Closing the Quality Gap in Michigan:

A Prescription for Mental Health Care

August 2004

Contents

APPENDIX A: Evidence-Based Practice Project Roles and Responsibilities
APPENDIX B: Record of Meeting 1
APPENDIX C: Record of Meeting 2
APPENDIX D: Record of Meeting 3
APPENDIX E: Record of Meeting 4
APPENDIX F: Record of Meeting 5
APPENDIX G: Record of Meeting 6
APPENDIX H: Record of Meeting 7
APPENDIX I: Michigan Implementation of Medication Algorithms (MIMA), Guidelines for Treating Schizophrenia, MIMA Physician Procedural Manual
APPENDIX J: Michigan Implementation of Medication Algorithms (MIMA), Guidelines for Treating Major Depressive Disorder, MIMA Physician Procedural Manual
APPENDIX K: Michigan Implementation of Medication Algorithms (MIMA), Guidelines for Treating Bipolar Disorder, MIMA Physician Procedural Manual
APPENDIX L: Survey Instrument, Protocols, and Frequencies

EXECUTIVE SUMMARY

The publication of this action plan—the work of a distinguished panel of 25 mental health experts who served as the project steering committee—is the first phase of a multiyear effort to improve the quality of mental health care in Michigan by encouraging physicians to adopt best-practice or evidence-based practice (EBP) in the prescription and monitoring of drugs for people with major depression, bipolar disorder, and schizophrenia. The steering committee's charge was to select the guidelines/algorithms best suited for Michigan and create a research-based plan aimed at encouraging their use.

Reliable and rapidly accumulating research demonstrates that the mental health care Americans receive is not always grounded in science or generally recognized best practices. Further, the lag between the discovery of new treatments and their routine incorporation into patient care is often unacceptably long. The best practice- and evidence-based tools advocated here—guidelines and algorithms—overcome both problems by summarizing treatment options in a way that reflects the state of scientific research or the expert opinion of practitioners in the field.

Funding for this project was provided by the Ethel and James Flinn Foundation of Detroit, which contracted with Public Sector Consultants Inc. of Lansing to manage the project.

Guideline/Algorithm Selection

After a careful review of available options, the steering committee recommends that the Texas Implementation of Medication Algorithms (TIMA) guidelines be appropriately modified for use in Michigan. The TIMA guidelines are scientifically sound, field-tested, and regularly updated. Equally important, they are part of a larger program of care that includes evaluation and measurement and the education and support of patients and families.

Principles

Research sponsored by and made available to the Steering Committee indicates that the action plan would be successful to the degree that it embodies the following principles:

- The guidelines/algorithms must be easy to use and part of a broader education and disease management approach.
- Differences in knowledge and needs among psychiatrists, primary care physicians (PCPs), and consumers must be part of the plan.
- The plan should be rolled out over time, with pilot programs to enlist opinion leaders and early adopters.

Elements of the Plan

The action plan itself offers both general recommendations and specific tactics associated with seven different strategic areas. The two general recommendations are:

- **Pilot Programs**. *The steering committee and its leadership successor team should implement the EBP action plan by supporting and sponsoring three to six pilot programs at locations around Michigan over the next three years. The pilot programs, which would be designed to implement and test the efficacy of the EBP guidelines and algorithms, would be based upon the strategies and tactics described below. To the degree possible, all three conditions*

(major depression, bipolar disorder, and schizophrenia) would be included in each pilot, which would also cover public and private systems of care and accommodate the differing needs of primary care physicians and psychiatrists. The committee notes that state hospitals, university consortia, and private mental health practices that are university affiliated would be logical pilot program candidates.

■ **Leadership Team**. *To maintain the continuity and momentum of this effort and facilitate the establishment and ongoing operations of pilot programs there should be established in Michigan a leadership team with the following components:*

1. *A "committee of the whole" composed of current steering committee members that will meet once or twice annually to review progress in the implementation of the report, suggest mid-course corrections, and serve as "ambassadors" for the project within Michigan.*

2. *An "executive committee," composed of volunteers from the steering committee and including both public- and private-sector participation that will provide oversight and assistance in a number of areas, especially in the critical area of funding. This group would meet more regularly, perhaps every other month.*

3. *A "project coordination group" charged with staffing the project and doing the day-to-day work of implementation—including meeting with potential funders, developing requests for proposals (RFPs), evaluating proposals for local pilot programs, and coordinating the activities of the pilot programs that are established.*

The two recommendations create a framework within which this EBP project can proceed in Michigan and reflect the committee's belief that EBP principles are best advanced by means of local pilot programs guided by state-level leadership. A table outlining the roles and responsibilities of the leadership team and the pilot programs is included in the report as Appendix A.

The following strategies and tactics indicate the work the pilot programs must accomplish.

Strategies for the Packaging and Distribution of Guidelines and Algorithms

Tactic 1: The leadership team should oversee the reformatting and disseminating to the pilot programs of Michigan-specific guidelines and algorithms based upon the Texas (i.e., TIMA) model.

Tactic 2: The reformatted guidelines/algorithms should be available in both short and long versions and disseminated to accommodate differing needs and uses.

Tactic 3: The guidelines/algorithms should be tailored specifically for use with information technology, the Internet, local networks, and PDAs.

Tactic 4: Existing disease management tool kits available for treatment of major depression, bipolar disorder, and schizophrenia should be collected and analyzed, and, if necessary, new tool kits should be developed for use in the pilot programs.

Tactic 5: The newly formatted Michigan algorithms should be updated regularly.

Strategies for Physician Education

Tactic 1: *The leadership team and pilots should develop strong, consistent messages as to explain the value of guidelines and algorithms. These should be focused on critical issues such as expected outcomes and physician autonomy and, whenever possible, be accompanied by stakeholder endorsements.*

Tactic 2: *As part of a commitment to being "centers of excellence," one or more state medical schools should adopt and teach guidelines/algorithms as part of the medical school curriculum and in residency training programs.*

Tactic 3: *The leadership team and pilot programs should explore ways of offering Continuing Medical Education (CME) credit for conferences, training programs, and regional sessions devoted to evidence-based mental health care and the use of guidelines and algorithms.*

Tactic 4: *The leadership team and pilot programs should work together to develop site-specific physician training programs for each pilot program.*

Strategies for Consumer Education

Tactic 1: *The leadership team and pilot programs should develop materials and methods for improving patient-physician communication on the nature, importance, value, and use of guidelines and algorithms during individual treatment sessions—that is, on a "one-to-one" basis.*

Tactic 2: *Pilot programs and the leadership team should collaborate on a broader program of consumer education and awareness through the use of public service announcements, and, most especially, by employing existing advocacy groups as messengers to their constituents.*

Tactic 3: *The leadership team should evaluate the need to conduct further research into consumer needs and preferences as well as the possibility of offering consumer education tailored to specific subgroups or settings—for example, CMH settings.*

Strategies for Ongoing Physician Support

Tactic 1: *The leadership team and pilot programs should devise mechanisms to support and assist clinicians in the treatment of specific cases and patients.*

Tactic 2: *The leadership team and individual pilots should mutually develop support mechanisms to help with administration and logistics of the pilot itself.*

Tactic 3: *The leadership team should work with payers to develop prescriber profiles and make them available to prescribers and researchers, while remaining sensitive to privacy issues. As part of this process, the group should encourage as much as possible movement toward universal use of electronic medical records.*

Strategies to Develop Incentives for Change

Tactic 1: *The leadership team and pilots should develop nonfinancial incentives for the adoption of guidelines and algorithms.*

Tactic 2: *The leadership team should offer CME credit as an incentive as well as an educational opportunity.*

Tactic 3: *The leadership team should approach payers to secure their buy-in for: (1) paying or creating rewards for guideline/algorithm adherence and (2) increasing reimbursement to improve the quality of care and reporting.*

Tactic 4: *The leadership team should work with the Michigan Department of Community Health to ensure that contracts with providers reflect EBP principles.*

Strategies for Evaluation and Measurement

Tactic 1: *The leadership team, working with representatives from the pilot programs, should develop multidimensional evaluation and measurement techniques that assess adherence to and variation from guidelines, effectiveness of guidelines, consumer and physician satisfaction, cost, and variations among prescribers.*

Tactic 2: *The leadership team and the local pilot programs should work together to establish registries of persons with the conditions of interest (depression, bipolar disorder, and schizophrenia), while remaining sensitive to privacy issues.*

Strategies for Stakeholder Buy-in

Tactic 1*: The leadership team should assist pilot programs in developing EBP buy-in at each site through informational outreach efforts.*

Tactic 2: *The leadership team should identify a suitable contractor to coordinate marketing efforts to consumer advocacy groups and other groups with an interest in mental health care.*

Tactic 3*: The leadership team should encourage current steering committee members to serve as active ambassadors for EBP, the use of guidelines and algorithms in mental health care, and the pilot program process.*

Tactic 4: *The leadership team should serve as a liaison to private foundation and corporate funders, within Michigan and nationally, and develop strategies for engaging their support for the project.*

INTRODUCTION

This action plan, or "blueprint," is the first phase of a multiyear effort to improve the quality of mental health care in Michigan by encouraging the fuller incorporation of best-practice or evidence-based principles into the delivery of health care. The plan's focus is the use of medication guidelines or algorithms in the treatment of three conditions: major depression, bipolar disorder, and schizophrenia. Project funding was provided by the Ethel and James Flinn Foundation of Detroit, which contracted the services of Public Sector Consultants Inc. of Lansing to manage the project. Founded in 1976, the Flinn Foundation supports research into the treatment of mental illness.

The plan is the work of the distinguished panel of 25 experts who served as the project steering committee. This group of practitioners, payers, consumer advocates, state and community mental-health officials, and academic researchers met over a period of 18 months to:

- Select from a number of available options the guidelines/algorithms best suited for use in Michigan

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- Identify barriers to their adoption in the field
- Create a research-based action plan aimed at more fully integrating the use of medication guidelines and algorithms into mental health care, thereby bridging the gap between what we know through research and the care clinicians offer in practice

The steering committee operated on a consensus basis and the resulting action plan is, therefore, the product of its strongest areas of agreement. A full record of the committee's activities including agendas, PowerPoint presentations, and summaries is available in Appendices B–H. Steering committee members are listed in the table below.

Steering Committee Members	
Patrick Barrie, Deputy Director Health Programs Administration Michigan Department of Community Health	**Jed Magen**, DO, MS, Acting Chair Department of Psychiatry Michigan State University
John Baugh, MD, Medical Director St. Clair County Community Mental Health	**Michael Massanari**, MD, MS, Director Center for Health Care Effectiveness Research Wayne State University School of Medicine
Richard C. Berchou, PharmD Assistant Professor Wayne State University Psychiatric Center	**Karen K. Milner**, MD, Director Psychiatric Emergency Services University of Michigan
Hubert A. Carbone, MD Director of Psychiatric/Medical Services, Michigan Department of Community Health	**Barry Mintzes**, PhD Psychologist Lansing Psychological Associates PC
Tom Carli, MD, Medical Director Medical Management Center/Disease Management Programs University of Michigan Health Plans	**Michele Reid**, MD, Medical Director Detroit-Wayne County Community Mental Health
Wayne Creelman, MD, Medical Director Pine Rest Christian Mental Health Services	**Mark Reinstein**, PhD, President and CEO Mental Health Association in Michigan
Calmeze H. Dudley, MD, Medical Director Mental Health Services Blue Cross Blue Shield of Michigan	**Robert Sheehan**, MSW, MBA, Executive Director Clinton-Eaton-Ingham Community Mental Health
Michael F. Engel, DO, President Michigan Psychiatric Society	**Manuel Tancer**, MD, Interim Chair Department of Psychiatry and Behavioral Neurosciences Wayne State University
Michael Fauman, MD, PhD, Medical Director Magellan Behavioral of Michigan Inc.	**Philip E. Veenhuis**, MD, MPH (retired)
Jonathan G. A. Henry, MD, Medical Director CEI Community Mental Health Board	**Daniel J. Wilhelm**, MD, Pediatrician Children's Healthcare (Port Huron)
Hubert Huebl, MD, President National Alliance for the Mentally Ill (Michigan Chapter)	**Kathleen Williams**, President American Psychiatric Nurses Association (Michigan Chapter)
Robb Imonen, DO, Psychiatrist Marquette General Health System	**Michael L. Zarr**, MD, MBA, Vice President, Medical Director ValueOptions, Detroit Service Center
Kevin B. Kerber, MD, Director Adult Ambulatory Services University of Michigan	**Thomas C. Zelnik**, MD, Chairman Department of Psychiatry St. Joseph Mercy Health System

While the specific focus here is psychopharmacological treatment of mental illness, it is understood that no adequate treatment plan can be developed in the absence of accurate diagnosis and assessment and a comprehensive array of effective rehabilitation services. Further, the project steering committee recognizes that the document cannot be read in isolation but comes, in fact, at a time when there are other important and far-ranging discussions taking place

about the future of mental health care in Michigan. In particular, the report of the Governor's Mental Health Commission will also be made public in the fall of 2004. The steering committee's hope is that this document, like the report of the Mental Health Commission, will contribute to a rich and important dialogue about how best to offer care in the first decades of the new century.

"BEST" AND "EVIDENCE-BASED" PRACTICES

No doubt many Americans were surprised earlier this year when a major study by the RAND Corporation demonstrated that patients get substandard health care about half the time, even if they live near a major teaching hospital.[1] For medical researchers, however, the study merely confirms evidence that has been accumulating for some time. The care patients receive in practice is often not as good as it could be. This is the case for mental health care as well as general medical care.

Evidence-based practice has been defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients."[2] It is not a substitute for clinical judgment or what is commonly called "the art of medicine." Indeed, both clinical expertise and patient values will always play an important role in determining a course of treatment.

In the sense in which it is used here, the phrase "evidence based" is consistent with the concept of "best practices." The acronym "EBP," which is used throughout, is employed broadly to refer to both concepts. Practices that are evidence based reflect the current state of knowledge. They are not gospel but, rather, a useful first step in treating an individual patient at a specific point in time. The federal Agency for Healthcare Research and Quality (AHRQ) classifies "evidence" according to strength or certainty. From highest degree of evidence to lowest, here are the classifications:

- Meta-analysis of multiple well-designed controlled studies
- Well-designed randomized controlled trials
- Well-designed nonrandomized controlled trials
- Observational studies with controls (retrospective studies, interrupted time-series studies, case-control studies, cohort studies with controls)
- Observational studies without controls (cohort studies without controls and case series)

Best practices may result from any of these five categories of evidence.

American health care certainly ranks among the best in the world, and many citizens naturally assume that the care they receive is firmly grounded in science. Yet, a substantial body of recent

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[1] As reported by Lawrence K. Altman, "Study Finds Widespread Problem of Inadequate Health Care," *New York Times* (May 5, 2004). RAND's "First National Report Card on Quality of Health Care in America" included interviews with 13,000 individual adults in 12 metropolitan areas, including Lansing. Depression was one of the conditions in the project's quality assessment tool. For more information consult "RAND Health" on the website: *www.rand.org*.

[2] D. L. Sackett, S. E. Strauss, W. S. Richardson, et al., *Evidence-Based Medicine: How to Practice and Teach EBM*, 2d ed. (New York: Churchill Livingstone, 2000). As quoted in Gregory E. Gray, *Concise Guide to Evidence-Based Psychiatry* (Washington, D.C.: American Psychiatric Publishing, 2004), 3.

research demonstrates that this is frequently not the case. As the Institute of Medicine recently notes:

> Quality problems are everywhere, affecting many patients. Between the health care we have and the care we could have lies not just a gap, but a chasm.[3]

The same Institute of Medicine report cited evidence that the lag between the discovery of new treatments and their routine incorporation into patient care was unacceptably long—15 to 20 years in some cases.

What is true in health care generally is also true in mental health care and psychiatry. For instance, a 1999 Surgeon General's report—the first ever on mental health—notes an imperative need to develop "innovative strategies" to bridge the gap "between what is known from research and what is practiced."[4] More recently still, the President's New Freedom Commission on Mental Health noted that the mental health care system "needs dramatic reform because it is incapable of efficiently delivering and financing effective treatments, such as medications, psychotherapies, and other services, that have taken decades to develop." In view of this, it is not surprising that the implementation of evidence-based practice in mental health care is a high priority in most states.[5]

One of the clearest signals that mental health and other kinds of medical care are not optimal is the documented wide variation that occurs in treatment. If practice were firmly evidence-based, one would expect far less variation than has been observed. The variation in care that has been observed in medical care nationally has also been observed in Michigan. For example, Blue Cross/Blue Shield of Michigan's *Dartmouth Atlas of Health Care in Michigan* shows considerable small area variation in the frequency with which SSRI medications are prescribed.

Practices that are not based upon science, or at least expert consensus, are often based instead upon tradition, convenience, clinician preferences, and even payer policies. This has costs. Patients may receive inappropriate, unnecessarily costly, or even harmful care. Even when no overt harm is done, an opportunity is lost to provide patients with the care they need and expect on a timely basis.

Two general types of information problems contribute to patients receiving less than optimal care:

- The simple inability of individual practitioners to stay abreast of new developments
- The over-reliance of practitioners upon unreliable sources of information

The best practice- and evidence-based tools we advocate here—guidelines and algorithms—overcome both of these problems by reliably summarizing treatment options in a way that reflects the state of scientific research or the expert opinion of practitioners in the field. Yet, the steering committee is also acutely aware that the dissemination of practice guidelines alone will

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[3] Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, D.C.: National Academy Press, 2001), 1.
[4] United States Department of Health and Human Services, *Mental Health: A Report of the U.S. Surgeon General – Executive Summary* (Washington, D.C.: HHS, 1999), 20–21.
[5] Presentation to the Steering Committee by Vijay Ganju, Center for Mental Health Quality and Accountability, National Association of State Mental Health Program Directors (NASMHPD), June 4, 2003.

have limited beneficial effect upon clinical practice. As the document suggests, best- and evidence-based care practices will only bring about productive change if they are part of a broader program of clinical support, education, and research.

GUIDELINES/ALGORITHM SELECTION

The question of what guidelines and/or algorithms should be recommended for use in Michigan was addressed by means of separate working groups devoted to the three conditions (major depression, bipolar disorder, and schizophrenia). The groups approached the question independently of one another and examined a number of guidelines and algorithms including the American Psychiatric Association guidelines, the Harvard algorithms, and the Texas Implementation of Medication Algorithms (TIMA), to name some of the better known examples. Each group decided that the TIMA guidelines, with appropriate modifications, would be the most useful in Michigan. Their reasons can be summarized as follows:

- The TIMA algorithms are well grounded in science and comport well with the best available evidence.
- The TIMA algorithms are not stand-alone documents, but are, rather, part of a larger program of care that includes evaluation and measurement and the education and support of patients and families.
- The TIMA algorithms have been field-tested and evaluated in Texas with largely encouraging results.
- The TIMA algorithms are regularly updated, something that would make the necessary updating process in Michigan far easier to accomplish.

The latest version of the algorithms recommended for Michigan, called the Michigan Implementation of Medication Algorithm (MIMA), is available in Appendices I–K.[6]

COMMITTEE-SPONSORED RESEARCH

Having identified algorithms that could be used in Michigan, the steering committee then identified both barriers to and promoters of their adoption. It did this in two ways: (1) a steering committee member, Dr. Michael Massanari, Director of the Center for Healthcare Effectiveness Research at Wayne State University, provided an overview on the conclusions of research into how change in practice occurs among physicians; and (2) the committee oversaw and guided a survey of prescribers in Michigan designed to produce information on their knowledge of and attitudes toward best and evidence-based practice in mental health care.

Literature Review: Implementation Barriers and Promoters

The literature reviewed by Dr. Massanari supports the following conclusions:

- Guidelines should be implemented under carefully designed protocols and linked to a concurrent evaluation process designed to measure adherence to guidelines and the impact on outcomes of care. Evaluation should include feedback from users regarding the format and usefulness of Michigan treatment guidelines.

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[6] The original TIMA algorithms upon which it is based are available at: *www.mhmr.tx.us/centraloffice/ medicaldirector/TIMA*.

- Design of implementation protocols should be based on a detailed clinical process analysis that includes input from process engineers and practitioners with the objective of developing a "user-friendly tool kit" that will facilitate implementation.
- Implementation protocols should be multifaceted and include:

  - Education of providers and consumers
  - Making available a tool kit to support providers
  - Administrative support for implementation
  - Feedback of results of evaluation to providers
  - Access to technical support for implementation

- Additional factors to consider in promoting adoption and implementation of guidelines:

  - Mechanisms for dialogue between physician champions and practitioners who are reluctant adopters
  - Information technologies to facilitate adoption and implementation
  - External incentives to promote adoption and implementation through contracts and public rewards
  - Incorporation of case-managers into the care process

Survey of Prescribers

Staff worked with committee members and with representatives of the prescribing community to create and field a survey instrument.[7] Some of the key findings include:

- Prescribers place a great deal of emphasis upon requiring proof that evidence-based practices actually improve patient outcomes.
- Respondents are influenced most by expert opinion, scientific evidence, and the views of colleagues.
- Peer-reviewed journals, workshops, and information provided by professional organizations are the most useful avenues of communication.
- Any plan to attack the systemic barriers to EBP needs to accommodate the differing experiences and needs of primary care physicians and psychiatrists.
- Guidelines or algorithms will be useful to the degree that they are evidence based and easy to use.

Because of concerns about the low rate of response, the quality of the contact lists, and a lack of randomness in response, the steering committee views the survey results with caution, while noting that they have a certain face validity because they comport well with the conclusions of research offered by Dr. Massanari. Further information on the survey instrument, protocols, and frequencies is available in Appendix L.

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[7] The researchers worked with groups like the Michigan State Medical Society to develop a master list of some 6,000 possible respondents to whom the survey instrument was distributed. Approximately 530 prescribers (9 percent) responded.

STRATEGIES

The survey and the literature review produced consistent and compatible results, allowing the steering committee to formulate a series of linked strategies for encouraging the greater use of medication guidelines and algorithms.

■ **Strategies for packaging and presenting guidelines and algorithms.** The guidelines/algorithms must be fully customized for use in Michigan and disseminated in a way that is useable and attractive.

■ **Strategies for physician and consumer education.** Physicians, patients, and families have to fully understand the guidelines/algorithms, how to use them properly, what their limitations are, and how they relate to other therapies.

■ **Strategies for ongoing physician support.** There must be a structured mechanism for providing physicians with information, updates, and logistical support as well as immediate (i.e., "bedside") assistance with difficult or complex cases.

■ **Strategies to create incentives for guideline adoption.** Research suggests that certain direct financial, indirect financial, and nonfinancial incentives will hasten and promote guideline/algorithm adoption.

■ **Strategies for the evaluation and measurement of guideline/algorithm use.** To provide information to physicians and other stakeholders, a multifaceted evaluation approach will be required that is firmly grounded in practice and focused upon both outcome and process measurements.

■ **Strategies for stakeholder buy-in.** For the EBP project to succeed there must be buy-in from stakeholders—practitioners, patients, advocacy groups, payers, and academic researchers on both the broad state and local level.

The steering committee also discussed the specific tactics that would be appropriate to each strategy area. If the strategies describe the "*what*" of an EBP action plan, the tactics provide the "*how*." A discussion of the strategies and tactics, endorsed by the steering committee makes up the bulk of this report.

PRINCIPLES

The survey and literature review also revealed the importance of a number of cross-cutting principles that should guide and inform the strategies and tactics:

■ Guidelines/algorithms must be easy to use and valuable.

■ Guidelines/algorithms by themselves are not enough; they must be part of a broader education and disease management approach.

■ Differences in knowledge and needs among psychiatrists, primary care physicians (PCPs), and consumers must be part of the action plan.

■ The action plan should be rolled out over time, with pilot programs to enlist opinion leaders and early adopters.

The final point warrants special attention because it identifies the framework within which the action plan can be operationalized in Michigan.

GENERAL RECOMMENDATIONS

Two general recommendations suggest a framework within which this EBP project can proceed in Michigan. They reflect the committee's belief that EBP principles are best advanced by means of local pilot programs undertaken in coordination with an ad hoc state-level leadership team. Information gleaned from these efforts should be used to improve the pilots and disseminated more broadly to the practitioner community at large.

Recommendation: Pilot Programs

The steering committee and its leadership successor team should implement the EBP action plan by supporting and sponsoring three to six pilot programs at locations around Michigan over the next three years. The pilot programs, which would be designed to implement and test the efficacy of the EBP guidelines and algorithms, would be based upon the strategies and tactics described below. To the degree possible, all three conditions (major depression, bipolar disorder, and schizophrenia) would be included in each pilot, which would also cover public and private systems of care and accommodate the differing needs of primary care physicians and psychiatrists. The committee notes that state hospitals, university consortia, and private mental health practices that are university affiliated would be logical pilot program candidates.

Rationale and Description

Any attempt to impose EBP on the entire system of mental health care in Michigan would be unrealistic and ultimately doomed to failure for a number of reasons:

- The value of guidelines and algorithms is not universally understood among prescribers and those who are aware of them do not necessarily use or agree with them.
- The contextual issues—defined as the managerial and financial constraints under which care is offered—at best do not offer incentives for better care and at worst discourage it.
- By their nature, individual practitioners will not accept change at the same rate; some will be much more likely to adopt guidelines and algorithms than others, at least in the short term.

The effort to encourage the greater use of evidenced based medicine is essentially an attempt to diffuse a complex innovation (EBP) through a complex social system (the health care system). Common sense and diffusion theory suggest that such a complex innovation is unlikely to be rapidly adopted by a majority of practitioners.[8] Far more likely is the possibility that pioneering practitioners—innovators and early adopters—can be persuaded to change. Only if the innovation is successful—if, that is, it produces measurable, positive results—will it be widely adopted.

The best way to accommodate this dynamic of change is to encourage and support the use of guidelines/algorithms among the innovative and early adopting "champions" who are most likely to use them. If success can be demonstrated at that level, the likelihood of still broader adoption will increase dramatically. Well-designed pilot programs that incorporate the strategies enumerated above—that is, which are intelligently packaged and marketed and contain educational materials, physician support, incentives, and evaluation—are the best way to do this. In this manner the "EBP" innovations can be diffused appropriately from a group of innovators

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[8]For an excellent discussion of the application of diffusion theory to health care change see D. M. Berwick, "Disseminating Innovations in Health Care," *JAMA* 289 (April 16, 2003): 1969–75.

and early adopters to early and late majorities in the field. To facilitate the exchange of information, each pilot program should have a designated contact person.

The effort cannot be coercive, but must be built upon willing participation at the local level. Furthermore, while some level of consistency across pilot programs is imperative, they need not be identical copies of one another. Each pilot program will use the MIMA algorithms and adopt the general strategies described below. On the local, tactical level, however, there can be room for flexibility and innovation at the discretion of local leaders. For that reason it is important that the local users of MIMA and the EBP approach be regularly consulted and stay involved in the unfolding process, possibly by means of an advisory "users group."

Recommendation: Leadership Team

To maintain the continuity and momentum of this effort and facilitate the establishment and ongoing operations of pilot programs there should be established in Michigan a leadership team with the following components:

1. *A "committee of the whole" composed of current steering committee members that will meet once or twice annually to review progress in the implementation of the report, suggest mid-course corrections, and serve as "ambassadors" for the project within Michigan.*

2. *An "executive committee," composed of volunteers from the steering committee and including both public- and private-sector participation that will provide oversight and assistance in a number of areas, especially in the critical area of funding. This group would meet more regularly, perhaps every other month.*

3. *A "project coordination group" charged with staffing the project and doing the day-to-day work of implementation—including meeting with potential funders, developing requests for proposals (RFPs), evaluating proposals for local pilot programs, and coordinating the activities of the pilot programs that are established.*

Rationale and Description

Pilot programs cannot be undertaken without significant financial resources, nor should they be undertaken absent coordination at the state level. Both considerations argue strongly for the establishment of an ongoing "leadership" structure utilizing the expertise and skills of current steering committee members. The role of the executive committee and project coordination group would be particularly key here in the coordination of fundraising and the development of pilot programs by selecting pilot programs, developing requests for proposals (RFPs), evaluating proposals, and completing certain tasks best done at the state level (for example, the modification and updating of the MIMA algorithms).

The relationship between the newly established leadership team and the local pilot programs should be flexible, innovative, and nonbureaucratic. Lessons learned on the local level would be used for local improvements but also disseminated to the other pilots via the state-level leadership team. Individual pilot programs might well serve as contractors to produce information and tools for use by all the pilots. In other words, the pilot programs will carry out most of the work of the project (collecting and analyzing data, identifying best practices, advising the leadership team, and others).

The most logical step would be for leadership positions to be filled from the ranks of the current members of the steering committee, whose duties, in addition to those outlined below, would be to serve as in-house advocates for the action plan at the September conference. Above all else it is understood that the action plan is a dynamic, not static, document; the plan will necessarily change as new evidence becomes available.

The leadership team would have the following responsibilities:

- Overseeing the preparation, printing, dissemination, and, ultimately, the updating of guidelines and algorithms
- Preparing RFPs and evaluating subsequent proposals
- Overseeing the implementation of the pilot programs and deciding what program features must be standard from pilot to pilot
- Providing expert assistance for data collection and evaluation design
- Identifying and hiring contractors who provide ongoing physician support
- Identifying, approaching, and advising potential funders
- Serving as the visible, public presence of the EBP project

All these responsibilities would be discharged with the intention of improving the chances of success for the local pilot programs. The utilization of strong and knowledgeable project coordination will be essential to the success of all implementations efforts.

RECOMMENDATIONS: STRATEGIES AND TACTICS

The following recommendations are organized according to the strategies identified above and their attendant tactics. That is, there are strategies for:

- Packaging and presenting the guidelines/algorithms themselves
- Providing physician and consumer education
- Providing ongoing physician support
- Creating incentives for changes in medical practice
- Evaluating and measuring success in implementing guidelines algorithms and the effects of doing so
- Achieving further buy-in on the part of key stakeholders

Taken together, these offer a blueprint for the types of activities that will be undertaken by the local pilots and the state leadership team. The strategies are listed separately here for the purposes of discussion and completeness. In reality, the leadership and pilot groups could very well combine them—for example, by using Web technology to respond to inquiries by both physicians and consumers. Evaluation and measurement within each pilot program will serve a dual function: (1) allow each pilot to make ongoing, mid-course corrections and (2) provide information to other pilots and to the field.

Strategies for the Packaging and Distribution of Guidelines and Algorithms

To be maximally effective, guidelines and algorithms must be adapted for practice in Michigan, easy to understand and/or use for all stakeholders, and distributed through different media and

channels, and must come from an objective and authoritative source. This implies both that the guidelines must be customized for use in Michigan and that they be formatted for different practice settings, audiences, and uses.

Tactic 1: The leadership team should oversee the reformatting and disseminating to the pilot programs of Michigan-specific guidelines and algorithms based upon the Texas (i.e., TIMA) model.

Rationale and Description

The Texas algorithms that the steering committee identified as most appropriate and useful for use in Michigan need to be further customized for use here. References to Texas-specific materials, procedures, and organizations have been removed and replaced with Michigan-specific references. Furthermore, a strong emphasis on diagnoses must be a part of the guideline package since a correct initial diagnosis is indispensable to proper treatment.

Roles and Responsibilities

- The state leadership team will oversee the reformatting process by identifying potential contractors, evaluating proposals, and disseminating the resulting product to pilot projects.
- The pilot programs will use common guidelines and algorithms.

Tactic 2: The reformatted guidelines/algorithms must be available in both short and long versions and disseminated to accommodate differing needs and uses.

Rationale and Description

The same basic material can be formatted to meet the needs of two very different audiences. Primary care physicians (PCPs) may well need short, easy-to-use algorithms and guidelines, especially for initiating proper treatment of depression. Other physicians, including those in public settings and specialty care, may well need more in-depth material for complex or difficult-to-treat cases. Wall charts, flyers, CDs, personal digital assistants (PDAs), laminated cards, and Web technology are all communication channels that might be used to convey information on symptoms and treatment options.

Roles and Responsibilities

- The leadership team will identify qualified contractors and otherwise oversee the creation of both long and short versions of the guidelines and algorithms and provide them to the pilot programs.
- The pilot programs will use both versions in accordance with local need.

Tactic 3: The leadership team and pilots will conduct the research necessary to package the guideline and algorithm material specifically for use with information technology, the Internet, local networks, and PDAs.

Rationale and Description

Electronic technology is the wave of the present and future. As the survey of Michigan prescribers showed, many respondents now use Web technology in the office. While research on PDA use is lacking, it is presumed to be substantial. Web-based technology can provide information via either a computer or a PDA to physicians and staff. Further, electronic

technology can be an efficient and easy to way update guideline and algorithm information for large numbers of users. It is important to stress, however, that in order for this technology to be engineered intelligently, additional investigations must be made as to the way practitioners use it.

Roles and Responsibilities
- The leadership team will sponsor research and assist in the translation of guideline and algorithm material into a form suitable for use with information technology.
- The pilot programs will provide input into the engineering of the system and will use information technology in practice.

Tactic 4: *Existing disease management tool kits available for treatment of major depression, bipolar disorder, and schizophrenia should be collected and analyzed to determine their suitability for further use and dissemination. If necessary, new tool kits should be developed for use in the pilot programs.*

Rationale and Discussion

Several payer groups—among them Blue Cross/Blue Shield of Michigan and Magellan—have developed "tool kits" for the treatment of certain mental illnesses. The kits contain features—for example, disease screening instruments—that can be useful in the identification and management of illness. In the interest of efficiency, these payer groups should be approached to see if all or part of existing kits could be employed in the pilot programs. If necessary, new kits, or new kit elements, should be developed.

Roles and Responsibilities
- The leadership team should approach payers such as BCBSM and Magellan and others to seek the right to evaluate and use existing materials. If new materials need to be developed the group will assist in the identification and engagement of a contractor.
- The local pilots should use existing or newly developed tool kits as appropriate.

Tactic 5: *The newly formatted Michigan algorithms must be updated on a regular basis.*

Rationale and Description

By its very nature, evidence-based medicine is linked to new research developments and the availability of new medications. It is therefore imperative that the guidelines and algorithms be updated regularly. Experts in the area—for example, university research programs or practitioner groups like the American Psychiatric Association, the Michigan Psychiatric Society, and the Michigan State Medical Society may be available to assist with the updating, the merits of several approaches to updating should be considered:

1. Updating every 1 to 2 years through the convening of an ad hoc group of experts

2. Collecting and reviewing data *continuously* in a quality improvement process designed to rapidly alter practice

3. Updating different sections of the guidelines/algorithms regularly on a rotating basis

Roles and Responsibilities

- The leadership team will assist in the identification and engagement of a contractor or contractors.
- The pilot programs will use the updated guidelines.

Strategies for Physician Education

Physicians, both psychiatrists and those in primary care, will require additional information about the virtues of guidelines and algorithms, how best to run a local pilot program, and how to incorporate EBP principles into practice.

Tactic 1: *The leadership team and pilots should develop strong, consistent messages as part of programs to explain why physicians should use guidelines and algorithms. These should be focused on critical issues such as expected outcomes and physician autonomy and, whenever possible, be accompanied by stakeholder endorsements.*

Rationale and Discussion

The compelling reasons for adopting EBP principles and guidelines/algorithms in mental health prescribing are not fully understood in the field. The survey of prescribers showed that the majority of psychiatrists were aware of algorithms and guidelines but did not necessarily use them. Primary care physicians, however, tended not to know about mental health guidelines and algorithms and used them in even smaller numbers. The fact that guidelines and algorithms can improve care and reduce errors needs to be stressed.

Roles and Responsibilities

- The leadership team will evaluate proposals from outside contractors (e.g., groups like the Michigan State Medical Society [MSMS] or the Michigan Psychiatric Society [MPS]) to develop consistent messages on guidelines and algorithms and conduct training.
- The individual pilot programs will ensure that physicians who are a part of their efforts receive this information or training.

Tactic 2: *As part of a commitment to being "centers of excellence," one or more state medical schools should adopt and teach guidelines/algorithms as part of the medical school curriculum and in residency training programs.*

Rationale and Discussion

In the long term, EBP principles and guidelines/algorithms will be widely adopted only if they are used in the training of future generations of physicians. Although medical school curricula are unlikely to change quickly, the greater use of guidelines/algorithms should begin now with an understanding that fuller adoption will take time to accomplish. Members of the steering committee believe that with proper encouragement and assistance one or more of the state's medical schools could do so for mental health care. Further, a commitment to guideline and algorithm use could establish the participating medical school as a "center of excellence"—i.e., a place where better care is offered because it is clearly and explicitly evidence based.

The value of EBP has also been recognized and endorsed by the Accreditation Council for Graduate Medical Education for use in residency training programs. However, Michigan training programs in psychiatry have not generally interpreted this to require teaching the use

of guidelines and algorithms, though in other specialties, cardiology, for example, their use is more common.

Roles and Responsibilities

- The leadership team should approach the state's medical schools to explore in detail the possibility of their becoming centers of excellence committed to the teaching and use of algorithms and guidelines in mental health care.
- A medical school should be a part of at least one pilot program.
- A hospital-based training program should be a part of at least one pilot program.

Tactic 3: The leadership team and pilot programs should explore ways of offering Continuing Medical Education (CME) credit for conferences, training programs, and regional sessions devoted to evidence-based mental health care and the use of guidelines and algorithms.

Rationale and Discussion

The continuing education of physicians currently in practice complements the education of physicians in medical schools. Offering CME credit would serve as both an educational opportunity for physicians and as an incentive for change.

Roles and Responsibilities

- The leadership team should approach CME-granting organizations to ensure that EBP programs are available.
- Pilot programs should require or strongly encourage attendance at these sessions by their participating physicians.

Tactic 4: The leadership team and pilot programs should work together to develop site-specific training programs for each pilot program.

Rationale and Discussion

There is more to EBP than information on drug treatment options. The use of guidelines and algorithms is part of a broader approach that includes information on pharmacology, screening tools, monitoring and tracking, evaluation and measurement, physician/patient communication, and the education of patients and family members. While all of the pilot programs should have common features and elements, they by no means need to be identical. Tailoring the core program strategies to site-specific requirements will be necessary.

Roles and Responsibilities

- The leadership team will oversee the creation of a site-specific training program through proposal evaluation and selection of a training organization.
- The pilot programs will incorporate site-specific training for physicians, administrators, and other personnel.

Strategies for Consumer Education

The tactics in this subsection flow from the idea that care will also improve to the degree that consumers and their families are involved in care, understand EBP, and actively seek practitioners who offer it. Consumer education may take place in three contexts: (1) one-to-one encounters between physicians and individual patients; (2) population-based efforts whose aim is

to assist consumers in understanding and recognizing various conditions; and (3) specific treatment settings, for example, CMHs.

Tactic 1: The leadership team and pilot programs should develop materials and methods for improving patient-physician communication on the nature, importance, value, and use of guidelines and algorithms during individual treatment sessions—that is, on a "one-to-one" basis. The "medical decision making" CDs used by BCBSM to aid patients suffering from diseases such as breast and prostate cancer may be a useful model.

Rationale and Discussion

If the long-term goal is to more fully integrate guidelines and algorithms into standards of care, consumers are a powerful agent of change. Furthermore, consumers have a right to fully understand and participate in medical decisions that affect care.

Roles and Responsibilities

- The leadership team will invite potential contractors to propose an integrated program of messages and materials to improve communication between physicians and consumers.
- Pilot programs will have an integrated consumer education program as part of their activities.

Tactic 2: Pilot programs and the leadership team will collaborate on a broader program of consumer education and awareness through the use of public service announcements, and, most especially, by employing existing advocacy groups as messengers to their constituents.

Rationale and Discussion

This tactic is designed to augment the communication between physicians and patients through direct marketing to consumers. Where the previous tactic dealt with the quality of communication in a clinical setting, this tactic focuses on other channels of communication. Using public service announcements and "free media" provided by advocacy groups are among the communication channels that should be explored. A broader public awareness campaign has been used to great effect in the case of bipolar disorder among children.

Roles and Responsibilities

- The leadership team will identify contractors to develop messages and disseminate them to consumers outside of clinical settings.
- The pilot programs will design their programs in a way that is congruent with the message imparted by the public awareness campaign.

Tactic 3: The leadership team should evaluate the need to conduct further research into consumer needs and preferences as well as the possibility of offering consumer education tailored to specific subgroups or settings—for example, CMH settings.

Rationale and Discussion

In the short term, there is ample material available with which to begin an education outreach effort to consumers, on either a one-to-one or a broader population level. In the longer term, the effort to encourage EBP may benefit from an effort to learn more about the knowledge, attitudes, and preferences of consumers. The steering committee notes that a series of focus groups with consumers in different areas of Michigan could be especially valuable. The

possibility that consumer education materials should be designed for specific treatment settings should also be considered.

Roles and Responsibilities

- The leadership team will formally address the need for additional research and/or the development of educational materials for subgroups and settings.
- The pilot programs will assist in the research as needed and use or disseminate additional educational materials if appropriate.

Strategies for Ongoing Physician Support

This tactic area focuses on physician support that cannot be covered during an initial training period. It recognizes that a successful pilot program will require ongoing support on a number of levels, including assistance with specific patients and cases, assistance with the administration and logistics of the program, and "real time" information on prescribing patterns. The support of organized health care systems on each of these levels is especially important.

Tactic 1: The leadership team and pilot programs should devise mechanisms to support and assist clinicians in the treatment of specific cases and patients.

Rationale and Discussion

Clinicians in specialty care will need assistance with difficult or unusual cases. Primary care physicians would benefit from more general assistance with all three conditions. Assistance may be either immediate (i.e., sought while the patient is in the office) or of the sort that can be sought at regular intervals in the course of treatment (i.e., "virtual rounds"). Academic researchers, specialty societies, or health plans would be logical candidates to develop and provide ongoing support. The M-line program offered by the University of Michigan is one such example. As part of its service to the community, the university underwrites the cost of a "call in" consultation with the physicians it employs.

Roles and Responsibilities

- The leadership team will evaluate proposals and/or hire credentialed contractors to create and implement the support program.
- The pilot programs will ensure that their clinicians use the established support networks as needed.

Tactic 2: The leadership team and individual pilots will mutually develop support mechanisms to help with administration and logistics of the pilot itself.

Rationale and Discussion

As has been shown in Texas and amply confirmed in additional research, successful use of EBP principles is more than the use of guidelines and algorithms. Success also involves new ways of communicating, new ways of screening and monitoring patients, and a new way of monitoring. Physicians would be hard pressed to undertake comprehensive change without support.

Roles and Responsibilities

- The leadership team will evaluate proposals and ensure that contractors are available to assist when problems and unforeseen events inevitably create challenges for new program.
- The pilot programs will help in the development of support mechanisms and use them as necessary in the ongoing administration of the pilot.

Tactic 3: The leadership team will work with payers to develop prescriber profiles and make them available to prescribers and researchers, while remaining sensitive to privacy issues. As part of this process, the group should encourage as much as possible movement toward universal use of electronic medical records.

Rationale and Discussion

Having prescribing profiles available serves two purposes: (1) it can help clinicians see their own prescribing activities in a broader perspective and (2) it provides important data for the evaluation and measurement of practice changes due to EBP. Profiles will allow the individual practitioner to see how his/her prescribing patterns compare with those of others. Because they shed light on variations in practice, profiles are an important part of the evaluation mechanism. In this sense, adherence to or departure from guidelines/algorithms are not examined directly. Rather, variations are identified, triggering a further investigation as to the cause. The greater use of electronic medical records, already endorsed by the federal government, would greatly facilitate the creation and analysis of profiles.

Roles and Responsibilities

- The leadership team will approach provider systems and independent practice associations to determine how prescriber profiles can be developed.
- The pilot programs will encourage participating prescribers to review their profiles regularly and to analyze fully the reasons for any perceived variance.

Strategies to Develop Incentives for Change

Research suggests that a number of direct financial, indirect financial, and nonfinancial incentives will produce improvements in practice—ranging from reimbursement for legitimate expenses to enhanced status among peers and consumers.

Tactic 1: The leadership team and pilots should develop nonfinancial incentives for the adoption of guidelines and algorithms.

Rationale and Discussion

The nonfinancial incentives for change can be considerable. Quite apart from any financial compensation, practitioners are inspired by the prospect of offering better care and being recognized for doing so. There are other examples—the development of national cancer centers, for example—where practitioners willingly join a broader movement and group because of the advantages that accrue from being perceived to offer the best care possible. Participation in the EBP program could be signaled in a number of ways—perhaps through wall plaques or decals or listings on a website.

Roles and Responsibilities

- The leadership team will examine the question of how best to describe and market participation in the pilot program, perhaps through the development of a "Michigan EBP in Mental Health Care Network" or some similarly named program.
- The pilot programs will use plaques or other forms of notification to explicitly identify themselves as being participants in an effort to improve quality.

Tactic 2: The leadership team should offer CME credit as an incentive as well as an educational opportunity.

Rationale and Discussion

Continuing Medical Education Credit can be a valuable vehicle for education (see above) and, since practitioners are required by law to upgrade skills and education as a condition of re-licensing, a significant incentive as well.

Roles and Responsibilities

- The leadership team will approach CME-granting organizations to ensure that EBP programs are available, focused specifically upon medication EBP in mental health care.
- Pilot programs will encourage physician attendance at these sessions.

Tactic 3: The leadership team should approach payers to secure their buy-in for: (1) paying or creating rewards for guideline/algorithm adherence and (2) increasing reimbursement to improve the quality of care and reporting. This buy-in should build upon existing efforts by the Greater Detroit Area Health Council, Center for Medicare and Medicaid Services, Michigan Quality Forum, and Michigan Quality Improvement Consortium to standardize quality indicators and rewards.

Rationale and Discussion

Prescriber activities are influenced by the incentive structure in which they take place. Practitioners are more likely to adhere to guidelines and algorithms if there is a financial incentive to do so. Further, some disease management tactics—for example, using a social worker or case manager to ensure that prescriptions are filled—unquestionably cost money. Changing the incentive structure for practitioners so that they are rewarded and reimbursed for a desired behavior requires payer buy-in.

Roles and Responsibilities

- The leadership team will approach employers, health plans, CMHs, and MDCH to explore the possibility of creating rewards for guideline/algorithm adherence and reimbursement for expenses incurred that improve care.
- The pilot programs will adhere to the guidelines and undertake other activities that improve care in the expectation that they will be rewarded or reimbursed.

Tactic 4: The leadership team will work with MDCH to ensure that contracts with providers reflect EBP principles.

Rationale and Discussion

The Michigan Department of Community Health (MDCH) is a major payer, in fact, the dominant payer in cases involving schizophrenia and bipolar disorder. As such, it has contracts—with community mental health service programs, prepaid inpatient health plans, and Medicaid health plans—worth many millions of dollars, which could be used to leverage guideline/algorithm use. A policy decision by MDCH to support the goals of the action plan could be given teeth through department contracts.

Roles and Responsibilities
- The leadership committee should approach MDCH to develop a plan for encouraging guideline and algorithm use, at least within one of the pilot programs.
- One or more pilot programs could be used as a venue for testing the utility of this approach.

Strategies for Evaluation and Measurement

Evaluation and measurement strategies will provide an important informational base and will, over time, link the pilot programs to the long-term use of guidelines and algorithms to treat mental illness in Michigan. An evaluation of individual pilot programs as well as a "master" evaluation of all pilots will be necessary.

Tactic 1: The leadership team, working with representatives from the pilot programs, should develop multidimensional evaluation and measurement techniques that assess:

- *Adherence to and variation from guidelines, as well as the reasons for variation*
- *Effectiveness of guidelines*
- *Consumer and physician satisfaction*
- *The cost of implementing guidelines in practice*
- *Changes in observable variation among prescribers*

Rationale and Discussion

The information needs of the project will be many and varied. It would be useful to know, for example, the extent to which practitioners adhere to guidelines, how satisfied they and consumers are with the pilot program, what the program costs were, and how successful the program was in improving outcomes or reducing practice variations. Equally important, the evaluation would provide the basis for continuous pilot program improvement.

A full array of evaluation and measurement techniques would be needed to answer these questions, including the analysis of medical records and claims data and surveys of practitioners and consumers. Assessment tools must be uniform across the pilots so that they can be meaningfully compared.

Roles and Responsibilities
- The leadership team should set the evaluation and measurement agenda by identifying suitable program evaluation contractors, if there are not evaluators already affiliated with the pilots.
- The pilot programs should make the data collection and analysis an integral part of their local program.

Tactic 2: *The leadership team and the local pilot programs should work together to establish registries of persons with the conditions of interest (depression, bipolar disorder, and schizophrenia) within the local settings, while remaining appropriately sensitive to privacy issues.*

Rationale and Discussion

Developing registries of persons with the diseases or conditions of interest is an indispensable first step, and the foundation of any measurement scheme. Unless practitioners are able to readily identify all of their patients who suffer from depression, bipolar disorder, or schizophrenia, it is difficult to measure or evaluate such things as adherence to guidelines, patient satisfaction, outcomes or variations in practice. In the development of registries, privacy protections newly enacted into law must be recognized and respected.

Roles and Responsibilities

- The leadership team should work with payers to create registries within each of the pilot programs.
- The pilot programs should collect information to establish the initial registry in support of subsequent data collection activities.

Strategies for Stakeholder Buy-in

Initially, stakeholders are all those that the EBP project will affect or influence—physicians, consumers, families, payers, and employers. Initially buy-in will be essential to the local pilots, but it will be necessary eventually to seek buy-in on a broader basis. Over time, stakeholder groups will expand to include not only patients, but also their support networks and other mental health professionals such as psychologists as well.

Tactic 1: *The leadership team should assist pilot programs in developing EBP buy-in at each site through informational outreach efforts.*

Rationale and Discussion

Buy-in from the larger stakeholder community is essential, particularly if the object is to diffuse EBP more broadly within the mental health care system. Yet, one cannot simply take buy-in for granted. It has to be intelligently sought though a number of specific tactics. Using regular information outreach mechanisms such as "e-mail grams" is one way of bringing supporters on the local, pilot level into agreement.

Roles and Responsibilities

- The leadership team will coordinate efforts to achieve stakeholder buy-in statewide and provide information and techniques that can be used in local pilots.
- The local pilots will implement and employ the buy-in tactics locally.

Tactic 2: *The leadership team should identify a suitable contractor to coordinate marketing efforts to consumer advocacy groups and other groups with an interest in mental health care.*

Rationale and Discussion

A research-based public relations strategy would be at the center of efforts to achieve greater stakeholder buy-in at both the individual pilot and state level. Efforts should be made to

identify key stakeholder groups and their leaders and provide them with timely information on the pilot programs. This may well require contracting the services of a professional public relations firm with demonstrated expertise with medical care issues.

Roles and Responsibilities
- The leadership team should assist in the identification of a contractor to coordinate an ongoing stakeholder buy-in effort.
- The local pilots should share information on their activities and be the focus of buy-in efforts locally.

Tactic 3: The leadership team will encourage current steering committee members to serve as active ambassadors for EBP, the use of guidelines and algorithms in mental health care, and the pilot program process.

Rationale and Discussion

Effectively promoting change requires knowledgeable and committed change agents. Current steering committee members, who have standing within the medical and consumer communities and a demonstrated interest in EBP issues, would be excellent ambassadors to stakeholder groups. Since the steering committee itself is highly representative, its members will have the contacts and credibility necessary to fulfill this role effectively.

Roles and Responsibilities
- The leadership team will coordinate the activities of the steering committee members, ensuring that they have a comprehensive, coherent, and factually sound message with which to approach other stakeholders.
- The pilot programs will serve as demonstration projects.

Tactic 4: The leadership team will serve as a liaison to private foundation and corporate funders, within Michigan and nationally, and develop strategies for engaging their support for the project.

Rationale and Discussion

Unless adequate funding for the action plan and its elements is secured, many elements of the action plan cannot be implemented. Funders—defined as private foundations, payer and employer groups, corporate giving programs, and perhaps even state and federal government—need to be viewed as a key constituency whose buy-in is needed and actively sought. Funders need to be made aware of the pilot programs, the rationale behind them, and how they will be structured and evaluated. In some cases, it may be necessary as well to "tailor" funding requests to specific funders—for instance, local community foundations may help segments of the local pilots.

Roles and Responsibilities
- The leadership team should take responsibility for securing funder support.
- The pilot programs will be responsible for providing in-kind, matching, or purely local funding whenever possible.