organization, it's quite easy to implement changes, you're a person that should be helping me talk here because it is not easy to do. And so let's talk about some of the reasons why it's not easy.

Well, actually, before we do that, I'd like all the folks on the call to please respond to this survey over the next couple of minutes or just the next minute or so. We'll do that real quick.

OK. We'll just do another 30. And this is just a question to see what kind of implementation projects people are working on. And you can pick more than one for this.

That's why you're the percentages aren't lining up exactly. And it looks like a lot of folks have voted. So improve opioid care is a big win. Improve access to care, yeah, that's certainly an important issue. Improving clinical practice. Some people want and implement new technologies. And then actually what's very interesting to me is very few of you do not have any implementation projects right now. And so it shows, sort of, the timeliness of the subject. And shows you where our field is right now, too.

There's a lot happening. And I think there was a time organizations could afford to sort of stand still, and that's no longer the case. OK. To move on-- I'll go back to the presentation here. And so why the gap?

And what I want to talk to you about is one of the main models around implementation science and research is what they call the CFIR model. It's Consolidated Framework for Implementation Research put together by Dr. Damschroder in 2009. And what she did when she put this together was sort of say, OK, these are the different areas you need to have in mind as you're thinking of these implementation issues. And I want to go through each one of them and just sort of describe a little bit how they made the list. And then, from there, we're going to transition into well, OK, great, Todd. You've told us where issues can be. Now, it'd be really good if you could tell us ways to sort overcome those.

And so let's take one thing at a time. And from that chart, I'm just going from left to right. So characteristics of the innovation-- I think just to simply say it is, is I think if you're thinking of some of the things you've implemented in the past, some are easier than others. And really what we sort of look at quite a bit is just is whatever we're trying to implement A, is it is it complex? In other words, it really takes a lot to get it in place.

Or B, does it does it take a pretty high level of skill? And I think with either one of those, you can create some barriers, just the nature of the innovation or the practice or what have you itself. And I think the other thing we have-- and so you sort of have this complexity skill issue around some innovations. And then the others is just quite simply, people tend to like some practices more than others.

You probably have seen that, in your own experiences, some things are easier than others to implement and just because people like them for whatever reason, whether it makes their job

easier or if they feel like it leads to better outcomes, what have you. And so that's something we'll talk about a little bit here is this whole notion of the innovation itself and how to reduce that as a barrier for you.

The other-- going across Dr. Damschroder's items is the other's outer settings. And with there, there's the general sense that-- I mean, what this covers is everything outside the organization. And some of the things that are covered there are things like the opinions of others, and is there a trend?

Like, right now quite a view few of you are working on opioid use disorders. OK, part of that is probably the populations you have coming in. A lot of that is probably due to things like STR in your states, the things you're seeing on the media, and saying, well, this is a pretty big deal.

Another part of outer settings that I think is obviously pretty basic and important is the innovation or practice that you're willing to implement, is it paid for? And then also, is there, sort of, regulatory barriers, things like it's not part of the state's licensure rules for providers to provide. Or if it's a medication, back in our early days of MAT, is it on the formulary for Medicaid, things that make it so it's like, well, we really can't do this because of this rule.

Or if you're not going to get paid for it, that always can be a challenge. The other thing that where barriers can be is with individuals involved. And how I usually hear this is it's like, OK, Todd, we're having trouble implementing this. And I say, well, tell me more about that. And I'll hear-- the key word I'll usually hear around this is buy-in.

We don't have buy-in from clinicians. Or we don't have buy-in from certain people. And so that's part of all this is the, for lack of a better term, the sales job. Do people like it? Do they agree with it is one issue.

So it's sort of an opinion issue. And the other is, is whether or not they can do it and whether or not they have the skill and the like. And just a real relevant current example, which is becoming less current-- it was a very big deal five years ago when we were starting this-- is with MAT implementation.

That was a huge concern of individuals currently in the field, counselors and the like, saying, hey, we're replacing one drug for another. And really over time, there's a lot of education examples, coaching and the like to sort of show the benefits of MAT and how it can be helpful. So this whole notion of we really need the people who are going to be actually doing the work

buy into whatever we're doing is very important.

The next item is what they call inner settings. I call it the organization. And I think there, I look at things like does the workflow support it? Does leadership support it-- a big, big, big issue. Administrative leadership-- like the executive director and things like that. And clinical leadership-- if you have physicians involved with your organization, are they supportive of it?

Clinical supervisors, are they supportive? And those are some key issues, as we all know. And we know if those pieces aren't in place, that the job of implementation can be much harder and sometimes even impossible. And the other thing, too, with the whole organizational piece is organizational capacity and resources.

Capacity, here with the NIATx work we do, capacity just for organizational change-- are you an organization that's good at that, has a model for organizational change and can approach that when you need to? And do you have some resources available for organizational change, some money for training workshops? But really the bigger issue is this sort of time to work on it. And organizations who are constrained that way have greater challenges with implementation. And you don't need a lot of those kind of resources, but you certainly need some. And then the last thing on Dr. Damschroder's list was the implementation process.

I think I just sort of mentioned this earlier. But really within your organization, do you have, sort of, a competent process for implementing innovation? Are you an organization-- and I'm going to talk about this and a little bit here. Are you an organization that's good at that or maybe not as good at that? And without a good implementation process, that can certainly create some challenges as well.

So those are the different pieces. In talking about that, we-- again, I'm sort of putting in there sort of-- first of all, I wanted to give you, sort of, the dimensions of implementation science. When an implementation person is approaching a situation, what are some the different areas they're considering and thinking about? So I think that's important.

And then what I want to talk-- and then within each of those areas-- and we're starting with the poll here-- is in your own organizations, where do you find the biggest challenge in implementing a new practice? And with a lack of organization support, that can be leadership often and executive leadership. And this is really interesting is as you're completing this, as we had last time, there's not a clear one.

Yeah, except for item is too complex, not as much of that as an issue. That's actually good. It probably shows good discretion in choosing issues. And I'm glad to hear that purchasing and regulatory aren't as big because those are harder to get at.

But obviously, based on the polling, they're certainly there. OK, I'm going to give it about 10 more seconds here to get the last votes in. And then we'll move on. And it seems like that the two biggies are around organizational support and support from key clinicians.

So let's sort of-- we'll talk about that more as we proceed here. That's good to know. So let's talk next about, OK, with these five areas around implementation, what are ways to approach?

What I'm going to key off of is work that's about 20, maybe 25 years old, called the *Diffusion of Innovations* by Everett Rogers. And what he did is look at all the evidence at that time around implementation. They didn't call it implementation in science at that point.

But by doing that, he did it in a way where there's just a lot of practical lessons that either the way he defined and looked at things or ways to approach things, that I'm going to apply to those five areas. And really with implementation science itself, even that model, the Damschroder model I was describing earlier, this work heavily influenced that model. So this is sort of that around-- I would call this, sort of, the bedrock of the implementation science field. And I think as a person who's in this field for good reason because it just gives us a lot of practical items to consider as we're approaching this.

So how Everett Rogers began all this work is he was actually an agricultural extension agent the back after World War II, back that far in '50s and '60s. And his job was-- in the '30s, historically, if you go back, there was what they called the Dust Bowl in '20s and '30s, but mostly in the '30s, where the way our agricultural practices were in such a way, that plants were not very drought resistant. So when drought came, plants would die.

When the plants would die, there was no roots in the soil to hold onto the soil. And then when winds would come, you'd have this these terrible dust storms. They were very bad on the environment. And it made it inhabitable for the people to live there.

So what's the answer to that? The answer to that was drought-resistant corn. And there's these-- and so they figured out the answer.

They have an evidence-based practice, if you will. And their job was then to go out and get farmers to use these new corn seeds. And these farmers, who had been planning a certain

type of corn for years, sometimes decades-- and so these people who were here to go out and change their minds were what they call these agricultural extension agents. And their job was to go from farm to farm and talk to the farmers and talk them into using drought-resistant corn. And every time I think about this story, I think of, like, some farm.

It wasn't like they could do an email and sort of set up an appointment or even set up a phone appointment even. I mean, they would drive down the road to this farm, find this farmer, basically pull them off the tractor or whatever they're doing, and make their pitch about, hey, you should really be using these seeds over here. And as you might expect, that was not an easy task.

They learned a lot from that. And they learned from other types of implementations. And a lot of implementation science knowledge comes from trying to implement items in third-world countries and the like. And so let's talk about some of the things that Everett Rogers discovered.

First thing, he overall discovered and realized that there's what they call, whether it's farmers implementing corn, whether it's clinicians using MAT, or maybe motivational interviewing, whether it's you and I using cell phones, there's a diffusion curve that's pretty predictable. Now, whether these percentages are exactly right, eh, we can tweak that here and there. But there's a group of folks who are the innovators.

These are the folks who are-- and you probably, if you think of your own lives, your own social circles, they're the first to get the newest technology. They're the first to try new things. And in the end, these people are really important because they get the curve going.

They aren't always the most influential people because they're often seen as sort of the little wacky folks sometimes. That they go out and are trying everything that comes along. But they do get the diffusion curve going.

Next comes the early adopters. And these are the people who are watching these innovators and saying, wow, a smartphone looks really great. I want to use that, or I want to-- you know, Snapchat looks really great. I want to use that. And they start using it. And this is the group that really gets the whole thing going because they tend to be more people that are quote unquote, "mainstream." And they get that they get the whole thing moving. And then the early majority is they see these early adopters doing things, like using motivational interviewing or

just whatever practice you want to insert there. And then that sort of gets the whole thing going.

You get the early majority, late majority. And the last is you always have a group that just will hold on to the current practice as long as they can. And so they're like, OK, I'm going to go get a cell phone or whatever it might be. And those are quote unquote, the "laggards."

What I'd like to do is go on to, I believe we have a survey here, where I'd like you to-- I'd be curious just based on sort of your impressions, would you consider your organization an innovator, an early adopter, early majority, late majority, or laggard? And if we could just sort of get an idea of what people are thinking. And in fact, you guys are sort of following the diffusion pretty good here, although we have more innovators than you would expect, with a normal distribution.

But maybe the group who wants to be on this call and learn more about implementation science are sort of an innovator group to begin with. And so let's-- we'll take another 10 seconds here to see what else. But it looks like we have a pretty innovative group overall. And that's great. So it's a pleasure to be presenting to you.

Moving along, let's talk about how this Everett Rogers guy can help us move through this diffusion curve quicker. So first, the characteristics of the innovation-- whenever we're designing innovations here or items here, we always want to make it as simple as we can. For those of you who know about NIATx, we developed the NIATx model.

We spent months and months on trying to make that as simple as possible, as few steps as possible, as intuitive as possible for people to do because why? Because when we are asked by the Robert Wood Johnson Foundation and SAMHSA to start doing this within the behavioral health field, we had already had a lot of experience in general health care, where there was these complex models that people just didn't have the patience for, truthfully. And so we were trying to make it as simple as possible. And so as you're thinking of items that you're going to implement, try to make it as simple as possible-- simple in the number of steps, the number of things you have to do, the amount of time you have to spend on it.

Anything you can do to simplify what you're trying to innovate, that's going to help. These next four bullets are items that Everett Rogers would say, hey, these are things that if you can make this happen, it will be easier to implement your innovation. Now, the first is relative

advantage. And quite simply, is what you're trying to implement superior to the current practice? And there's different ways for it to be superior. And what you want to do is with these innovators and these early adopters is talk to them and find out why they think it's better. And then that gives you, sort of, your stump speech or your elevator speech to say, hey.

I mean, even just from the MAT world, people were having a lot of trouble with the use of buprenorphine because of diversion and things like that and one drug for another. And then what they would hear is from other clinicians that, hey, my patients that are on buprenorphine are starting to show up for group much more and are able to participate better and things like that. And patients, giving that kind of feedback, that's the relative advantage. And there's other kinds of relative advantages.

There could be customer satisfaction. There could be financial advantages. But being able to identify those advantages in whatever you're trying to implement and make that as part of a communications strategy to get others involved is really important. Trialability. Basic NIATx principle is you want to pilot test things and try them.

Why we advocated for that is we found that if you go and say, hey, Sue or Joe, you have to implement this. This is the best. We've evaluated it. Please don't ask any questions. Just implement it. People are like, well, wait a minute. You say it's the best. How do I know it's the best? And then that's where we have this whole notion of just you want to test things.

Observability is very important, too, to be able to observe people using the practice. I'm sure for the farmers initially, there's a drier year. And the farmers who had the drought-resistant seeds had better crops.

The farmers would drive down the road and say, wow, farmer Todd seems to have better crops. Why is that? Well, he's using that corn. That guy that drove down the road a year ago actually sort of did know what he was talking about. And adaptability is the ability. And it's really interesting because I know when you're doing evidence-based practice implementation, they talk about fidelity.

Fidelity is important to a point. But you also need to be able to adapt the innovation or practice or whatever you call it to your organization. And in doing that, why do you want to use fidelity? You want to use fidelity because that's going to be better for outcomes. And maybe retention is an outcome.

Well, it's like, OK, let's adapt this a little bit. Let's look at our retention just to make sure by whatever we did doesn't jeopardize the main intent of the evidence-based practice. And I think what that helps is, is it helps with acceptance is when you can be adaptable. Very good.

So those are just some of the things around the characteristic of innovation itself. Outer settings, frankly, this is harder to control. What you can do with it, and I say, find the leverage points. What you want to do with it if it's a payment issue, is there ways to get money for it through grants, through different kinds of reimbursement?

I mean, we had a whole effort around finding ways to get involved with insurance plans and things like that. So outer settings, of all the boxes, this is probably the hardest one because it's the one you have the least control of, right? But it's not impossible.

But you have to do some strategies, sort of, from outside the organization. And sometimes those are possible. Sometimes they're not. And just you have to figure out where you can make a difference, whether it's payment or regulation or what have you. And sometimes, frankly, there's strength in numbers, as sometimes you have to pull together with other organizations and agencies to sort of make some of this happen and frankly, take advantage of existing trends.

The opioid epidemic is huge. Most states have governor task forces that are trying to get things done. If there's certain things that could be helpful in preventing and treating people and preventing overdose deaths, that could be a leverage point, if you will.

Moving on, the individuals involved-- here at the ATTC, we spend a lot of time with this, as you have, and particularly around clinical practice, you have-- all of us are very used to what we're doing. We're comfortable with it. We wouldn't be doing it if we haven't gotten some feedback that it's working well. And so when it comes time to do something different, we need knowledge.

We need to know how to do it. And often that needs to be done through training, whether it's classroom training and sometimes with some individual coaching. And then also we need-- beyond knowledge, we need the skills just to be able to do it. And then there's this whole term they use around this called self-efficacy, right?

Many of you know what that means. But it's basically just the confidence, making it so people are confident in providing the task. And so a lot of-- when we're trying to get people set up in

new practices, as you're trying to do that in your organization, think through how can knowledge and skills be developed. And really, for the evidence-based science, one of the main findings so far is training alone typically is not sufficient for individual and organizational change.

It's critical for building knowledge. It's critical for building awareness. But often, people need more than that. Whether it's case management reviews, whether it's anything where you're just doing more team-- at NIATx, we have team meetings once a week, once every couple weeks to give people a chance to sort of think through next steps and say, you know, wow, this isn't working here. What can we do to address that? Or wow, I was going to implement it with this patient or in this situation, and I wasn't comfortable with that. So how do I improve that?

With all this, what's a big issue is persuasive communication. And the literature's been pretty solid on this for a while now. And you'll see it. Now that I mentioned it to you, watch commercials. And in the commercial, you typically would you want to do, what a marketer wants to do is when they're going to market to a person, they either want to have a person who can be identified as an expert-- the classic is the sports star talking about the piece of equipment they use or someone like you.

If you're, let's say, what do you call it, an amateur golfer, to have someone else, it's like, hey, this is Todd. I'm an amateur golfer like you. And once I got this new putter, whatever, it made me great. And so what that means in your world is bringing people in who can be seen as experts or particularly in the physician realm, having peer-to-peer discussions. And then also, around the whole individual issue is this notion of finding and cultivating champions.

I like executive champions. In our NIATx work, we ask for executive sponsors. And then really for a lot of MAT work we're doing and the like, we're looking for clinical champions and then ideally a physician. And so finding these people-- or even like in health systems, more and more, addictions and behavioral health work is happening there, finding champions in those settings.

Champions are helpful. They're not always possible. But when you can find them, when you can cultivate them, if you will, it can really make a big difference. And Everett Rogers called these people change agents and opinion leaders and things like that. And they definitely can make a difference.

Approaches to use around persuasive communication-- a couple that work well. One, you know from your own world, motivational interviewing works. It works in a variety of situations. We have a motivational interviewing trainer here. She'll be talking to people in homeless shelters. She'll be talking to dental groups. She'll be talking to behavioral therapists.

There's a lot of applications and frankly, using some of the concepts of motivational interviewing and not trying to do the full piece that you do in clinical therapy. Another one is what they call academic detailing. This is something you can look up and learn more about. And it began as a practice to use-- the pharmaceutical sales would use in talking to physicians. And really, it's a pretty compact practice, where you go and say, this is what I'd like to present to you today.

This is what we feel is a relative advantage of this. Here's some ways to use it. Here's some other people who are using it, if you can do that, and academic detailing. And earlier, it was said, wow, we have some leadership, other kind of buy-in issues. These kinds of persuasive communications are ways to begin to get at that.

Within organizations, things that we within the NIATx model, we have five principles we use. And three of those principles are here. One is leadership support.

Earlier I mentioned this whole notion of an executive sponsor. It's very helpful. And I know. I talk to people all the time. It's like, well, I'm not an executive. I think this is really important. How do I develop that? And I think it is have to either through yourself, through some other kind of champion, develop that or through waiting for external sources sometimes. But the leadership support's important.

Using a change agent-- a change agent, very ' similar to the corn example, you need someone who's going out and talking to the farmers. In the NIATx world, you need someone who's working the change project. They're sort of the point person. They're the day-to-day person.

They'll go to the executives sometimes for help. But they're the ones making things happen. And without this person, it's sort of hard to create that momentum and forward motion that you need on some of these. And change agents are important people. And it's an important skill.

In organizations, you know, fortune 500 companies around the world now, they have this Six

Sigma training and things like that that's basically training people how to be change agents. And if you can do-- and then that's usually a part of promotion. And sort of the thought is if the person can be an advocate for change, that's the kind of person we need in our leadership ranks. And then the last one is just around inner setting, certainly don't forget the customer and use the customer as a way to sort of guide your approach.

We in the NIATx world, we talk about walk-throughs. If you're doing a clinical practice, some of the clinicians are going to be customers, so getting their buy-in. And ways to get buy in is some of the things we talked about earlier. And then also just talking to them about it is just a real simple approach.

A quite a few of you are working on access. And a lot of times a lot of people are like, wow, if we improve access, is that going to be more people are coming in? And what does that mean? And I think just to be able to have some of those conversations of why should we improve access? Well, we have more people in care. OK, so let's focus on that and see if we can make this other piece work. So inner settings, those are some of the things that I think are pretty important.

Implementation process-- one must first learn by doing. Though you think you know it, you have no certainty until you try. The wise Sophocles said this. And really, I mentioned this in the last slide. Doing walk-throughs is important. Doing patient simulations is important.

For clinical practice, doing role plays is important. And really, for adults, adult learning, it's experiential. And that's just so important.

I think an implementation process, too, the things that I would encourage you to do within your organization is use a structure change process when you can. You can use the NIATx model. There's all kinds of models out there.

I would just pick one because that just creates some-- the evidence shows when there's a structure change process used, the chances of successful change are much greater than when people are just trying to just do it through intuition, committees, what have you. And so use a structure change process, if at all possible. Learn from others.

Learn from others. If someone else has already implemented the practice or what have you, one of the NIATx principles is get ideas from outside the field or outside your organization. Learn from others. Quite a few of are innovators. So you'll be the first out. But when you're

not, you can learn from others, and sometimes it makes the path easier.

Things that we find to be helpful is to actually do set a target of what you want to accomplish. I think this creates focus. It creates accountability at times. And with that focus, you have a measure.

Some of you were saying wait time, again, just to pick on that one. Look at-- I mean, excuse me, access, measure for that. A good measure for that is wait time. Another potential measure for that is no-shows. If they're not showing up, that's an access issue, too. And then as you're doing the implementation, the change project, whatever you call it, collect data on progress to give you feedback. And as you're trying to impact that, use pilot tests whenever you can.

OK, what I'm going to do in the last portion here quickly before I wrap up and open up to questions is apply some of this to MAT use more above and beyond some of the things I've already mentioned and so just to give it some application. First, as you're going to implement MAT, keep it simple. Keep it simple. Keep it simple.

There's plenty-- we've worked with over, like, I think, 100 organizations now on MAT implementation. And there's definitely complex and simple ways to do it. The simpler, the better. It makes it easier on workflow, you know, for buprenorphine, how you're doing initiation. For diversion prevention, how are you doing some of the things around that?

Make it simple. Avoid complexity. I mean, you have to do initiation induction, obviously. You want to do some kind of diversion control. But those are tasks you have to do. But there's simpler and more complex ways to do it.

Make it observable, particularly if you still have clinicians who are aren't sure if it's a good idea. There's nothing better than patients getting better to convince people. And then for doctors, too, you know, I think doctors are worried if they start doing MAT, their practice will be overrun by certain kinds of people and they're going to have all these complex cases they don't know what to do with. And there will be some complex cases in there. You can't deny that.

But I think for them to observe and talk to other physicians who are working with MAT, I think, would reduce some of that anxiety. And then what we do in our projects around MAT is reduce prescriber burden whenever we can. There's a lot involved with MAT, particularly the diversion part of it. And if you're asking or expecting the prescribers to do that or be accountable for it, it's a much harder sell. And so as far as reducing the characteristic of innovation, that's one.

Outer settings-- getting MAT paid for, there's more and more options for this. There's STR money out there. And there's more money coming out every day around the opioid epidemic, so to speak. Find ways to get it paid for because it's not cheap, and it's not sustainable if you can't do that.

Individuals involved-- for prescribers, physician-to-physician communication. In Wisconsin right now and other states, there is a whole ECHO initiative, where physicians can see different case examples. And I think that's a great way to do some training around this.

Counselors, the MAT piece, frankly, it's this understanding what some of the side effects are and what some of the issues are. But I think the training there is possible. And where we spend a lot of time in training now, too, is the people who are doing intakes or doing other kinds of screenings.

We find organizations where those folks are bought into that MAT. And then they're like, well, wait a minute. We've got physicians who want to prescribe. We have some counselors who are behind it. But we're not doing it in MAT. Why is that? And a lot of it is what's happening as a patient is first or a consumer's first hitting the organization.

Use champions. I mentioned this earlier. In this world, clinical champions are very helpful. So use them. And certainly there's enough people doing this now. Use mentoring and ECHO training and things like that whenever you can. And I would I would also say just for the MAT piece, too, is just we've had a few collaboratives around this. And there's definitely steps to follow that can make it easier, easier either to implement or more so where we're running into more now is people are like, well, we've started doing this. But we're not doing as much of it as we'd like to and just sort of looking at capacity expansion.

So to summarize, first of all, implementation is a science. It's emerging. Things that we are finding helpful is training alone does not work. What does tend to work is coaching of some sort.

Using structured models to implement things does help. And those are three things you can put your hat on. It's not always easy. Change isn't easy. You guys deal with this every day with your consumers.

But it can be made easier with some of these things we've talked about, having just some of

these nuggets that Everett Rogers has provided us. And by doing that, reduce barriers caused by the innovation characteristics. Make it simple. Develop beliefs and skills. Make it so that organizational processes are supporting the change and use the best implementation approaches you can and learn from those because that's a continuous improvement cycle in itself.

What I'd like to do next is see if there's any questions. And then-- great. So I'll stop now and see if there are any or what questions you have. Also, what I will say, too, is we are in the process of putting together an opioid use disorder MAT learning collaborative, or whatever, or technical assistance effort to help organizations implementing and/or expanding their MAT capacity. If you are interested in being part of that, please email me at todd.molfenter@wisc.edu.

Having said that, through the chat box or otherwise, what questions do people have or comments, too? I mean, some of this-- I see some of the names here. Some of you could certainly add to this discussion in a very credible way.

And we will have the slides available. Mulitple attendees are typing, so we'll wait for some of the questions to come through. And it looks like the way I'll take these is through the chat box.

Michelle, thank you for that feedback. Appreciate it. And again, like I said, we've done-- I think we work with about 100 organizations on the MAT piece right now. So we're not-- it's not perfect. It's a challenging process because of workflow issues and buy-in and things like that. But we've gotten pretty good at helping people implement, expand it. So please, if you're interested in more of that, please let me know.

Scott, I cannot believe you asked the question about coaching competency. And actually, I mean, that's an issue. And I probably should have clarified this as I presented. Coaching is helpful. The intensity and style and the like, things are still emerging around that. And so to say more about that, I really can't-- just to say evidence-based practice, per se. And I wish we could turn your mic on because I'm sure through some of your work and the like, you have things you at least have preferences to.

Yeah, and Julie, thanks for telling us about your work at the St. Mary's in Duluth. And that's a really, really important area. And hopefully you're able to identify moms with opioid issues and engage them, most importantly, because it can have a huge difference with outcomes and

things like NICU days and things like that.

Yes, and there is a lot of stigma. And I think that's some of the-- I didn't talk about that a lot. But thanks for raising that. I mean, when we talk about individuals, the individuals, as you're trying to reach out to them, particularly pregnant moms, is there will be stigma, shame there. And using some of these different communication approaches to help reduce that is going to be critical. And then I think overall I was just in a meeting yesterday with a Nora Volkow, from NIDA. And we were talking about ways to address the opioid epidemic and reduce overdose deaths. And it was interesting.

We talked about a lot of different things. But one of the things that Nora is very interested in working on is reducing the stigma around opioid use disorders and addiction, use disorders overall. And in the context for that was that a lot of what they're using to address the opioid epidemic they're taking from how the AIDS and HIV epidemic was addressed 20 years ago. And at that point, a fair amount of stigma reduction was accompanying that. And so the people who are wise about this and work at a higher policy level realize that that's an issue and are thinking of ways to try to address it.

We all have opinions about that. But I think this overall need to address it is really important. So thanks for raising that, Julie. OK, so if there's no other questions, we will wrap it up. And appreciate everyone's time. And hopefully you found this helpful and good luck with your work.

Actually, we have a few folks typing, so I'll hold on. Martin, then, thank you Martin. Appreciate that comment.

PRESENTER 1: And while we're waiting for additional questions--

TODD MOLFENTER: David Moore is typing around the coaching issue. It would be great to get his input. He's one of our great-- one of our competent NIATx coaches. David, thanks for that feedback. It means a lot for me for you to say that. I have a lot of respect for your opinions around this subject. Maureen, I'll turn it over to you.

PRESENTER 1: Well, it looks like we don't have any additional questions right now. And we'd like to thank everyone for joining us today. We'll give a few minutes for additional questions. But we want you all to know that we'll be offering 1.5 CEUs for your participation today. And the recording will be available on the Great Lakes ATTC website, along with a PDF of the PowerPoint slides.

Well, thanks for joining us today. We're signing off now. And part two of the implementation science series will be taking place in July. Watch your email for more information.