

Context: A challenge in navigating adaptation and fidelity for EBP Implementation

Chair: Junius Gonzales, MD, MBA, USF

Presenters:

Gregory Aarons, PhD, UCSD

Kimberly Hoagwood, PhD, Columbia

Phyllis Panzano, PhD, DSS, Inc.

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Agenda

- Set the stage
 - Purpose; 3 questions; key definitions & concepts

 - Presentation of Case Material
 - The tale of two contexts: IDDT
 - Related case references and reflections

 - Active Think Tank Discussion - 3 questions

 - Concluding comments and questions
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Setting the Stage

Dilemma

- Change the context to fit the practice?
 - Change the practice to fit the context?
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Think Tank Questions

1. What issues arise (during adoption decision-making, planning and/or active implementation) that impact decisions to change the practice, the context or both?
 2. What strategies can be used to balance fidelity and adaptation while planning for or implementing EBPs?
 3. What are the implications of the tension between fidelity and adaptation for: future research questions, research design, and methods and measurement?
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Key Concepts

Working definitions...

Context

The constellation of multi-level factors – from individual to organizational and system – that can impinge on the achievement of desired outcomes. These factors are multi-dimensional (e.g., structural, process, political, cultural) and can be historical, current or future-oriented.

Innovation

A new value-added way of doing that is comprised of 'novelty: a new configuration of behaviors, techniques or resources [and] problem orientation: improving the way in which desired outcomes are obtained.' (Lomas)

Important Considerations

- Innovations can be processes, products , services , thinking, or structures.
 - Innovation can be: An idea, practice, or service... perceived as new by an individual or other unit of adoption (Nord & Tucker, 1987; Mihalic, S., 2003)
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Fidelity

the degree to which, or level of adherence, actual programs, including their procedures, are delivered as intended by the developers and match the original protocol

Important Considerations

- Core Elements: distinguish here between core elements (active ingredients) and ancillary features (e.g., training schedules)
 - Elements should be discrete and operationalizable
 - Core Types: Foundational (required elements that represent the intent, theory, and internal logic of the intervention) & Mechanistic (most likely produce the intervention's main effects)
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Adaptation

Modifications or changes made to a 'program' and its procedures so as to be suitable and functional to a new or special situation, group or application, including the processes of change

Important Considerations

- No 'contradiction' to core, including mechanisms of action
 - Degree of change is important
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Reinvention

The process of reformulating something, applying lessons learned from use and experience, to achieve the same original or closely related function or 'a process of recreating an innovation in a different context from a different perspective' (Van de Ven, 1993)

Important Considerations

- Often used interchangeably with 'adaptation', but is the distinction a matter of degree?
 - Does reinvention require addition of something new to the program model?
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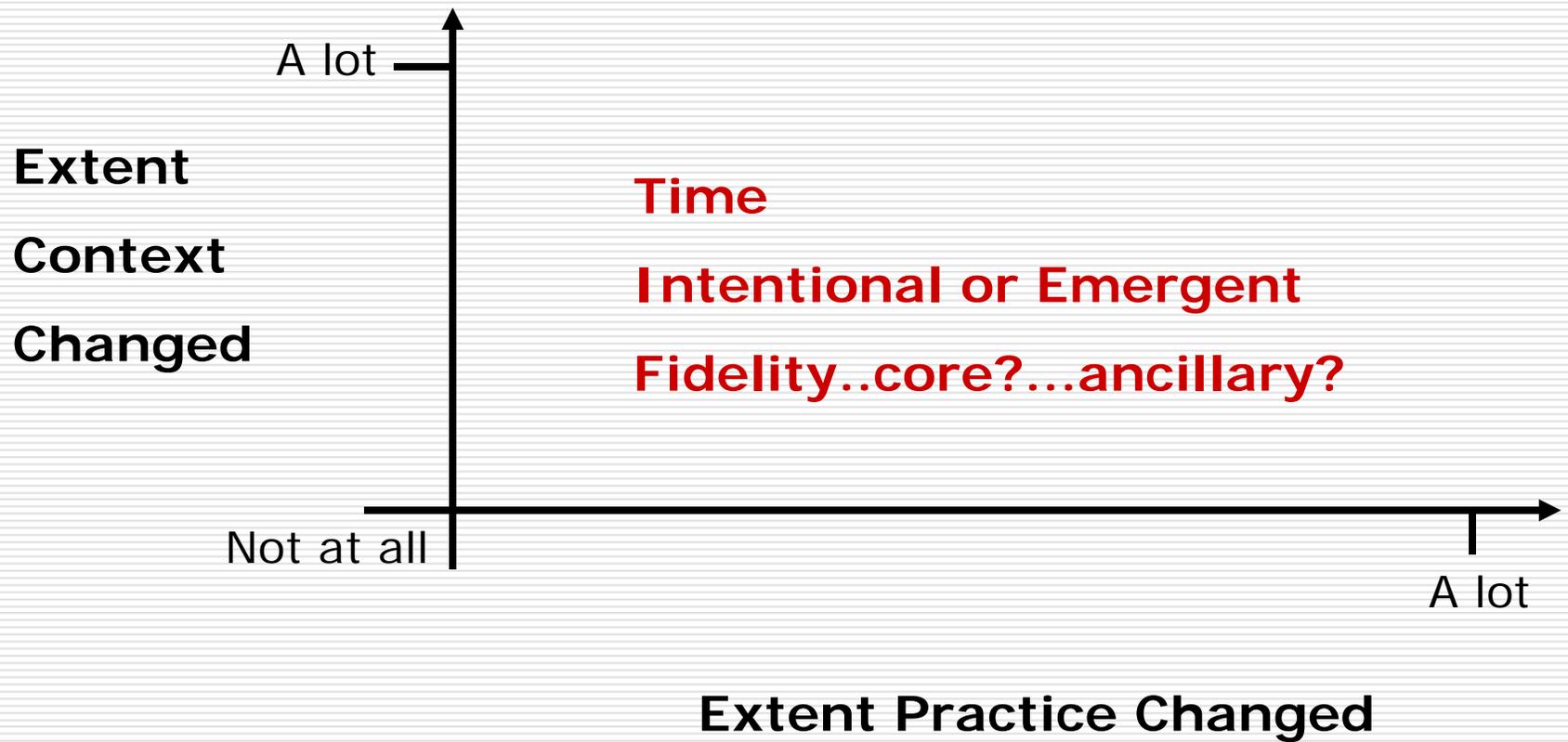


Pinky & The Brain

Presentation of Case Material

A Tale of Two Contexts

There's a lot to think about...



Adopting IDDT in an inpatient setting

Hospital Adoption of IDDT

- Problem identification: large dually-dx pop; no targeted programs and little in-house expertise
 - Initial steps: in-house SAMI committee; special SAMI unit; general training; union negotiation to re-assign staff
 - Adoption decision: IDDT was-research based but not designed for inpatient; SMHA support of IDDT (e.g., CCOE) and interest in inpatient adaptation
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Implementation Start-up

- Engage IDDT developers, CCOE, SMHA
 - Modify fidelity tool
 - Translate meaning of key concepts

 - Create stage – based units
 - Convert SAMI unit to a 'persuasion' unit
 - Create active treatment units

 - Add substance abuse screening to intake process
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Implementation & Sustainability

- ❑ Continue efforts to increase buy – in by psychiatrists and tenured staff
 - ❑ Refine process of training staff on IDDT units
 - ❑ Rely on Regional Task Force for facilitative administration with CJ and other systems
 - ❑ Continue to pursue efforts to increase fidelity of the translated model (e.g., outpatient assignment among probation violators)
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Locus of Change?

Locus	Change EBP	Change context
Practice components	Modify operational definitions of fidelity	Add substance screening to intake
Workforce	Modify training in light of productivity demands	Get union approval to reassign staff
Collaboration	Consult with Dartmouth and CCOE	Educate judges to reduce CJ barriers
Leadership	Determine best modifications in light of feasibility	Create MH courts

Focus of Change?

Locus	Change EBP	Change context
Practice components	Modify operational definitions of fidelity	Add substance screening to intake
Workforce	Modify training in light of productivity demands	Get union approval to reassign staff
Collaboration	Consult with Dartmouth and CCOE	Educate judges to reduce CJ barriers
Leadership	Determine best modifications in light of feasibility	Create MH courts

Planned? Emergent

Locus	Change EBP	Change context
Practice components	Modify operational definitions of fidelity	
Workforce	Modify training in light of productivity demands	Get union approval to reassign staff
Collaboration		Educate judges to reduce CJ barriers
Leadership		Create MH courts

Adopting IDDT in a community setting

Community Adoption of IDDT

- Problem identification: large dually-dx pop in community creating ongoing problems; no specialized community programs
 - Initial steps: Create special 'Track' in the agency; medical model and same as traditional track; no noticeable improvement in outcomes
 - Adoption decision: Worked w/ Board; IDDT seen as best outpatient option; technical support from CCOE; start-up funding from SMHA
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Implementation Start-up

- Partnered with SA agency to deliver IDDT
 - Primarily financial; SA expertise an added bonus

 - Recruited IDDT Team from both agencies
 - MH staff: more interest and philosophical buy-in

 - Formed and trained IDDT team
 - Leaders, psychiatrist, nurse at Dartmouth
 - 6 case managers trained locally
 - High turnover of IDDT case managers
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Implementation & Sustainability

- ❑ Referrals, supervision (MH); billing (SA)
 - ❑ Challenging IOR to maintain (e.g, admin burden, poor communication, philosophy & culture clash)
 - ❑ IOR dissolved: MH agency took over; agency-wide assimilation of IDDT principals; turnover no longer a problem
 - ❑ Ongoing challenge to find money to pay for IDDT, particularly early-stage services
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Changes: Locus? Focus? Planned?

Locus	Change EBP	Change context
Practice components	Some services not offered – ltd \$ for early-stage services	Modified Tx plans to fit with model
Workforce	Mixed buy-in by case mgrs; high turnover	Team leaders: Dartmouth trained
Collaboration	Important program info not shared	Agencies had defined roles
Leadership	Limited support and cooperation by SA agency leadership	Assimilation of IDDT principles MH agency-wide

References and Reflections

Think Tank Discussion

- 3 Questions
- 15 minutes per question
- Quick pace
- Round-robin....
 - 1 answer per turn ...
 - Let's hear from everyone!

Question 1:

What issues arise (during adoption decision-making, planning and/or active implementation) that impact decisions to change the practice, the context or both?

Question 2:

What strategies can be used to balance fidelity and adaptation while planning for or implementing EBPs?

Question 3:

What are the implications of the tension between fidelity and adaptation for:

- future research questions
 - research design, and
 - methods and measurement?
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Concluding Comments & Questions
