ASSESSMENT OF PROJECT DEVELOPMENT IN COHORT ONE OF

ADVANCING RECOVERY:

A MULTI-METHOD APPROACH

BY THE *ADVANCING RECOVERY* EVALUATION TEAMS AT

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INTRODUCTION

The following report is based upon interviews and observations conducted over a two year period among the first cohort of sites involved in the Advancing Recovery (AR) project and the coaching staff that supported them. The report is in three parts, first reporting on a qualitative overview of the initial observations of the role of state substance abuse agencies in creating environments for system change within which innovation adoption can be facilitated at the level of treatment organizations, as well as in the overall state system of treatment delivery. The second section describes the participating treatment programs' roles in the innovation adoption process. A final section provides overview information derived from qualitative interviews of the AR project's coaching staff.

1. AN OVERVIEW OF THE ADVANCING RECOVERY PROJECT

AR (AR) is a set of collaborations between state substance abuse treatment authorities and treatment providers. The site projects, the National Program Offices at the University of Wisconsin and the University of Pennsylvania, and the Evaluation Team at the University of Georgia and Oregon Health Sciences University are supported by grants from the Robert Wood Johnson Foundation.

The goal of AR is to promote the use of five evidence-based practices: 1) use of addiction treatment medications, 2) screening and brief interventions in primary care settings, 3) psychosocial clinical interventions (e.g., motivational interviewing, contingency management), 4) continuing care to foster a chronic care model of addiction treatment, and 5) case management, wraparound and supportive services.

Two cohorts of 6 grantee sites were funded, with a two year interval in between. Grantees initiated two-year change efforts with selected pilot treatment centers but there is an expectation of broader change throughout the state treatment system. Currently, government-provider coalitions at 12 sites receive financial and technical support to develop and implement system changes that produce more hospitable environments for the adoption of evidence-based practices.

The AR approach recognizes that factors at the level of state systems can either serve as barriers to the adoption of evidence-based practices or as facilitators of positive change. The presumption is that, a small cadre of government officials and innovative providers can instigate changes that promote best practices and demonstrate their viability and set the stage for diffusion of evidence-based practices throughout state systems of care.

AR is built on the work of the National Quality Forum's *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices* (National Quality Forum, 2007; Power et al., 2005). The Consensus Standards identify four sets of evidence-based practices (i.e., identification of substance use conditions, identification and engagement in treatment, therapeutic interventions to treat substance use illness, and continuing care management of substance use illness) and propose four factors that may accelerate adoption of evidence-based practices (i.e., financial; regulatory; education and training; and changes to health care infrastructure). State substance abuse authorities participating in AR are using the four change strategies to facilitate the five evidence-based practices.

2. APPLYING TOOLS OF STATE GOVERNMENT TO PROMOTE EVIDENCE-BASED PRACTICES

Changes in state regulatory statutes allow officials to mandate practice innovations by making evidence-based practice innovations a condition for provider accreditation, credentialing and state licensure. Policymakers can, for example, require that providers within their state have an on-site capability to provide the best practice of medication-assisted addiction therapy as a licensure requirement. Research shows that the nature of state licensing and accreditation rules has a measurable impact on the kinds of services offered by addiction treatment providers (Chiquri, et al. 2007). Of course, because regulations tend to be a "top-down" approach to policymaking, assuring compliance can be problem, particularly if the rules are not backed up by active enforcement through fidelity measures, systematic auditing and monitoring (Elmore, 1979-80). And even the best regulations may lead to hidden non-compliance if policymakers fail to address the potential for implementation problems on the front lines (Lipsky, 1980).

Regulatory requirements represent a "stick" that allows state authorities to promote practice innovations. A second tool of government, creates financial incentives for innovation, and represents the "carrot." State agencies award contracts or grants to private and governmental entities to deliver treatment and prevention services. Competitive awards provide financial leverage to promote the adoption of evidence-based practice innovations. Particular innovations may be required in contractual agreements or financial incentives can be built into reimbursement schemes to reward providers for their use of evidence-based practices. In a study of the adoption of evidence-based practices in eight state mental health systems, Rapp et al (2005) found that contract incentives were one of the most effective tools for bringing about desired changes in the capacity of providers to implement best practices. The creation and

manipulation of funding streams represents a related financing tool available to state policymakers seeking to promote the use of evidence-based practices. State authorities may reallocate funds in ways that promote evidence-based practices, while draining resources from interventions that lack documented effectiveness. They may also work within the intergovernmental lobby to bring new public funds into the system, or pursue private grants and discounts, that give providers resources to adopt evidence-based treatments. A pertinent example is the recent lobbying and successful creation of health care procedure codes to permit reimbursement for screening, brief intervention and treatment (SBIRT) programs—a policy change with the explicit purpose of promoting the adoption of an evidence-based intervention among primary care providers.

A final tool at the disposal of state government officials is that of developing and underwriting the costs of technical assistance programs that educate and train providers in emerging treatment modalities. State authorities can promote continuing medical education conferences and in-service trainings that bring providers into contact with expert consultants. A longer-term strategy is to address workforce development by promoting changes in state university curricula, so that new generations of providers will be trained in emerging treatment modalities. The addiction treatment field, like many segments of the healthcare industry, faces the growing problem of an aging workforce. This problem may also represent an opportunity to train new cohorts in more innovative, evidence-based treatment modalities. State authorities support workforce development and use that support to promote training in specific evidence-based practices.

Finally, structural characteristics influence the capacity for successful systems change, including the size and complexity of the state bureaucracy and institutional placement of those

seeking change within it (Laumann and Knoke, 1987). Administrative capacity – including data management capacity, manpower and oversight capabilities – may place limits on the ability of state officials to implement more complex systems of incentive-based contracting, regulatory monitoring programs. Characteristics of healthcare environments within states also influence the choice of politically possible policy measures. The stability and ease of relations between government leaders and organized provider constituencies can be either a constraint or facilitator of policy change. The overall amount and mix of the funding available affects the degree of leverage that state governments have over providers. In situations where state government is the largest payer of services, as is sometimes the case in addiction treatment, government officials may possess considerable leverage over providers to influence innovation (see: Pfeffer and Salancik, 1978). Finally, broader characteristics of the healthcare environment, such as the degree geographic dispersion of providers across urban and rural areas, and the receptiveness of provider communities to new clinical modalities, are likely to influence the capacity to successfully implement new policies. State agencies use all four acceleration techniques to foster adoption of evidence-based practices.

Methods for the State-Level Data Collection: Qualitative data from the first wave of national evaluation of *AR* (AR) sponsored by the Robert Wood Johnson were reviewed for this report. During the first wave of AR, which began in 2005, the Foundation selected government-provider partnerships in six sites to instigate two-year system change projects promoting the adoption of evidence-based practices in their addiction treatment systems. A second round with, (six additional sites, began the initiative in the Spring of 2008. For the present analysis, data come from the first 18 months of the first wave evaluation, and are confined to observations of

the governmental side of government-provider partnerships. This report emphasizes an analysis and description of state authority efforts to promote clinical innovations.

The National Program Office provides sites with expert consultation in best practices and organizational change. "Coaches" provide assistance with systems change through bimonthly conference calls. Sites also come together for semi-annual national "learning sessions;" participants share experiences and problem-solve in collaboration with coaches and other organizational consultants. Interest circle conference calls discuss implementation of specific evidence-based practices during monthly conference calls; participants share experiences and experts provide specific content information and trouble-shoot problems. Each of the six wave one sites focused on two specific evidence-based practices. In most sites, the two innovations were rolled out sequentially. Therefore, the data collected during the first 18 months of implementation, primarily focus on the first of the two planned change efforts.

Table 1 provides an overview of the six sites selected for participation in the first round of the AR initiative. States partnered changes with different numbers of pilot providers. The table also shows that states in the AR initiative's first round opted for one of three evidence-based practices. Medication-assisted therapy (MAT) was promoted in three states (including Florida, Maine, Missouri) to reduce relapse (e.g., buprenorphine for opiate dependence, oral and injectable naltrexone for alcohol use disorders, and acamprosate for alcohol dependence). Two sites (Kentucky, Rhode Island) selected continuing care (CC) and emphasized ongoing support services and recovery management using a staged-care approach in keeping with the more general chronic care model. Finally, Delaware promoted the use of motivational incentives (MI) to encourage patients to comply with treatment and sustain sobriety.

Table 1: AR Cohort 1 Treatment Providers

	All	DE	FL	KY	ME	MO	RI
Mean # Employees	30	14	21	72	40	26	15
Mean # Counselors	10	8	6	17	10	13	8
Mean # Admissions/yr	657	732	803	789	563	787	254
Mean % Masters @ Counseling Staff	55	24	69	83	51	51	57
Mean % Recovery @ Counseling Staff	32	29	23	39	47	34	22
Mean % Public Paid Pts	76	96	89	68	61	79	67
EBP 1		MI	MAT	CC	MAT	MAT	CC

Advancing Recovery — The University of Georgia

Data sources include project-related documents states and provider organizations submitted to the Foundation (e.g., grant proposals, annual reports), transcripts of minutes from project planning, coaching and interest circle conference calls, and field notes collected from direct observations of annual site visits, biannual AR learning sessions and other project-relate events. The most heavily used data source used during analysis was transcripts from a series of structured, in-depth interviews with representatives from SSAs in each participating site. Semi-structured interviews were conducted in-person or by telephone, lasted approximately sixty to ninety minutes, and often included state directors, along with key staff in the state's SSA. To strengthen both data validity and our ability to build rapport with interviewees, we conducted the interviews as casual conversations in private, encouraging people to speak in their own way about issues we raised. This required a flexible, unobtrusive method that allowed us to probe for

clarification, and to uncover any contradictions and discrepancies in the accounts of different individuals while maintaining some degree of comparability across sites.

The analysis examined the decision-making process within state SSAs and compared and contrasted state utilization of governmental tools to promote evidence-based practices, and assessed how facets of the state environment shaped decision-making and policy implementation. Data were collected and analyzed using standard methods for the analysis of qualitative data, with a particular focus on the method of constant comparison to explore similarities and differences across sites {see: Glaser and Strauss, 1967)). Data analysis unfolded in an iterative process within a team of five intestigators, during which the developed hypotheses and then returned to the data looking for confirmation, modification, or refutation of the initial themes. Incorporating multiple analysts from different disciplinary backgrounds, who were located in different parts of the US, strengthened the team's capacity to mine the data from different perspectives as well as reducing the travel costs associated with data collection. The team approach to analysis required adaptations of standard techniques for qualitative analysis.

Findings: The six state substance abuse authorities (SSAs) participating in the initial round of AR drew on multiple strategies to promote systems change, including new regulations, contract incentives, funding initiatives and technical assistance. However, few placed a strong emphasis on more than two major policy changes simultaneously. Table 2 provides an overview of the relative emphasis on policy strategies in each of the six states.

Table 2. Government Tools Emphasized by Six Initial *AR* Sites

SITE	Regulatory Mandates	Contract Incentives	Funding Initiatives	Education & Technical Assistance
Maine	Strong	Strong	Strong	Weak
Rhode Island	Strong	Strong	Moderate	Weak
Kentucky	Moderate	Weak	Moderate	Moderate
Delaware	Moderate	Strong	Moderate	Strong
Missouri	Moderate	Weak	Moderate	Strong
Florida	Moderate	Strong	Moderate	Moderate

Regulatory and Contracting Approaches: Most states in the AR initiative relied on changes in state regulations to promote the adoption of evidence-based treatment practices. States varied, however, in how much they relied on regulatory strategies to promote change, and if and how they combined new regulations with other policy options. A common thread across sites was the complementary use of regulatory and contracting initiatives. The momentum built up during efforts to rewrite regulations that promoted a given evidence-based practice seemed to naturally spill over into the language of contracts with providers. In most sites, eligibility for state contracts required state certification or licensure. Adding contract language and financial incentives that were consistent with state regulations gave states an added layer of leverage since contracts are monitored for compliance.

In Missouri, for example, the state SSA released certification standards for addiction treatment programs that required a capacity to provide medication-assisted therapy. Once these regulatory changes were fully vetted with providers, it was logical to modify state reimbursement contracts to echo the language of the new regulations. The results were such that providers would "voluntarily apply for certification by the state…. Contract requirements [would then] regulate services provided within the framework of the certification standards." Missouri's SSA went even further by adding medication-assisted therapy to the criteria used by its utilization review panel for extending length of stay and exceeding customary service authorizations.

Some state authorities, with Maine serving as the best example, relied more heavily on formal regulations and contract incentives. Maine's SSA reworked the language of both its facility licensing statute and reimbursement contracts to require that all facilities build the capacity to prescribe and administer addiction treatment medications, such as naltrexone, to patients. Maine's emphasis on a regulatory and contracting approach seemed largely driven by constraints within the state's healthcare environment, most notably, a strong philosophical opposition to medication-assisted therapies within the state's provider community, particularly among more traditional providers in the state's rural areas. In Maine, over half of the longstanding addiction treatment workforce subscribed to the "Twelve Step" or Alcoholic's Anonymous (AA) approach which, in its most traditional forms, advocates for complete abstinence from all mind-altering substances, which could include the new medications used in addiction treatment to reduce drug craving.

SSA officials in Maine tried to understand these philosophical differences in hopes of working out common solutions with providers and the wider AA "recovering community:"

We did a big consumer/recovering persons survey and they've been holding focus groups. They're working on that.,…you know, because the attitudes that treatment providers have, to a large extent, are the same attitudes in the recovery [Twelve Step] community. You are frequently not welcomed in AA. And there are many AA groups that will not welcome you if you're on medication. And so, [we're] working from that angle, first of all, to get a sense of why is that? You know, why are people in recovery so anti-medication? And then based on the responses of why, try to figure out what the levers are to change that.

However, it was soon clear to the SSA staff in Maine that they had reached an impasse with providers and the recovering community. The depth of the philosophical differences left policymakers feeling that they had few alternatives other than use of government authority. Maine's SSA started by collaborating closely with a small cadre of providers who shared the state agency's commitment to medication-assisted therapy—providers referred to as the "'early adopters,' they're the [AR] pilot agencies." Licensing regulations and contract requirements were put in place for "the rest of the providers that, since we've rewritten the contract, …[will] have to make changes whether they want to or not." SSA staff hoped that eventually even 12-Step rural providers—after being legally and contractually required to use medications—would come to see that medications could be useful for some patients: "People don't believe it works…We need to change practice and that will help change attitudes."

It was apparent from other sites in the AR evaluation that relying on government regulation and contract rules had uses in contexts where relations between government and providers were more harmonious. In several AR sites, regulations and contract language came about at the end of a negotiation and consensus-building process between state officials and

13

providers. In these states, new regulations and contract language helped to formalize and codify

agreements. In Rhode Island, for example, the state SSA drafted, ratified and implemented new

contract language while in continuous dialogue with the provider community. Rhode Island

providers actually drafted the most critical element of the contract language for state officials –

they defined "continuing care" "because the state lacked a prescriptive definition." Similarly,

SSAs in Florida, Kentucky and Missouri adopted new regulations as a means of "supporting"

providers in the adoption of medication-assisted therapy. A state official from Kentucky

explained that he viewed the SSA role as authorizing and enforcing agreements that emerged

from the provider community:

> The theory is … that the barriers and issues will percolate up to us through the
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> interactions at the regional level between…providers…. So, theoretically the changes
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> that we need to see made were things that are recommended that bubble up from working
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> down at that level.

Another general theme that emerged in the analysis was the importance of the

organization of state government – and the SSA's placement within it – in shaping the

implementation of new regulations and contract incentives. SSAs in Rhode Island and Maine

exemplified one end of the spectrum, where the state officials had considerable autonomy and

good working relationships with other key units of state government. The small size of

government in these states seemed to facilitate autonomy and trust: Maine's SSA Director said,

"we're like family." The ease of relationships between governmental units facilitated the writing

of new regulations and empowered enforcement. Thus, changes in regulations and contract

incentives came on board rather early in the AR initiative in both of these states.

At the other end of the spectrum were Kentucky and Florida, where the organization of government was larger, more hierarchal and complex, and the authority over addiction treatment systems was fragmented across multiple, loosely coupled divisions within government. In Kentucky, the SSA wrote licensing regulations but had no statutory authority to either award licenses or enforce provider compliance – powers seated at the higher level of the state's Office of the Inspector General (OIG). This arrangement was dysfunctional for promoting best practices because the OIG was contracting providers, had little knowledge about their activities, and did not have the substantive expertise to help addiction treatment providers troubleshoot problems and judge their clinical effectiveness. As one SSA representative explained, some of the most critical systems changes required to promote evidence-based treatment in Kentucky were those that had to come about from within the government:

> That's one of the barriers that we identified, …having to work through another agency, particularly as far as our regulatory changes… [It's one of the] changes that we're trying to implement with this grant. We have to incorporate them [OIG] in our strategy for doing that and send them copies of what it is that we have—that we are attempting to achieve… We wrote the AOD [alcohol and other drug] regs here in this office. But the way the government structure is set up in Kentucky, the only ones…that have permission to license programs is the Office of Inspector General. And that's why that reg is basically theirs to monitor, as far as safety of the structure, credentials of the staff and…planned safety and staff credentialing is basically their focus. So, actually, we kind of oversee the programmatic pieces, but they oversee…Their charge was overseeing the reg as far as the licensure procedures.

Fragmentation of authority in Florida's state government posed similar constraints on efforts to promote clinical innovation. The Florida state government was a sprawling, multi-layered bureaucracy. The Florida administration, moreover, was regularly in the midst of internal reorganization. This resulted in considerable instability and uncertainty for staff within the SSA. Efforts to promote medication-assisted therapy were significantly encumbered by the extent of internal red tape and program capabilities required for the purchasing and use of the preferred addiction treatment medication, Vivitrol® (injectable long-acting naltrexone):

> With regard to Vivitrol and provision of medication-assisted treatment, providers are required to obtain permits for use of medications. This process requires that participating agencies meet State Pharmacy and Board of Pharmacy requirements, which include the need for a Medical Director who oversees dispensing of medications. The language and regulations currently in place with regard to medication-assisted treatment may require revision based upon the AR initiative and requirements therein.

Bureaucratic barriers arising within the Florida state government tended to further percolate down to addiction treatment providers, often bypassing the state authority. Each provider was required to engage with the state's Central Office in the Division of Quality Management, as well as the state's OIG, by entering into its own, separate contract. Reports of provider compliance with contractual obligations had to be reviewed by state multiple agencies prior to reimbursement for services. To obtain a supply of Vivitrol, providers were also required to obtain approval from a number of additional sources. Delays in funding at the level of the state's Legislative Budget Commission often made it challenging to synchronize all of the necessary elements to keep agencies afloat and able to purchase medications. In response to this complexity and uncertainty, staff within the Florida SSA found themselves troubleshooting

administrative problems for providers rather than fulfilling their primary duties. Ultimately, they took it upon themselves to appeal directly to the drug companies involved in marketing and distributing Vivitrol for discounted supplies, but even this meant working with the State Pharmacy to negotiate rates for the purchase of medications.

New Funding Initiatives: Most sites participating in AR lacked funds to cover all of the costs of rolling out new evidence-based treatments. While state officials made concerted efforts to generate resources, only Maine had a significant degree of success, amounting to a one-half million dollar allocation from the state's general fund and coverage in the state's Medicaid plan for pharmaceuticals used in medication-assisted therapy. Since coverage for addiction treatment is an optional benefit under federal Medicaid rules, Maine's success was particularly noteworthy:

> In Maine, we use Medicaid to fund everything. One of the things we use it for is it's a big purchaser of substance abuse treatment services, including medications. Part of our work plan [for AR] was to make sure that all of the medications were available through Medicaid.

Maine's success also showed how some characteristics of state governments seem more conducive to internal fund-raising. The small size of the state bureaucracy and close relationships between the SSA and other key government divisions simplified the process. In 2001, Maine's SSA merged into the larger state Department of Health and Human Services. In the process, sub-units of the new department developed closer ties and a sense of common interests. The state's SSA Director explained that when it came time to promote coverage of addiction medications on the Medicaid formulary, she could simply "walk down the hall" to negotiate with the staff responsible for such decisions. And because Medicaid and the SSA were housed under the same organizational umbrella, it was easier for SSA officials to make a compelling case that

the cost-savings resulting from the adoption of best practices would come back to the state's

Medicaid plan.

By comparison, SSAs in states with less tradition of public funding for addiction

treatment services, and less tightly coupled health and human service administrations, found it

difficult to generate resources to support evidence-based treatments. In Florida, Medicaid seemed

an unlikely source of coverage for addiction medications. SSA officials there went straight to the

private sector to negotiate for discounts with drug manufacturers. However, even these efforts

were encumbered by the necessity to work in tandem with other, slower-moving units within the

government administration, including the State Pharmacy, the Board of Pharmacy and Legislative

Budget Commission. In another site, just as Missouri's SSA was promoting Medicaid coverage

for medication-assisted therapy, Medicaid was in the midst of unprecedented cutbacks and a

"substantial reduction in eligibility for Medicaid" that lowered even existing reimbursement

levels. In this environment, any attempt to increase benefits was doomed. Similarly, in

Kentucky, the SSA's attempts to increase Medicaid coverage for continuing care services met

with little success. As state officials explained, the task was made more difficult by a tradition of

limited coverage for addiction treatment in Kentucky:

> At this point we're working with Medicaid to expand the substance abuse benefits
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> through Medicaid because right now our Medicaid department only pays for pregnant and
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> postpartum women, sixty days postpartum, with substance abuse issues. That's the only
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> substance abuse benefit we have. And we're looking at, hopefully in the very near future,
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> expanding that to caregivers who are Medicaid eligible for the period of time from the six
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> months postpartum to when the child is eighteen years of age. And that's our first step in
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> expanding the Medicaid benefits. You know, hopefully we can take it beyond that in the

future, but that's the first step that we're looking at right now. And we're looking at phasing in that process in the state.

When the staff of SSAs found such barriers to new funding initiatives insurmountable, they typically defaulted to one of two alternatives: One was to reallocate existing funds to evidence-based treatments. The second was to increase flexibility in the rules by which innovative providers were allowed to spend existing state funds, thereby devolving to them greater financial control. Rhode Island's strategy exemplified creative use of both options. Here, the overall size of the SSA's budget and levels of resource allocation to providers remained constant. However, the SSA addressed the funding issue by converting a portion of outpatient slots into slots for the evidence-based treatment, continuing care. At the same time, the SSA amended its contracts with providers to permit contract expenditures for continuing care; they approved a continuing care billing code. Changes in patient discharge protocols, moreover, facilitated continuing care services by allowing providers to keep records open without treatment contact for up to 30 days. However, even these more modest changes did not come easily. State agency staff felt that the lack of new direct funding resources for continuing care created considerable uneasiness among treatment providers in the state.

State officials in Florida reported that "funding has proven to be a significant barrier to MAT [medication-assisted therapy]." Failure of the SSA's initial legislative budget request for funds to purchase the medication, Vivitrol, left officials searching for existing pots of money that could be diverted to meet this need. They ultimately uncovered a specific category for reimbursement within the state's Indigent Drug Program. While a creative solution to the problem, again, even this strategy required SSA staff to overcome numerous administrative hurdles in their efforts to redirect funds towards evidence-based care.

Missouri's SSA focused on a goal of increasing provider flexibility through changes in contract requirements. Because they had no new resources providers gained flexibility to reallocate resources and purchase addiction treatment medications. Additional contract changes included expanded authorization for patients using medications, a waiver on the state contract's per-case spending cap for providers participating in AR, as well as new billing codes, treatment guidelines and a centralized medication purchase capacity to lower the costs to providers.

Education and Technical Assistance: There was considerable variability across sites in emphasis on education and technical assistance. This variability seemed to align with characteristics of state treatment systems, particularly levels of geographic dispersion between urban and rural areas, healthcare market characteristics and the tenor of relations between SSAs and providers constituencies. Geographically dispersed treatment systems made it more difficult for SSAs to take on a strong, centralized role using regulations. Physical distance made active monitoring of compliance with regulations and contract requirements difficult, making periodic educational events seem like a more practical alternative. Moreover, in treatment systems in which the SSA was only one of a number of payers upon which providers depended for resources, the centralized power of state authorities was weakened, leaving states with little leverage to gain compliance with strict contract rules and regulations. This again encouraged SSAs to take on the role of a resource and support for providers through education and technical assistance. Providers, in turn, tended to be viewed as independent players and equal partners with state authorities.

Missouri and Delaware best exemplified these dynamics. In both states, SSAs wound up placing a heavy emphasis on technical assistance in their efforts to promote evidence-based treatment. This typically focused on warehousing and disseminating information on treatment

innovations, and providing a centralized place for brokering communication among providers. In Missouri's geographically dispersed, poorly resourced treatment system, communication was difficult, with most occurring through telephone and internet-based channels. A peer-based, collaborative relationship between SSA officials and providers had evolved in this context. The unique quality of this relationship was apparent from the very start, when Missouri's SSA agreed to partner with all willing providers, leading to 10 pilot agencies. In field notes, members of the evaluation observed that, in Missouri, "treatment providers are relatively independent. They are located throughout the state and medication practice patterns vary among the treatment agencies." Similarly, officials in the Delaware SSA described providers as "equal partners." In interviews, SSA representatives noted that the provider participants in AR …

> were involved from the very beginning. We talk all the time; it's like being a partnership, and they [providers] saw it as a partnership because they felt they were included in the decisions that were made about how we would do this… What has been done in the collaboration with [providers] is making sure that they were fully part of the planning process, they were fully part of planning for the budget and during the implementation phase we've been available to assist in any way possible.

Within other sites in the AR initiative, it was apparent that education and technical assistance programs could be used to complement the adoption of evidence-based therapies. Sometimes it appeared that the side effects of technical assistance programs constituted their greatest benefits. The very process of providing education and technical assistance to providers appeared to have latent benefits beyond simply increasing knowledge. Training brought people together in a positive enterprise, when could help to build stronger coalitions between providers and state authorities. Moreover, in the context of these educational conferences and training

events, SSA officials often brought local providers into contact with nationally recognized leaders in the field, thereby lending an element of prestige. In Kentucky, representatives of the state authority noted that they "had several national training events or brought people in—brought national figures in for training events for evidence-based practices."

Education and training programs could also have the side effect of changing attitudes among providers—a latent benefit that was particularly important for states promoting medication-assisted therapy amidst provider opposition. To one degree or another, SSA officials in Missouri, Maine and Florida, viewed education and technical assistance as a means of shifting provider attitudes. However, Maine's SSA, which confronted considerable provider resistance to medication-assisted therapy, found that provider education had its limits with respects to changing attitudes. This ultimately led them to consider the alternative of routinizing medication use through required "practice guidelines, both for the physicians and [other] clinicians around identifying when it is and when it is not appropriate for people to have medication and…what medication is used for what symptoms."

Summary: The national evaluation of *AR* gave us the opportunity to observe the process by which government officials promote the adoption of evidence-based practices. Systems change tended to unfold as a gradual, trial-and-error process of "political learning" (Heclo, 1974; March and Olsen, 1989). State officials typically pursued multiple policy changes. Those that seemed to work—and seemed to work well together—were pursued and emphasized while others were abandoned or placed on a back burner. Through a rather disorderly, incremental process, policymakers tested the limits of their environments. Regardless of whether any single approach worked or failed, it was still possible to use what one learned to regroup around other options. Through the continual back-and-forth of policy revision and real-world implementation,

each state authority felt its way towards a bundle of policy changes that respected the limits of political acceptability.

The observations of the first cohort in AR have implications for future attempts to promote evidence-based medicine through government reforms. Wider efforts to use the tools of government to promote innovation are likely to require a considerable amount of trial and error as officials learn to bundle policies and achieve a fit with healthcare environments. Theories of the policy process tend to assume that policymaking unfolds in discrete stages of policy development and policy implementation. In light of what we have observed, such accounts may foster unrealistic expectations for a tidy process of linear change. One can expect multiple inputs and a certain degree of chaos, but what matters is the quality of the long-term result, not the elegance of the process through which that result came about. By its very nature, systems change is likely to require a certain degree of flexibility, as well as tolerance for disorganization and frustration, as policymakers pursue the best fit with the environment.

Another implication is that effective solutions developed in one state may be difficult to translate to another. Because state environments differ, solutions that work in one state may not have the same effectiveness in another. However, despite the pronounced variation we observed across states participating in the AR initiative, similarities may guide future efforts to promote evidence-based practices. It may be possible to translate lessons learned between states of similar size, governmental complexity and healthcare market characteristics.

First, several characteristics of state environments seemed more conducive to particular types of policy changes. Geographically dispersed treatment systems, states with complex, multi-layered government bureaucracies, and states that were either under-resourced or had

multiple payers in the market, tended to find top-down approaches to contracting and regulation more difficult. As we saw in the cases of Florida, Missouri and Delaware, conditions of this kind tend to reduce or fragment the financial and regulatory leverage of state agencies, and may also make it difficult to monitor provider compliance. In AR sites, such conditions seemed best suited to approaches that exploited the governmental "carrot" rather than the "stick," and more collaborative government-provider relations. Education and technical assistance programs, as well as contract incentives, seemed to emerge as common policies in these settings. And while conditions made it difficult to succeed with new funding initiatives, state agencies often fell back on alternatives, such as seeking new funds from the private sector, diverting existing funds towards evidence-based care and offering providers greater flexibility and control over their existing funds. Note that, in the AR initiative, these states contrast with Maine and Rhode Island, which had less complex government administrations and relatively more generously funded systems. Strong emphases on regulations emerged in these states, and at least in Maine, it was more possible to succeed with new funding initiatives.

A second lesson from the state authorities is that systems change often takes the form of testing the environment to see how far the limits of policy change can be pushed. In the case of AR, it was possible to push the limits due to the strong Foundation support for change, and robust partnerships between providers and state officials. However, this kind of risk-taking was also facilitated by the knowledge that, even if one's initial experiment failed, it was still possible to use what one learned from the environment to regroup around some alternative. This was most clearly visible in efforts in all six sites to generate new public funds for covering the costs of evidence-based treatments. Generating new funds was one of the most challenging tasks for state SSAs – only one state in this study experienced a significant degree of success within the

18-month observation period. However, in all cases, state officials made progress towards a larger goal of providing financial supports for evidence-based practices. They did so by diverting existing funds and enhancing flexibility in contract expenditure requirements.

A final observation is that government efforts to promote practice innovations are likely to involve bundles of initiatives rather than discrete measures. At the end of the day, the "gestalt matters" for systems change, and trial-and-error processes seemed well suited to piecing together a mix of policy interventions that fit with each state's environment. State authorities that bundle policies are also able to take advantage of their inherent complementarities. Most prominent in this study were the complementarities between new regulations and contract incentives. Once state authorities had gone through the process of making changes in state licensing statutes, there were considerable efficiencies gained by echoing the language of state regulations in provider contracts. This made it possible to use the added strength of contract rules and incentives to reinforce compliance the regulations.

We also observed interesting complementarities between regulatory and technical assistance approaches for promoting evidence-based practices. When new regulations, contract requirements and funding changes pushed the limits of provider tolerance, as occurred in both Maine and Rhode Island, education and technical assistance had the latent benefit of bringing state authorities into a more collaborative partnership with providers and perhaps even changing attitudes. It is notable that Rapp and colleagues (2005) found that education and technical assistance were relatively ineffective for promoting evidence-based practices in state mental health treatment systems. This may be true in comparisons of these approaches as discrete policy alternatives. However, policymakers in the AR initiative point us towards the ways that policies

can be combined to greater effect, a lesson learned through their pragmatic attempts to find better

ways to encourage the widespread diffusion of healthcare innovations.

3. PARTICIPATING AR TREATMENT PROGRAMS' ROLES IN THE INNOVATION ADOPTION PROCESS.

The Delaware Partnership. The state of Delaware's AR collaboration includes Delaware Health and Social Services – Division of Substance Abuse and Mental Health, the SSA, and three DSAMH funded community-based outpatient substance abuse treatment programs. Involvement in AR was sought by the state of Delaware to utilize EBPs with the goal of improving the active participation of clients during the treatment process and cultivating a sustainable partnership between treatment providers and the state.

Reasons for AR Involvement: Delaware chose Motivational Incentives as their first EBP and means by which to utilize an EBP to increase active participation of clients during the treatment phase. Delaware reported high levels of confidence in that their state and provider partnership would be able to carry out a quick and easy implementation of their chosen EBP in the upcoming 24 months. Previous extensive participation in AR-type projects along with the NIATX culture deeply imbedded in the state of Delaware's substance abuse treatment system were the main reasons stated for such confidence.

The population of underserved, minority clients which Delaware providers chose to focus on was the Hispanic community. By reaching out to the Hispanic population through visits to Hispanic community-based organizations along with visits to businesses that employ high levels of Hispanics, the Delaware partnership will be better able to implement their chosen EBP in a way which meets the needs of this minority population.

In the early stages of the AR initiative, Delaware reported satisfactory consumer involvement through the active participation of a consumer advocate located within DSAMH and the direct participation of consumers as change team members. Along with Motivational Incentives for clients in treatment, the treatment providers also chose to implement a Motivational Incentive program for high performance staff, a distinctive managerial innovation as compared to the use of MI as a treatment technique.   Possible barriers to the implementation of Motivational Incentives for staff included difficulty in devising equitable rewards in a manner which provided all staff members an equal chance to be rewarded for exemplary job performances. Barriers to the implementation of Motivational Incentives for clients included lack of staff training along with staff scheduling and assignments. In addition, the novelty of the Motivational Incentives was seen as a barrier due to the value lost when the incentives become overly routine. Suggestions for overcoming this barrier included refreshing the types of Motivational Incentives on a regular basis.

The Active Participation rates of each program were proposed to be collected each month and compared with the baseline. When improvements are shown, issues of sustainability are then addressed. Quarterly reports are also to be submitted to DSAMH along with participation in quarterly meetings. DSAMH performance based contracts are to be used to determine the Active Participation rates.

Successes and Barriers at the Project Midpoint. After first half of the implementation period for Innovation 1, one out of the three provider agencies saw an increase in Active Participation rates attributed to use of Motivational Incentives. At the agency which showed an increase in Active Participation, the use of Motivational Incentives was strongly endorsed by staff members. The other two agencies cited staff resistance which was eventually helped by

establishing training sessions. Overall, the delay in the rewarding of consistent participation of clients remained a salient issue during the first half of the implementation period for Motivational Incentives in the state of Delaware. Although the staff grew increasingly committed to the sustainability of Motivational Incentives, concerns surrounding funding remained.

Year One Wrap-up. As the second half of the implementation period for Innovation 1 drew to a close, the state and provider partnership reported that the main success of participation in AR was the increase in EBP use serving the same number of consumers as were being served prior to involvement in AR. One agency in Delaware concluded that the original Motivational Incentives design should be redesigned due to the input of consumers during group treatment centers. Suggestions for the redesign were centered on greater consumer involvement in choice and delivery of rewards. Current efforts are being put forth to expand the use of Motivational Incentives throughout the state and among all levels of care.

Interviews with Round 1 Innovation 1 provider change leaders indicated an ongoing clarification of the role of the providers in the implementation of Motivational Incentives and in the concept of the AR partnership with the state. Involvement in AR has become a focal point for change leaders in the state of Delaware in many ways who have centered their efforts on removing any existing or developing barriers to implementation such as staff resistance or lack client interest in participating. Increased acceptance of the use of Motivational Incentives by treatment agency staff members was reported by change leaders and understood to be the result of internal training programs simple encouragement and support for change by provider change leaders. Counselors were said to exhibit excitement and a strong belief in Motivational Incentives as a way to advance and professionalize the field of substance abuse treatment.

Due to state involvement in Delaware's performance based contracting, the successes seen as a result of participation in AR are viewed by providers as an added bonus. Not only are participation and retention rates improving, but the ability to track these clients and present such data to the state places participating agencies in a better position to receive increases in funding. Provider change leaders also report no barriers to the involvement of the recovery community in the state of Delaware during the implementation of the first EBP. Such involvement was described as unnecessary though due to the complimentary nature of Motivational Incentives to the state's current treatment system. The recovery community retains the ability to provide informal feedback on treatment strategies to treatment providers and staff.

Diffusion Efforts. A closer look at client data revealed a high percentage of women dropping out of treatment within 45 days. Delaware decided to deal with this issue by making this phenomenon their change project and focusing on Motivational Incentives that would be appealing to female clients. Therefore, outreach to minority populations included the uninsured and specifically women. Personal hygiene products that could be used for women and their children were reported to be greatly appreciated by female clients. Visits have also been made to Hispanic community-based organizations and Hispanic places of employment in order to gain insight on the effectiveness of Motivational Incentives from this minority population. Overall, the use of Motivational Incentives expanded throughout the state of Delaware and among all levels of care.

Remaining Barriers. Due to the implementation of performance based contracting in the outpatient treatment system in Delaware in 2001, few barriers presented themselves on the state level during the implementation period for Innovation 1. However, there were several barriers on the provider level including staff resistance and turnover. Pertaining to the diffusion

of Motivational Incentives throughout the state, provider leaders suggested seeking insight from the state component of the Delaware partnership due largely to the current cost barriers to spread of Motivational Incentives.

Upon commencement of Innovation 2, provider change leaders in the state of Delaware reported confidence in their projects' capacity to enter into the second implementation period while sustaining Innovation 1, Motivational Incentives. The restructuring reward timing and frequent change in types of incentives rewarded has now been implemented in the treatment system in the state of Delaware as a result of participation in AR. Management practices that will be used to ensure the continued sustainability of Motivational Incentives during the implementation of EBP 2 include the continuation of project meetings, contacts with the project's steering committee, etc.. The goal of providers in the state of Delaware is to integrate changes within the existing system so the system can evolve around such changes. The cost of Motivational Incentives remains a salient issue for providers as they head into the implementation period for EBP 2. In regards to the implementation of the second EBP, Telephone Based Continuing Care, Delaware had already begun to discuss barriers such as licensing regulations that would require there to be a minimum number of face to face meetings every month. At the closing stages of the first implementation period, they had already requested that these telephone contacts be included in the licensure regulation standards.

The Florida Partnership. The AR partnership in Florida is comprised of Florida's

Department of Children and Family's Substance Abuse Program Office, Florida Alcohol and

Drug Abuse Association, and three individual provider networks: River Region, Operation PAR,

and Spectrum Programs, Inc.. The three networks are demographically and geographically

diverse which allows for greater reach and possible diffusion of EBPs and a strong state and

provider partnership.

Reasons for AR Involvement. The first EBP chosen by Florida for Round 1 Innovation

1 was Medication Assisted Treatment. Due to recent research findings supporting the use of the

once a month dose of injectable Naltrexone, Florida sought to expand the use of MAT beyond

the typical methadone treatment approach. On the state side of the partnership, implementation

activities included cost reduction attempts and the development of redesigned treatment

guidelines. Providers researched the best strategies by which to educate treatment staff and

clients on the efficacy of injectable Naltrexone in increasing client retention and commitment to

the monthly injection schedule.

Expected outcomes resulting from involvement in AR included the dissemination of

regulatory requirements among all participating providers and staff, increases in cost-saving

mechanisms encouraging the increased use of injectable Naltrexone, and an increased number of

clients receiving the monthly injection. Other expected outcomes included increased screening,

assessment, and prescribing of injectable Naltrexone for clients along with improved numbers of

support groups for such clients. Providers also claim the need for greater client utilization of the

indigent drug program which allows qualified individuals to receive addiction medication.

Successes and Barriers at the Project Midpoint. At the midpoint of the Round 1 Innovation 1 implementation period, the state was actively pursuing avenues by which to purchase injectable Naltrexone in bulk at a reduced price. Advances included work on adding injectable Naltrexone to the state Medicaid formulary, establishing protocol in the state pharmacy system, and licensure rule changes. Midcourse successes achieved by the provider networks included the implementation of MAT/injectable Naltrexone with multiple clients returning for subsequent monthly injections and documentation of positive treatment outcomes.

Barriers remaining at the provider level included the costs and labor needed to cover medical testing and lab work, more funds needed for related case management services, and the necessary development of new treatment protocols for the use of injectable Naltrexone. Issues concerning the sustainability of Florida's first EBP centered on funding especially for non-Medicaid clients due to the high cost of each injection. Other issues brought forth at this time concerned the need for more case managers matched with injectable Naltrexone clients and less pressure placed on providers to diffuse their first EBP as they claim a strong state and provider partnership is the foundation that will push the diffusion forward in an appropriate time period.

Year One Wrap-up. As the implementation period for Round 1 Innovation 1 came to a close, Florida reported promising outcomes attributed to the implementation of MAT/ injectable Naltrexone. Starting with a baseline of zero, by the end of October 2007, Florida providers reported more than thirty clients receiving injectable Naltrexone along with subsequent increases in consumer involvement. For example, consumer representatives were included as change team members, lead the formation of consumer focus groups, along with their opinions on project functioning being consistently solicited at regular intervals.

Each of the three provider agencies were able to focus on specific underserved minority populations due to their unique geographical locations. Spectrum, located in Miami, serves a mainly Hispanic population. Operation PAR serves mainly children, adolescents, and females at it's location in Pinellas County. The third provider network, River Region, located in Jacksonville serves mainly African Americans and those with co-occurring disorders. For example, Spectrum services developed a Customer Satisfaction Survey which they had translated into Spanish so as to ensure the inclusion of all clients in the project evaluation process.

The provider follow-up interviews revealed significant advances in the use of MAT and the existence of a promising system change. Provider experiences throughout the project remained positive despite the setbacks and barriers to the implementation of injectable Naltrexone. Communication was described by providers as a strongpoint of the project and providers reported appreciation for the state initiating, scheduling, and developing an agenda for the Florida bimonthly calls. Communication between providers and the Florida provider coach has also been consistent and beneficial. One positive outcome of this strong relationship was the suggestion by the Florida provider coach to implement the use of the Robert Wood Johnson Change Form. According to providers, this Change Form will be very useful in the implementation of Innovation 2 as it lends itself to Rapid Cycle Change much more than the implementation of MAT/injectable Naltrexone. Providers report the form to be very helpful as encourages consistent progress.

Diffusion Efforts. Communication with other provider agencies not involved with AR has helped in increasing state-wide interest in the utilization of injectable Naltrexone. This has given AR providers hope that there is an overall awareness of the medication and its effectiveness which is vital to diffusion efforts. Although the provider leader in the state of

Florida is confident that the full implementation of injectable Naltrexone has occurred, the most salient barrier to sustainability remains the cost of the medication. Another barrier mentioned was the lack of large scale injectable Naltrexone training which may result in staff and client resistance if not addressed. Although no barriers were mentioned, providers reported no formal involvement of the recovery community in Innovation 1 implementation efforts.

Successes reported by Florida providers at the end of the implementation period for Innovation 1 were the expansion of the types of MAT utilized in the state of Florida, increases in the number of providers in the state that offer MAT, and increases in evidence based assessments. The number of treatment centers that can obtain medications from the State Pharmacy has lead to a greater spread of the use of MAT throughout the state. Providers also found that increasing staff education and training in the benefits and efficacy of MAT resulted in greater staff support for the implementation of MAT/injectable Naltrexone. This education and training developed into one the key achievements in the state of Florida among providers along with the creation of the Indigent Drug Program and the development of treatment protocols for the administration of Injectable Naltrexone to clients. Another key achievement was the development of a data base for the purpose of tracking MAT clients throughout the treatment process. This data base would allow providers to measure advancements in client treatment successes as a result of the state of Florida's participation in AR.

Remaining Barriers. Upon the commencement of the implementation for Innovation 2, providers questioned the sustainability of injectable Naltrexone in Florida as issues of funding continued to be the most significant barrier. The providers are confident, however, in the project's capacity to enter into the implementation period for Innovation 2. Even though several administrative changes have been made, overall the same individuals involved in the

implementation of injectable Naltrexone are now involved in Innovation 2 implementation efforts. The biggest lesson learned during Innovation 1 reported by providers at this time was that efforts should be made to ensure all angles of the implementation process and all possible barriers are examined early on. Due to past experience with methadone and buprenorphine in the Florida treatment system, providers felt as if going into the project, their only concerns in implementing and administering injectable Naltrexone would be similar to their prior experiences with MAT, and even less so because the dosage of injectable Naltrexone is only once a month. This proved to be a wrong assumption due to difficulties with client medication compliance, pain at the injection site, lack of funding for injectable Naltrexone, etc. Providers reported spending much more time than originally expected in brainstorming ways to overcome these barriers.

The Kentucky Partnership. The AR Partnership in Kentucky consists of Kentucky River Community Care, Inc., a non-profit Community Mental Health Center, Chrysalis House, a residential addictions recovery center, Appalachian Regional Healthcare Psychiatric Center, and the SSA. Most clients enter the treatment system through the Hazard Psychiatric Program which is an inpatient psychiatric service provided by the Appalachian Regions Healthcare Psychiatric Center which is a multistate group of hospitals and is under contract with the Kentucky Division of Mental Health and Substance Abuse.

Each of these agencies has pooled their resources to form PARK – the Partnership for AR in Kentucky. Participation of PARK allows for the complex network of agencies to test the implementation of EBPs in both urban and rural settings throughout Kentucky, acknowledging the diverse demographics across multiple agencies. PARK began the implementation of Innovation 1, Continuing Care, utilizing the Plan, Do, Study, Act Model they have relied on during previous initiatives. As the recipient of several prior grants, the provider team in the state of Kentucky was secure in their ability to set and accomplish project goals.

Diversity of the partners involved in PARK was crucial in accessing the widest range of underserved, minority populations. In addition to partner diversity, the clientele at each partner agency represent a varying group of drug and other addiction problems. Throughout Kentucky, ARH is a part of a larger hospital system and Chrysalis House focuses treatment on inner city women from various backgrounds including corrections and social services. The impoverished Appalachian population is served by Kentucky River Community Care, Inc..

Reasons for AR Involvement. Previous involvement in AR-type activities has educated the PARK partnership on the importance of maintaining a good rapport with the recovery

community. They acknowledge the recovery community's insight as an essential part of any attempt at change in an already existing system. Walkthroughs following the transition from impatient care to outpatient care (aftercare) brought attention to the lacking outpatient referrals upon discharge and high readmission rates to inpatient care due to lack of structured outpatient services. Upon further discussion with the state component of PARK, the provider team chose the Wraparound Model of Case Management as their Round 1 Innovation 1 EBP.

The goal of this EBP implementation was to improve the continuity of care from Appalachian Regional Hospital and Kentucky River Community Care outpatient care via a new case management strategy, Wraparound. Providers in the state of Kentucky assert that Continuing Care is the most appropriate category of EBP to improve retention during the transition from inpatient to outpatient treatment. These providers believe that outreach to hospitalized individuals prior to discharge is the key to ensuring continuity of care. Kentucky points to five elements necessary to the sustainability of Innovation 1 and they are: a Sustain Leader, Core Change Team, Written Reports, Clinical Protocols, and the maintenance of an EBP supportive culture within PARK.

An executive from each agency presides over 8 different work groups which all work towards the goal of "Promoting wellness by developing a roadmap and bridging system that demonstrates increased continuation and decreased dropouts in the continuum of care." These 8 work groups include 1) Shared Tools (standardized assessment tools), 2) Technology (technological solutions to patient care problems), 3) Case Management, 4) Braided Funding (braided and blended funding strategies), 5) Regulation, 6) Road Map (patient education), 7) Health Information (client tracking software) and 8) Memoranda of Understanding (developing MOUs that create service linkages).

Data collection plans included KRCC and KDMHMRS using the Aarons scale to measure and monitor implementation progress. A baseline was set in 2005, which would allow for comparisons of the baseline and progress from 2006 to 2007 to be made. Several expectations were had by PARK in the beginning of AR including: the implementation of a revised ARH referral form within two weeks of walkthrough, implementation of a revised ARH discharge packet within 30 days of walkthrough, a 9% recidivism rate by August 1, 2006.

Other outcomes expected by August 1, 2006 were an increase in the number of clients receiving intensive case management, increases in client retention in outpatient treatment, and decreased AMA discharges. Each team, with the help of a data specialist at each site, focused their efforts on data collection. Using the PDSA model, data collection is simplified by focusing efforts on rapid cycle changes at one location, at one level of care, and on one aim. The reason reported by Kentucky providers for the focus on data collection was to increase the utilization of available technological resources such as web-based client tracking systems and PDA's.

Within four weeks of the initial walkthrough, the referral form and discharge packet had been revised. Efforts were also being made to appoint an individual who would be in charge of transmitting information regarding case management to providers. Within the provider change team, five measures were tracked using MIS and staff logs and they were: the number of clients referred for assessment, provided case management with Continuing Care, number of clients receiving 3 or more contacts per week, number of case conferences held, and number of recidivists.

Success and Barriers at the Project Midpoint. At the midpoint of the implementation period for Round 1 Innovation 1, several successes were noted by the PARK partnership.

Successes included progresses in the utilization of available technical resources, the development of the Recovery Roadmap for clients and families, and improved transfer rates. Some program level barriers existing at the midpoint included a difficulty implementing certain new technologies in an already existing system and the renegotiating of a consistent assessment instrument. Other issues brought forth at this time included feelings of "working on everything at the same time" and being rushed to complete the implementation of Innovation 1 in a shorter amount of time than was actually needed. The partnership overall indicated staff attitudes, lack of knowledge, and administrative practices such as confidentiality as presenting barriers to implementation.

Few concerns were brought up at the midpoint concerning the sustainability of Continuing Care at the end of AR funding. Providers in Kentucky were not concerned about depending on AR funding to accomplish full implementation. There was, however, a sense of confusion surrounding whether or not Continuing Care had been implemented at the midpoint of the project. According to agency reports, one agency said they had achieved full implementation by the midpoint, another said they will have full implementation by the end of AR funding, and yet another simply reported that they did not fully implement Continuing Care.

Year One Wrap-up. The wrap-up of the implementation period for Innovation 1 revealed both multiple successes and remaining barriers. The most notable advancements over first implementation period included the development of the Recovery Roadmap and a bridging system which lead to an increase in treatment continuation and a decrease in the number of drop outs during the transition from inpatient to aftercare.

Greater client retention was seen especially within the population of mental health clients. Throughout the first implementation period, consumers and consumer advocates were consistently solicited for their insight and opinions on the first EBP both during the design phase and continuing on after active implementation. Data was consistently gathered on a weekly basis, a video was created for clients' first visit/admission to treatment, and client tracking and auto-reminder software was identified and tested for future use.

Involvement of the Recovery Community. There has been considerable involvement of the recovery community in the process of Innovation 1 implementation reported by providers. Benefits of this involvement have been assistance to providers and agency staff in the restructuring of the client transfer process and the identification of the most efficient Continuing Care strategies. The main barriers to recovery community involvement reported by providers have been time and anonymity. Distance was also reported as a barrier by some due to the project commencing in a small, remote location, moving, and now existing in a semi-large city.

Diffusion Efforts. Provider attitudes toward the implementation period for Innovation 1 reported during follow-up interviews were positive and confident in the overall strength of the partnership and in the project's ability to move toward the sustainability and diffusion stages of Innovation 1. Techniques of promoting system changes learned from participation in AR continue to be implemented on a variety of levels by participating providers. Through this process, providers report an increase in communication and relationship strength between fellow agencies and with state representatives which will enhance their ability to successfully implement Innovation 2 and diffuse Innovation 1. The efficient teamwork efforts established during the implementation for Innovation 1, along with a centralized core change team, enables

the continuous monitoring of project successes and barriers as has been the protocol for past NIATX projects.

According to providers, the state component of the Kentucky AR partnership has been an integral part of provider implementation efforts. Calls have been the main form of communication between providers and the state occurring once a month along with face to face meetings every quarter. This partnership is viewed by providers as a sustainable connection which will ultimately carry on past the end of the AR funding period. Communication with other states such involved in AR has also proved beneficial to providers in Kentucky by providing ways to get state agencies to work together, identifying similar barriers to implementation and ways in which to work around these barriers if not to absolve them completely, and identifying alternate sources of funding. Meetings with other treatment center representatives from Tennessee, West Virginia, Virginia, and Ohio have also been useful in spreading the knowledge and experience with EBP implementation that Kentucky has acquired during the first implementation period.

Remaining Barriers. Providers also reported during follow-up interviews that their concept of full implementation of Innovation 1 has not yet occurred and according to some will never be achieved. Although Continuing Care has greatly advanced in the participating agencies, providers still report barriers to full implementation including inadequacies at the program level in regards to the transfer of clients and the effective use of technological resources meant to enhance the utilization of Continuing Care. Provider level barriers remaining at the end of the first implementation period incorporated into Kentucky's first annual report included lack of staff knowledge concerning the efficacy of Continuing Care and a lack of desire to change the existing system of care to accommodate a single diagnostic. Efforts were being made to plan a

presentation of positive project outcomes at several different treatment organizations throughout

the state in order to spread the AR's approach to system change.

The Maine Partnership. The AR partnership in Maine consists of four major partners including the Office of Substance Abuse (SSA), the Maine Association of Substance Abuse Programs, the state provider association, and the Maine Alliance for Addiction Recovery. The OSA in Maine has participated in numerous grant projects and has combined the efforts of both MASAP and MAAR to implement several diverse programs. The OSA and MASAP have and will work collaboratively on the AR project in the state of Maine. All participating agencies work closely together to advocate for consumer involvement throughout the system change process within the state's substance abuse treatment system. The MAAR program focuses its efforts on representing the recovery community and will send its staff to participate in site visits to oversee the implementation process and the monitoring of progress. It will be MAAR's task to identify barriers on the consumer level through walk-throughs, focus groups, and surveys.

Reasons for AR Involvement . Two main reasons motivated Maine to choose MAT as their Round I Innovation I EBP. The first reason is the mortality rate of the opiate addicted patients in the state of Maine who could have succeeded in recovery with the use of medications. The second reason behind their choice was the increase in available medications for addiction treatment which were not being utilized by providers within the state. Walkthroughs made evident the lack of appropriate protocol for opiate detoxification along with employee resistance being the biggest impediment to MAT implementation in the existing treatment system.

Choosing MAT for their first EBP allows Maine to address pertinent issues such as the demands for opiate addiction treatment not being met and the inability to establish the necessary methadone treatment programs needed as a result of negative community feedback and interference from local government. The goals of MAT implementation include a 15% increase in the number of clients receiving MAT, 10% retention improvement, 3% reduction in

readmissions, and 3% outcome improvement. These goals became even more attainable for providers after the $500,000 additional funding which was appropriated by the state director who requested the funds from representatives form the Governor's Office and the state Legislature. A potential barrier to the implementation of MAT often mention by individuals is many feel that treating addiction with medications prevents clients from being drug free and interferes with active participation in cognitive/behavioral treatment programs.

Several steps were to be made by the partnership in Maine to increase the utilization of MAT and included identifying barriers to the utilization of MAT, restructure the reimbursement process so that MAT is the primary treatment for those suffering from severe levels of addiction, and providing medical practitioner training. Tracking progress was a matter of conducting provider surveys before and after the first year of AR. These surveys would assess any changes in provider attitudes toward MAT.

The expectations of Maine for the first implementation period were an increased use of medications in the Medicaid and other populations, an increase in positive attitudes of counseling staff and supervisors toward MAT, and a difference in the length of stay in treatment and subsequent outcomes between MAT clients and non-MAT clients. Medicaid data will also provide insight into any increases in MAT treatment utilization by the Medicaid-specific population. MASAP and MAAR were also said to be conducting surveys to monitor clinician attitudes toward MAT.

Maine asserts that their performance based contracting system will set the standard for implementation and sustainability throughout the implementation period for Innovation 1. Successful performance is gaged by efficiency and effectiveness measures. The change exercise

chosen by Maine was the Health Reach program's initiative to remove the detoxification requirement prior to entering their program.

Successes and Barriers at the Project Midpoint. At the midpoint of the implementation period for Innovation 1, MAT, providers in Maine reported increases in Suboxone prescriptions, secured funding, established provider and patient education programs pertaining to the uses of medications to treat addiction and consistent processes in place for prescribing, billing, and dispensing. Program level barriers existing at this time included continued staff resistance to the utilization of MAT and due to linkages with DATA waived physicians for Suboxone, increases in the pool of physicians trained in other medications are needed. In reference to sustainability, the partnership in Maine remained confident that MAT has lead to sustainable system change. The main concern at this point was adequate staffing to handle increases in both clients and retention rates.

Year One Wrap-up. The end of the implementation period for Innovation 1 found an increase in the utilization of MAT as identified in the data tracking MaineCare Expenditures. Data was not available to compare outcomes with the initial baseline since the Treatment Data System, redesigned by the OSA, had originally only included methadone, LAAM, and burprenorphine. Upon the redesign in 2007, Campral, Naltrexone, Injectable Naltrexone, and Antabuse were added to TDS.

Providers report that with their main aim to introduce MAT for individuals with an opiate addiction, they do consider that the full implementation of MAT has occurred as it has been introduced as a viable option to a large number of patients. By the end of the AR funding period,

providers believe that MAT will be sustained as the clinical culture in the state of Maine has been changed in a way which has made MAT a practical treatment strategy.

Providers have also reported that they can statistically demonstrate that counseling staff attitudes have become much more open and supportive of MAT since the start of AR. Statistics reported by providers claimed that in January 2007, of the 20 counselors surveyed, 75% somewhat or strongly agreed that MAT can help with both drinking and drug addictions. By the end of 2007, 100% showed support for the use of MAT for drinking addictions and 95% showed support for the use of MAT for drug addictions.

As far as project communication is concerned, providers have reported that throughout the project, communication with coaches has been logistically confusing as teleconferences were often cancelled or postponed with very little notice given to providers. National calls were also described as problematic.

Involvement of the Recovery Community. Consumer involvement was significant at the end of the first implementation period. Providers reported one specific woman from the recovery community who made significant efforts at filling the position as liaison between the providers and the recovery community. She was very active during the implementation period for Innovation 1 and providers became very familiar with her as a resource for insight from the recovery community. Providers also reported a desire for even more involvement of the recovery community during the second implementation period as the current level of involvement was not as extensive as they would like.

MASAR, MAAR, and OSA worked collaboratively to conduct numerous surveys and establish focus groups with providers and members of the recovery community. Focus groups

brought about discussions centering on issues important to and affecting those individuals receiving MAT treatment and the recovery community. Such issues include attitudinal barriers faced by people in MAT recovery, personal use stories, and experiences with treatment providers, experiences receiving medications, what issues are important for community members to be aware of, what those on other recovery paths should know, and what peer support is most beneficial.

The outcome of the focus groups included in-depth discussions of the stigma and discrimination faced by MAT clients, especially those receiving methadone. It seemed apparent that encouraging long-term recovery clients to share their experiences proved to lend valuable insight to system change efforts. Most seemed to agree that there continues to exist a lack of positive recovery role models willing to step forth. Other sentiments were an appreciation that staff had taken the time to listen to MAT clients' opinions which they claimed had never been done in such a comfortable setting. Ideas presented by clients we received as possible future change projects and initiatives for establishing peer lead parenting support groups along with community based peer support groups.

Diffusion Efforts. Maine's combined involvement in STAR-SI, the Co-Occurring Disorder Support Grant (SAMHSA) and AR has lead to a wider focus on multiple efforts at system change and EBP implementation. An additional positive outcome of this combined involvement is the fact that the four AR projects in the state of Maine are also STAR SI pilot agencies and are now working to spread MAT services to the 14 other STAR SI agencies throughout the state. Other key achievements by the project in Maine include system changes brought about by the use of provider survey results which have lead to the implementation of specialized change projects and the improvement of staff attitudes and beliefs about MAT.

AMHC is also working with clients to promote recovery advocacy efforts by contributing stories and letters to the local newspapers about MAT and the recovery community. Overall, Maine has seen a steady increase in the number of clients receiving MAT which is illustrated in data which was set to be released in June 2008.

Remaining Barriers. As they head into the implementation period for Innovation 2, providers in Maine report that they are cautiously optimistic due to the continuous concern of acquiring a sufficient number of medication prescribers as the largest prescriber in Maine is now moving out of the state. The only solution to this possible barrier to sustainability and diffusion is, according to providers, to continue the active recruitment of physicians and other prescribers. Efforts by to diffuse MAT throughout the state include continued education and encouragement of involvement of potential providers. In addition, providers assert that a number of dinner and discussions have been arranged over the year to discuss possible interests in providing services and prescribing medications. Funds remain in the budget for a clinical position yet providers have been holding back on filling this position until they can secure a physician with prescribing privileges.

One issue brought up by the provider coach in Maine was a lack of continued emphasis on reaching underserved and minority clients on all level of the project. The coach reported that although this appeared to be a focal point of AR when the initiative first began, the interest in the effects of the project on this specific population seem to have waned significantly and should be reassessed if the participants in AR are to accomplish the level of impact which they set out to achieve.

The Missouri Partnership. The AR partnership in Missouri consists of the Missouri Department of Mental Health – Division of Alcohol and Drug Abuse (ADA) and 10 substance abuse treatment providers located throughout the state. These agencies include Comprehensive Mental Health Services, Family Counseling Center, Family Counseling Center of Missouri, Gibson Center, Family Guidance Center, Ozark Center, Preferred Family Health Care, Queen of Peace, Rediscover, and St. Patrick Center along with the Missouri Institute of Mental Health.

All participating providers in Missouri are nonprofit, tax exempt, and mainly rely on public funding. Each site receives over 100 annual admissions and serves minority populations and at all levels of care. The partnership has had numerous past experiences with AR-type activities and is confident in the partnership's ability to carryout complex, large-scale projects. Missouri was included in one of the first Access to Recovery Grants awarded by SAMHSA and feel well able to adapt to the ever-evolving treatment system. All providers selected had responded to an open request for participation in the AR initiative. In additional, all providers chosen to participate are advocates for and knowledgeable about the use of Naltrexone and Acamprosate in the treatment of alcohol dependence.

Reasons for AR Involvement . The EBP chosen by the partnership in Missouri for Round 1 Innovation 1 was the use of Medication Assisted Treatment in the treatment of alcohol dependence. More specifically, the medications targeted for implementation were Naltrexone and Acamprosate. This EBP was chosen by the partnership as the most common diagnosis seen by participating providers in Missouri is alcohol dependence while only a small percentage of the providers in the state actually utilize MAT for such diagnoses. The task of the state during the first implementation period is to focus on developing provider contracts to permit reimbursement for physician and laboratory services, medications, and enhanced treatment services. It was the

challenge of the providers to improve current treatment practices by increasing the utilization of EBPs.

There were three mains ways in which consumer involvement would play a part in the implementation of Innovation 1 that were reported by the Missouri partnership. Psycho-educational groups focusing on informing clients about MAT were formed for consumers, the development of support groups for MAT consumers which allow for the consumers' voices and opinions to be heard, and inviting treatment graduates to take part in the walkthrough and change exercises along with the involvement of a recovery support network. Consumers were overall very supportive of the implementation of MAT. Some concerns brought to the forefront by consumers early on were centered on the risk that MAT may temporarily mask cognitive and behavioral problems which can go unaddressed during treatment with MAT. Providers and staff abated their concerns by explaining that retention as a result of successful compliance with MAT will enable providers more efficient time to address these issues.

Early in the project, several barriers to the successful implementation of Innovation 1 were claimed by the partnership in Missouri and included, from the state side, a lack of authorized funds to purchase medications, laboratory work, and physician services for the evaluation and treatment of consumers with alcohol dependence diagnoses. From the provider side, a few of the most significant barriers included lack of a screening method to address the appropriateness of Acamprosate and Naltrexone for individual clients and no existing reimbursement policy for medications, the increase in physician time, nor for the increase in laboratory services. Due to the first barrier mentioned, the providers in the state of Missouri chose the screening process as their change project.

The provider goals at the beginning of the project were to stabilize consumers more quickly by using MAT and as a result reduce the need for residential support services and facilitating the transition to outpatient (intensive) or day treatment. Data collection was to be achieved through the use of technology developed by the Missouri Department of Mental Health. The MO-DMH developed the web based Customer Information Management Outcomes and Reporting system used. In the early stages of the project providers would have collected baseline data regarding the number of clients receiving Naltrexone or Acamprosate. System change on the provider level is measured by: the number of consumer referrals for MAT treatment, the number of consumers receiving Naltrexone or Acamprosate, the number of consumers receiving refill prescriptions, and number of consumer services received per month of treatment, and number of consumers arriving for their first outpatient treatment, and the length of treatment in each modality.

Successes and Barriers at the Project Midpoint. By the midpoint of the first implementation period, several successes were reported by the partnership in Missouri. Successes included the development of a new eligibility screening intake process, new laboratory testing and billing codes, staff training, and added time for physician assessment and prescribing. The few barriers remaining at the midpoint included some staff resistance and the growing need to educate clients about the availability of MAT options for treatment. Sustainability issues at this point included the need to locate additional funding due to the inability of uninsured clients (most clients) to afford the medications. Suggestions were to conserve costs by shifting the prescribing of such medications to other staff members rather than strictly psychiatrists. Other problems mentioned at this time involved getting assessment systems established and clients then processed quickly and conveniently.

Year One Wrap-up. According to Missouri's annual report, at the closing stages of Round 1 Innovation 1 the partnership had 10 contracted providers now screening all consumers admitted to treatment for MAT appropriateness. This was definite success as reports assert that no clients were receiving MAT prior to involvement in AR. At this point in the project, over 175 clients were now receiving prescriptions for Naltrexone or Acamprosate and over 150 were now receiving some form of MAT for an alcohol use disorder. Clients receiving MAT are now being given more time to remain in active treatment due to counselors' overwhelming support for the EBP. They have found that clients are much more responsive to MAT later in the treatment process than they had originally expected.

Diffusion Efforts. Provider leaders in the state reported that the full implementation of MAT has been achieved and will continue to be an ongoing process enhancement. Once the state began to reimburse medications, providers saw the diffusion of MAT throughout the state as a possibility. Peer coaching is now being provided by AR participants to the remaining centers in the state of Missouri. The staff resistance still existing at the midpoint of the first implementation period was no longer an issue as providers reported positive changes in staff acceptance of MAT after information sessions with prescribing physicians and drug representatives.

Providers were also instrumental in increasing time for psychiatrists, reworking schedules so as to provide more opportunities for clients to meet with psychiatrists, and working with pharmacy staff to become more knowledgeable about Naltrexone and Acamprosate. Throughout the implementation period for Innovation 1, communication with other providers in the form of conference calls or training sessions provided an opportunity for providers to get to know one another on a professional level and exchange experiences with EBP implementation. Support from the provider coach in the state of Missouri was described as both positive and professional.

Providers contend that MAT will no doubt be sustained at the end of the AR funding period. Although at this point in time MAT has not diffused throughout the state, once the state made changes in reimbursement policies, other providers became increasingly aware of their ability to be reimbursed for medications.

As the state of Missouri heads into the implementation for Innovation 2, Motivational Interviewing, providers are effectively preparing for training sessions and report a staff very positive and excited about utilizing the techniques they have recently learned.

The Rhode Island Partnership. The AR partnership in Rhode Island consists of the Department of Mental Health, Retardation & Hospitals – Division of Behavioral Healthcare, NRI Community Services, Tri-Hab, and Family Resources Community Action. Implementation of Innovation 1, Continuing Care, was to be undertaken by current staff members from three provider agencies in the state of Rhode Island along with the State Substance Abuse Authority. All three agencies involved have a long working history allowing for a smooth transition into the first implementation period. Due to this already existing relationship, there were no delays in the commencement of AR in Rhode Island.

Another positive aspect of the partnership in Rhode Island is the SSA and three provider agencies' strong rapport with Rhode Island Communities for Addiction Recovery Efforts (RICARES) the local recovery community advocacy organization. RICARES members were invited to participate on change teams and to present their thoughts on Innovation 1 during meetings with project stakeholders.

Reasons for AR Involvement. Early in the project, walkthroughs revealed clinical staff unaware of the importance task developing an aftercare plan early on in terms of prolonged successful client recovery. Rhode Island reported that they chose Continuing Care as Innovation 1 with belief that it should ultimately be a component of the initial, primary treatment. The Continuing Care design would be developed into a treatment plan that would ideally be tailored to each individual client and will involve all appropriate treatment services in a multitude of settings including homes, community agencies, etc. Continuing Care would initially be focused on co-occurring disorder clients and those in residential treatment programs and eventually all program clients.

Rhode Island was very interested to work with other states or agencies with prior experience with Continuing Care. Any changes in EBP utilization are monitored by the use of fidelity scales that work to identify core elements vital to implementation efforts. Scales are completed quarterly by providers to identify any existing barriers to implementation.

Initial expectations for Innovation 1 include the number of clients admitted to the specific levels of care, number of clients sober and drug free at 12 months, and the number of referrals to community services. These outcome measures assume that sustainable recovery at 12 months due to enrollment in a post-treatment programs following discharge will result in successful referrals to community resources.

A Lead Data Specialist oversees the data collection at each provider location which is supervised by the NRICS Lead Data Specialist. The master spreadsheet covering all sites will track all consumers along with demographic and proximal outcome measures and will occur biweekly. Providers will ensure all measure definitions are identical to their best ability. Baseline data for Continuing Care was not available at the beginning of the project.

Each provider agency serves a diverse, multiethnic population of African Americans, Native Americans, Hispanics, Southeast Asians, and Portuguese. Bilingual staff members representing multiple organizations are available when needed. There is also a Diversity Consultant from NRICS who provides regular staff training and is directly involved with the implementation of Continuing Care.

The change exercise chosen by Rhode Island was a redesign of provider intake protocol and staff training to include points and questions relating to a post-treatment care plan. The

change exercise outcome is measured by the actual redesign, staff knowledge and acceptance of Continuing Care, and the number of post-treatment questions completed.

Successes and Barriers at the Project Midpoint . At the midpoint of the implementation period for Innovation 1, successes reported included the development of new billing codes and procedural manuals, the development of new referral and tracking procedures, and the start of diffusion efforts. At this time several program level barriers remained. According to providers, there had been difficulty in getting clients to accept Continuing Care as most are eager to exit the treatment system as soon as they are discharged. Other issues included barriers to staff acceptance a greater need for staff buy-in along with internal rules mandating a review of brochures and educational materials. This formality created resulted in a barrier to implementing new Continuing Care brochures and manuals.

Issues of sustainability of Continuing Care in Rhode Island brought to the forefront at this time were that of staff acceptance and the overwhelming nature of Innovation 2 starting all at once. Providers felt that more time was needed to achieve staff acceptance and design Continuing Care programs in a way in which meets individual client needs. The providers also made clear their frustration with the overlapping of Innovation 1 sustainability and spread with Innovation 2, MAT, implementation.

Year One Wrap-up. The end of the implementation period for Innovation 1 in Rhode Island revealed significant progress in the use of EBPs. Prior to involvement in AR, Continuing Care was not practiced in the state of Rhode Island at any provider treatment agency. Aftercare services had been simple follow-ups by phone which were left to the discretion of providers and was utilized by only one client in the two years it was provided.

Client tracking systems indicate that of the 19 clients enrolled in Continuing Care in October 2007, 11 remained active at the time of Rhode Island's AR Annual Report. Average enrollment for active clients was 98 days and 23 days for terminated clients. Providers also found that those who remained active in Continuing Care were most likely those who participated in their first Continuing Care session.

Providers reported a strong team approach to all tasks throughout the first implementation period. Communication was strongpoint of the provider and state partnership in Rhode Island along with the consistent support and encouragement of provider implementation efforts. Although the involvement of the provider coach in Rhode Island had decreased due to illness, providers still agree that he was an extraordinary individual to work with and provided the guidance and structure needed during the early phases of the project. Although changes in staff attitudes toward the use of EBPs had occurred, this change was not allotted the typical amount of time as suggested by the NIATX principles used by providers. Providers also assert that time has caused some problems with project efficiency so that although staff are beginning to accept Continuing Care, they are being faced with the transition into the second implementation period and having to keep up with Innovation 1 while transitioning into Innovation 2.

Involvement of the Recovery Community. Throughout this implementation there has been consistent participation of the Director of RICARES as well as others from the recovery community. More recently there has been a change of directors which has lead to recent decreased involvement of the new RICARES Director. Despite such changes, providers report more than adequate involvement of the recovery community, most notably representation from RICARES, throughout the project.

The most emphasized proposal by the recovery community representative was to increase Continuing Care services from 12 months to two years if needed as they claimed that 12 months was much too short for some individuals needing prolonged recovery support services. Providers in Rhode Island felt that there were no barriers to the involvement of the recovery community other than the voluntary nature of recovery community representatives and thus there is only so much you can demand.

Diffusion Efforts. The project has continued to focus Continuing Care efforts on the underserved, minority population mentioned previously. Reports from providers indicate all have expanded Continuing Care throughout their agencies. Diffusion efforts have begun as project members were to request, from DATA, the opportunity to provide trainings throughout the state. Another salient diffusion effort is the attendance at SSA and Community Mental Health Centers meetings in order to advocate for the use of Continuing Care. Providers have reported the need for much more involvement of the recovery community in diffusion efforts. They also claim that although spread has been attempted at the individual client level, more marketing needs to be done on a larger scale and directed toward agencies such as the Department of Children and Families and the Division of Parole and Probation.

Remaining Barriers. The main barrier to the implementation, sustainability, and diffusion of Innovation 1 at the end of the first implementation period remained staff resistance. According to providers, staff fear being inundated with Continuing Care clients and have been influenced by insight from the members of the recovery community and other staff members indicating that clients are much more receptive to the idea of Continuing Care only after they have established an alliance with clinicians. Despite these remaining barriers, providers contend that although the initial stages of implementation were slow to progress, the project appears to be

increasing in energy. They also assert that clients have reported that Continuing Care has been

helpful to their recovery efforts. The new goal of the project is to enroll at least 50 clients in

Continuing Care by June, 2008.

4. THE ROLE OF COACHING AT THE AR INNOVATION IMPLEMENTATION SITES

The final section of this report is based on data collected from 10 state and provider coaches in the AR Project funded by the Robert Wood Johnson Foundation. The 10 coaches' interviews were conducted via telephone by members of the University of Georgia AR evaluation team. The qualitative interview instrument consisted of 39 questions designed to assess the coach's experience during the implementation period for Innovation 1.

Coaching Split Assignment. AR coaches were first asked if the split assignment of coaches proved useful during the implementation of EBP #1 and why. All coaches were in agreement that the split assignment was very useful especially in state or provider - specific situations or when presented with barriers that required expertise and action from either the provider or state component. The splitting up of coaches on either side was described as one coach as great model to implement in such a project. Coaches were then asked whether they had actually ended up working on both sides of the partnership or whether the two coaches maintained a pretty clear division of labor.

All but one coach reported that they had ended up actually working on both sides of the partnership. About half reported that the division was very clear unless certain situations or problems required the involvement of both coaches. The other half reported that the partnership was very collaborative with the exception of situations which fell into either coach's area of expertise. Coaches were then asked about the frequency and substance of communication with their fellow coach. Answers pertaining to frequency of contact outside of regularly scheduled coaches' calls ranged from once a month or less to three times per month. Issues discussed

during such communication included simply checking in on the status of the project, planning next steps to take in order to overcome barriers to implementation, sustainability or diffusion, and problem solving or modifying their approach. One coach did report increases in AR related conversations with their fellow coach following an SSA administrative transition which resulted in the temporary disruption of the project's diffusion efforts.

Communication and Site Visits. Coaches were asked, overall, how they would characterize their level of communication with the project, was it was more than adequate, adequate, or less than adequate and why. An equal number of coaches reported more than adequate and adequate with only one reporting less than adequate. Those that responded more than adequate described their project as extremely responsive and highly active in monthly calls and learning sessions. One such provider coach did report that although their level of communication with the provider side of the project was more than adequate their description of their level of communication with the state component was like "a black hole," although recent improvements have been made. The single report of a less than adequate level of communication with the project cited problems reaching the project director in the state along with a lack of contact by project personnel.

When asked, on average, how many times did project personnel contact them monthly, responses ranged from less than once a month to two or three times a month with only one coach reporting no contact with project personnel at all. Coaches reported the reasons behind these contacts to be discussions pertaining to the involvement of the recovery community and in what ways they'd be most helpful, new staff members joining the project, and to gain information or resources only available through the coaches. When asked how many site visits were made during the first implementation period, coaches responded from two to four site visits. These

visits primarily occurred at a central location within the project state and were initiated by

coaches except for one case in which all site visits were prescheduled and decided upon by

project personnel. Coaches were then asked if they felt that more site visits would have been

helpful in the implementation of Innovation 1 to which all but one reported no, more site visits

would not have been helpful.

  Coaches' Role and Performance. In order to assess the characteristics of the role of

provider and state coaches, coaches were asked what specific ways their coaching relationship

had a direct impact on the implementation of the first EBP. Responses centered on providing

crucial knowledge, training, and support for system change. Some found their main role was to

identify potential barriers to implementation, providing knowledge of NIATX principles to

project personnel, along with consistently emphasizing the importance of inclusion of the

recovery community in project decisions and throughout the implementation period. Only one

coach reported that they had very little impact on the implementation of the first EBP other than

providing encouragement.

  When asked if they felt as if they missed opportunities for influencing EBP

implementation coaches the responses of coaches were divergent. The coaches that reported

missed opportunities cited issues such as a failure to involve the recovery community in the

project, failure to focus on process improvement, not advocating for combining EBP 1 and EBP

2, two complimentary practices, and not responding to issues quickly enough, mistakenly

assuming project personnel had rectified the problems.

  Coaches were then asked what indicators they used to measure their performance as a

coach during the first implementation period. Most suggested that they knew they had done a

satisfactory job of coaching if the main aims of the project had been accomplished and to the extent that project personnel actually utilized their suggestions and feedback during EBP 1 implementation. One coach claimed that they had not developed any indicators by which to measure their performance as a coach and suggested that it may be useful to create a coach performance related instrument to give to coaches at the start of each implementation period.

Linkages with Additional Resources and States. The coaches contacted the National Program Office at varying rates. While some claimed they had not contact the NPO at all during the first implementation period, others claim that they sought contact from once to 4 times on issues such as clarification and logistics. The main reasons the coaches have consulted the NPO have been for feedback regarding what the other side of the partnership was doing and as one coach put it "in order to figure out where the end of consulting and the beginning of grants monitoring begins."

Most coaches claim that they have utilized the AR website infrequently or never and describe it as useless to them. There were, however, a couple who assert that they frequently log on to the website to check the status of other projects, to view other states' storyboards and for ideas and different angles of other states which they may be able to put into practice. About ¼ of the coaches reported no contact with projects or coaches from other state.

Of those who did reach out to other states, the most beneficial contact reported occurred at the AR learning sessions. One coach in particular reached out to two other states implementing similar EBPs and asserts that this contact was very useful when tackling issues of sustainability. Another claimed that although they did not reach out to other coaches or states, their connections

with clinicians and researchers in the field that had extensive experience with their state's chosen EBP provided the most valuable information during implementation efforts.

When coaches were asked whether they would describe the level of involvement of the SSA in the implementation of EBP1 as either more than adequate, adequate, or less than adequate most reported more than adequate. Those who responded "more than adequate" described their state's SSA as very supportive of the AR project and committed to seeing the project succeed. In one state, the original SSA director, whose involvement was said to be "more than adequate," left the project. The position was filled shortly after by an individual who did not share the same vision and had many more responsibilities which lead the coach in that state to rate the new SSA director's involvement as just adequate.

Another coach reported similar issues with the SSA in their state explaining that although the involvement of the SSA was more than adequate in the beginning of the project, numerous changes in state and SSA personnel resulted in severely less than adequate levels of involvement by the SSA. Only one coach reported that the SSA's level of involvement in their state was less than adequate throughout the first implementation period with reason being that the agenda for the state calls was always distributed at the last minute and the SSA would choose random substitutes for calls and meetings when AR project personnel were out of the office.

Major System Changes: Achieved? Sustained? Diffused? The next series of questions pertained to the major system changes which have occurred as a result of participation in AR. Coaches were first asked in what ways the project team in their state had been guided by the concept of "system change."

All but two coaches reported that their project was guided by the concept of "system change" in numerous ways. Of these, one reported that the only influence of the state thus far had been removing barriers and that actual full scale system change and spread had not yet occurred. The other explained that system change was a much grander view than is possible for their project to attempt in its current state and that this will hopefully be a more tangible goal in during the implementation period for Innovation 2.

When asked to describe the specific system changes which have occurred, all responses from coaches revolved around their project's ability to draw from both the state and provider components of the project to create a system conducive to EBP implementation and practice. New ways of operating were created by redesigning information systems, communication channels, data systems, and creating new levels of care.

Cooperation between the state and providers seemed to be a key theme described by each and every coach. If sustainable system change is to occur, their must be consistent cooperation from both sides. Coaches were then asked whether the partnership had achieved full implementation of EBP 1. All but three of the coaches interviewed reported that yes, their partnership had achieved full implementation. Different reasons were noted by those coaches who responded no and they were that in one state there was still a divide between the provider and state components of the project while another claimed that the project was not as invested in the process of implementation and sustainability as they had been at the start of the project. The third coach that responded no claimed that in order to do so, the project will have to attempt to spread the EBP across the state and they have yet to do this.

When coaches were asked whether they believed that the implementation of the first EBP had created sustainable system change they responded with divergent outlooks. Those who responded yes claimed that they have embedded the new practice within their system and made it a viable treatment option. Others stated that they believe that the system change that had occurred on the program level will definitely spread to other regions of their state and that they have also reorganized their staffing and funding in order to accommodate this change.

Turning to the two coaches who stated no, one explained that until the EBP is implemented correctly, the project has no investment or incentive to sustain or diffuse the EBP any further. One of the two did claim, however, that although they do not see this EBP diffusing anytime soon, they are confident that it will at least be sustainable within the three agencies with whom they are working.

The next question referred to the diffusion of Innovation 1 and asked coaches what efforts had been made to diffuse the first EBP throughout the state. Responses indicated much discussion between AR providers, state representatives, and other treatment agencies throughout the participating states yet little actual diffusion. For example, in one state, a new billing code was created for the purposes of reimbursement to providers for the new EBP treatment. After this billing code was in place, the state decided to allow the remaining 13 treatment agencies in the state who were not involved in AR to utilize the same billing code if they were interested in implementing the EBP in their programs also. At the time of the follow-up coach interviews, the coach in this state indicated that only two of the 13 had actually done so. Coaches reported that they will continue to present their successes and results of implementation at learning sessions and statewide presentations.

Role of Recovery Community. The role of the recovery community in the AR project

was described as almost nonexistent by all but two coaches. The lack of involvement of the

recovery community included a lack of recovery community members on change teams and all

other aspects of implementation. Most of coaches reported that they were very regretful of this

and that they are working hard to rectify this issue during the next implementation period.

Of those who reported that they had selected an appropriate representation of the

recovery community for involvement in the project, both cited the active involvement of either

one specific advocate or several advocates who were present at all meetings and even

participating in AR conference calls. One coach described one specific recovery community/staff

advocate as thinking much like a researcher by gathering pertinent information on the

implementation process and presenting such information for evaluation purposes. This collection

of information occurred in the form of the creation of 9 new focus groups along with hundreds of

surveys and the development of a speakers' bureau with the purpose of encouraging other

recovery community members to feel comfortable telling their story of recovery.

Positive and Negative Consequences of the AR Project. The next two questions

pertained to both the positive and negative outcomes associated with the implementation of

Innovation 1. First, coaches were asked what they felt were the most positive outcomes of having

a state/provider partnership in terms of carrying out the implementation of the first EBP.

Coaches identified several positive outcomes to this partnership such as the fact that now the

systems understand each other much better, their have been advances made that could only have

been made with the cooperation of both sides of the partnership, and that the growing strength of

the partnership will inevitably lead to future projects advancing system change even further.

Coaches were then asked if they felt as if there were any negative outcomes associated with the implementation of EBP 1. The majority of coaches could not identify any negative consequences or outcomes. Those who were unsure stated that they felt that if there were any negative outcomes of the implementation of EBP 1 than it was too early to tell. One coach did assert that the first implementation period did increase provider frustration with the state but that this issue is being rectified in the next implementation period.

Thoughts on the AR Mode . Coaches were asked a series of questions pertaining to the critical role of coaches in the basic design of the AR project. First, coaches were asked whether the role of a coach was well defined for them at the beginning of the project and whether they considered this definition "more than adequate," "adequate," or "less than adequate," and why. Coaches were divided between those who responded "adequate" and "less than adequate" with no coaches responding "more than adequate."

Those that reported "less than adequate" all claimed that this definition did eventually become clearer throughout the first implementation period simply due to greater experience in the role, discussions at learning sessions and other meetings, along with the creation of the Practice Implementation Enhancer (PIE) which was devised at the midcourse meeting in Philadelphia in 2007.

Coaches were then asked to think of AR coaching as a job description and to name as many specific coaching roles that they had to carry out in order to make an appropriate impact on the implementation of the first EBP. Of these roles, the most frequently cited role was that of facilitator. Other salient roles mentioned by coaches included supporter, motivator, mentor, teacher, provider of reinforcement, and liaison.

Next, coaches were asked if there were any changes they would make to the basic design of AR. Some suggestions for improvement were to provide a website for all members of the project which would provide resources and discussion threads pertaining to experiences with EBP implementation, to receive more feedback from state leaders, better direction provided for coaches along with more time set aside for coaches' calls. Many coaches also complained about the overwhelming amount of emails sent out by the NPO with little information that they felt was actually beneficial. They also noted that it would have benefited their efforts as coaches to have a clearer sense from the NPO of where consulting and monitoring begin and end.

Thoughts on Innovation 2. In regards to the commencement of the second implementation period, coaches were asked what lessons they had learned during the implementation period for the first EBP which will guide them in their role as a coach during the implementation of the second EBP. Coaches pointed to being much more aggressive in their coaching strategies, tackling barriers and other obstacles with solutions much more quickly, along with accepting that at times there is only so much one can do and to not get involved if there is nothing that can be done.

Coaches were then asked if they would make any significant changes in their coaching style/coaching role during the implementation of EBP 2. All but two coaches reported that they would not make any changes to either their coaching style or coaching role during the second implementation period.

One coach reported that all new providers were chosen for the implementation of EBP 2 and therefore it was like starting over all together and changes in coaching style or role may be inevitable. The other coach who responded yes claimed that they would become much more

assertive in the next implementation period along with becoming much more forceful in terms of pushing system change. All coaches were very confident that the partnership between providers and that state would carry on past the end of the AR funding period citing that this was a system change that is now embedded in everyday practice and that this partnership goes way beyond the boundaries of the AR project.

Additional Observations. At the conclusion of the follow-up coach interviews, all coaches were asked if there were any additional points which they would like to add to the discussion about their experiences with the first implementation period. Additional points were varied. One coach stated that they would have liked to have seen more emphasis placed on the underserved, minority populations which were a large focus at the beginning of the project and lost momentum as the project progressed.

Another coach reported that the role of a coach and member of the NPO should never blend as this places such a large amount of responsibility on just one individual which most could not live up to. Still another coach suggested that much more effort should be made to strengthen the state and provider partnership prior to the actual start of the implementation process. Mention was also made to the effect that in one state, a student at a local college maintains that state's AR website which provides information such as data that has been collected and numerous EBP resources. This information is available to providers who all claimed that this information was very important to them although they have yet to do anything constructive with it such as using it in focus groups.

5. Final Observations from the AR Provider Data Collections

The principal conclusion that can be drawn from the provider level data collections is that the targeted innovations have been adopted and remain in the process of being fully implemented in the participating treatment programs

It is clear from our observations that there is consideration variation in implementation processes. There is a clear need for adaptation of EBPs to local environment and system configurations. Practices cannot be taken off the shelf from the CTN, translated through the ATTCs and then successfully implemented into local settings. There are clearly "mechanical difficulties" integrating some EBPs into treatment, demonstrated most clearly in AR by experiences with motivational incentives and with medication-assisted treatment.

Counselor "buy in" is a necessary ingredient, and is probably the best foundational measure of the implementation of new treatment practices. There is generalized counselor resistance to change, explained at least in part by the fact that a great many work in high stress environments. Further, high turnover reflects some degree of problem with organizational commitment, hence a lowered interest in implementing changes that may be perceived as difficult and demanding.

Moreover, there is the problem of imposing new counseling responsibilities on top of old responsibilities, making certain changes non-rewarding simply because of perceived overload. Finally, some innovations are presented without a clear rationale, suggesting only that *"any Evidence-Based Practice is better than what we have been doing."* This attitude does not support acceptance of change at the level of the front-line counselor.

AR's initial recognition of the importance of support for innovations among the various recovery communities appears to have been a very useful insight, and propelled the use of innovations in ways that are difficult to capture quantitatively. However, beyond this important stakeholder consideration, little attention is typically given to client resistance in terms of:

(a) Novelty, namely how does a counselor with incomplete understanding or commitment to an innovation effectively introduce clients to that innovation?

(b) Inconsistency, namely how to explain that the proffered treatment is not the "treatment as usual" that was the client's expectation? and

(c) Unwanted "extras," namely the offering of supportive medications or long-term continuing care that is perceived by clients as unnecessary or even undesirable.

Our data collection generated some observations from the provider partners about their state partners, including the well-known comments about bureaucratic redundancy and ineffectiveness in chains of communication that seems beyond change. Other problematic issues are leadership and personnel instability within the bureaucratic structures of the SSAs, and the common inabilities of inter-agency communications necessary to fully support an innovation over the long term.

Respondents also commented on the variation in the "pace" of moving ahead within the state systems. Using the concepts of the NIATx initiative, treatment programs are often left too long in the "waiting room." Further, treatment programs may be inadequately engaged in an initiative if stifled by bureaucratic procedure.

Finally, as the funding for Cohort One has come to a close, the evaluation team will now proceed to address criticial issues of sustainability of the systems changes and the EBPs that have been adopted, and the degree to which we will be able to observe sustained spread of these system changes and innovations within the respective states.

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