Evidence-Based Implementation: The Role of Sustained Community-Based Practice and Research Partnerships

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This column describes a process for adapting an evidence-based practice in community clinics in which researchers and community providers participated and the resulting framework for implementation of the practice—Replicating Effective Programs–Facilitation. A two-day meeting for the Recovery-Oriented Collaborative Care study was conducted to elicit input from more than 50 stakeholders, including community providers, health care administrators, and implementation researchers. The process illustrates an effective researcher-community partnership in which stakeholders worked together not only to adapt the evidence-based practice to the needs of the clinical settings but also to develop the implementation strategy. (*Psychiatric Services* 63:205–207, 2012; doi: 10.1176/appi.ps.201200032)

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It can take decades to transfer evidence-based practices into community treatment settings. Millions of research dollars can be wasted if these practices do not reach the populations in need (1). Successful transfer requires an ongoing collaboration between researchers and community providers, which involves a shared vision and operational plan. Gaps in communication and lack of a process for addressing competing priorities can impede the creation of a shared vision and, ultimately, the implementation of evidence-based practices.

The field of implementation science has produced numerous frameworks to facilitate the implementation of evidence-based practices (2). With some exceptions (3,4), implementation frameworks tend to be developed by researchers and then "rolled out" in community practice, rather than developed in partnership with community providers. Consequently, community providers and researchers lack a shared structure to facilitate communication and an operational plan for implementing evidence-based practices that reflect mutual goals.

Recovery-Oriented Collaborative Care (ROCC) is a randomized controlled trial to assess the effectiveness of an enhanced version of the Research-to-Practice framework developed by the Division of HIV/AIDS Prevention of the Centers for Disease Control and Prevention (CDC). The objective of this study was to compare the enhanced framework with the CDC's standard procedures in enhancing fidelity and improving health outcomes for patients randomly assigned to the two conditions. Community-based mental health and primary care sites in Michigan and Colorado are participating in the trial.

The evidence-based practice chosen by community providers at the ROCC sites was the collaborative–chronic care model (CCM) adapted for bipolar disorder, which involves group self-management sessions, care management, and community resource linkages. In the ROCC study, the enhanced Research-to-Practice framework has been named the Replicating Effective Programs framework because of its successful application in implementing group-based HIV prevention interventions that share similar elements with the CCM (5).

A meeting of researchers and community-based providers from the ROCC sites was held to develop an implementation framework to facilitate the rapid transfer of the evidence-based practice—CCM adapted for

bipolar disorder. This column describes feedback generated from a two-day meeting of researchers and community-based providers from the ROCC sites to refine Replicating Effective Programs to more effectively facilitate the rapid transfer of the evidence based practice—CCM adapted for bipolar disorder—and how a similar process might be applied as a strategy for community providers who are implementing other evidence-based practices.

Engaging stakeholders in ROCC

Relationship building between researchers and providers began in the fall of 2008, and the meeting was held in the fall of 2011. Seven community-based primary care and mental health sites were identified as potential study participants by leaders from two regional community-based practice networks (Colorado Access in Aurora, Colorado, and Washtenaw Community Health Organization in Ann Arbor, Michigan). Participating sites were similar to other community-based mental health and primary care sites from the same region.

To encourage participation in the parent study, researchers met with providers before the start of the study (spring 2007) to obtain their input on implementing the CCM. All sites volunteered to take part in the study, in part because they felt that the CCM should be applied to bipolar disorder, because unmet need for bipolar disorder treatment is costly to their practices. When the study was funded in 2008, all sites participated in the planning process, which included the meeting described in this column. Because community providers had been involved from the beginning, they joined the study knowing that their input was valued, sharing a common understanding and supporting the partnership to implement the CCM.

Developing the framework

The meeting content and structure were based on the Replicating Effective Programs framework (5). The framework includes four phases: preconditions (identifying need and a suitable evidence-based practice), preimplementation (community input and packaging the evidence-based practice), implementation (package dissemination, training, technical assistance, and evaluation), and maintenance and evolution (sustainability). [A table summarizing components of the four phases is available online as a data supplement to this column.] Some of these components have been used in other implementation frameworks (2,4) but they have not heretofore been operationalized in combination.

The first day of the meeting included an overview of the study, CCM, and Replicating Effective Programs, followed by group discussions. On the second day, partners separated into focus groups composed of administrators, providers, researchers, and federal representatives that discussed adaptations to the CCM. Partners reconvened in the large group and discussed augmentations to Replicating Effective Programs in light of the recommended adaptations to the CCM. Participants provided informed consent in accordance with local institutional review board requirements.

Fifty-three individuals participated in six focus groups. Results from the group discussions were categorized into two main themes: creating organizational and financial incentives (for the CCM and for Replicating Effective Programs) and promoting implementation and sustainability. Providers and researchers generated roughly equal numbers of suggestions, and both groups were generally consistent in their support of these suggestions. At the end of the meeting, partners desired to continue their relationship beyond the implementation phase.

Organizational and financial incentives

For organizational incentives, community providers and researchers stressed that support from frontline providers was crucial for integrating the CCM into clinic operations. A key to sustaining frontline support is having internal facilitators, who reside in the practices and build bottom-up support for the CCM and who work collaboratively to resolve organizational barriers to implementation, such as patient flow and space limitations.

Others suggested incentives about provider training and division of labor for maximizing sustainability. Participants from both groups suggested that clinic staff could assume responsibility for various CCM functions; for example, peer specialists could run mental health group sessions and the care manager could focus on clinical care and outreach. One researcher suggested using technologies (for example, telemedicine and smartphones); however, a provider noted that consumers are reluctant to use technologies for symptom assessment.

Providers and researchers differed in two key areas in their recommendations about organizational incentives: intervention customization and technical assistance. One provider recommended that the CCM could be blended with existing interventions, such as peer support. In contrast, researchers cautioned against blending programs without keeping each intervention's components intact. Some providers wanted researcher partners to provide technical assistance for other programs in addition to the CCM, such as peer support.

To support financial incentives (such as reimbursement of CCM services) participants from both groups recommended that credible data on positive effects of implementing the CCM (such as fewer hospitalizations) should be provided regularly to community providers and administrators. Others stressed the importance of enlisting external leaders who could facilitate efforts at the regional and state levels to secure funding reform to allow reimbursement of CCM services.

Providers and researchers had some contrasting suggestions for enhancing financial incentives. Providers stressed the importance of respecting the community partner's current fiscal priorities and the need to be flexible in the implementation timeline. Researchers were less aware of the need to have flexible implementation timelines but acknowledged the lengthy federal funding timelines.

Promoting implementation and sustainability: expanded framework

The meeting participants recommended an expanded version of the Replicating Effective Programs framework, consisting of additional facilitation to address organizational and financial incentives [see online appen-

dix]. In contrast to technical assistance, which involves more specific guidance in implementing the evidence-based practice, facilitation is a process by which ongoing support to frontline providers who are implementing the practice is created by developing relationships between different types of providers and leaders and enhancing organizational and financial incentives. For example, the preconditions phase of the expanded framework includes an initial assessment by the facilitator to identify unmet needs and areas that the CCM can address to help mitigate organizational barriers at the site and also to identify how the evidence-based practice should be adapted to address the site's needs.

The expanded framework, which is called Replicating Effective Programs–Facilitation, also emphasizes financial incentives to maximize sustainability, such as aligning the core functions of the CCM with existing reimbursement models and an upfront discussion of trade-offs with initial investment and long-term return on investment. Both researchers and community providers recommended establishing a cross-functional team that provides input on the business case for implementing the CCM, such as alignment of clinical procedures with existing billing codes or initiatives (for example, the medical home model).

Ongoing research-community partnership

Three core principles made this researcher-community partnership particularly strong: a practice-based research agenda, inclusion of multiple levels of personnel from the health care organizations, and enhancement of an already established implementation framework to collaboratively sustain an evidence-based practice for bipolar disorder. Together, these inform a road map for ROCC through practical feedback not only on the CCM but also on the expansion of the Replicating Effective Programs–Facilitation framework.

Overall, meeting participants suggested practical strategies for improving the implementation of evidence-based practices and the implementation strategy itself. Many of the recommended changes to the CCM reflect a more public health–oriented practice model proposed in other implementation frameworks (3). Moreover, key enhancements to the Replicating Effective Programs–Facilitation framework reflect established community-based strategies in mental health services research, notably engaging multiple stakeholders and identifying organizational and contextual factors that facilitate or impede implementation (4). Although the original CDC Research-to-Practice framework was successfully used to implement psychosocial evidence-based practices for HIV prevention (5), in many cases funding was tied to intervention adoption and completion. In contrast, evidence-based practices delivered in health service systems, such as the CCM, often face organizational and financial barriers to implementation at multiple levels and across different stakeholders (4). Thus the process for eliciting community-based input was vital to the development of the enhanced framework to address these key issues and to increase the probability of successful implementation of evidence-based practices for mental disorders in real-world practice.

All participants agreed on key organizational and financial incentives, notably facilitation and alignment of the CCM with reimbursement strategies. Nevertheless, providers and researchers differed in how the framework components should be applied, such as technical assistance beyond implementing the CCM and opportunities to blend the CCM with other treatment modalities. Acting on these suggestions may lead to win-win situations, especially if it produces effective combinations of treatment models that help consumers. Therefore, careful consideration of the community providers' priorities, focus on the evidence-based practice's components, and dialogue between partners and researchers (4) can enhance the balance between fidelity to the evidence-based practice and flexibility.

Replicating Effective Programs–Facilitation is potentially applicable to a wide range of evidence-based practices for community health care settings. All partners agreed on the recommendations to expand the framework to include more formal facilitation, alignment of the goals of the CCM with those of changing clinic program priorities, and linking core components of the CCM to reimbursement models. The resulting framework includes guidance on organizational and financial incentives that are aligned with providers' needs and goals, notably through the establishment of program facilitators. Overall, we demonstrated the effectiveness of a research–community provider partnership in which stakeholders had active roles in not only enhancing the intervention but also expanding the implementation framework. Such partnerships could facilitate the use of other evidence-based practices across real-world treatment settings.

Acknowledgments and disclosures

The authors thank the National Institute of Mental Health for support of this program (grants R01 MH 79994 and R01 MH 74509) and the U.S. Department of Veterans Affairs (VA) Health Services Research and Development Program (HSRD 07-115). They also acknowledge the support of the University of Michigan Comprehensive Depression Center (Director's Innovation Fund). They acknowledge support and input from the ROCC core coinvestigators, consultants, consumers, and site leaders. The views expressed are those of the authors and do not necessarily represent the views of the VA. The findings and conclusions in this report are those of the authors and do not necessarily represent the views of the CDC.

The authors report no competing interests.

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