EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

Evaluating Your Program

Appendix F: General Organizational Index Protocol

General Organizational Index Protocol

The General Organizational Index Protocol explains how to rate each item of the index. In particular, it provides the following:

- A definition and rationale for each item; and
- A list of data sources most appropriate for each fidelity item (for example, chart review, program leader, practitioners, consumers, and family interviews).

When appropriate, a set of probe questions is provided to help you elicit the critical information needed to code the fidelity item. These probe questions were specifically generated to help you collect information from respondents that is relatively free from bias, such as social desirability.

Decision rules will help you code each item correctly. As you collect information from various sources, these rules will help you determine the specific rating to give for each item.

G1. Program Philosophy

Definition: The program is committed to a clearly articulated philosophy consistent with the specific evidence-based practice (EBP), based on the following five sources:

- Family intervention coordinator;
- Senior staff (for example, executive director, psychiatrists);
- FPE practitioners;
- Consumers and family members; and
- Written materials (for example, brochures).

Rationale: In agencies that truly endorse EBPs, staff members at all levels embrace the program philosophy and practice it in their daily work.

Sources of information:

Overview: During the site visit, be alert to indicators of program philosophy consistent or inconsistent with the EBP, including observations from casual conversations, staff and consumer activities, etc. Statements that suggest misconceptions or reservations about the practice are negative indicators, while statements that show enthusiasm for and understanding of the practice are positive indicators.

The intent of this item is to gauge the understanding of and commitment toward the practice. It is not necessary that every element of the practice is currently in place (this is gauged by the EBP-specific fidelity scale), but rather whether all those involved are committed to implementing a high-fidelity EBP.

The practitioners rated for this item are limited to those implementing this practice. Similarly, the consumers rated are those receiving the practice.

1. **Family intervention coordinator, senior staff, and practitioner interviews**

   At the beginning of the interview, have practitioners briefly describe the program.

   - "What are the critical ingredients or principles of your services?"
   - "What is the goal of your program?"
   - "How do you define [EBP area]?"

2. **Consumer interview**

   - "What kind of services do you receive from this program?"
   - Using a layperson's language, describe to the consumer or family the principles of the specific EBP area. [Probe if the program offers services that reflect each principle.]
   - "Do you feel the practitioners of this program are competent and help you address your problems?"

3. **Written material review (for example, brochure)**

   - Does the site have written materials on the EBP? If not, then rate item down one scale point (i.e., lower fidelity).
   - Does the written material articulate a program philosophy that is consistent with the EBP?

Item response coding: The goal of this item is not to quiz every practitioner to determine if each can recite every critical ingredient. Rather, the goal is to gauge whether the understanding is generally accurate and not contrary to the EBP. For example, if a senior staff member says, "We are having trouble identifying consumers for our FPE program since most families are unsupportive," then that would be a red flag for the practice of FPE.

If all sources show evidence that they clearly understand the program philosophy, code the item as "5." For a source type that is based on more than one person (for example, practitioner interviews) determine the majority opinion when rating whether that source endorses a clear program philosophy. Note: If no written material exists, then count that source as unsatisfactory.

G2. Eligibility/Consumer Identification

Definition: For EBPs implemented in a mental health center: All consumers in the community support program, consumers in crisis, and those in the hospital are screened using standardized tools or admission criteria that are consistent with the EBP.

For EBPs implemented in a service area: All consumers within the jurisdiction of the service area are screened using standardized tools or admission criteria that are consistent with the EBP. For example, in New York, county mental health administrations are responsible for identifying consumers who will be served by Assertive Community Treatment (ACT) programs.

The target population refers to all adults with serious mental illness (SMI) served by the provider agency or service area. If the agency serves consumers at multiple sites, then assessment is limited to the site or sites that are targeted for the EBP. If the target population is served in discrete programs (for example, case management, residential, day treatment), then ordinarily all adults with serious mental illnesses are included in this definition.

Screening will vary according to the EBP. The intent is to identify all who could benefit from the EBP. In every case, the program should have an explicit, systematic method for identifying the eligibility of every consumer. Screening typically occurs at program admission; programs that are newly adopting an EBP should have a plan for systematically reviewing consumers who are already active in the agency.

Rationale: Accurately identifying consumers who would benefit most from the EBP requires routinely reviewing eligibility, based on criteria that are consistent with the EBP.

Sources of information:

1. Family intervention coordinator, senior staff, and practitioner interviews

- "Describe the eligibility criteria for your program."
- "How are consumers referred to your program? How does the agency identify consumers who would benefit from your program? Do all new consumers receive screening for substance abuse or severe mental illness (SMI) diagnosis?"
- "What about consumers who are in crisis (or institutionalized)?"
- Ask for a copy of the screening instrument that the agency uses.

2. Chart review

Review documentation of the screening process and results.

3. County mental health administrators (where applicable)

If eligibility is determined at the service-area level (such as the New York example), then interview the people who are responsible for this screening.

Item response coding: This item refers to all consumers with SMI in the community support program or its equivalent at the sites where the EBP is being implemented; it is not limited to consumers who receive EBP services only. Calculate this percentage and record it on the fidelity scale in the space provided. If 80 percent or more of these consumers receive standardized screening, code the item as "5."

G3. Penetration

Definition: *Penetration* is defined as the percentage of consumers who have access to an EBP as measured against the total number of consumers who could benefit from the EBP. Numerically, this proportion is defined by—

$$\frac{\text{Number of consumers receiving an EBP}}{\text{Number of consumers eligible for the EBP}}$$

As in the preceding item, the numbers used in this calculation are specific to the site or sites where the EBP is being implemented.

Rationale: Surveys have repeatedly shown that people with SMI often have a limited access to EBPs. The goal of EBP dissemination is not simply to create small exclusive programs, but to make these practices easily accessible within the public mental health system.

Sources of information:

The calculation of the penetration rate depends on the availability of the two statistics defining this rate.

Numerator: The number receiving the service is based on a roster of names that the family intervention coordinator maintains. Ideally, this total should be corroborated with service contact sheets and other supporting evidence that the identified consumers are actively receiving treatment. As a practical matter, agencies have many conventions for defining *active consumers* and *dropouts*, so that it may be difficult to standardize the definition for this item. Use the best estimate of the number actively receiving treatment.

Denominator: If the agency systematically tracks eligibility, then use this number in the denominator. (See the rules listed in G2 to determine the target population before using estimates below.) If the agency doesn't track eligibility, then estimate the denominator by multiplying the total target population by the corresponding percentage based on the literature for each EBP.

According to the literature, the estimates for EBP KITs available at this writing should be as follows:

- Integrated Treatment for Co-Occurring Disorders—40 percent
- Supported Employment—60 percent
- Illness Management and Recovery—100 percent
- Family Psychoeducation—100 percent (some kind of significant other)
- Assertive Community Treatment—20 percent

Item response coding: Calculate this ratio and record it on the fidelity scale. If the program serves more than 80 percent of eligible consumers, code the item as "5."

G4. Assessment

Definition: All EBP consumers receive standardized, high-quality, comprehensive, and timely assessments.

Standardization refers to a reporting format that is easily interpreted and consistent across consumers.

High quality refers to assessments that provide concrete, specific information that differentiates among consumers. If most consumers are assessed using identical words or if the assessment consists of broad, noninformative checklists, then consider this to be low quality.

Comprehensive assessments include the following:

- History and treatment of medical, psychiatric, and substance use disorders;
- Current stages of all existing disorders;
- Vocational history;
- Any existing support network; and
- Evaluation of biopsychosocial risk factors.

Timely assessments are those updated at least annually.

Rationale: Comprehensive assessment or re-assessment is indispensable in identifying target domains of functioning that may need intervention, in addition to consumers' progress toward recovery.

Sources of information:

1. **Family intervention coordinator, senior staff, and practitioner interviews**
   - "Do you give a comprehensive assessment to new consumers? What are the components thatxyou assess?"
   - Ask for a copy of the standardized assessment form, if available, and have practitioners go through the form.
   - "How often do you re-assess consumers?"

2. **Chart review**
   - Look for comprehensiveness of assessment by looking at multiple completed assessments to see if they address each component of the comprehensive assessment every time an assessment is performed.
   - "Is the assessment updated at least yearly?"

Item response coding: If more than 80 percent of consumers receive standardized, high-quality, comprehensive, and timely assessments, code the item as "5."

G5. Individualized Treatment Plan

Definition: For all EBP consumers, an explicit, individualized treatment plan exists (even if it is not called this) related to the EBP that is consistent with assessment and updated every 3 months.

Individualized means that goals, steps to reaching the goals, services and interventions, and intensity of involvement are unique to this consumer. Plans that are the same or similar across consumers are not individualized. One test is to place a treatment plan without identifying information in front of supervisors to see if they can identify the consumer.

Rationale: Core values of EBP include individualizing services and supporting consumers' pursuit of their goals and progress in their recovery at their own pace. Therefore, treatment plans need ongoing evaluation and modification.

Sources of information:

Note: Assess this item and the next together; that is, ask questions about specific treatment plans along with questions about the treatment.

1. Chart review (treatment plan)

Using the same charts as examined during the EBP-specific fidelity assessment, look for documentation of specific goals and consumer-based, goal-setting process.

- "Are the treatment recommendations consistent with assessment?"
- "What evidence is used for a quarterly review?"

2. Family intervention coordinator interview

"Describe the process of developing a treatment plan. What are the critical components of a typical treatment plan and how are they documented?"

3. Practitioner interview

When feasible, use the specific charts selected above. Ask practitioners to go over a sample treatment plan.

- "How do you come up with consumer goals?" [Listen for consumer involvement and individualization of goals.]
- "How often do you review (or follow up on) the treatment plan?"

4. Consumer interview

- "What are your goals in this program? How did you set these goals?"
- "Do you and your practitioners together review your progress toward achieving your goals?" [If *yes*, "How often? Please describe the review process."]

5. Team meeting and supervision observation, if available

Observe how the treatment plan is developed. Listen especially for discussion of assessment, consumer preferences, and individualization of treatment. Do they review treatment plans?

Item response coding: If more than 80 percent of EBP consumers have an explicit, individualized treatment plan that is updated every 3 months, code the item as "5."

If the treatment plan is individualized but updated only every 6 months, code the item as "3."

G6. Individualized Treatment

Definition: All EBP consumers receive individualized treatment meeting the goals of the EBP.

Individualized treatment means that steps, strategies, services, interventions, and intensity of involvement are focused on specific consumer goals and are unique for each consumer. Progress Notes are often a good source of what really goes on. Treatment could be highly individualized, despite the presence of generic treatment plans.

An example of a low score on this item for Integrated Treatment of Co-Occurring Disorders is the following:

If consumers in the engagement phase of recovery are assigned to a relapse prevention group and are constantly told they need to quit using, rather than using motivational interventions.

Rationale: The key to the success of an EBP is implementing a plan that is individualized and meets the goals for the EBP for each consumer.

Sources of information:

1. **Chart review (treatment plan)**

   Using the same charts as examined during the EBP-specific fidelity assessment, examine the treatment provided. Limit the focus to a recent treatment plan related to the EBP. Judge whether an appropriate treatment occurred during the time frame indicated by the treatment plan.

2. **Practitioner interview**

   When feasible, use the specific charts selected above. Ask practitioners to go over a sample treatment plan and treatment.

3. **Consumer interview**

   "Tell me about how this program is helping you meet your goals."

Item response coding: If more than 80 percent of EBP consumers receive treatment that is consistent with the goals of the EBP, code the item as "5."

G7. Training

Definition: All new practitioners receive standardized training in the EBP (at least a 2-day workshop or its equivalent) within 2 months after they are hired. Existing practitioners receive annual refresher training (at least a 1-day workshop or its equivalent).

Rationale: Practitioner training and retraining are warranted to ensure that evidence-based services are provided in a standardized manner, across practitioners and over time.

Sources of information:

1. **Family intervention coordinator, senior staff, and practitioner interviews**

   - "Do you provide new practitioners with systematic training for [EBP area]?" [If *yes*, probe for specifics: Mandatory or optional? Length? Frequency? Content? Group or individual format? Who trains? In-house or outside training?]
   - "Do practitioners receive refresher trainings?" [If *yes*, probe for specifics.]

2. **Review training curriculum and schedule, if available**

   Does the curriculum appropriately cover the critical ingredients for [EBP area]?

3. **Practitioners interview**

   - "When you first started in this program, did you receive a systematic and formal training for [EBP area]?" [If *yes*, probe for specifics: Mandatory or optional? Length? Frequency? Content? Group or individual format? Who trains? In-house or outside training?]
   - "Do you receive refresher trainings?" [If *yes*, probe for specifics.]

Item response coding: If more than 80 percent of practitioners receive at least yearly, standardized training for [EBP area], code the item as "5."

G8. Supervision

Definition: FPE practitioners receive structured, weekly supervision from a supervisor experienced in the particular EBP. The supervision can be either group or individual, but CANNOT be peers-only supervision without a supervisor. The supervision should be consumer-centered and explicitly address the EBP model and how it applies to specific consumer situations. Administrative meetings and meetings that are not specifically devoted to the EBP do not fit the criteria for this item. The consumer-specific EBP supervision should be at least 1 hour each week.

Rationale: Regular supervision is critical not only for individualizing treatment, but also for ensuring the standardized provision of evidence-based services.

Sources of information:

1. **Family intervention coordinator, senior staff, and practitioner interviews**

   Probe for logistics of supervision: length, frequency, group size, etc.

   - "Describe what a typical supervision session looks like."
   - "How does the supervision help your work?"

2. **Team meeting and supervision observation, if available**

   Listen for discussion of [EBP area] in each case reviewed.

3. **Supervision logs documenting frequency of meetings**

Item response coding: If more than 80 percent of FPE practitioners receive weekly supervision, code the item as "5."

G9. Process Monitoring

Definition: Family intervention coordinators and administrators monitor the process of implementing the EBP every 6 months and use the data to improve the program. Process monitoring involves a standardized approach, for example, using a fidelity scale or other comprehensive set of process indicators.

An example of a process indicator would be a systematic measurement of how much time case managers spend in the community instead of in the office. Process indicators could include items related to training or supervision. The underlying principle is that whatever is being measured is related to implementing the EBP and is not being measured to track billing or productivity.

Rationale: Systematically and regularly collecting process data is imperative in evaluating program fidelity to EBP.

Sources of information:

1. **Family intervention coordinator, senior staff, and practitioners interviews**

   - "Does your program collect process data regularly?" [If *yes*, probe for specifics. Frequency? Who? How (using [EBP area] fidelity scale vs. other scales)? etc.]
   - "Does your program collect data on consumer service use and treatment attendance?"
   - "Have the process data affected how your services are provided?

2. **Review of internal reports and documentation, if available**

Item response coding: If evidence exists that standardized process monitoring occurs at least every 6 months, code the item as "5."

G10. Outcome Monitoring

Definition: Family intervention coordinators and administrators monitor the outcomes of EBP consumers every 3 months and share the data with FPE practitioners in an effort to improve services. Outcome monitoring involves a standardized approach to assessing consumers.

Rationale: Systematically and regularly collecting outcomes data is imperative in evaluating program effectiveness. Effective programs also analyze such data to ascertain what is working and what is not working and use the results to improve the quality of services they provide.

Key outcome indicators for each EBP are discussed in the EBP KITs. A provisional list is as follows:

- **Integrated Treatment for Co-Occurring Disorders**—substance use (such as the Stages of Treatment Scale);
- **Supported Employment**—competitive employment rate;
- **Illness Management and Recovery**—hospitalization rates, relapse prevention plans, medication compliance rates;
- **Family Psychoeducation**—hospitalization and family well-being; and
- **Assertive Community Treatment**—hospitalization and housing.

Sources of information:

1. **Family intervention coordinator, senior staff, and practitioner interviews**

   - "Does your program have a systematic method for tracking outcomes data?" [If *yes*, probe for specifics: How (computerized vs. chart only)? How often? Type of outcome variables? Who collects data?]
   - "Do you use any checklist or scale to monitor consumer outcome (for example, Substance Abuse Treatment Scale)?"
   - "What do you do with the outcomes data? Do your practitioners review the data regularly?" [If *yes*, "How is the review done (for example, cumulative graph)?"]
   - "Have the outcomes data affected how your services are provided?" [If *yes*, "How?"]

2. **Review of internal reports and documentation, if available**

Item response coding: If standardized outcome monitoring occurs quarterly and results are shared with FPE practitioners, code the item as "5."

G11. Quality Assurance

Definition: The agency's quality assurance (QA) committee has an explicit plan to review the EBP or components of the program every 6 months. The steering committee for the EBP can serve this function.

Good QA committees help the agency in important decisions, such as penetration goals, placement of the EBP within the agency, and hiring and staffing needs. QA committees also help guide and sustain the implementation by doing the following:

- Reviewing fidelity to the EBP model;
- Making recommendations for improvement;
- Advocating and promoting the EBP within the agency and in the community; and
- Deciding on and keeping track of key outcomes relevant to the EBP.

Rationale: Research has shown that programs that most successfully implement EBPs have better outcomes. Again, systematically and regularly collecting process and outcomes data is imperative in evaluating program effectiveness.

Sources of information:

1. Family intervention coordinator interview

"Does your agency have an established team or committee that is in charge of reviewing the components of your [EBP area] program?" [If *yes*, probe for specifics. "Who? How? When?"]

2. QA committee member interview

- "Please describe the tasks and responsibilities of the QA committee." [Probe for specifics. "What is the purpose? Who? How? When?"]
- "How do you use your reviews to improve the program's services?"

Item response coding: If the agency has an established QA or steering committee that reviews the EBP or components of the program every 6 months, code the item as "5."

G12. Consumer Choice About Service Provision

Definition: All consumers who receive EBP services are offered a reasonable range of choices consistent with the EBP; practitioners consider and abide by consumer preferences for treatment when they offer and provide services.

Choice is defined narrowly in this item to refer to services provided. This item does not address broader issues of consumer choice such as choosing to engage in self-destructive behaviors.

To score high on this item, it is not sufficient that a program offers choices. The choices must be consonant with the EBP. So, for example, an agency implementing Integrated Treatment for Co-Occurring Disorders would score low if it only worked with consumers who were abstinent.

A reasonable range of choices means that FPE practitioners offer realistic options to consumers rather than prescribing only one or a couple of choices or dictating a fixed sequence or prescribing conditions that consumers must complete before becoming eligible for a service.

Examples of Relevant Choices by EBPs

Current at this writing

Integrated Treatment for Co-Occurring Disorders

- Group or individual counseling sessions
- Frequency of treatment
- Specific self-management goals
- Selection of other supporters to be involved

Supported Employment

- Type of occupation
- Type of work setting
- Schedules of work and number of hours
- Whether to disclose
- Nature of accommodations
- Type and frequency of followup supports

Family Psychoeducation

- Consumer readiness for involving family
- Who to involve
- Choice of problems and issues to work on

Illness Management and Recovery

- Selection of other supporters to be involved
- Specific self-management goals
- Nature of behavioral tailoring
- Skills to be taught

Assertive Community Treatment

- Type and location of housing
- Nature of health promotion
- Nature of assistance with financial management
- Specific goals
- Daily living skills to be taught
- Nature of medication support
- Nature of substance abuse treatment

Rationale: A major premise of EBP is that consumers are capable of playing a vital role in managing their illnesses and in making progress towards achieving their goals. Providers accept the responsibility for getting information to consumers so that they can more effectively participate in treatment.

Sources of information:

1. Family intervention coordinator interview

- "Tell us what your program philosophy is about consumer choice. How do you incorporate consumers' preferences in the services you provide?"
- "What options exist for your services? Give examples."

2. Practitioner interview

- "What do you do when a disagreement occurs between what you think is the best treatment for consumers and what they want?"
- "Describe a time when you were unable to abide by a consumer's preferences."

3. Consumer interview:

- "Does the program give you options for the services you receive?"
- Are you receiving the services you want?"

4. Team meeting and supervision observation

Look for discussion of service options and consumer preferences.

5. Chart review (especially treatment plan)

Look for documentation of consumer preferences and choices.

Item response coding: If all sources support that type and frequency of EBP services always reflect consumer choice, code the item as "5."

If the agency embraces consumer choice fully except in one area (for example, requiring the agency to assume representative payeeships for all consumers), then code the item as "4."

Note: Ratings for both scales are based on current behavior and activities, not planned or intended behavior.

The standards used for establishing the anchors for the *fully implemented* ratings were determined through a variety of expert sources as well as empirical research.