Intermediary Organizations in Implementing Evidence-based Practices

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Rationale for Using Evidence-based Practices

- Changing “landscape” of practice in mental health, juvenile justice, education & health
  - Push for Accountability…”where is the data?”
  - Increased quality and relevance of research

- Emergence of the concept “Best Practices”
  - What is a best practice?
  - More than…”what we already do”
  - More than a theoretical approach
Biases about EBPs

“They are too rigid and cookbook”

“Doesn’t apply to real world kids with real world, multi-problem histories”

“Developed in some lab”

“Overly simplistic”

“Too difficult to implement in community setting”

“Just a band-aid and doesn’t address underlying issues and concerns”

“Another passing fad”

“My training and expertise are not valued”
Economic barriers to implementing EBPs

• Little financial support for implementation
• Community-based and independent providers “barely getting by”
• No mechanism for supporting supervision and training necessary for implementing EBP’s in a fee-for-service environment
• Providers do not see that up front investment will yield longer term gains
• Turnover is high
• Medicaid and managed care do not routinely reimburse or create incentives to deliver EBPs
Workforce
Barriers to Implementation

- Some clinicians may not share theoretical perspective and see EBPs as incompatible with their worldview
- Neophyte clinicians may not receive adequate training and not sufficiently prepared exiting graduate programs
- Turnover is high and clinicians are underpaid
- For some types of EBPs work can be intensive and not “traditional”
- Difficulty finding appropriate supervision
- Lack of incentives or support to change practice
Elements necessary for successful implementation

- Practice Changes
- Organizational Changes
- Systems Changes
- Continuous Quality Improvement
- Outcome Evaluation
- Consumer Involvement
- Policy Changes
- Adequate ongoing funding and support
Bridging the gap

• Difficult to bridge the gap between science and practice

• Practitioners in community settings often feel that evidence-based models are developed in some laboratory and are both impractical and inaccessible in real world settings

• Systems of care often do not have the capacity or knowledge to effectively implement best practice or model programs

• Result is lack of innovation and improvement in community based settings
Bridging the gap

- Organizations work “in between” treatment developers or researchers and providers in the community

- Help identify best practice models and adapt them to community based settings

- Fixsen (2009) identified these organizations as “purveyor” or “intermediary” organizations
Expanding the Definition

What is an “Intermediary Organization”??

How does it differ from a “Purveyor”??
Purveyor and Intermediary Organizations

Purveyor Organizations

An individual or group of individuals representing a practice that work to implement a model program with fidelity and good effect.

Typically involved in the implementation of a specific evidence-based practice (e.g., MST).

Intermediary Organizations

An individual or group of individuals that acts as an intermediary between two or more entities to promote the implementation of model programs with fidelity and good effect.

Defined as having a broader role to promote implementation including building the capacity of providers or systems to implement and sustain best practice models.
Expanding the definition

• Intermediary organizations do more than just purvey a specific program or programs

• Serve multiple roles and functions to build capacity, promote systems change and sustain best practice models

• Intermediary organizations are crucial to implement and sustain change
Case Example of an Intermediary Organization

- The Connecticut Center for Effective Practice developed as an intermediary organization to promote the implementation and sustainability of best practices in children’s mental health in the State of Connecticut, USA.

- Works with multiple national and local partners in a variety of capacities to implement best practice models and promote systems change.

- Housed in a non-profit policy and research institute and funded by multiple sources.
Connecticut Center for Effective Practice

- An example of an intermediary organization

- Formed over 10 years ago to address the challenge of implementation of evidence-based and best practices within a state system of care

- Housed at a non-profit with strong collaborative relationships with state agencies and major universities

- Emphasis on partnerships and collaborative relationships
Framework of the Intermediary Organization

Case example of the Center for Effective Practice

1) Identification, adoption and implementation of evidence-based and best practice models in children’s healthcare

2) Research, evaluation, and quality assurance of new and existing services

3) Education and public awareness about evidence-based and best-practice models

4) Development of infrastructure, systems and mechanisms for implementation and sustainability
7 Major Activities of the Intermediary Organization

1) Consultation Activities
2) Best Practice Model Development
3) Purveyor of Evidence-based Practices
4) Quality Assurance and Continuous Quality Improvement
5) Outcome Evaluation and Research
6) Training, Public Awareness, and Education
7) Policy and Systems Development
Consultation Activities

- Consultation to state agencies on systems development, implementation of model practices and practice improvement

- Consultation to provider organizations on workforce development, strategic planning, capacity building, organizational development, senior leadership and systems change

- Active participation in statewide forums, committees and task forces that promote systems change
Best Practice Model Development

• Therapeutic Supports Services
• Extended Day Treatment Services
• Emergency Mobile Psychiatric Services
• School-based Diversion Initiative
Purveyor of EBPs

• Multisystemic Therapy
  – 30 agencies over 4 years

• Trauma-focused Cognitive Behavioral Therapy
  – 16 agencies over 3 years through statewide learning collaborative

• Community-based Wraparound
  - Two pilot regions expanding to statewide dissemination

• Child FIRST
  – 8 regions over three years through statewide learning collaborative
Quality Assurance and Continuous Quality Improvement

• Help agencies develop quality improvement systems, use metric data, and monitor outcomes

• Training, capacity building and technical assistance

• Online data systems, analysis and continuous feedback

• Helping providers use data to promote organizational and systems change

• Example: Performance Improvement Center
  Emergency Mobile Psychiatric Services
Outcome Evaluation and Research

- Promote systematic evaluation of all services and programs
- Build systems based on best practice models and established research
- Qualitative and quantitative methods
- User friendly reporting and use of data to inform clinical decision making
- Example: Statewide evaluation of MST
Training, Public Awareness, and Education

- Provider trainings
- Family & consumer education
- State agency trainings & workforce development
- Local, state, national and international conference presentations and participation
- Comprehensive communications strategy including publications, briefs, web content and media relations
- Website development
Many Examples of Success

• Development and implementation of best practice models of care resulting in improved outcomes for children and families (TSS, EDT, SBDI).

• Statewide dissemination and implementation of evidence-based models: (MST, TF-CBT, Wraparound, Child FIRST, CONCEPT)

• Implementation methodology development (Learning Collaborative)

• Continuous Quality Improvement (PIC)
Policy & Systems Development

• Advocacy efforts
• Leadership in statewide governance and advisory roles
• Ongoing engagement of state legislators
• Policy development
• Medicaid management and reform
Challenges and Lessons Learned

• Ongoing funding (particularly in current economic environment) is challenging

• Training, implementation activities, evaluation and quality improvement are first services to be cut

• Systems level, organizational level and individual readiness are key to successful implementation

• Process of buy-in and sustainability are continuous and never ending
Lessons learned

“An organization cannot function as an intermediary if the entities among which it intermediates are not ready and do not have sufficient motivation and capacity for change.”
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Reference

Please visit our websites:

www.chdi.org

www.kidsmentalhealthinfo.com