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Correspondence

Letter to the Editor

In their July 2006 article on barriers and strategies to implement evidence-based practices [*Journal of Substance Abuse Treatment, 31* (1), 25 ff], Miller, Sorensen, Selzer, and Brigham suggest that failure to adopt evidence-based practices (EBPs) is not a training issue but rather is an issue of helping clinicians to become aware of the practice and getting them to implement it through strategies such as monitoring practice and giving feedback, increasing supervision and coaching, and offering incentives.

Although we agree with these points, we feel that successful implementation of EBPs must also take into account the organizational context, the systems that finance and deliver care, and the policies, procedures, and practices that guide care. The sparse research available to date tells us that "organizational factors" are more significant than either clinician skills and knowledge or customer "resistance" in adopting change (Ebener & Kilmer, 2003). In short, a skilled and knowledgeable clinician, working with a willing customer in an environment that is functionally inhospitable to a full range of proven interventions, is unlikely to offer quality treatment.

For instance, if block grants or Medicaid reimbursements do not cover a particular practice and if that practice costs money to implement, is it reasonable to expect an organization to adopt the new practice? Both treatment agencies and payers need to see the business case (the potential for a practice to increase revenue, to reduce costs, or both) of adopting a practice. In many cases, trials that evaluate the practice do not consider the business case—and they should do so. In other instances, the practice of purchasing discreet services, rather than a full episode of care or desired outcomes, encourages organizations to deliver *primarily* those services and to not link with related step-down or wrap-around services that drive better results.

The Advancing Recovery Program, which was recently funded by the Robert Wood Johnson Foundation, supports six state–provider partnerships to explore options for improving the business case of adopting five categories of evidence-based practices. Some of these are options that could be undertaken at the state level. Specifically, they include the following:

- Braiding financing and standardized purchasing across state accounts. For instance, New Mexico and Iowa are working to allow providers to pool funding across state public payers and to offer multiple services to patients with multiple needs.
- Identifying unintended consequences of processes and procedures that discourage EBPs in funding mechanisms, regulatory policies, and other policies. For instance, Massachusetts has licensed a community health center in a treatment agency, allowing for reimbursements for medications and complementary primary care.
- Promoting diversity in a provider network to ensure that consumers have access to staff members whose cultures and languages are compatible with their own. For instance, Arizona purchases sweat lodge and healer services to accompany other treatments for Native American consumers.
- Purchasing networks of services instead of discrete services. New Jersey has demonstrated that this approach allows consumers seamless transfer across levels of care for children's mental health services.
- Promoting an activated consumer base so that patients can ask for and monitor care to ensure that evidence-based practices are delivered.

Organizations can also use numerous *provider-level approaches* to overcome barriers that have limited the use of proven practices. The Advancing Recovery Program encourages five approaches that agencies in 27 states used in an earlier program delivered by the Network for the Improvement of Addiction Treatment (NIATx), as follows:

- Strengthen business and clinical systems. Examples are NIATx member agencies in redesigned systems that engage patients and their families by integrating motivational enhancement approaches into their first contact, admission, assessment, and early engagement processes.
- Focus on intersystem linkages. Several agencies demonstrated that creating seamless linkages with community health centers could increase screening

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and brief interventions for pregnant women and could make medications more available.
- Import approaches from outside the field. Several agencies have taken customer responsiveness lessons from the hospitality industry, resulting in greater focus on patient follow-up and monitoring.
- Embrace the value of the customer as a key partner in shaping organizational change. The concept of "customer walk-through" experience is now a routine practice in many agencies.
- Employ technology in new roles. Simple use of cellular phone call-back and reporting features may improve compliance with treatment and aftercare.

Finally, we would be remiss if we did not mention what Rogers (1995) referred to as "innovation bias." His point was that researchers have a natural bias for evidence-based practices, assuming that a randomized clinical trial is sufficient to prove that a practice should be implemented everywhere and in all conditions. This happens while trials take place in very controlled circumstances with populations that volunteer to participate and where differences between subjects are factored out through complex statistical analyses. These trials rarely take into account differences in subject comorbidities, culture, race, education, and socioeconomic status. In randomized clinical trials, it may be that the decision not to implement is a perfectly rational one given specific circumstances.

In conclusion, we feel that although clinician training and awareness are critical factors, an organization's unique systems and culture also play key roles in the successful implementation of EBPs.

Victor Capoccia, (Ph.D.)
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