

Chapter

7

How to Support Your Organization/ Program in Implementing Evidence- Based Practices

The best planning and implementation at the program level can run into barriers at the organizational or system level that may frustrate program managers, practitioners, and/or consumers and families. These barriers are best dealt with by identifying them early, understanding where they come from, and figuring out how to change them or work around them to provide the best possible care for consumers and their families. This chapter describes some of the barriers that might be encountered, using information from organizational change literature and from the observations of experts who have worked to implement changes at each of the levels discussed here. This chapter also suggests ways program managers and practitioners, along with consumers, families and other advocates, might go about dealing with these barriers.

It should be noted that at times the organization or system will be pushing for changes and for implementation of evidence-based practices and will be helping programs to deal with these barriers. This chapter is written to describe as many of the possible barriers programs and practitioners might face if the impetus for change is coming primarily from the program level.

ORGANIZATIONAL AND SYSTEM BARRIERS THAT MIGHT BE ENCOUNTERED

As program managers and practitioners begin to identify, plan, and implement new practices, based on evidence of effectiveness for the populations they serve, the program itself or the organization within which the program operates may have a culture, structures, ways of doing business, financial issues, and 'political' forces that work against the successful implementation of evidence-based practices. Examples of these possible barriers are discussed below.

PROGRAM AND ORGANIZATIONAL CULTURE

Some programs and organizations are comfortable with change and some are not. For those programs and organizations not comfortable with change, the implementation of evidence-based practices may be a challenge for program managers or for practitioners who work within them. Such organizations and programs are sometimes called 'change-averse.' For a program whose staff and clients are used

to and comfortable with change, but which exists within an organization that is not comfortable with change, the introduction of new practices can be especially frustrating. Likewise, an organization that is interested in changes at the program level and that has program managers and staff who are not as comfortable with change may face conflict as pressures are put on the program and its staff to implement new practices.

The reasons for a change-averse culture can vary. The philosophy and leadership style of top level managers or boards, the length of time the organization or the leadership has been in existence, the size of the organization, the context within which the organization operates, the financial stability of the organization, and the history of the organization with other recent change efforts can all contribute to the comfort of the organization or program with the introduction of new ideas.

It is critical that program managers, practitioners, and advocates assess whether the organization is change-averse or is going to be supportive of the introduction of new practices, especially if the new practice will have a significant impact on existing programs or on the perception of the organization within the community. It is also important that persons embarking on changes within a change-averse environment consider carefully the process and pace of change so that the organization, its leaders, and needed colleagues within the organization will not become an impediment to the new practice.

One issue that is critical to the implementation of any new practice is the capacity of supervisors to assist in and reinforce efforts of individual practitioners. Often, behavioral health programs hire or promote clinicians into supervisory roles on the basis of a credential, an academic degree, or longevity with the program. While education and experience certainly help practitioners to be successful supervisors, the process of supervising other practitioners is a skill in and of itself and is often

quite different from the skills necessary to provide direct service. Programs often have little or no time and resources to assist supervisors in learning these necessary skills. Sometimes programs do not evaluate and provide feedback to supervisors about their supervision activities. In its extensive research and publication on behavioral health workforce, *The Annapolis Coalition Action Plan on Behavioral Health Workforce Development* (Hoge, Morris et al 2007) has highlighted the critical role of the supervisor and the competencies required to be effective.

Changes at the program level will affect many other people within the organization and the community. Recognizing those effects early and planning for them will assist in assuring that the new practice is successful and sustainable.

Appropriate feedback to practitioners as they are learning new skills or a new practice has been shown to be critical to obtaining fidelity to the model being implemented and to successful outcomes. If supervisors are not given the opportunity to learn the new practice, or if they do not have good supervisory skills, the new practice may be doomed to be less than it could be and in fact to be a frustrating failure to consumers and practitioners alike.

It is important to recognize that change is hard work! It can be exciting and fulfilling, and is, in fact, a necessity for high quality work and for survival in today's world. However, changes at the program level will affect many other people within the organization and the community. Recognizing those effects early and planning for them will assist in assuring that the new practice is successful and sustainable.

Another cultural context that can cause a barrier is the culture of the community in which the program or organization exists. Whether the community is primarily rural, composed of a single or multiple ethnic groups, or is a university town can have profound impacts on the ease or difficulty of implementing new practices. In rural areas, it may be difficult to find practitioners to staff teams or to provide knowledgeable supervision for the new practice. In communities that have a number of different ethnic groups, the cultural specificity of clinical practice can impact the approach to implementing new ideas, as well as the content of the new practice itself. In university or college towns or in locations where community colleges are active, there may be researchers and academicians eager to assist you in identifying practices and barriers, and in evaluating the impact of the implementation of new practices. They may also provide a ready resource for training that may be difficult to find in locations where they do not play a role.

ORGANIZATIONAL STRUCTURE

Sometimes the very structure of an organization or system can be an impediment to change. If all the physicians are supervised by a single Medical Director who is not interested in the new practice, and the new practice requires the involvement and support of physicians assigned to the program, this structure can impede the ability of the program manager and other practitioners to engage those physicians in the change process. If the new practice requires utilizing and accounting for financial or human resources differently than in the past, and the person in charge of financial management or the human resource director is not interested in or actively opposed to these financial and personnel changes, the practice may not be able to be implemented successfully.

In some systems, a local authority (county or free-standing board) has control over the direction of program development, financial planning, payment

for services, quality efforts, data collection, training, and/or strategic planning. Any of these processes can impede program development if the decision-makers in the system structure are not interested in or actively oppose the changes proposed by the program or organization.

A good example of such a structural impediment would be a system in which decision-making and resources about substance abuse services or about vocational services are separated from decision-making and resources for mental health services. For a program attempting to implement integrated services for persons with co-occurring substance abuse and mental illness or a program interested supported employment, these structural divisions may present considerable constraints.

BUREAUCRATIC PROCESSES

Individuals wishing to implement a different practice will often find that the ways in which the program, organization, or system is set up to do business are impediments to the new practice. By definition, bureaucracy is the policies, procedures, and requirements by which an organization is operated. These rules of doing business are necessary for the orderly management of public or private resources and activities. In and of themselves, they are not bad. However, they exist to support and organize what is, not what is dreamed of or what is hoped for in the future.

Therefore, any new practice is likely to find that existing policies and procedures, forms, definitions, productivity standards, reporting processes, and other bureaucratic requirements are not supportive of a new way of thinking about practices and personnel deployment. There is much promise in the role of an electronic client record, decision support systems, and information technology in impacting the practice of health and behavioral health care. To the extent resources are available, these should be seriously considered.

It is important to approach these impediments with an open mind rather than a desire to resist and destroy. Program managers and practitioners will need to identify where such processes are true impediments and where they can be easily changed or adjusted. Consumers, families, and advocates participating in the planning and implementation process will need to be helped to understand why existing processes are in place and the process for changing them. Identifying who controls these bureaucratic requirements will also be important. If they are controlled locally (e.g., at the program or organizational level), the process for getting them changed will be much different than if they are controlled at a system level (e.g., the county or state) or if they are controlled through a political process (e.g., legislative rule-making body) or by an independent body (e.g., accreditation or credentialing organization).

These bureaucratic processes are often used as excuses for not implementing a new practice. As simple a thing as a reporting form or an assessment tool can drive activities toward old outcomes, or old ways of behaving rather than allowing new thinking to guide the development of a practitioner's care of an individual client or a program change, based on evidence-based thinking (see Chapter Two). All these processes must be inventoried when a new practice is being planned to determine what will impede or be used as an excuse. Programs often make the mistake of creating more bureaucratic processes, including policies, forms, assessment tools, and reports, rather than adapting or eliminating the current ones. Programs also often make the mistake of avoiding dealing with these current processes to their detriment when reimbursement or evaluations are based on the current processes.

These impediments need not be completely overcome in order to proceed. However, they do need to be actively reviewed to determine what actions must be taken to remove or mitigate impediments, support new ways of thinking, and assure compliance with the active components of the evidence-based practice.

FINANCIAL ISSUES

Reimbursement mechanisms are often driven by service definitions and criteria about who is qualified to deliver services. Sometimes these definitions were developed a long time ago and bear little relationship to the new services or practitioners that are being developed today. This is particularly true for a funding source, such as Medicaid, that now represents a significant portion of the funding for mental health services (especially for children) and an increasing portion of funding for substance abuse services.

Perhaps the most critical potential barrier to the implementation of evidence-based practices is the way in which services are funded and practitioners are paid.

Financing mechanisms also frequently drive or constrain service delivery changes. For example, if the primary financing mechanism is reimbursement for an individual service for an individual client by an individual clinician in an office or facility-based setting, providing services in a team, by a peer support professional, in a home or community-based setting (such as a restaurant or library) or with a collateral contact becomes difficult. Sometimes payment rates or limitations are identified as reasons why new practices cannot be developed or implemented properly. For example, if a program can produce more revenue through the use of licensed practitioners as individual therapists or clinicians seeing clients in individual or group sessions than the use of these same practitioners as client or family educators or as case managers, nurses, or physicians on an Assertive Community Treatment

team, it will be hard for a program to reassign these practitioners to a team-based approach. If a program cannot bill for more than one therapist at a time seeing a client face-to-face, it will be difficult to spend the time conducting a team-based or multi-disciplinary assessment or treatment team-planning session. If a program cannot secure higher cost medications that are necessary to appropriately implement medication algorithms, or if the process for getting authorization for the use of such medications is difficult or time-consuming, it will be hard to convince physicians to utilize such medications and algorithms, especially if case-loads are high and other expectations on their time are significant.

Sometimes these payment limitations are national in scope, as with the Medicaid program, or the various block grants and federal funding streams that have different and confusing requirements and goals. Sometimes these payment limitations are state-imposed system plans and regulations (e.g., the state Medicaid plan, the state vocational rehabilitation plan, the state IV-E plan or waiver, or the state plan for use of TANF monies). Payment limitations can also be created at the county or local authority level where such entities exist and play a role in program design and funding. In the best of all worlds, these payment limitations are organizational or programmatic. The Centers for Medicaid and Medicare Services (CMS) Medicaid regulations have been a moving target in this regard, for a time supporting bundling of rates, then opposing bundling of rates, and as of this edition going to press appearing ready to allow bundling. So it is important to remain current on what is permissible if the new evidence-based practice you are considering will be financed in your state, even in part, by Medicaid reimbursement. However, any of these limitations outlined above are not easy to affect if the organization or its leaders or colleagues are not amenable to change for any of the reasons identified earlier in this chapter. Generally speaking, the further away from the program the financial impediment

originates and the less knowledgeable and interested those in charge of these decisions are in supporting the implementation of evidence-based practices, the more difficult it will be to change these financing limitations.

Sometimes a program's own decisions about salary and compensation, productivity requirements, and their relationship to financial outcomes of the program or the individual practitioner, and financial support for new endeavors through the seeking of grants and donor contributions will have an important impact on preventing or encouraging experimentation and practice changes. It is not uncommon for bonuses and rewards either directly or indirectly to support only the use of existing practices rather than encourage the identification and utilization of new practice methods.

Financial barriers may be among the most difficult, but should not be considered impossible to overcome. Creativity, advocacy, and persistence may be necessary to create the financial changes to provide incentives to implementation of new practice approaches. The ability to identify and overcome such barriers or to create such incentives is the mark of a true program or clinical leader.

'POLITICAL' FORCES

In this context, we are thinking of the term 'politics' in its broadest application, that is the range of competing interests that are present in any organization: workers, management, advocates, etc. (There may also be partisan politics involved, if a governor or country supervisor, for example, makes adoption of evidence-based practices an issue.) There are often advocates and system stakeholders that have reasons to support practices and outcomes that have little to do with evidence-based practices or evidence-based thinking. This behavior may stem from lack of knowledge about new practices, a different perspective on desired outcomes, or personal or group agendas driven

by interests other than the best quality of care for consumers and their families. For example, decision-makers responsible for funding decisions (e.g., Congress people or state Medicaid officials), may have little information about behavioral health evidence-based practices and may have responsibilities that make it difficult for them to have the interest or to take the time to learn about the implications of such knowledge on financial decisions. Decision-makers responsible for other systems may have a different mission and, therefore, seek different outcomes for the same individuals or groups. For example, family court judges may see keeping a child safe as their primary mission, and thus, may demand immediate out-of-home placement, whereas treatment professionals may see an in-home, family systems approach as the best treatment intervention for the child's ultimate well-being and healthy development. Both positions are understandable, and a compromise in the pace or extent of program change may be required. Resolving differences requires educating all stakeholders and answering their legitimate concerns.

Sometimes representatives of a group of practitioners may express interests different than

evidence-based practice. For example, a union may support facility-based approaches that make it easier to obtain and oversee rights and safety of employees when community-based and in-home approaches have been proven to have better client and family outcomes. A professional association may oppose efforts to utilize peer professionals or new practitioners to do what they have traditionally done, for fear that limited resources will be diluted and their expertise will be less valued. This may make it difficult to engage professionals in teams, in multi-disciplinary activities, or in activities that include peer professionals as part of the overall effort.

It is important to see all these 'political' forces for what they are: legitimate differences of opinion about the outcomes desired for the public resources expended, and legitimate differences of opinion about the best method to effect the highest quality of care. They help identify differences in priorities that will impact the ability of a program or practitioner to change. They also reflect real resource limitations in tax dollars, health care and human service dollars, and time that must be respected in order to impact them. Political forces are a fact of life in any human endeavor, especially those funded largely by public dollars. Effectively managing these forces is the mark of a true leader and will be necessary to be successful in implementing evidence-based practices and evidence-based thinking.

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OBJECTIONS TO THE IMPLEMENTATION OF EVIDENCE-BASED PRACTICES

Objections heard within an organization when a new evidence-based or promising practice is proposed by a program manager, practitioners, or clients are likely to reflect any of the barriers described in Chapter Six or in this chapter. These objections may stem from lack of knowledge about evidence-based practices or evidence-based thinking, misinterpreted

professional standards, arguments appealing to tradition of practice or of the organization, *ad hominem* arguments (that is, arguments, based on who or what part of the system initiated the requirement or proposal), arguments appealing to ethics, or philosophy, or values. Any of these objections may mask or reveal individual readiness concerns or organizational barriers. Some may be legitimate and some may be based on fear or excuses.

In any case, those interested in implementing evidence-based practice(s) must figure out what is going on about the practice itself, in the program or organization that is being asked to adopt the practice, and in the nature of the relationship between the diffusing and the adopting organizations. You must also understand why individuals who are identifying or creating barriers are doing so and the legitimacy of their concerns. Resistance of an organization or individuals should never be seen as individual or organizational failure, but rather as opportunities to assess readiness and to provide support and encouragement for a change of thinking toward new approaches to delivery of care that will augment or in some instances replace current practices and result in better outcomes for clients.

A WORD ABOUT ‘FIDELITY TO THE MODEL’

In many circumstances, the barriers you face will make it difficult to adopt a practice with complete fidelity to the components of the practice that the evidence shows are critical to achieving the desired outcomes. Maintaining complete fidelity may not be possible due to complexity of the client population; unique conditions within the community; human resource, supervision or financial constraints; or policies and procedures that cannot be changed. Increasingly, researchers and organizational decision-makers are beginning to understand that fidelity to the model being implemented is critical to success

for consumers. There is debate in the field about whether adaptation of the model to meet existing conditions is better than not implementing the new practice at all, especially when some of the constraints that inhibit complete fidelity cannot be overcome. Some say there is no evidence to suggest that a practice that is not faithful to the experimental model will produce positive results. Others say that getting as close to the model as possible is all that can be expected in the real world of insufficient resources and bureaucratic barriers. For the latter, the argument is that doing something is better than continuing to deliver practices that do not live up to practitioners’ or clients’ expectations.

This debate is far from over. You should make your own decision about this dilemma, based on the circumstances in which you find your current program and practice. Obviously, the closer you can come to the model you are trying to implement, the better. If you adapt the model to fit your reality and your constraints, it is especially important that you track results and client outcomes to see whether the practice you implement has the outcomes expected and that you and your clients desire. (The role of outcome tracking and quality management and improvement processes is discussed in Chapter Eight.) However, if you are unable to fully implement a particular model, you should not promote it as if it were. Doing a program that is loosely based on the principles of Multi-systemic Therapy (MST), for example, should not be referred to as MST. In this regard, we think ‘truth in advertising’ is an appropriate guide.

STAGES OF INDIVIDUAL AND ORGANIZATIONAL READINESS

The strategies employed for overcoming barriers need to be designed, based on the stage of readiness of an organization or group of practitioners. As indicated in Chapter Three, organizations could be in any one of five stages:

- Unaware/Uninterested (or pre-contemplation)
- Consensus Building/Motivating (contemplation/preparation)
- Implementing (action)
- Sustaining (maintenance)
- Improving

If your program or practitioner group is unaware or uninterested in evidence-based practices or evidence-based thinking, efforts to expose staff and consumers/families to these ideas and possibilities may be the best approach. If the program or group is aware and somewhat interested, the level of interest and the level of resistance may suggest differences in approach to building consensus and motivating individuals to change.

Decisions about when a program or group of practitioners is ready to begin implementation may not be entirely in your control. Aside from the level of knowledge, interest and motivation, a mandate from a funding source, a decision-making body, or a program supervisor may leave little room for discussion about implementation timeline or process. In such a case, the strategies for engagement may need to be adjusted and focus more on explaining and assisting staff in understanding what is required and by when, with the work of awareness and consensus building occurring during and after implementation.

Once the practice has been implemented, there are specific strategies that ought to be a part of assuring that the practice is sustained, and that adjustments are made to improve these efforts so that results continue to get better over time as experience provides information and as new technologies and service models are researched and disseminated, either within the program itself or within the field.

ASSESSING INDIVIDUAL AND ORGANIZATIONAL READINESS AND IDENTIFYING REAL OR PERCEIVED BARRIERS

Some of the barriers described in this chapter and in Chapter Six can be mitigated. Some will have to be changed in order for implementation of the practice to be successful. In some cases, the barriers can be worked around without directly affecting the identified barrier itself. Program managers, practitioners, consumers, and families will need to determine which barriers are simply irritants and which will prohibit the successful implementation of the new practice. This requires a systematic assessment of potential barriers as part of the planning process before beginning implementation of a new practice.

The American College of Mental Health Administration (ACMHA) refers to such an assessment as a ‘fearless inventory’ of organizational and individual cause and effect of a given policy or practice. The ‘fearlessness’ is necessary to look fully and completely at those things that might aid or hinder the outcomes you are trying to achieve. ‘Fearlessness’ also implies looking at each environmental factor and assuming that anything that is in the way can be changed or mitigated, if enough thought, energy, creativity, or political pressure is brought to bear to address the issue. Persistence is also the key to getting beyond some of the barriers and identifying ways to begin new practices in spite of barriers that may exist or resistance that may grow as practices change. The ability to keep your focus on the desired outcomes and to compromise and keep trying to find ways to succeed is often a critical ingredient to getting the job of change done.

Development of techniques to address barriers depends in part on asking the right questions during the planning process (whether this is a formal or informal process). Just as with services for clients,

program and practice changes must start with where the organization, program, practitioners, and stakeholders are, and developing an individually tailored plan to capitalize on strengths and address identified barriers.

To conduct this assessment, work with your planning group of practitioners and consumers, and ask yourselves the following questions:

A. Practitioner/Staff Assessment

1. How many practitioners need to be involved in the new practice?
2. How long have these practitioners been in practice and how long have they been with the program?
3. Have any of them been exposed to or trained in evidence-based practices or the particular new practice to be implemented? If not, are there training, reading, or discussion opportunities that can provide this information?
4. Are there natural leaders in the group to whom the other practitioners look for support and guidance (formal or informal)?
5. Are there individual practitioners that are often interested in new things or who have expressed an interest in evidence-based practices in general or the new practice in particular?
6. Are there practitioners you can expect will be unfavorable about trying something new? If so, who are they and why?
7. What impacts will there be on other practitioners if some practitioners are asked to or requested to be part of the planning of the new practice or its implementation?
8. Is there another group of staff who are critical to the implementation of the new practice (e.g., information services staff, support staff, building maintenance or janitorial staff, transportation providers)?

9. Are there real or perceived limitations on time caused by current caseloads, inadequate financial resources, unfilled positions, or demands on practitioner or program manager time other than client care and program management? Is there a reasonable change in the use and deployment of human resources that can be proposed to affect these perceptions or the reality of these limitations?

10. Are supervisors in the program aware of and competent in the evidence-based practice you are trying to implement? Do they support the introduction of new practices? Are they able to learn the specific information or skills needed to encourage and support line staff in implementing the new practice?

11. Are there rewards or sanctions (e.g., monetary, training opportunities, reduction in reporting requirements or oversight, public recognition, public embarrassment through reporting failure to meet standards or requirements) that can be offered or imposed to encourage and support the implementation of new practices?

B. Stakeholder Assessment

1. Who are the program's current clients? Is the new practice going to positively affect these clients or require that the program's resources address new clients?
2. Who are the advocates for the current program? Will the new practice bring additional advocates or make current advocates feel left out?
3. Who among the program's current advocates are likely to support or resist the implementation of the new program and why?
4. Are there stakeholders in the community that will be interested and excited about the clients served or the outcomes achieved by the new approach?
5. Are there natural leaders or usual detractors that need to be engaged about the changes that will occur?

6. Do the current stakeholders or potential new stakeholders have information about evidence-based practices or the particular practice to be implemented? If not, what ways are there to make this information available to them?

C. Program and Organizational Assessment

1. How old is the program and the organization that is being asked to implement the new practice? What is its history of responding to new technologies and practice improvements?

2. Have there been recent attempts at change that have been successful or unsuccessful? If so, what factors contributed to the success or failure of that earlier effort? How long ago was it, and are staff, stakeholders and decision-makers still talking about the success or failure of that effort?

3. Is there a structure in place at the staff, leadership, or organizational (board or owners) level responsible for planning, innovation, or quality management?

4. In what ways does your organization or program engage staff and clients in planning processes? What are the expectations about involvement in planning and decision-making processes?

5. How big is the program or organization in terms of budget, clients, types of programs, and staff? Does the size make it more or less difficult to implement new approaches to care?

6. Does the program or organization have current threats or strengths that will make it more or less likely to want to change? Are there other new requirements or changes that are taking the attention of the program or organization that will make it hard to focus on the new practice?

7. Are there structures either within the program or within the organization that make it difficult to align all the staff, resources, and stakeholders to accomplish the identified task? If so, is there any way to work around those structures or to suggest changes that would support the new practice (e.g., a

combined child/family task force to oversee TANF-funded programs and mental health/substance abuse programs for children or a combined substance abuse and mental health task force)?

8. Are there factors in the program's or organization's environment that either make it difficult or will help to align all the staff, resources, and stakeholders necessary to accomplishing the plan to implement the new practice?

9. Are there other things in the program not directly involved in the new practice that will need to change (e.g., the client assessment process or tool, the client intake protocol, the process of who is on-call after hours and how those staff interact with existing crisis services in the community)?

D. Financial Assessment

1. How are services currently funded at the program and organizational levels?

2. Will the new practice fit within the current funding mechanism? If not, exactly what changes will be needed or what questions will need to be clarified to assure the new practice can be funded?

3. Who controls the answers to each of the questions – the program, the organization or a system decision-maker or funder outside the organization?

4. Does the organization or system have experience with multiple funding mechanisms?

5. Have funding decision-makers been willing in the past to be creative or work with programs to change or clarify service definitions, units, provider qualifications, or financing mechanisms to support innovation? If so, who has been instrumental in that process? If not, who has been unwilling to do so and why?

6. Are there any ways to work around financial definitions, processes, or mechanisms by changing the way the program or practice is designed, delivered, or documented?

7. Is there anyone who has authority or influence over financial decision-makers who is interested in the new practice, the population the practice will affect, or the outcomes to be achieved?

8. Are there non-traditional financing sources that might be willing to help with funding pilots or those parts of the practice that cannot be readily funded with traditional funding sources (e.g., businesses willing to fund adjunct services for persons who are homeless with co-occurring disorders; an electronics store willing to provide laptops, cell phones, or handheld devices for mobile teams; local or national foundations willing to fund a pilot that would identify the pros and cons of a new service approach; a TV station or university willing to provide videoconferencing equipment for telemedicine approaches for rural areas)?

9. Is there a creative financing mechanism that can be proposed to decision-makers that will provide the flexibility to implement the new practice but that will not cost more (or may even cost less to funders) than current approaches? Can this mechanism and program design be proposed as a pilot with financial analysis, as well as client outcomes as part of the evaluation criteria?

10. Are there funds currently provided for a less effective activity or practice that can be redeployed in whole or in part for the new practice?

E. Policies and Procedures Assessment

1. Review current policies and procedures and determine which of them support and which prohibit or impede the introduction of the new practice in whole or in part. Specify what would have to change to remove the impediments.

2. Review service unit and definitions and determine which of them are consistent or inconsistent with the services in the new practice (e.g., systems of care or multi-systemic therapy versus individual therapy sessions for behaviorally involved children). For those that are inconsistent, specify how they would have to change to support the new practice.

3. Who controls the policies and procedures and service definitions? Are they easily changed? If not, is there anyone who controls these changes that has exhibited an interest in supporting innovations in the past or who might be interested in the populations or outcomes the new practice is meant to affect?

4. What forms are consistent or inconsistent with the new practice (e.g., assessment tools, intake forms, documentation forms, reporting forms)? If inconsistent, specify how and what it would take to make them consistent.

5. Who mandates the use of these forms? Are they easily changeable or eliminated? If not, can they be done in a way that minimizes their impact on the program or practice?

6. Are there computer screens in use that make the implementation of the new practice difficult? Are there computer screens or programs that could prompt or assist practitioners in using the new practice? Who controls these decisions?

7. What is the history and purpose of each of these policies, procedures, definitions, forms, and computer screens/programs? Are there champions of these current processes that will object to changing them? If so, why?

8. Are there program staff or stakeholders committed to the new practice willing to offer time or expertise to make necessary changes? Are they able to propose policies and procedures, service definitions, forms or computer programs that will encourage and support the new practice while also providing the organization the controls or information it needs?

F. Political Assessment

1. Who will benefit and who will not benefit or who will be perceived as losing something in the change to the new practice?

2. Who are the decision-makers at the organizational and system levels that have a stake in what the program does and who it is for?

3. Are there people in positions to make decisions affecting the program or barriers to implementing the new practice that have different ideas about what the appropriate outcomes are for persons to be served (e.g., legislators who believe less taxpayer money should be spent on mental health and substance abuse; county commissioners who believe putting behaviorally involved children or adults in facilities where they and the community can be safe should be the primary goal of treatment; officials who believe service dollars should be used primarily by licensed practitioners in office-based settings)?

4. Are there individuals or groups who know such people personally and to whom such people will listen about the value of evidence-based practices, the value of person-centered planning and outcomes, and the wisdom of the outcomes expected from the implementation of the new practice?

5. Are there communication outlets that might be sympathetic to the process you are undertaking? Are there places you, supportive practitioners, or influential stakeholders can speak about these ideas that will reach those whose opinion needs to be swayed?

6. Are there influential individuals or associations (advocacy, guild, trade, business, unions) that will be your allies in getting the new practice implemented and barriers removed or mitigated?

7. Who is likely to be opposed and why? Is there any way you can work to reduce that opposition from the beginning by including those individuals or groups, or by understanding their opposition and working to implement in a fashion that will ease their fears and concerns?

8. Is there anything you can trade for support or reduced opposition? That is, is there something the potential allies or opponents want that you can help them with in exchange for them helping you to achieve your goals in the process of implementing the new practice?

TECHNIQUES FOR OVERCOMING IDENTIFIED BARRIERS AND CAPITALIZING ON STRENGTHS

The assessment questions suggest ways to overcome identified barriers and capitalize on the strengths of the program, the organization, its stakeholders and allies. Techniques to accomplish the task of implementing a new practice are almost endless, depending on the answers to the questions above and the unique situation each program encounters. However, a few examples may help you to think about how to put these techniques together to fit your particular needs. These examples are simplistic for the sake of illustration. Your situation is likely to be much more complex, and will require the use of multiple techniques to implement and sustain new practices.

EXAMPLE ONE: IMPLEMENTING A REQUIRED EVIDENCE-BASED PRACTICE FOR ADULTS

You have been told that your major funding source is interested in implementing Assertive Community Treatment (ACT) teams for adults with serious and persistent mental illnesses (SPMI). Each agency that serves a significant number of such individuals will be required to have at least one such team. The funding for these teams will come from usual billing and funding mechanisms, that is, billing Medicaid, private insurance, private pay, and general funds for the delivery of mental health services.

Your agency serves many more adults with SPMI than can be served by one ACT team. Additionally, your local consumer group has already begun to advocate against the use of ACT teams, since they consider them to be overly structured and coercive. Your local NAMI chapter has embraced ACT teams and helped to lobby the funding authority to implement this required new practice.

You have heard a great amount about ACT teams, and read some of the literature about them. However, you are not sure about all the elements of these teams, or how they differ from regular case management with treatment teams for SPMI clients. You have been told that the funding authority will be expecting agencies to keep track of outcomes of those clients served by ACT teams, including days in the hospital, days in stable housing, and treatment/medication compliance.

Your program now has therapists that see clients for individual or group counseling, in the office at scheduled times, although you do have drop-in hours for emergencies. You also have case managers who provide in-community services for SPMI clients, primarily during business hours and sometimes on weekends in special circumstances. You do not currently offer after-hours crisis services. The emergency room of the local hospital provides for such care, and either holds clients until your agency opens the next business day or admits clients if they meet the criteria for hospitalization, and if they have a payment source. Otherwise, the hospital sends crisis cases to the state hospital about 25 miles away.

Your clinical supervisors are Masters-prepared social workers with many years of experience in office-based therapy services. Your staff is generally happy with the way things work now, and consumers who come to your agency like being able to see the same therapist for many sessions. They indicate that they look forward to coming to see their therapist every week, indicating that they appreciate having someone to talk to about their problems.

Therapists have productivity requirements, that is, they are expected to see and bill face-to-face client time at a set number of hours per week. These productivity requirements are crucial to keeping the revenue of the agency sufficiently high to pay for salaries and operations of the agency. In fact, these productivity requirements have increased in the last couple of years as costs have increased and rates for services have decreased. No shows (i.e., individuals who are scheduled for an appointment but who do not come) are a big problem for therapists and for the agency as a whole since they negatively impact the productivity performance of therapists.

TECHNIQUES TO ILLUSTRATE

- ❖ Learning about the EBP
- ❖ Engaging reluctant staff; finding champions
- ❖ Working with consumers to understand their concerns
- ❖ Identifying the clients most likely to benefit from this EBP
- ❖ Implementing outcome measures
- ❖ Helping supervisors change and support staff to change
- ❖ Managing changing finances
- ❖ Changing relations with community partners
- ❖ Organizing work in new sites
- ❖ Advocating for changes in implementation requirements to meet the needs of consumers and the agency

Here are some ways you might think about proceeding:

Think about the practitioners and other staff in your organization/program. Do they know about ACT teams? Who has been most interested in finding new ways to serve the high risk, high cost clients who do not do well in the community and/or are often readmitted to the hospital? First identify a staff person or two who has shown such interest or often thinks creatively and is willing to try new things. Then think of a staff person or two who are most likely to be unwilling to change the way services are currently provided. Talk with each of these individuals and ask their help in guiding this new service. These will be your champions (although other 'natural' champions may arise as the process of implementing the program occurs.) Sometimes, people who are most unwilling to change can be best engaged by including them from the outset in the process of doing what must be done. Find out what these individuals think will be needed to make it successful, and listen to the concerns about what might get in the way. Ask them to present the issues to the staff at the next staff meeting and lead a discussion about how to proceed. Sometimes, an ally in this process may be outside the program. That is, the information technology leader or the quality management leader may be important to bring to this initial meeting and to engage as a champion.

During the staff meeting, be prepared (with your chosen champions) to talk about the requirement to implement ACT teams, the benefits that are likely to accrue from such a program and what research says about the value of ACT teams for adults you serve. Ask the staff to read a review or a study that you provide for them about ACT teams and be ready to discuss it at the next staff meeting or a brown bag lunch set up for this purpose. Also at the staff meeting, ask the champions and then staff members to talk about what the positive results of this change can be for consumers, for the program,

and for the community. Ask the staff to identify what they feel they need to know about ACT teams and the challenges they feel will need to be overcome. Ask them what questions they have about what this change will require of staff and the organization, as well as the consumers to be served. While it is important to let staff brainstorm issues, it is also important that this session not be a session to say why ACT teams 'won't work here.' Rather, it is important that the session end with assignments for individuals or groups of staff to come back with information about ACT teams and their value for what kinds of consumers or suggestions about how to meet the challenges that will be posed.

Have a separate meeting with supervisors about the new practice. Ask them to identify specifically what they will need to do differently as supervisors to support the new practice, and what they need to know to do this well. Asking a supervisor from an existing ACT team to share techniques and sources of information may help this process. Make sure supervisors have a comfortable and regular place to come to convey feelings of uncertainty or just to ask questions about how to approach supervision when staff are not all in one place or are doing things that seem less like the traditional therapeutic skills taught in clinical training.

You will need to be ready to identify the clients that will be eligible for, or likely to benefit from, an ACT team approach. To do this, someone should be charged with learning enough about the research on ACT teams to know what type of consumer is likely to benefit and what outcomes can be expected, if ACT teams are implemented with fidelity to the model of ACT that has been shown to produce the result. Staff may need to identify what data is currently being collected and what data will need to be collected in order to assure that the outcomes being sought are in fact those that ACT teams have been proven to produce, and that these outcomes are in fact achieved. The program will need to show this to the funder, board, or community.

A consumer group, either existing or specially created for this purpose, should be convened shortly after the staff meeting to talk about their interests, hopes, and concerns about implementing this new approach. Consumer representatives should be identified by the group to work with the staff champions to identify issues, work through solutions, obtain input from other consumers, and provide information to consumers as the process unfolds. Some consumers may feel that ACT teams are too restrictive or 'coercive' as they read about some consumer groups' opposition to this practice. Listening to how you can make sure the teams are not coercive, but rather supportive and how consumers would like them to be developed can help to alleviate this concern. It will be more effective if the staff and consumers work together as a group to guide the implementation of this new effort.

In this example, the local NAMI chapter will be a big ally if you can engage them without making them the 'other' perspective. That is, it will be important to have family members, consumers, and staff work together and respect each others' views and concerns. Ask the NAMI chapter to lead discussion groups with consumers and truly listen to their concerns. Ask them to bring back suggestions agreed to by consumers and family members about how to assure concerns and fears are addressed in the implementation process. Perhaps the NAMI group will be willing to help identify and raise resources for training, equipment, consultants, trips/visitors, etc., that would otherwise be unfunded during this process. Also ask the NAMI group to help you when you tell funders about barriers you need their help in resolving.

The staff/consumer/family champion group should identify where the organization will need to change to support this new effort. For example, do human resource policies about work hours need to change? Will the staff involved in the ACT team need new technology, such as laptop computers, pagers, or cell phones? If these do not now exist, how can

the resources for this equipment be obtained? Will the funding mechanisms of critical staff need to change? For example, if physicians are now paid for each client seen and it is expected that the physician will see 20 patients per day in a clinic setting, how will the physician be paid if he/she is working at least one half time with an ACT team? If ACT team staff is expected to be available for crisis calls during the evening, how will they be paid? If staff is used to working in an office setting and they are now expected to see clients mostly in the community, what will that mean to their productivity calculations? How will staff and consumer safety be considered? If the program's forms and reports are set up for individual rather than team reporting, how will these need to change?

One issue that often arises is that staff selected to be part of the new ACT team may have never seen such a team in operation. It is one thing to read about such teams, it is another to operate them. Arranging for a visit to an existing and successful ACT team, with the ability to have ongoing interactions as the project unfolds will be helpful. Consumer and staff representatives should visit together to learn how ACT teams function, issues they have to address, and techniques they have used to be successful and to track their success.

Finally, externally required new programs often do not account for barriers that make it difficult to implement smoothly. Brainstorm with staff and consumers how to have a process that identifies issues as they arise, and focus these issues toward solutions needed rather than reasons the process cannot continue. Talk with the funders or those requiring the change and ask that they come to the program at regular intervals to listen to staff, consumers, and managers about the issues that have been identified and about potential solutions the program has identified to overcome those issues, with the help of the funder or entity requiring the change. If approached in a positive manner, this kind of advocacy that says 'here's the problem, and here's

how we can make this work – with your help’ is much more likely to result in real solutions.

Finally, make sure you begin early to provide regular reports to consumers, staff, funders, and community and organizational leaders about the status of the implementation. It is important to convey this activity as progress and as a process leading toward better outcomes for consumers. Finding out what these stakeholders want to hear from you and the program as it is implemented is one way to engage them in your change process. Giving them updates and eventually data (i.e., facts) about the positive changes for the consumers served will go a long way to gaining support.

EXAMPLE TWO: IMPLEMENTING A NEW PRACTICE TO ADDRESS THE NEEDS OF A PARTICULAR TYPE OF CONSUMER (CHILDREN)

In this example, you have identified within your program a group of consumers for whom the program is not as successful as you would like it to be. This might be a group of consumers you find difficult to keep engaged in services; a group that uses most of the resources and staff time, thereby taking away time and resources from other consumers; or

a group that is a priority for your organization, community, or funder, but for whom the outcomes are not good (for example, children who exhibit more truancy or behavior problems, have less success in school, are more likely to be taken out of the home for care, are more likely to have interactions with police and juvenile authorities). These consumers may be identified by staff, other consumers, funders, organizational leaders, the community, families, school officials, or juvenile judges.

Even though you and your staff can almost name the children/adolescents that are in this group, you cannot exactly say what the common characteristics are of the group as a whole, or even if there are commonalities across the whole group. You have staff that does not want to work with some of these children/adolescents, and you have growing concerns expressed about the value of your program, since it cannot meet the needs of these individuals. You have some staff that are ‘blaming’ the children/adolescents and suggesting that the program stop serving these children/adolescents. You have some community leaders or funders indicating that if you cannot help find a solution for these consumers, your program will not continue to be funded at the same level (that is, they will find someone who can!)

TECHNIQUES TO ILLUSTRATE

- ❖ Describing the problem to be solved
- ❖ Identifying the outcomes to be achieved
- ❖ Engaging staff and consumers in picking a practice to try
- ❖ Understanding, implementing, and measuring fidelity to the model
- ❖ Convincing the organization and funders to support the efforts
- ❖ Determining whether the desired results were achieved
- ❖ Reporting results to staff, consumers, organizational leaders, and funders

HERE ARE SOME WAYS YOU MIGHT THINK ABOUT PROCEEDING:

First, think about the problems that are being identified by you, staff, funders, or the community. Write down the problem as you believe it to be from their point of view. Check out your understanding of the problem with a representative you trust from each group. If the issue is simply one you have identified, ask trusted staff or advisors if they have the same concern.

Once you have identified the problem and a couple of individuals who agree with you about the nature of the problem, begin to identify the consumers that are the subject of the problem. For example, you might have a group of children and their families who do pretty well in therapy or programs you offer until they reach 12 – 15 years old. Then the children begin to exhibit increasing behavioral difficulties and substance abuse, families become less able and less willing to deal with them, criminal justice interactions increase, school work declines, willingness to engage in mental health treatment declines, and many of these children/adolescents end up in out-of-home placements or in juvenile detention facilities. Eventually, many of these children are identified as serious adolescent or adult offenders and are incarcerated or become homeless as young adults.

It is important to write down the characteristics of these children/adolescents. Look at the clinical records for the children you know. Do they share common diagnoses, common family interactions or histories, or common behavior patterns? Do they have similar educational statuses (e.g., they are often in special education for learning disabilities or behavioral issues)? Do they come from a similar school district or type of school environment? Is there something about their age, gender or sexual experiences or orientation that make them similar?

As you begin to identify the children/adolescents you know about, review the records of other children/

adolescents your agency has served to determine if other children and their families have similar characteristics but did not come to your attention because they dropped out of treatment, ended up in adult treatment settings or are still in your program but not really progressing (e.g., they have been in therapy for an exceptionally long time but exhibit the same functional concerns or symptoms). It is important to sort through important clinical differences with similar exhibiting behaviors to make sure you pick a program or service approach that is likely to be successful for the children/adolescents you are trying to serve. You might want to talk with other child-serving agencies to see if they have similar patterns of clinical presentation or behavior in their caseloads as well.

Now try to describe, in writing, the problem and the potential consumers and families you think need a new approach. Write the outcomes you want to see, as well (e.g., less difficult behaviors, more family satisfaction and willingness/ability to work with the youth, less criminal involvement, less substance abuse, better outcomes in school, more days in school, less out-of-home placement, etc.). Identify stakeholders who you believe want to see these same outcomes. Meet with a group of staff, consumers, families, and community members (especially juvenile judges or their staff and school officials) and talk about the problem as you have described it and the outcomes you would like to see. Ask them to help you refine the description of the problem and the outcomes. Ask for volunteers to work with you to research program options in order to achieve such outcomes. Make sure the group knows that it is likely you will have to start small and will need help to identify resources to try to make a difference. Ask for their help in identifying others in the community or organization who might want to join in making this difference.

Once your volunteer group learns about possible program models (by going to conferences, looking on the internet, reading reviews, calling national

advocacy groups or trade associations, talking with academicians, etc.), think together about what it would take in your program or community to implement one of these models. What are the core components that have made the model a success (that is, what would it take to be faithful to or have fidelity to the model that has produced the positive outcome elsewhere)? What barriers will you face in trying to obtain the resources and staff and change the program or organizational structures to support implementation of such a model? Are there options, that is, are there different models to choose from? If so, what are the pros and cons of each? Which one is most likely to be fundable, given the sources and rules of your potential funding streams?

Ask your group of volunteers to keep an open mind until you have all discussed and analyzed the models together. It is critical to be certain that whatever model you choose has actually been shown to produce the results you are seeking for the population or subpopulation you describe. Implementing a program for children/adolescents with conduct disorder may not work the same as for children/adolescents with ADHD, even if both groups of adolescents have difficulty in school, at home, and in the community.

Talk with your organization's executive leadership and the governing board to describe the problem you have identified, the clients you want to impact, and the results you want to achieve. Talk about the model(s) you have identified that might be successful in achieving these results and what it might take to implement such a model (including time, staff, money and other resources). Ask if you can pursue a small grant to bring in the developers of the model(s) or someone in the country who has successfully implemented the model to talk with community stakeholders, staff, and consumers/families. See if you can find a local foundation, business, chamber of commerce, or other funding source that will be positively impacted by the outcomes you want to

achieve to fund the visit and perhaps a small planning phase for the program.

Begin to identify potential funding sources for the program. Can you continue to bill your existing sources (e.g., Medicaid, federal block grant, school sources, private insurance) for the program? Will you need special start-up funds? Will funding sources have to change? If so, how can you frame the changes needed as a pilot to see if the new program will achieve the positive results? Will the changes needed be difficult for the funder or can you propose relatively easy solutions? For example, can you provide a suggested service definition that will work for Medicaid and analyze the potential cost if the state plan amendment is made, or can you show how providing a flexible case rate for the described children might actually save the funder money if you agree to keep the children/adolescents out of state-operated or state-funded facilities? You may be able to project savings to managed care companies who are at risk for higher levels of care for such children/adolescents.

As you develop the program design and identify the funding for the initial implementation, remember to set up methods with staff to measure how close to fidelity to the model you are staying and to measure the outcomes expected and achieved. If the outcomes you are getting are not what you expected, go back to the description of the consumers and their families and make sure the model you chose is consistent with their characteristics. Look to see if your program is being implemented true to the components of the model that you selected to implement. Make adjustments as needed, using an advisory group of stakeholders (including consumers and their families) to help you monitor the results of your process. Make regular reports to organizational leaders, governing body, community leaders, and funders about your success. Be sure to report openly when the results were not what you expected and what you are doing to change those results.



Do not be afraid to analyze where the process of implementation may have gone wrong. Do not be afraid to say that the model did not work as you wanted, therefore another model needs to be tried to achieve the results you and stakeholders were seeking.

Remember that these processes are dynamic and should include ongoing improvements as you learn what works and what does not, and why. This is at the heart of implementing evidence-based practices and at the heart of having a dynamic evidence-based practice in your organization or program.

A FINAL THOUGHT

The examples given above are greatly simplified. Your experience is likely to be more complex and messy. That is okay. It is a learning experience. You

are creating a learning environment, able to change, and willing to monitor results and act when they are not what you want them to be. Also remember that changing or implementing a new practice is not as simple as just telling staff to do it or even just providing them the training or skills to do it. The structure of their practice will need to be adjusted. The organization and program will probably need to change, too. Financial policies, reporting policies, forms, data collection, supervision processes, human resource policies, and interactions with community, consumers, and funders will all be impacted.

Think about what you are trying to achieve. Track it to see if you did. If you did not, ask why and make adjustments. Do not assume initial positive results will continue. It takes as much effort to sustain a new practice as it does to implement. Chapter Eight discusses what it takes to keep evidence-based practices going over time.

