

Financing Evidence-Based Programs and Practices:

Changing Systems to Support Effective Service

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Context

As a result of the public demand for improved mental health services and positive mental health outcomes for children and adolescents, evidence-based programs and practices (EBPs) have emerged at the federal, state and local level as an important and necessary strategy for providing effective treatments.¹ Evidence-based programs and practices are well defined services and therapeutic interventions that demonstrate positive mental health outcomes as evidenced by controlled research (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). These practices involve the incorporation of research, clinical expertise, and the individual client's choices and values in the selection of treatment, and they have spurred new excitement and hope for making a difference in the lives of youth and their families.

Indeed, the President's New Freedom Commission on Mental Health (2003) recommends the implementation of evidence-based practices as an essential component of a successful behavioral health care system. In addition, the Substance Abuse & Mental Health Administration (2002) has noted that implementing evidence based practices helps ensure that the mental health services being provided are the most appropriate for the individual and are the best possible from the perspectives of effectiveness and appropriateness.

Certainly, the implementation of EBPs holds great promise for serving children and families and promoting positive mental health outcomes. However, new and innovative methods are difficult to implement and sustain when funding to support the new services is not available, perceived as risky to obtain or sustain, or available only for small demonstration projects. Although increasing the availability of and access to effective programs and practices in the field is desirable and necessary, financing is essential to support the service and the infrastructure required to ensure high quality implementation, continual quality improvement, and sustainability of evidence based programs and practices. However, the rules, regulations, and resources that have supported traditional service systems often do not adequately support the high quality implementation of EBPs and, in many cases, unintentionally create barriers to both high quality service and sustainability.

Several important risks and consequences are associated with the lack of appropriate financing and infrastructure support for evidenced based programs and practices.

- The provision of effective treatments for children and families only will be available to a limited few, rather than on a larger scale to significant numbers of children and their families.
- Failure to finance effective services will make evidence based programs and practices difficult to sustain, and evidence-based services will have limited impact in improving the lives of children, youth, and families in need.
- Consumers and providers may experience unfulfilled expectations about the promised benefits of evidenced based practices, either due to lack of access or to poorly implemented attempts that do not result in effective service and therefore do not achieve desired outcomes. Such unfulfilled expectations may erroneously cast evidenced based practices as ineffective, inadequate, or as "ideal" practices which cannot be provided effectively in the "real world."

¹ The abbreviation EBP will be used throughout to include both evidenced-based programs and practices.

- Implementing evidence-based initiatives requires a considerable investment of time, effort, and money. When these practices cannot be sustained, such investments may become viewed as unwarranted and undesirable.
- Lack of sustainability also means that clinical services are disrupted or no longer available for children and families.

Clearly, the availability of adequate financing is critical for the future of evidence-based practices and effective mental health services for youth and families.

This brief will provide recommendations to address the current misalignment of financing and policy directives related to high quality, cost effective evidence-based programs and practices. The following sections will discuss financing needed for the critical components required to implement an evidence based program or practice, review the current funding challenges for the key components of programs and practices, provide rationales modifying this system, and provide specific and summative recommendations related to financing evidence-based practices.

Financing Three Critical Components of Evidence Based Practice and Programs

The implementation of an evidence-based program or practice is a complex process rather than a discrete event, and there are several important components involved in the implementation of evidenced based programs and practices. To successfully implement an EBP and provide benefits to consumers, three critical components require financing: (1) start-up activities to explore the need, feasibility, and installation of a program or practice, (2) the direct service provided to consumers by the EBP, and (3) the infrastructure needed to successfully implement and then sustain the quality of the EBP. The following section will review these three components and, describe the role that each plays in successful implementation efforts as well as the implications for financing.

Start-Up. Before a child or a family can benefit from an EBP, specific preparatory activities need to occur. As noted above, these preparatory activities can be grouped together and identified as the “start-up” phase necessary for implementing evidence based practices. This process begins when communities, state agencies, consumers, and providers identify the needs in their community or state and explore the availability of evidence-based practice to meet those needs. If an evidence-based practice matches that need, then the stakeholders explore the feasibility of implementing the evidence-based program or practice. If a state, county, or community decides to proceed with implementing an EBP, purveyors/developers of evidenced based programs may then begin meeting with organizations that are interested in implementing their programs. Engaging a knowledgeable source, such as a purveyor/developer, greatly increases the likelihood that the EBP will be successfully implemented (Panzano & Roth, 2006). Costs associated with this exploration process and the engagement of the purveyor/developer include travel, per diem, and consulting fees attached to meetings, with and without the purveyor/developer, to explore the fit of the EBP with the need and resources in the state and community. Additional activities during the “start-up” process that require funding may include staff time for creating referral mechanisms, realigning current staff functions to support the EBP, hiring new staff who are qualified to provide the treatment specified by the evidenced based program or practice, securing required space, purchasing necessary technology (e.g., laptops, cell phones, computers,

video cameras), and reimbursing the time in meetings with stakeholders as well as the time needed for staff to complete training (Fixsen, et al., 2005). All of these activities require “start-up” costs that are rarely integrated into the financing structures of publicly funded mental health service systems.

Currently, start-up costs are financed through a disparate array of sources at the federal, state and local levels. For example, start-up funding may be “cobbled together” from federal grants, federal block grants, or it may be possible for organizations to receive one-time grants from foundations or from the state. Organizations, charged with broadly assisting in the effort, may receive funding that can be disbursed to counties or agencies to support start-up activities. In some states, there may be county-level training funds available to assist with these costs. Given that start-up activities include a time-limited set of one-time costs, agencies and governmental entities interested in implementing EBPs generally can fund this planning phase with their own budgets, one-time grants from foundations, or other federal, state, county, or local resources. A clear best practice in financing start-up activities is the funding of planning time in the context of federal and state grants. However, not every initiative is started through a grant. Indeed, if the goal is to have the use of evidence-based programs and practices become the norm rather than the exception (e.g. pilot, one-time grant), then resources for start-up should be part of state and agency planning processes and acknowledged as key to successful implementation (Schoenwald, 1997).

Direct Service. The next funding component needed to implement EBPs is the funding for direct client services. Direct client service may take the form of a discrete evidence-based clinical practice (e.g., trauma focused cognitive behavioral therapy, dialectical behavior therapy, etc.) or an evidence based program (e.g., The Incredible Years, Multi-Systemic Therapy, Nurse Family Partnership, etc.), which has multiple components that are essential for the program’s successful operation and for generating positive outcomes for children and families. Direct clinical services that are characterized as a discrete clinical therapy or practice are often covered under typical medical funding sources, such as Medicaid, or may be paid for through private insurance policies. Such treatment sessions also may be funded through state contracts for children who do not qualify for Medicaid or have insurance coverage.

It is a different story for direct services that may incorporate non-traditional services and supports into a more comprehensive evidence-based program. Such nontraditional services and supports may include funding for transportation for families to attend support groups, food for families and children who participate in programs, child care for parents while they participate in services, or engagement of ‘elders’ in culturally diverse communities to assist with service support. With the prevalence of Medicaid funding in public sector mental health services, it is not likely that such services will be considered medically necessary, even though the effectiveness of clinical services may be directly impacted by the availability of these non-traditional supports. If parents cannot access services due to financial or logistical barriers (e.g. child care, transportation) or if parents choose not to attend due to the lack of cultural familiarity and language barriers, then there is little chance that the service components deemed and funded as medically necessary will reach the children and families in need.

Another challenge related to funding of the direct service is that financing can drive the program services, rather than having the program services drive the financing (Pires, 2002). This is particularly problematic when service components that account for a program’s effec-

tiveness, do not involve direct work with the child or youth. One example involves working with family members and teachers when the child is not present. Such interventions in the child's ecological system are critical to the demonstrated success of the program and are at the core of the theory base (e.g. MST), yet these services do not fit a 'medical model' that sees the child's problem as residing solely or primarily within the child. Medicaid billing for 15 minute units of face-to-face service with the child or adolescent can lead agencies by their wallets and encourage practices that overemphasize face-to-face service for the child but that reduce program effectiveness as family and school interventions are neglected (Surace, 2008).

Both non-traditional services and supports and services that work with the child's family, school, and community can be critical to achieving positive outcomes. Struggling to identify financial resources for these important components of an evidence-based program can make implementing an EBP difficult, fiscally risky, and therefore unappealing to providers. However, some funding sources and strategies that are in place provide non-traditional, but necessary resources. For example, FAST is a program set up by the State of Ohio to fund non-traditional services for children and can be used for a wide range of natural support services that augment treatment services.² FAST funds cannot be used for services that are reimbursed by Medicaid or other third party payers. Rather, FAST funds are accessed by local collaborative intersystem councils, typically for youth involved in multiple systems. Such examples can provide models for financing legitimate ancillary supports that enhance the likelihood of positive outcomes, but would not meet the definition of 'medically necessary'. Similarly, some states are funding program components that are not funded by Medicaid or are structuring Medicaid payments to include rates for direct child services that are inclusive of more of the costs of all the direct service components.

In addition to challenges associated with funding non-traditional services and family and community interventions and supports, there are challenges that arise due to cobbling together different funding streams in order to finance the direct services. For example, Multidimensional Treatment Foster Care (MDTFC) requires careful braiding of resources typically found in child welfare (for foster care purposes), mental health (for treatment purposes), and juvenile justice. Utilizing diverse funding streams, often with conflicting and/or frequently changing regulations and policies, adds to the administrative burden, cost, and risk and increases the reluctance of providers and payers to invest in what works for children and families.

Infrastructure. The final critical, and perhaps most complicated, component for effectively implementing an evidence-based practice or program involves funding for the infrastructure of the program. Infrastructure encompasses the training, coaching, fidelity monitoring, and outcome measurement systems for the program. All four of these infrastructure activities are essential to achieving positive outcomes and to the long-term sustainability of a program.

Training involves the process of providing knowledge, developing skills, and enhancing abilities of the practitioners who will be delivering an EBP. Information about the theory, philosophy, and rationale for the program components may be discussed, while skills and abilities related to carrying out the program components may be demonstrated and rehearsed during the training process. While not effective by themselves for producing changes in clinical settings, training is a necessary pre-requisite for effective service and is

² For more information about FAST Funds, please refer to the Ohio Department of Mental Health or <http://www.mh.state.oh.us/kids/kidsnewsletter/mayjun2008.pdf>.

an efficient way to impart the necessary information to practitioners (Ross, Luepker, Nelson, Saavedra, & Hubbard, 1991). However, attending training sessions for EBPs means that practitioners are not available to bill time for direct service, and this can decrease agency interest in participating as a host organization for an EBP, especially if the billable rate is already perceived to be too low or if there are fiscal pressures in the agency.

Coaching is the supervision, support and most importantly, continued assessment and development of practitioners' skills and abilities through direct observation, feedback, and attention to adherence to the principles and practices that make the program effective. Functional coaching to improve practitioners' clinical judgment and competence often requires lower supervisor to staff ratios and supervisors and coaches that are themselves competent in delivering the EBP. Although the requirements associated with functional coaching impact cost, there can be no cost-benefit ratio if practitioners cannot produce "benefits" for children, youth, and families. Research indicates that coaching makes clear contributions to the successful delivery of a program with fidelity (Joyce & Showers, 2002; Schowenald, Sheidow, & Letourneau, 2004; Harchik, Sherman, Sheldon, & Strouse, 1992). Despite the critical role that coaching plays in developing and maintaining staff competence, the current funding system does not readily support the costs associated with intensive coaching and supervision. Similar to the fiscal barriers associated with training, if senior practitioners are acting as coaches and practitioners are receiving feedback from coaches, then neither are seeing individual clients and thus not accruing billable time for direct service. If supervisors are providing the coaching, the fiscal barriers can be similar, with funding sources (e.g. Medicaid) reluctant to allow this cost as part of the direct service billing rate. Lack of support for functional coaching to promote therapist and practitioner competence and adherence serves as a further deterrent to the widespread and effective use of evidence-based programs and practices.

Outcome measurement and fidelity monitoring are also key infrastructure components. Fidelity monitoring ensures that the program is implemented as intended and that the individuals delivering the program demonstrate skill and attention to essential program components when they interact with consumers. Determining whether therapists, practitioners, and supervisors are delivering programs with fidelity requires regular monitoring, evaluation, and feedback from trained evaluators. Research demonstrates that individuals who are treated by therapists who provide service with high fidelity to the core components of a program have significantly better treatment outcomes (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997). Fidelity and outcome measurement and the use of the data are essential to the effectiveness of EBPs; however fidelity monitoring and evaluation costs are not uniformly covered under public financing systems. Without fidelity measurements, it is impossible to understand whether the practitioners delivering a program are providing the services accurately and skillfully. Continuous quality improvement is not possible without outcome and fidelity monitoring. If an EBP produces results that are not as positive as expected, the service provider and funders need to be able to determine if it is an implementation problem or an effectiveness problem, or a combination of both. Low fidelity and poor outcomes call for targeted efforts to improve staff adherence to the model. If fidelity is high and outcomes are poor then an examination of the appropriateness of the target population and the intervention are called for. Without regular fidelity and outcome measurement an EBP runs the risk of being mislabeled as "ineffective" or "inappropriate" rather than in need of improvement with respect to fidelity.

Outcome and fidelity measurement allow for agencies providing a service to document its effectiveness and engage in continual quality improvement so that the best quality services continue to be available to children and their families. Without good fidelity and outcome evaluation, even the most effective interventions will not produce positive effects over time. Or worse yet, if this infrastructure is unfunded then all that may remain of an evidence-based program is an empty label. Reliable, rigorous, and useful outcome data are largely missing within behavioral health care services, which make data-based decision making impossible. Fortunately, there are a few positive examples of such attention to outcome evaluation and even research agendas at the state level. (e.g., Michigan for Parent Management Training, Multisystemic Therapy, Functional Family Therapy, and Multidimensional Treatment Foster Care; Oklahoma for SafeCare; New Mexico and Connecticut for Multisystemic Therapy) but routine funding for outcome data collection, analysis and use is far from the norm

While funding start-up activities and the direct clinical services is not necessarily simple or sure, funding for the infrastructure components is very difficult. Currently, these infrastructure costs may be funded through Federal Block Grant funds, states may fund these costs through General Revenue sources, or organizations may use private foundation grants. There are also examples of states funding EBPs entirely under Medicaid using the Rehabilitation Option, where providers can bill through county mental health plans based on the actual cost of providing the EBP service (Surace, 2008). However, the process of providing funding for these infrastructure costs can be a laborious and risky process. Different sources of funding may need to be tapped for each component. Such sources may be from non-recurring sources (e.g. one-time grants) leaving agencies scrambling on an annual basis to cover costs associated with training new staff, developing their skills through coaching, and remaining vigilant with regard to fidelity and outcomes. Variations from state to state and year to year regarding allowable costs (e.g., bundling coaching and practitioner transportation costs into Medicaid rates) may make funding for the infrastructure tenuous at best. Providers are forced to “pretzel” together or pull funds from disparate and limited sources in an attempt provide necessary infrastructure. The lack of coherent, recurring funding sources for the infrastructure required for effective services increases the administrative burden for agencies and the perceived risk associated with providing EBPs.

An evidence-based program or practice that is not sustainable over time is not an effective strategy for providing services and supports for children and their families. Sustainability refers to the long-term survival and continued effectiveness of the program as the context changes over time and as the program is adjusted without losing the critical core components (Fixsen, et al., 2005). This requires funding for hiring new staff, providing timely training, meeting new program requirements, coaching, technical assistance, monitoring fidelity, and analyzing outcome data. These key aspects of infrastructure require continuity. Therefore, developing effective and reliable ways to finance these costs over time is essential for the long term sustainability of evidence based programs and practices. Without these supports in place, it is unlikely that evidence based programs and practices will go to scale, thus limiting the opportunity for significantly impacting positive outcomes for youth and families. Building the statewide capacity to sustain evidence-based practices requires the strategic allocation of time and money at both the state and local level for infrastructure.

In summary, this is what is required. The initial start-up activities, the direct clinical and support services, and the infrastructure needed to sustain a program or practice over time are all essential components of evidence-based programs and practices. Initial start-up activities are necessary to determine community needs and explore the EBPs available to meet those needs; as well as to determine the fit and feasibility of implementing a relevant EBP. The direct clinical and support services that comprise the core elements of the EBP that are required for positive outcomes to accrue to children and families also must be financed. And, training, coaching, fidelity monitoring and outcome measurement comprise the infrastructure that is part of the effective intervention. These infrastructure components are not “extras” that can be cut in times of a budgetary crisis; rather they are directly relevant to ensuring the provision of high quality, effective services. Financing all three components of evidence-based program implementation is a major factor in successfully providing widely available and effective evidence based programs and practices. Financing EBPs requires using current resources more effectively and differently to improve the mental health and well-being of children and families. The following are a set of broad recommendations for improving the coherence and availability of financing for evidence-based programs and practices.

Recommendations

EBPs require a new service and funding paradigm. In order to achieve effective and improved results, we will need funding streams and program designs that support the use of effective practices and services. We need financing that is more than rule-governed. We need financing that promotes positive outcomes.

- **Ensure that funding regulations support the delivery of the key elements** of the EBP. Funding regulations will need to be analyzed in collaboration with the EBP developers to ensure that such regulations support the delivery of the effective treatment mechanisms of the EBP. Funding can be fairly applied, well regulated, and also can support efficacious treatment protocols that are not limited to face-to-face contact with the child (e.g. service provision to family members, caregivers, and educators when the child is not present).
- **Fund services and supports that “boost” impact and access.** Non-traditional services and supports that ‘boost’ the impact of and improve access to clinical services and culturally appropriate services also will need to be viewed and funded as integral to EBP programs (e.g. transportation, food, support services provided by community ‘elders’).
- **Fund integrated infrastructures** to promote practitioner competence. Positive outcomes generated by EBPs are only achievable and sustainable when an integrated and effective infrastructure is funded. Training, coaching, fidelity monitoring and outcome measurement are all integral to producing positive outcomes for children and their families. Funders will need to ensure that service providers can demonstrate how this infrastructure is integrated and focused on the essential components related to the EBP. An integrated infrastructure focuses on developing highly qualified practitioners and front-line staff so that the EBP is implemented as intended with positive outcomes. This is in contrast to scattershot efforts comprised of one-time training events without follow-up or coaching, or to supervision systems that focus on compliance and production rather than developing competence.

- **Specifically tailor Requests for Applications (RFAs)** to promote successful implementation and sustainable services. State and federal governments can set the stage for effective and sustainable services by developing funding streams and RFA processes that:
 - » Require thoughtful planning and build in time and funding for start-up activities
 - » Cover all direct service costs including non-traditional or non-medical services and supports
 - » Build infrastructure costs necessary to achieve outcomes into the funding formulas and structures (e.g. funding for training, coaching, fidelity monitoring, and outcome measurement, funding for all parts of the service).
- **Ensure all children and adolescents are served effectively.** We know that evidence based programs can be both clinically effective and cost effective when implemented with fidelity. Requiring all programs and practices to report meaningful child and family outcomes will enable allocation decisions to be anchored in an assessment of the degree to which such outcomes are being produced. Cost-benefit analyses require that benefits be generated.
- **Reduce the perceived risk of implementing an EBP** by clarifying funding mechanisms and by reducing administrative burden. If effective programs and practices are to become widely available, funders must develop and authorize appropriate funding streams rather than leaving it to providers to ‘cobble together’ risky portfolios of financial practices. And the administrative burden can be reduced by structuring funding in the form of per diem, weekly, or monthly billing processes rather than requiring fifteen-minute billable units for service. Reducing administrative burden means that clinical and treatment resources provided by clinicians and front-line practitioners can be enhanced.
- **State government, federal and state Medicaid authorities, and private payers should work together to develop coherent funding streams** that are driven by creating positive results for children and their families. Braided funding streams can be proactively and collaboratively developed; funding can be appropriately leveraged; and each funding source can contribute to different parts of the required funding equations. Everyone has a stake in effective services.

As R. Spencer Darling, business and leadership expert, noted, “All organizations [and systems] are designed, intentionally or unwittingly, to achieve precisely the results they get.” If we want to change the status quo and encourage the adoption, implementation, and sustainability of effective programs and practices, we will need to change the conditions under which we are expecting communities, providers, and states to implement them. Financing must follow and fit the program if children and families are to benefit from the best that science, dedicated professionals, and family partnerships have to offer.

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The Child and Family Evidence-Based Practices Consortium is a collaboration of researchers, agency administrators, and purveyors seeking to promote the implementation and dissemination of evidence-based and promising practices in the area of child and family behavioral health. These individuals and organizations help to bridge the gap between research, policy, and practice. The Consortium provides a forum for sharing information about strategies, successes, and challenges in assisting agencies and organizations to incorporate evidence-based practices into their service systems. It also provides opportunities for collaboration to advance the knowledge and practice base.

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