

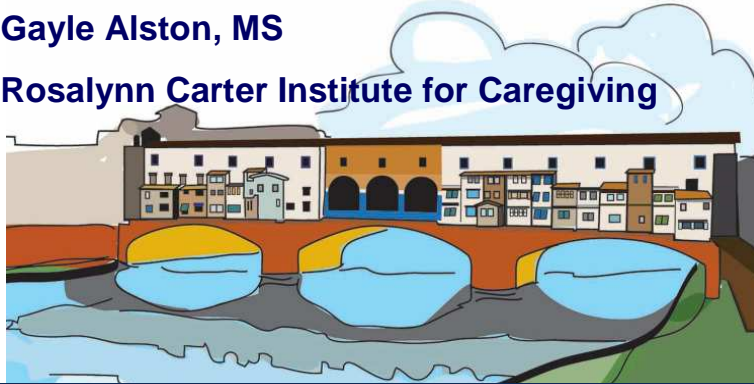


Innovations in Evidence Based Practice

MN Gerontological Society 2010 Conference

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Rosalynn Carter Institute for Caregiving



A Working Definition

Evidence-based Programs (EBPs)...

- have undergone rigorous scientific evaluation, typically in RCT
- have demonstrated their ability to achieve outcomes of importance to family caregivers
- and have been thoroughly described, including the intervention, in a peer-reviewed scientific journal



Why Implement EBPs?

- **Accountability:** Management accountability is the expectation that managers are responsible for the quality and timeliness of program performance, increasing productivity, controlling costs and mitigating adverse aspects of agency operations.
 - US Office of Management and Budget

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Why Implement EBPs?

- **Stewardship:** Stewardship is defined as the careful and responsible management of scarce resources entrusted to one's care, especially money, time, and talents.
- **Political Mandate:** A national imperative to implement EBPs exists in that more and more funders, legislators, and regulatory agencies require or endorse their use.

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Why Implement EBPs?

- **Quality of Care:** Patients and their families deserve access to the most effective, proven programs available.



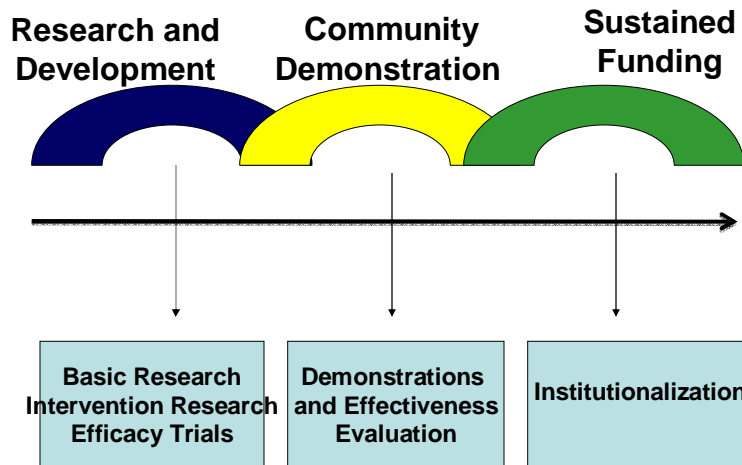
- **IOM Definition of Quality:**

“The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

“If these interventions were drugs, it is hard to believe they would not be on the fast track to approval.”

*Lenfant C. NEJM, 2003;349(9):868-874
Covinsky & Johnston, Ann Int Med, 2006, 145, 70-781*

In the Ideal World the Process of Creating and Implementing EBPs for Caregivers would be Seamless and Efficient ...



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But... there are three problems

- 1. Program/Interventions that show efficacy in trials are rarely ready for replication and dissemination **WITHOUT FURTHER REFINEMENT, MODIFICATION AND DEVELOPMENT OF SUPPORT MATERIALS.****
- 2. Agencies, although motivated and in need, are typically **NOT READY** to adopt and implement a complex intervention **WITHOUT BUILDING ADDITIONAL INTERNAL CAPACITY.****

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But... there are three problems

3. Host Systems may not support the new way of working without **FUNDAMENTAL CHANGES IN POLICIES, PROCEDURES, FUNDING, AND THINKING.**

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Program/Intervention Challenges

1. Intervention materials are not ready... manuals, training and certification process for use in community have to be developed.
2. Intervention is a poor fit in the agency or system that wants to implement it (wrong staffing, too many sessions, too costly, etc.).
3. Intervention may not be appropriate for intended target.

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1st Problem: Modify the Intervention

1. To improve its fit in an agency or suitability for a particular group is called “Translation”
2. Process that requires give and take between research and practice; pilot studies; trial and error (messy)
3. Translation can be a long and time-consuming process and is poorly defined

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Translation...

- How much “change” is Allowable?
- Change the Intervention... OR Change the System?
- Who decides? And How?
- How do we adapt an intervention AND maintain its “core” ... those characteristics that make it work in the first place?
- When do changes become so significant that an intervention must now be considered a “new” program and go through clinical trials again?



2nd problem: Agencies Willing but Not Ready

- Agencies may be motivated and in need, but **NOT READY** for adoption and implementation.
- They may need to Build Internal Capacity and Readiness.
- Capacity refers to both generic capabilities and capabilities specifically needed to deliver the intervention.

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Readiness and Capacity building

- Agencies may need to change organizational “culture” to embrace evidence-based programs.
- Build general capacity for data collection, fidelity measurement, staff recruitment, supervision and training.
- Build capacity to deliver a specific intervention; Not only expertise to deliver EBP protocol correctly; but referral, intake and tracking systems; public education and outreach, etc.

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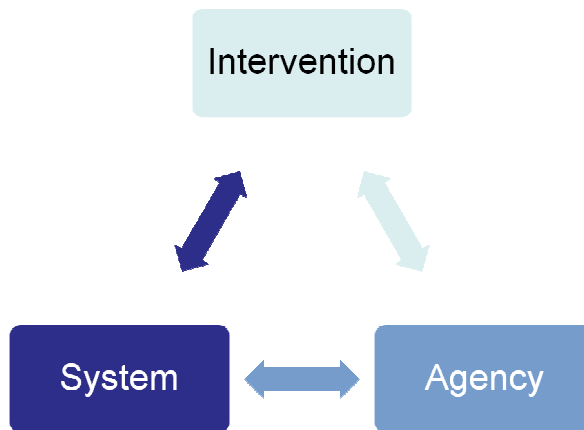
3rd Problem: Host Systems Not Supportive

- **Systems** in which agency operates and in which intervention will be delivered may not support the new way of working.
- Agency may have capacity to deliver the Intervention, but the funding, policies and procedures, hiring restrictions, regulations, etc. of the **Host System** may be incompatible with new way of working.
- System and Agency goals and priorities may be “out of alignment”.

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Three Simultaneous Change Processes



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Why are EBPs not Being Implemented?

- We have not fully understood and addressed the complexity of the change process involved in creating and implementing EBPs.
- The change processes have been managed and conceived of separately when they are actually interdependent.



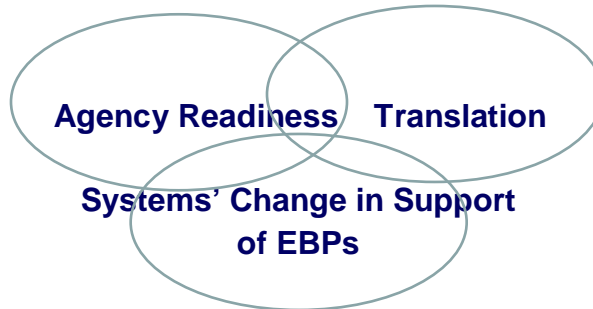
What we have done...

1. Created the National Quality Caregiving Network (NQCEN)
2. Adopted models and approaches from others who have passion and expertise for EBP implementation, particularly the National Implementation Research Network (NIRN)



National Quality Caregiving Network

A network of community demonstration sites and research & development sites working to integrate and study three key change processes:



National Quality Caregiving Network

- Solidifies links between researchers, agency leaders and practitioners and views them as equal partners whose work informs and supports one another.
- Serves as a learning community that generates “practice-based evidence” and technical assistance resources.
- Draws upon a wide array of expertise including administrators, practitioners and researchers.
- Serves as a forum to build consensus about needed policy and system changes to support more efficient development and implementation of evidence-based programs for caregivers.

National Quality Caregiving Network

Community Demonstration Sites

- Fletcher Allen Health Care, NH
- Cleveland Clinic Lou Ruvo Center for Brain Health
- Fox Rehab, PA
- St. Johns Council on Aging, FL
- Benjamin Rose Institute, OH
- Middle Alabama AAA
- Scott & White Hospital and Central TX AAA
- Southern Caregiver Resource Center, CA
- Wellness Community SE Michigan
- NEGAAA and SCAAA



Research & Development Sites

- New York U. School of Med.
- Center for Applied Research on Aging & Health/ Thomas Jefferson University
- Margaret Blenkner Research Institute
- U. of Mich/ School of Social Work and School of Nursing
- Emory U. School of Nursing
- Stanford U. School of Medicine
- Veterans Admin. Coordinating Center on Caregiver Research
- Rosalynn Carter Institute for Caregiving



Introduction to NIRN Model of Implementation

- All Community Demonstration Sites in NQCN are using the NIRN Model of EBP Implementation.
- Adoption and Implementation of evidence-based programs is a process that occurs over several years and requires the adopting agency to establish an EBP Infrastructure to deliver the intervention with fidelity.
- There are very specific, evidence-based strategies to follow in developing this infrastructure.



NIRN Model of Implementation

- Fixen, Blase and colleagues identified factors associated with successful implementation of evidence-based programs.
- These factors are termed “Implementation Drivers”.
- These are practices associated with high fidelity implementation and good outcomes.
- NIRN has developed them into a very useful model for agencies to use in developing their EBP Capacity and Readiness.



National Implementation Research Network

- <http://www.fpg.unc.edu/~nirn/>





Definition of Fidelity

- Fidelity is adherence to the key elements of an evidence based practice, as described in the controlled experimental design, and that are shown to be critical to achieving the positive results found in a controlled trial. (American Academy of MH Administration)
- *SO THAT* it is more likely that comparable outcomes will be consistently achieved.

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Fidelity Matters

- Fixen and colleagues at NIRN and others have found higher fidelity is correlated with better outcomes across a wide range of programs and practices.
 - Adult Mental Health – ACT, IPS, IDDT
 - Medicine – DOTS, Texas Algorithm, OMAP
 - Children’s Services – FFT, MST, Wraparound, TFM
 - Education – HiPlaces, SWPBS, STEP
 - School-Based MH Prevention Programs - PATHS

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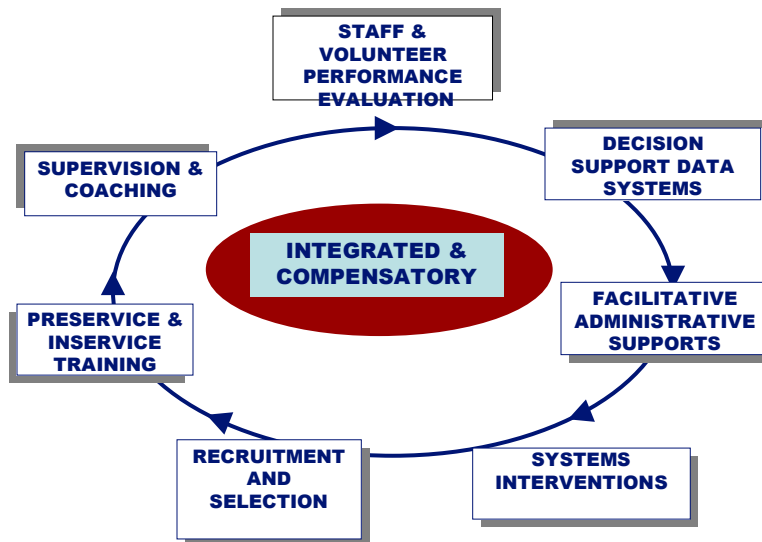
How Do We Assure Fidelity and Prevent “Drift”?

- **Requires creation of an organizational infrastructure to oversee:**
 - Staffing
 - Training/Coaching
 - Systems Interventions
 - Program evaluation
 - Administrative support

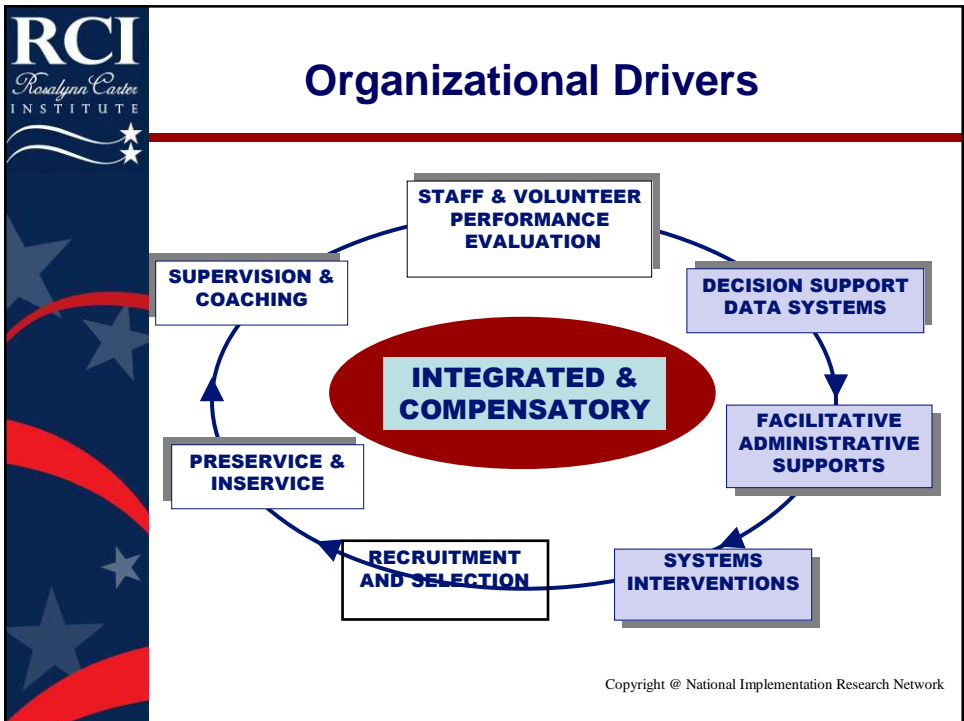
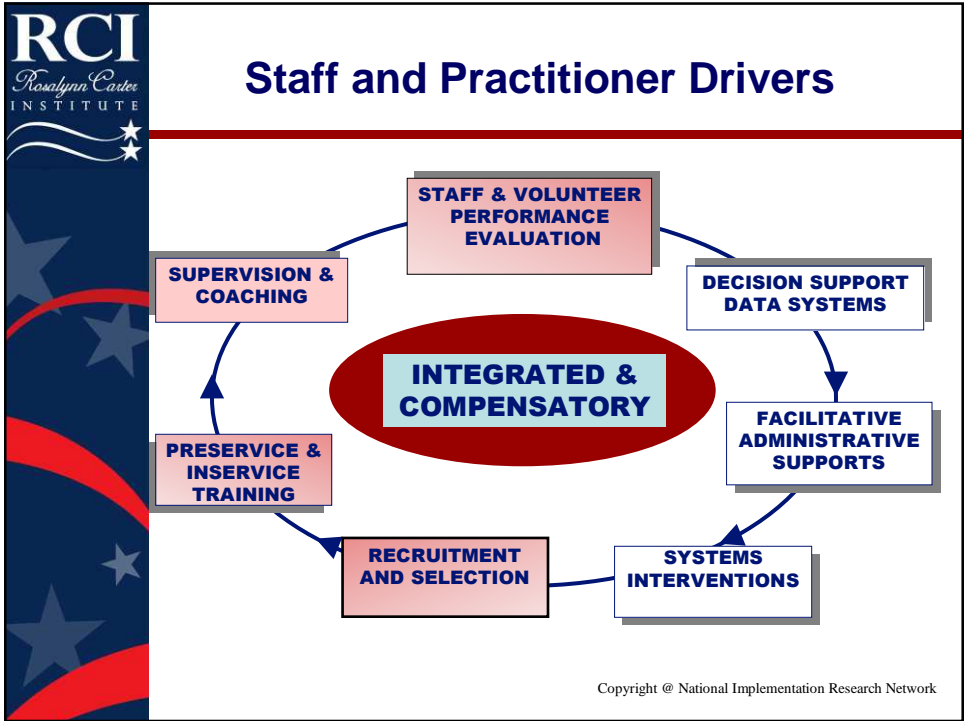
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Implementation Drivers: from NIRN



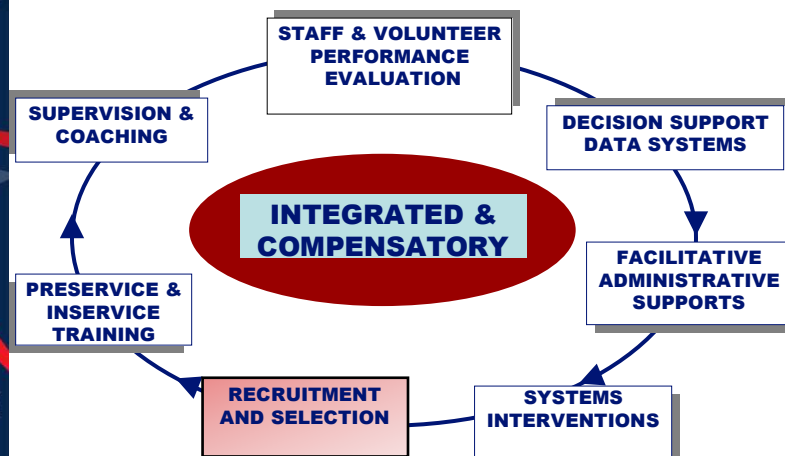
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Why So Much Focus on Practitioners' Behavior?

- In human services, the **Practitioner** Is The Intervention.
- Wide ranging inputs (individuals with diverse histories, levels and types of training, and experience).
- Behavior Change and Adoption of the required behaviors are **NOT** guaranteed!

Staff and Practitioner Drivers





Recruitment and Selection

Purposes:

- **Select for the “unteachables”**
- **Screen for pre-requisites**
- **Set expectations**
- **Allow for mutual selection**
- **Improve likelihood that training, coaching and supervision will result in implementation w/ fidelity**

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Recruitment and Selection

Implementation Best Practices:

- Job descriptions are clear about accountability and expectations (e.g. must achieve certification within x period of time; must deliver the intervention with fidelity)
- Pre-Requisites are related to “new practices” and expectations (e.g. ability to coach vs. “manage” caregiver; ability to stick to a script)
- Interview process involves interaction and role play

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Recruitment and Selection

Hire for the “unteachables”

- Concretely describe the “must haves” for the position.
- Brain storm ways to “uncover” these traits in a role play.
- Develop role play and scripts for “Caregiver”.
- Develop scoring sheet.
- Test role play exercise.

Recruitment and Selection

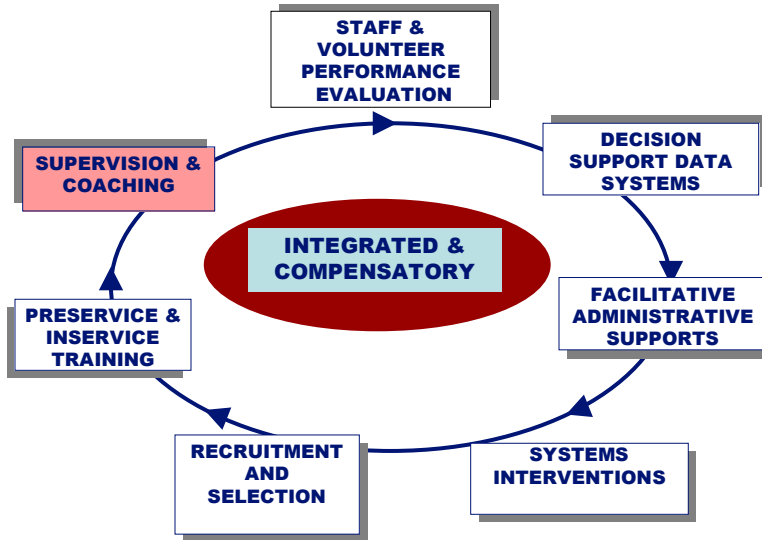
Role Play: the role play will be based on the first session of the intervention.

It will consist of:

- Introduction/rapport building
- Conduct an abbreviated assessment (5 questions)
- Close the session
- Interventionist will complete a brief questionnaire and case notes to document the session



Implementation Drivers



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Coaching Impact

TRAINING COMPONENTS	OUTCOMES		
	% of Participants who Demonstrate Knowledge, Demonstrate New Skills in a Training Setting, and Use new Skills in the Classroom		
	Knowledge	Skill Demonstration	Use in the Classroom
Theory and Discussion	10%	5%	0%
...+Demonstration in Training	30%	20%	0%
...+ Practice & Feedback in Training	60%	60%	5%
...+ Coaching in Classroom	95%	95%	95%

Joyce and Showers, 2002

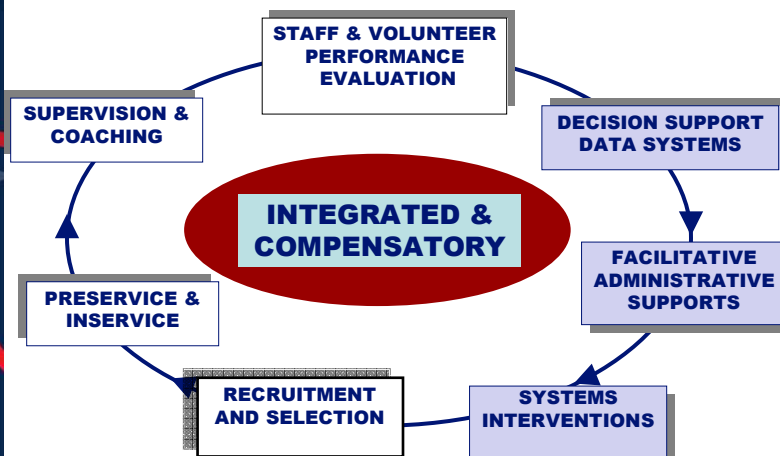
Supervision and Coaching

Implementation Best Practices:

- Design a Supervision Service Delivery Plan
- Develop accountability structures for Supervision – Supervise the Supervisor
 - Regular satisfaction feedback from employees and volunteers
 - Regular review of adherence to Supervision Service Delivery Plan
- Require supervisors to conduct in-the-field observations, or review audio tape sessions
- Have Supervisors Certified!

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Organizational Drivers



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Decision Support Data Systems

Focus on:

1. Program fidelity
2. Process
3. Intermediate outcomes

WE TRACK EVERYTHING!

Recruitment strategies

Loss analysis

Interventionist's Time

Client status and timing

Outcome data and Evaluation data



Decision Support Data Systems

- We use existing data systems and supplement with excel spreadsheets.
- Data from spreadsheets can be imported into SSPS for analysis.
- One staff member is assigned to monitor documentation and enter data.

Data Systems

Fidelity Data:

- **Fidelity Checklists**-self report, observation or supervisory.
- **Focus:** Adherence to intervention structure, # in-home visits, amt of face to face time, topics covered, schedules adhered to, sequence of actions, etc.
- **In addition to** self report checklists, important to review audio/video tapes and conduct in-the- field observations.

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Data Systems

Process Data:

- How is the program operating?
- Create and monitor a program “Dashboard” of program indicators that is regularly updated. For example:
 - **Source and numbers of referrals,**
 - **time to enrollment,**
 - **caseloads,**
 - **number of sessions completed,**
 - **number of drop outs.**

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Data Systems

Intermediate Outcomes:

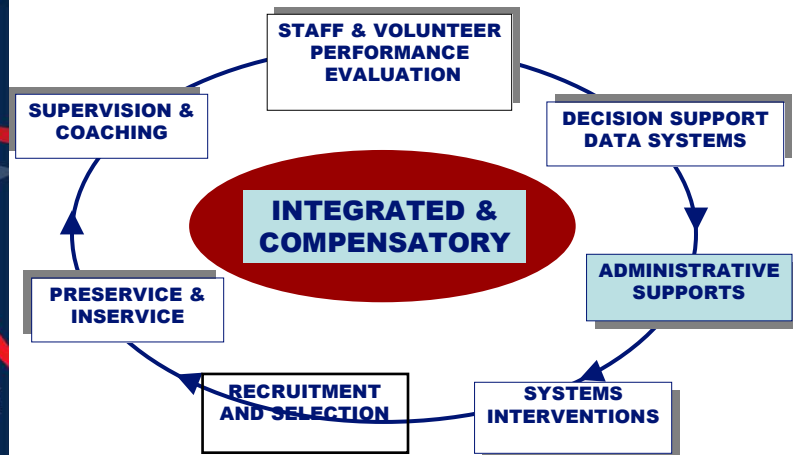
- May have little intermediate client outcome data to begin, so consider using intake and participation data until you do.
- For example, look carefully at outreach, enrollment & drop out data compared to your original assumptions.
- Are you seeing the enrollment demographics you predicted? (by age, race, scores on intake instruments, etc.)
- Are you delivering the correct intervention dose?

Data Systems

- **Measure Fidelity AND Measure Outcomes BECAUSE you need to know:**
 - Are we having an implementation problem?
 - **Low fidelity & Poor outcome = implementation problem.**
 - Are we having an effectiveness problem?
 - **High fidelity & Poor outcome = effectiveness problem.**



Organizational Drivers



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Implementation Best Practices

- An **Implementation Team** is formed and functional:
- Represents key staff / decision makers at multiple “levels” of the organization/system
- Meetings are regular, purposeful, and organized around the Total Quality Management process (Plan, Do, Study, Act)
- Installs and uses organizational feedback loops to make changes in Implementation Drivers

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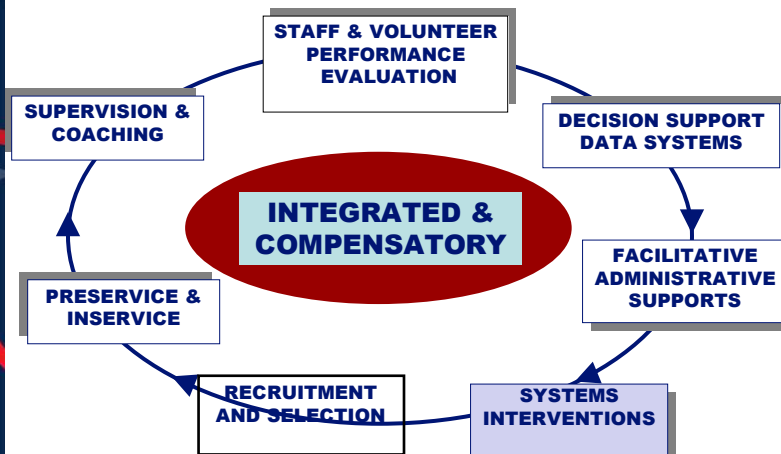
Implementation TEAMS, cont.

- Analyzes and revises policies and procedures to support the new way of work
- Feedback is solicited from staff, partners and clients
- Takes steps to reduce internal administrative barriers
- Makes or recommends program changes as needed

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Organizational Drivers



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Systems Intervention

Purposes:

- Identify Environmental Barriers and facilitators for the new way of work
- Create a “hospitable” environment for the new way of work
- Assuring community and stakeholder buy-in
- Contribute to cumulative learning in multi-site projects



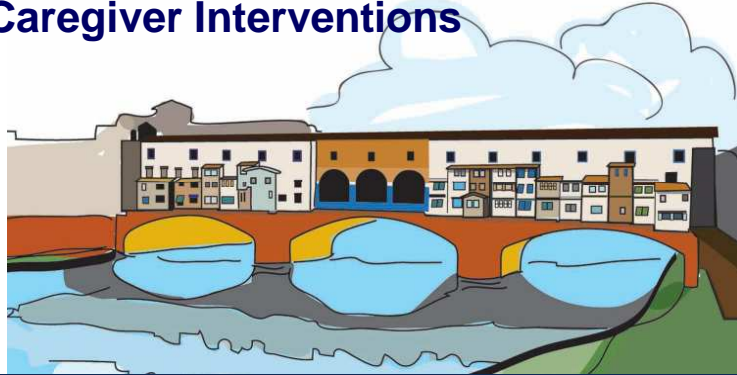
Systems Interventions, examples

- Cultivating Leadership & Champions
- Educating the Public
- Persuading “gatekeepers”
- Establishing an Implementation Task Force or Steering Committee
- Aligning organizations
- Advocacy for Needed Change!



Our Goal:

**Improving Caregiver Health through
widespread use of Evidence Based
Caregiver Interventions**



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To Learn More

www.rosalynncarter.org

- **Two Annual Training Events**
 - Day long workshop at the ASA/NOA conference in March
 - Annual RCI Summit in October
- **Gayle Alston**, Director of Community Initiatives
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