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Comparative Initial and Sustained Engagement in Web-based Training by Behavioral Healthcare Providers in New York State

Rachel Talley, M.D.,

New York State Psychiatric Institute, Department of Psychiatry, Columbia University Medical Center, 1051 Riverside Drive, New York, New York, 10032

I-Chin Chiang, M.S.,

Data Analyst, New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032

Nancy H. Covell, Ph.D., and

Assistant Professor of Clinical Psychology, New York State Psychiatric Institute, Department of Psychiatry, Columbia University Medical Center, 1051 Riverside Drive, New York, New York, 10032

Lisa Dixon, MD, MPH

Professor of Psychiatry, New York State Psychiatric Institute, Department of Psychiatry, Columbia University Medical Center, 1051 Riverside Drive, New York, New York, 10032

Abstract

Improved dissemination is critical to implementation of evidence-based practice in community behavioral healthcare settings. Web-based training modalities are a promising strategy for dissemination of evidence-based practice in community behavioral health settings. Initial and sustained engagement of these modalities in large, multidisciplinary community provider samples is not well understood. This study evaluates comparative engagement and user preferences by provider type in a web-based training platform in a large, multidisciplinary community sample of behavioral health staff in New York State. Workforce make-up among platform registrants was compared to the general NYS behavioral health workforce. Training completion by functional job type was compared to characterize user engagement and preferences. Frequently completed modules were classified by credit and requirement incentives. High initial training engagement across professional role was demonstrated, with significant differences in initial and sustained engagement by professional role. The most frequently completed modules across functional job types contained credit or requirement incentives. The analysis demonstrated that high engagement of a web-based training in a multidisciplinary provider audience can be achieved without tailoring content to specific professional roles. Overlap between frequently completed modules and incentives suggests a role for incentives in promoting engagement of web-based training. These findings further the understanding of strategies to promote large-scale dissemination of evidence-based practice in community behavioral health settings.

Address correspondence to: Rachel Talley, Address: New York State Psychiatric Institute, 1051 Riverside Drive, Suite 1300, Box 95, New York, New York, 10032, rachel.talley@nyspi.columbia.edu, Phone: 646-774-6377.

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INTRODUCTION

Despite the growing array of evidence-based interventions available to address mental health and substance use disorders, failure to consistently and widely implement evidence-based care in community practice threatens the quality of behavioral health care; national policymakers have noted the need for improved dissemination strategies for evidence-based practices (EBPs) as an important step in addressing this gap (Institute of Medicine 2005). Web-based learning strategies have been suggested as an inexpensive and effective dissemination tool for providers to obtain training in EBPs (Southernwood 2008). Web-based tools have particular potential utility for community providers who traditionally lack access to training due to staffing and financial limitations (Bennett-Levy and Perry 2009; Rees and Gillam 2001; Adler et al. 2013).

Prior pilot studies and RCTs have evaluated web-based training in several behavioral health conditions (Stoner et al. 2014; Weingardt et al. 2006; Weingardt et al. 2009; Larson et al. 2013; Samuelson et al. 2014; Ruzek et al. 2014; Stein et al. 2015). Promising findings from these studies include increased provider comfort with EBPs (Samuelson et al. 2014; Ruzek et al. 2014) and intention to implement EBPs (Stoner et al. 2014) as measured by self-report; increase in provider knowledge in pre- and post- multiple choice testing (Weingardt et al. 2006; Samuelson et al. 2014); and increased provider use of examined EBP as measured by post-training evaluation of real or standardized patient sessions (Larson et al. 2013; Ruzek et al. 2014) and patient survey (Stein et al. 2015). While this literature demonstrates such gains from web-based training in small research samples, it offers little insight into whether web-based modalities can effectively disseminate EBP training in large, real-world samples of community providers. Specifically, it does not capture initial and sustained engagement in training or what motivates that engagement. While there has been some study of user engagement in web-based training in widely disseminated trauma-focused EBPs (Vona et al. 2014; Heck et al. 2015), further study of web-based training in large samples of community providers with a specific focus on measures of initial and sustained engagement is needed to better understand how these tools are best employed to increase dissemination of EBPs.

Existing literature has frequently focused on use of web-based training in a single provider type (e.g., substance abuse counselors) (Weingardt et al. 2006; Weingardt et al. 2009; Larson et al. 2013). However, evidence-based practices are often relevant and useful across a range of disciplines rather than discipline-specific. Dissemination of EBPs to a *multidisciplinary* provider audience is particularly relevant in community behavioral health settings, which frequently employ a range of clinical staff providing team-based care including physicians, social workers, counselors, therapists, case managers, and others. Thus, a better understanding of the utilization of web-based training modules for dissemination of EBPs to multidisciplinary provider audiences is critical to determining how to deploy distance learning in spreading evidence-based practice to community settings

Among studies that have examined use of trauma-focused web-based training in large multidisciplinary provider samples (Vona et al. 2014; Heck et al. 2015), there has been evidence to suggest differences in use patterns based on clinical and training background. In

a large multidisciplinary sample of users of an online TF-CBT training, significant differences in training initiation and completion by user educational background, professional role, and years of experience were found (Heck et al. 2015). Significant differences in use and engagement by user's length of prior clinical experience were found in a publicly available web-based CBITS training among over 1400 users (Vona et al 2014). Further understanding of engagement with training by provider role will inform whether web-based trainings should be tailored for particular provider types, or whether broad dissemination of the same training can be effective in a multidisciplinary audience without such tailoring.

The New York State Office of Mental Health funds the Center for Practice Innovations (CPI) at the New York State Psychiatric Institute to develop mechanisms for promoting adoption of evidence-based practice which includes an online platform to deliver web-based training. As has been previously described for one of the EBPs that CPI supports (Covell et al. 2011), integrated services for people with co-occurring mental health and substance use diagnoses, early engagement with training was promising. Of 369 programs who participated in the initiative, 63% had at least one staff member accessing the online modules, and 30% had one-third or more of their staff accessing the online modules (Covell et al. 2011). Since this initial work, the CPI's online training platform, or Learning Management System (LMS), has expanded exponentially, now serving over 25,000 providers and including multiple additional online training initiatives supporting the dissemination of evidence-based practices for a variety of EBP. This expanded content includes, and is not limited to, assertive community treatment, individual placement model of support employment, suicide prevention, first episode psychosis, wellness self-management, person-centered treatment planning, and violence risk assessment.

This report evaluates engagement in a web-based training system in a large, multidisciplinary sample of community providers. Specifically, we report whether people in different professional roles initially engage in rates we would expect and, once engaged, how much of the training they watch and whether they prefer different topics.

MATERIALS AND METHODS

Program Description

The CPI's Learning Management System (LMS) is an online platform that currently hosts over 60 training modules from several curricula to which enrolled participants have 24-hour access. The majority of these training modules (39 out of 60) are part of the Focus on Integrated Treatment (FIT) curriculum. Four modules are part of the Assertive Community Treatment (ACT) curriculum, three modules are part of the Individual Placement and Support (IPS) for supported employment curriculum, and four are included under suicide prevention. Additional modules cover other topics with content relevant to providing evidence-based treatment to individuals with mental illness (e.g., Wellness self-management, working with families, and violence risk assessment). The modules feature personal recovery stories, clinical vignettes, interactive exercises, frequent knowledge checks, and expert panel presentations to engage the learner. The LMS automatically tracks user participation on an individual basis, including which modules are viewed and completed.

Staff members of any not-for-profit behavioral healthcare licensed program in New York State have access to take the training at no cost to the agency. The New York State Office of Mental Health significantly encourages agency leadership to have program staff make use of the available training. Once a program registers with CPI, the program supervisor receives a link that is unique for that program to forward to their staff. Staff members click on the unique link to create a username and password for the LMS. Individuals with LMS access are free to take any of the available training. In most cases, staff take whichever training they or their supervisor feels best supports their clinical work. In some cases, supervisors choose to assign training to staff; in other cases, supervisors encourage staff to choose the training themselves. However, people working within ACT programs and some staff in clinics that were participating in a quality improvement project are required to take some specific core trainings, in addition to anything else they feel would be beneficial.

Analysis

For this analysis, data were extracted from the LMS and analyzed using IBM SPSS Statistics Version 23. The data extracted represented usage of the LMS system from November 2009 through February 2017. Eleven functional job types were considered in the analysis; several of these functional job types represented groups of several professional roles. The professional roles that are encompassed by the eleven functional job types considered are defined in the Table 1 as per definitions provided by the New York Office of Mental Health for various professional roles.

To measure engagement in the LMS, a chi-square goodness-of-fit test was applied to compare the distribution of professions among registrants in the LMS to distribution in the NYS behavioral health workforce. Data on workforce distribution in the LMS workforce was extracted in June and July 2014 as part of a needs assessment for the Delivery System Reform Incentive Payment (DSRIP) program in New York State; this data includes all professionals both licensed and registered to practice. To match the professional roles available in the NYS behavioral health workforce data, we collapsed several functional job types resulting in the five professions shown in Table 2: psychiatrist/physician, psychologist, social worker, nurse practitioner, and mental health counselor.

To measure initial engagement with the training, we compared the proportion of registrants who went on to complete at least one LMS module within each of the 11 functional jobs (e.g., number of physicians who completed at least one module divided by number of physicians registered in the LMS). A chi-square test of independence was applied to compare proportions of completion across functional job types.

To examine sustained engagement with the training, we applied a one-way ANOVA to the average number of trainings completed for each functional job type. We further conducted post hoc t-tests using a Bonferroni correction ($\alpha = .0004$ 0.5/110)

To examine preferences for different training across professional roles, we calculated the proportion of registrants completing each available module by each functional job type. Any module that was among the five most frequently completed for any functional job type was then categorized based on Continuing Medical Education (CME), a credit incentive;

membership among modules required by the Office of Mental Health as part of a Continuous Quality Improvement (CQI) initiative, a requirement incentive; and membership among modules required by the Assertive Community Treatment (ACT) core training, another requirement incentive. It is important to note that all of the completed modules awarded both Credentialed Alcoholism and Substance Abuse Counselor (CASAC) credit and social work continuing education (beginning April 2015); as these incentives applied to all modules, they were not considered for this analysis. To determine the proportion of users potentially impacted by the CQI and ACT requirement, the proportion of modules completed by users in clinics with the CQI requirement as well as the proportion of modules completed by users in ACT programs was calculated.

RESULTS

Chi-square goodness-of-fit test indicated a statistically significant difference in the distribution of profession of LMS participants compared with the NYS behavioral health workforce ($\chi^2 4 = 1134.428$, $p < .0005$). As shown in Table 2, there were at least forty-percent fewer psychologists registered in the LMS (554 observed compared with 976 expected). There were slightly fewer social workers (4037 observed compared with 4526 expected), and significantly more medical professionals, with more than a third additional of psychiatrists (822 observed compared with 598 expected), and more than double of additional nurse practitioners (263 observed compared with 118 expected).

As shown in Table 3, 85.4% of all LMS participants completed at least one module in the learning system, demonstrating a high level of initial engagement across functional job types. Chi-square test showed a statistically significant association between the number of LMS participants that completed at least one module, and their functional job type ($\chi^2 10 = 387.295$, $p < .0005$). Participants most likely to complete at least one module in the system included those who self-identified within the functional job types of mental health therapy aide (94.7%), rehabilitation counselor (91.4%), nurse/nurse practitioner (90.5%), and psychologist (89.7%). Functional job types with percentage completion of at least one module falling below 84% included peer counselor, supervisor, psychiatrist/physician, and case manager.

Among those that completed at least one module, one-way ANOVA revealed a significant difference in the average number of modules completed across functional job type ($F(10,18834) = 33.181$, $p < .0005$). Post hoc analyses revealed 48 pairwise t-tests that were significant at the adjusted level ($\alpha = .0004$). The largest mean difference in the number of modules completed was between counselor/therapist and case manager (5.2012, $p < .0005$). The smallest mean difference was between counselor/therapist and rehabilitation counselor (.0017, $p = 1.000$). Figure 1 illustrates the average number of modules completed by functional job type.

Table 4 reviews comparative popularity of module by functional job type as measured by the five most frequently completed modules, including percentage of providers who completed each module. All of the most frequently completed modules appear within the Focused on Integrated Treatment (FIT) curriculum, which represents 39 of 61 modules currently

available in the LMS. The most frequently completed module across all functional job types was the initial module of the Motivational Interviewing series, *Motivational Interviewing I*. At least 2 out of the top 5 most frequently completed modules across functional job type were from the Motivational Interviewing series. Notable differences by functional job type included the *Philosophy and Perspectives on Recovery* module, which was among the most frequently selected by mental health therapy aides; the *CBT for Coping Skills and Problem Solving* module, which was among the most frequently selected by peer counselors, rehabilitation counselors, and occupational/physical therapists; and the *Motivational Interviewing and Harm Reduction* module, which was among the most frequently selected by social workers and psychologists.

As shown in Table 5, all of the most frequently completed modules across functional job type were among modules with incentives for completion with the exception of *Philosophy and Perspectives of Recovery*. As noted above, once a person has a login to the LMS, they are free to take whichever training they like. However, people may be more motivated to take training that is incentivized in some way. For example, among all users, 3.4% of modules were completed by users in ACT programs who are required to take certain modules as part of mandatory training requirements; 26.5% of modules were completed by users in clinics where there was some required training. Only 11 of the 61 LMS modules offer CME credit; 5 of these 11 modules were among the most completed modules across functional job types. The most frequently completed module across functional job types, *Motivational Interviewing I*, offered the highest incentive for completion as it belongs to both required curriculum sets and offered participants the maximum CME credit available per module in the LMS system (1 credit). The *Stagewise Treatment* module, which was the second most frequently completed module among 7 out of 11 functional job types, offered an almost identically high incentive, differing only in less CME credit available (0.75 credit). Modules offering only one of the three incentives evaluated included the *Introduction* module, the *Motivational Interviewing and Harm Reduction* module, and the *CBT for Coping Skills and Problem Solving* module. With the exception of the Introduction module, all modules with only one of the three evaluated incentives were among the most frequently completed for only 1–2 functional job types as described in Table 4. The *Philosophy and Perspectives of Recovery* module, which was among the most completed modules for mental health therapy aides, did not have any of the three credit or requirement incentives; however, as noted above, this module along with the others was eligible for CASAC credit and social work continuing education.

DISCUSSION

Our findings demonstrated high overall initial engagement in web-based training as measured by registration and completion of at least one web module. This suggests that, at least at the stage of initial engagement, a web-based training incorporating a range of topics can be broadly disseminated in a multidisciplinary behavioral health provider audience without tailoring unique content for different provider types. While significant differences were noted, the analysis revealed a generally high initial engagement rate across professional role. Further, the strong similarities in preferred modules across provider types supports the

idea that tailoring content to target a specific provider type may not be necessary or relevant for team-based community behavioral health work.

We additionally found significant differences in initial engagement by profession and significant differences in average sustained use. We also noticed a pattern between module preference and presence of particular incentives. Medical professionals (who are eligible for CME credit) were overrepresented among LMS registrants as compared to the NYS behavioral healthcare workforce, while psychologists (who have no CME requirements in NYS) were underrepresented. This could simply reflect a difference in the professional make-up of the not-for-profit behavioral health workforce as compared to that of the state at large (e.g. a bias towards hiring of prescribing professionals in the non-for-profit system). However, this could also suggest that potential to earn CME credit motivated medical providers to register with the system. Of note, 5 of the 11 modules that offered CME credit were among the most completed modules. CME aside, trainings required by particular program initiatives (OMH CQI and ACT) were also heavily represented among the most completed modules. Further inquiry into other factors motivating use is needed to interpret the differences in use by profession observed given that CME credit is only applicable to medical professionals, and all users were not subject to the ACT and CQI requirements; in particular, a relatively small proportion of the user group was subject to the ACT requirement.

This evaluation has several limitations. The preference data presented does not fully represent *depth* of usage - that is, as presented here, it is not possible to distinguish whether higher percentages of usage among preferred modules represents a few users completing multiple modules or many users completing a few of the same modules. Future evaluation of unique engagement patterns by user would offer deeper insight into preferences and motivating factors among the highest utilizers of this system. Examination of additional incentives would provide more insight into factors motivating differential providers use in this platform. Finally, while the findings presented here highlight provider engagement with this training tool, more study is needed as to whether these high levels of engagement translate into increased application of evidence-based practice in community settings. In spite of these limitations, the findings presented here offer further insight into how best to strategically design and incentivize web-based training to maximize the reach of evidence-based practices in community settings.

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Figure 1.
Average Number of Modules Completed by Functional Job

Table 1

Definitions of Office of Mental Health Functional Job Types

Professional Role	Professional Role Definition
Mental Health Therapy Aide ¹	An individual performing functions defined as teachers or therapists not otherwise coded
Psychologist	An individual licensed as a psychologist by the NYSED ² , or an individual with at least a Master's level degree in psychology who provide routine psychological services under the supervision of a licensed psychologist
Nurse	An individual licensed as a registered nurse by the NYSED; under the supervision of a physician or a supervising nurse, this person provides direct treatment and dispenses prescribed medications.
Nurse Practitioner	A licensed professional nurse who has an advance certification through the American Nurses Association in a clinical specialty area or who has completed a program registered by NYSED and received a certification of completion in a clinical specialty area relevant to the treatment of the disability being treated.
Rehabilitation Counselor	An individual who has either a master's degree in rehabilitation counseling from a program approved by the NYSED or current certification by the Commission on Rehabilitation Counselor Certification
Counselor	An individuals credentialed by the New York State Office of Alcohol and Alcoholism and Substance Abuse Services; or an individual responsible for providing assessment or counseling services to more than one member of family in a session.
Therapist	An individual with a Bachelor's or Master's degree in therapeutic recreation from a program approved by NYSED or a registration in this discipline by the National Therapeutic Recreation Society; or an individual who provides, supervises, or directs professional activities or creative arts therapy services.
Social Worker	An individual licensed as a master social worker or clinical social worker by the NYSED.
Case Manager	An individual who supervises the implementation of each individualized program, monitors services received, records progress and initiates required periodic reviews
Occupational Therapist	An individual licensed as an occupational therapist by the NYSED
Physical Therapist	An individual licensed as a physical therapist by the NYSED
Peer Counselor	An individual functioning as defined for Alcoholism and Substance Abuse Counselor under supervision but who does not have a credential issued by the Office of Alcoholism and Substance Abuse Services
Supervisor	Staff who directly supervise or assist in the supervision of provision of Clinical Services, Social Services, or Education Related Services
Psychiatrist	An individual licensed as a physician by the NYSED and certified by, or eligible to be certified by, the American Board of Psychiatry and Neurology
Physician	An individual licensed as a physician by the NYSED

¹Office of Mental Health definition of "Therapy Assistant/Activity Assistant"²New York State Department of Education

Table 2Distribution of Functional Job of LMS¹ Participants Compared to NYS Behavioral Health Workforce²

Functional Job	Observed N	Expected N	Percentage Difference (%) ³
Psychiatrist/Physician	822	598	+37.4
Psychologist	554	976	-43.2
Social Worker	4037	4526	-10.8
Nurse Practitioner	263	118	+123.8
Mental Health Counselor	1003	462	+117.3
Total	6679		

¹ Learning Management System² Chi-square goodness-of-fit was significant, $\chi^2_4 = 1134.428$, $p < .0005$ ³ Percentage difference is calculated as Observed N subtracted by Expected N, then divided by Expected N

Table 3LMS⁴ Participants Completing at Least One Module by Functional Job Type⁵

Functional Job	Total Participants (n)	At Least One Module Completed (n)	At Least One Module Completed (%)
Mental Health Therapy Aide	810	767	94.7
Rehabilitation Counselor	626	572	91.4
Nurse/Nurse Practitioner	3222	2917	90.5
Psychologist	554	497	89.7
Counselor/Therapist	4720	4140	87.7
Social Worker	4048	3462	85.5
Occupational/Physical Therapist	449	388	86.4
Peer Counselor	492	413	83.9
Supervisor	4783	3874	81.0
Psychiatrist/Physician	822	634	77.1
Case Manager	1542	1181	76.6
Total	22068	18845	85.4

⁴ Learning Management System⁵ Chi-square test, $\chi^2_{10} = 387.295$, $p < .0005$

Table 4

Top 5 Most Frequently Completed Modules by Functional Job Type

Functional Job	Top 5 Completed Modules (%)				
	1	2	3	4	5
Mental Health Therapy Aide	Motivational Interviewing I	Introduction	Stage-Wise Treatment	Motivational Interviewing III	Philosophy and Perspectives of Recovery
	4.7	4.5	4.1	4.0	3.9
Psychologist	Motivational Interviewing I	Motivational Interviewing II	Stage-Wise Treatment	Motivational Interviewing and Harm Reduction	Motivational Interviewing III
	4.8	4.2	4.2	3.9	3.8
Nurse/Nurse Practitioner	Motivational Interviewing I	Stage-Wise Treatment	Motivational Interviewing III	Motivational Interviewing II	Introduction
	5.8	4.6	3.9	3.7	3.6
Rehabilitation Counselor	Motivational Interviewing I	Stage-Wise Treatment	Introduction	Motivational Interviewing II	CBT for Coping Skills and Problem Solving
	4.7	3.8	3.7	3.5	3.5
Counselor/Therapist	Motivational Interviewing I	Stage-Wise Treatment	Motivational Interviewing II	Introduction	Motivational Interviewing III
	4.9	4.4	3.9	3.8	3.7
Social Worker	Motivational Interviewing I	Stage-Wise Treatment	Motivational Interviewing II	Motivational Interviewing III	Motivational Interviewing and Harm Reduction
	5.6	4.9	4.4	4.0	3.8
Case Manager	Motivational Interviewing I	Introduction	Motivational Interviewing II	Motivational Interviewing and Harm Reduction	Motivational Interviewing III
	6.4	5.1	4.2	4.0	4.0
Occupational/Physical Therapist	Motivational Interviewing I	Introduction	Motivational Interviewing II	Motivational Interviewing III	Stage-Wise Treatment
	5.6	4.7	4.4	4.2	3.9
Peer Counselor	Motivational Interviewing I	Introduction	Stage-Wise Treatment	Motivational Interviewing II	CBT for Coping Skills and Problem Solving
	6.1	4.5	4.2	3.8	3.8
Supervisor	Motivational Interviewing I	Stage-Wise Treatment	Introduction	Motivational Interviewing III	Motivational Interviewing II
	5.5	4.5	4.4	3.7	3.7
Psychiatrist/Physician	Motivational Interviewing I	Stage-Wise Treatment	Motivational Interviewing II	Motivational Interviewing III	Introduction
	6.4	5.3	4.7	4.2	3.9

Table 5

Most Frequently Completed Modules by Requirement and Credit

Module	CME ⁶ Credit Eligible	OMH CQI ⁷ Curriculum Requirement	ACT ⁸ Requirement
Motivational Interviewing I	1.00	X	X
Stagewise Treatment	0.75	X	X
Motivational Interviewing II	1.00	X	
Motivational Interviewing III	1.00	X	
Introduction	0.75		
Motivational Interviewing and Harm Reduction		X	
CBT for Coping Skills and Problem Solving			X
Philosophy and Perspectives of Recovery			

⁶Continuing Medical Education⁷Office of Mental Health Continuous Quality Improvement⁸Assertive Community Treatment