

Factors Affecting Implementation of an Evidence-Based Practice in the VA:

Illness Management and Recovery

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Illness Management and Recovery

Abstract

Illness management and recovery (IMR) is an evidence-based practice that assists consumers in managing their illnesses and pursuing personal recovery goals. Although previous research has examined factors affecting IMR implementation facilitated by multi-faceted, active roll-outs, little is known about IMR diffusion in absence of such a roll-out. We conducted semi-structured interviews with 20 local recovery coordinators and 18 local IMR experts at 23 VA medical centers. Interviews examined perceived and experienced barriers and facilitators to IMR implementation. Six factors differed between sites implementing IMR from those not providing IMR: awareness of IMR, importer-champions, autonomy-supporting leadership, Veteran-centered care, presence of a sensitive period, and presence of a psychosocial rehabilitation and recovery center. Four factors were common in both groups: recovery orientation, evidence-based practices orientation, perceived IMR fit within program structure, and availability of staff time. IMR can be adopted in lieu of active implementation support; however, knowledge dissemination appears to be key. Future research should examine factors affecting the quality of implementation.

Factors Affecting Implementation of an Evidence-Based Practice in the VA:

Illness Management and Recovery

Illness management and recovery (IMR) is an evidence-based practice that provides a comprehensive package of self-management treatments for people with severe mental illness (SMI; Mueser, 2006). The standardized intervention helps participants progress towards achieving personal recovery goals while learning skills to better manage their illnesses. The effectiveness of IMR has been demonstrated through numerous trials which provide evidence that IMR can improve illness self-management, as well as symptoms assessed by objective raters (McGuire et al., 2014).

Despite IMR's effectiveness, IMR implementation can vary widely. In the National Implementing Evidence-based Practices (EBPs) Project, only half of the programs providing IMR reached "successful" levels of fidelity (Bond, Drake, McHugo, Rapp, & Whitley, 2009) and subsequent multi-site studies showed substantial variation in fidelity (Hasson-Ohayon, Roe, & Kravetz, 2007; Salyers, Godfrey, et al., 2009). Importantly, higher program fidelity was associated with better consumer outcomes in one trial (Hasson-Ohayon et al., 2007). Similarly, consumer graduation and dropout rates have varied substantially between sites in previous studies (McGuire et al., 2014).

IMR implementation can be affected by factors at various contextual levels. In empirical examinations of IMR trainees (Salyers, Rollins, McGuire, & Gearhart, 2009), and as reported by the National Implementing Evidence-Based Practices Project (Whitley, Gingerich, Lutz, & Mueser, 2009), agency-level factors were mentioned most often. Particular factors include agency culture (Aarons & Sawitzky, 2006) such as policies and procedures, supervision specific to IMR (Bartholomew & Kensler, 2010; Bond et al., 2009; Rychener, Salyers, Labriola, &

Little, 2009; Salyers, Rollins, et al., 2009; Whitley et al., 2009), and adoption of clinical documentation to support IMR (Bartholomew & Kensler, 2010; Rychener et al., 2009; Salyers, Rollins, et al., 2009). Moreover, an agency's embrace of a recovery orientation and fit with other programming may affect IMR implementation (Isett et al., 2007). Factors external to the agency implementing IMR have also been identified as important, including state-wide consensus building (Magnabosco, 2006), technical assistance (Salyers, Rollins, et al., 2009), and funding (Rychener et al., 2009).

The Veterans Health Administration (VHA) is an important setting for the implementation of IMR and for psychosocial rehabilitation more broadly. VHA is a large provider of mental health care: 3.4% of Veterans served by VHA are diagnosed with schizophrenia and, more generally, severe mental illness (SMI) accounts for 11.7% of VA healthcare costs (Yu et al., 2003). In total, about 242,000 patients with a psychotic disorder diagnosis are treated in the VHA in a given year (Blow et al., 2009). With the mental health needs of consumers with SMI expected to expand in the future, the VA system will continue to grow as leading provider of services for individuals with SMI. Accordingly, VHA is underway with a transformative effort to promote evidence-based, recovery-oriented mental health services (U.S. Department of Veterans Affairs, 2004) through the establishment of psychosocial rehabilitation and recovery centers (PRRCs) designed to "provide a therapeutic and supportive learning environment for veterans in [and] maximize functioning in all domains" (p. 28). Illness self-management services such as IMR are required within PRRCs. However, a recent survey found less than 50% of Veterans Affairs Medical Centers (VAMCs) have adopted IMR and only about 37% of clinicians providing IMR have received IMR specific training (McGuire, White, White, & Salyers, 2013).

The limited adoption of IMR within the VHA system, a setting that embraces the ideals of rehabilitation and recovery, and has goals for IMR implementation, points to the importance of understanding the barriers and facilitators to IMR within this system. Previous studies of IMR implementation have taken place outside the VHA, in the context of intensive, multifaceted implementation strategies involving training, IMR-specific supervision, technical assistance, and fidelity monitoring (McGuire et al., 2014). Such an implementation strategy, while ideal, is often not possible. Research has yet to fully examine the situation within VHA, in which the practice is mandated, but there is not active roll-out or implementation support. Given that such a situation is common in other settings, research focused on implementation within VHA is needed to not only provide insights into the VHA system, but also as guidance for other rehabilitation and recovery centers.

As noted by Greenhalgh and colleagues (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004), the factors affecting implementation of a practice occur at multiple organizational levels and “interact in a complex, un-predictable, and non-generalizable way” (p. 606). Because of the complex, dynamic, and partially idiosyncratic nature of these relationships, qualitative methods can be particularly useful for examining program implementation. Qualitative methods can provide a richer and nuanced view of implementation within a given setting, which can provide guidance for subsequent implementation interventions. Therefore, we conducted semi-structured qualitative interviews with key stakeholders across VAMCs regarding the barriers and facilitators to IMR implementation in order to elucidate factors affecting IMR implementation outside the context of a research-driven implementation.

Methods

Participants

Participants included clinical staff from twenty-two VAMCs, derived from a stratified, random sample of sites that participated in a national VHA survey [author]. Sites were stratified by stage of IMR implementation (current IMR, planning IMR, no IMR ever, past IMR) and PRRC implementation (Certified PRRC, planning PRRC, or no PRRC plans). We used snowball sampling in which Local Recovery Coordinators (LRCs; staff charged with facilitating the implementation of recovery-oriented services) were contacted by phone and e-mail. Staff who agreed to participate were also asked to identify other staff members at their site with knowledge about illness self-management services (local IMR experts); referred staff were contacted as above. We attempted contact until staff agreed to participate, declined participation (n = 8), or gave no response after at least three contact attempts (n = 12). Research staff explained the study and obtained verbal consent. Thirty-eight out of forty-three (88.3%) identified staff participated, representing 22 out of 28 selected sites (78.6%; Table). Sites were defined as “non-IMR sites” if they have no history of IMR at the site.

Procedures and Measure

Research staff conducted a semi-structured phone interview which lasted about an hour. Separate interviews were developed for IMR sites and non-IMR sites. Non-IMR sites were asked about any programs similar to IMR, if IMR had been considered at their site, perceived potential barriers and facilitators to implementing IMR, and perceptions of potential implementation tools. IMR sites were additionally asked about the implementation of IMR and to provide details about their IMR programming (e.g., frequency, group versus individual format, average group size).

The interview protocol was iteratively developed, with information from previous respondents providing additional questions for subsequent sites.

Data Analyses

We conducted a thematic inductive/deductive analysis in the form of crystallization/immersion (Crabtree & Miller, 1999). We began with categories based on broad domains thought to affect implementation (Damschroder, Aron, et al., 2009) (factors within and outside of the program implementing IMR, the implementation process, the people providing IMR, and the nature of IMR itself) and read transcripts in a process of open coding to expand the coding system. We independently highlighted and labeled text relevant to implementing IMR and met to discuss observations. We continued this procedure with new interviews, developing a tentative set of working codes that we modified, combined, or deleted as we read additional transcripts. This process facilitated the development of a codebook with descriptions and exemplar quotes representing each code. Once the codebook was finalized, we coded transcripts independently (focused coding) and coded every fourth transcript in common to compare and maintain consensus over time. Throughout analysis, we kept working memos (e.g., possible themes, further questions) on the basis of our consensus discussions and individual readings. We used Atlas/ti to facilitate storage, access, and coding of our transcripts and memos. We then grouped interviews into sites and compiled profiles for each site using a structured guide for synthesizing information. Finally, the research team divided the profiles: half the team summarized profiles across sites which implemented IMR, while the other half summarized profiles across sites which did not implement IMR. We created matrices to display the presence and absence of codes as well as salient quotes across sites. We met to discuss similarities and differences.

Results

Ten themes emerged from our analyses. Six of these themes differed between IMR sites (n=11) versus non-IMR sites (n=11; i.e., common within one group of sites but not the other).

The remaining four themes were common in both IMR and non-IMR sites.

Differing Factors

Awareness of IMR. All IMR sites had staff members with working knowledge of IMR, whereas only two non-IMR sites had staff reporting prior awareness of IMR. It was rare for staff to consciously consider IMR and decline to implement it. In one of the two cases that IMR was considered and not implemented, the stated reason was time: “given the time that it would have to be allocated to make that happen on the unit ...that wasn't possible” (Site 22). In the other case, the LRC stated they were “...slowly implementing recovery-based programming and looking at different things we could do, and IMR was in that discussion. It's a great program to implement, but, again, it's staff's ability and having the resources to be able to do it, and the dedication and the willingness to be part of that programming [that] I think is the challenge here” (Site 18). Neither of these sites had staff that previously provided IMR or directly observed its implementation; rather, staff simply reviewed the IMR materials. These were also the only two sites to report poor fit between IMR, the site's structure/programming and the site's philosophy, *and* to perceive a lack of flexibility of IMR (see below for discussion of these themes).

Importer-champions. Almost all IMR sites had an “importer-champion”-- a person who was trained in and/or familiar with IMR from previous experiences at another location; there was no indication of such a person existing at non-IMR sites. The importer-champion was always key in implementing IMR: “this gal came from a pretty progressive PRRC out in California [and] there was a push, there was a need that she had as well to bring [IMR] to the patients and to

update the patients and move the patients along so they could start managing the different aspects of their illness” (Site 4). Findings showed that an importer provides several key functions: s/he reduces the need for training by already being trained (e.g., the IMR clinician “had some [IMR] training [on] internship” (Site 2)), provides knowledge, can trigger a sensitive period (see below), and can be an active advocate for IMR.

The three IMR sites without importers were vulnerable to and affected by outside influence (i.e. champions) to implement the practice. One site underwent a CARF audit that “introduced” IMR (Site 3), while another site had an IMR champion that had “gone to school with” one of IMR’s creators (Site 6). At the remaining site (Site 7), the LRC “started to... look into what would be a good recovery-based curriculum... [and] that’s when I came across IMR. Was looking at it a little and then I went to the PRRC conference... they were presenting on it... and I said, well, it sounds like a good one.”

Autonomy-supporting leadership. Staff at most IMR sites viewed their leadership as being “supportive” of IMR, but also stressed that their leadership delegated decisions and execution to the program-level leaders. For instance, one site talked about leadership “giving freedom” to select programs: "They [the leadership] were fine with the psychologist facilitating IMR as she saw fit" (Site 2). In contrast, many non-IMR sites indicated that program implementation requires active involvement from high-level site or outside leadership (e.g., Office of the Inspector General, Central Office). To illustrate, one site stated programming decisions were made from “the top down” (Site 15), while another noted it takes "more external pressure to implement... kind of a top-down approach. The pressure comes from the top” (Site 18).

PRRC. All but four IMR sites had a certified PRRC while only one non-IMR site had a PRRC. One potential explanation for the importance of the PRRC is that illness self-management programs like IMR are mandated programming within PRRCs (U.S. Department of Veterans Affairs, 2008). However, only one IMR site mentioned the mandate, and one non-IMR site even demonstrated ignorance of the existing mandate: “I think they’re *gonna*... mandate that it’s offered” [emphasis added]. Moreover, several non-IMR sites stated that a mandate would increase the chances that IMR would be implemented. For example, “If [IMR] is an evidence-based treatment and is considered mandated...that of course is going to be a much more acceptable to the facility to motivate them to have staff trained. I mean that’s the main thing that [would] make it easier” (Site 17).

A sensitive period. Another common theme among IMR sites was a *sensitive period* in which the site was open to or searched for new programs. Oftentimes, the development of a PRRC provided such an opportunity-- “Well, when we were told that we needed to switch the drop-in center to a PRRC, I started to look into what would be a good recovery-based curriculum” (Site 7). In some cases, champions at IMR sites caused sensitive periods by forcefully advocating for evidence-based practices in general, or IMR more specifically. In a few other IMR sites, an entity from the outer setting triggered a sensitive period. Notably, one non-IMR site is currently considering IMR because of an audit that triggered the examination of their programming: “Recently after our visits with... VACO and OIG, [the] psychiatrist that’s over inpatient came to me and asked about Illness Management and Recovery and how they might be able to implement that there.” At another non-IMR site, the statewide IMR coordinator contacted the site to encourage IMR implementation and offer training. As for non-IMR sites, the only evidence of a sensitive period occurred at sites who had or were planning a PRRC.

Although there was no evidence of sensitive periods at other sites, this particular aspect of the inner setting was not specifically asked about, so it is impossible to determine whether such a period existed.

Veteran-centered care. More IMR sites (9/11) than non-IMR sites (2/11) talked about how Veteran choice and opinion drove programming at their site. An emblematic quote of veteran choice at an IMR site was: "We take their feedback and we use it... and that's really our philosophy" (Site 5). At another site, an IMR group leader said that IMR being maintained was up to him, because if Veterans did not value it, it would be discontinued: "If I screw it up and I implement it wrong... and the Veterans start dropping out and saying it's not worth their time, then, obviously, it's in trouble" (Site 7).

Common Factors Among IMR and Non-IMR Sites

Recovery orientation. Frequently, both IMR sites (8/11) and non-IMR (6/11) sites reported programming based on a recovery orientation. This was indicated by explicit statement of "recovery" as a philosophical underpinning, or a description that closely aligned with recovery values. One respondent stated that their program is "designed to help [Veterans] understand their illness and manage it more effectively, try to use, utilize their recovery oriented goals" (Site 20) and another stated "...that's part of our PRRC because it is Veteran support and recovery oriented." Some respondents noted that staff varied in their acceptance of recovery; in some cases the respondent felt they were the lone champion for recovery at the site: "...not that recovery is a bad word here, but...it's a very treatment-focused place, so anything with recovery in the name, people may not have considered as much until we brought it to their attention and showed that it actually seems to work well and people liked it" (Site 1). Advocating for and implementing a recovery philosophy was often viewed as a difficult transition: "[I'm a] bad guy

[because] I've hammered away at mental health programs and said you have to have recovery-based interventions” (Site 6). At another site, this struggle was made painfully apparent: “I had that whole time to really start working with [Veterans] that have been coming, and there's a lot of animosity [regarding changing to recovery-oriented programming]. I'm surprised my car tires weren't slashed” (Site 7). He went on to say that the transition worked and that IMR is now the “linchpin” of their recovery work.

Evidence-based practice (EBP) orientation. Although IMR is an EBP, few IMR (3/11) or non-IMR sites (4/11) mentioned EBPs as being important to their site. One site noted, “I'd like to see... programs like IMR more touted in the clinical training. I think we really have to fight the concept that any manualized program is for idiots” (Site 6). Many actively expressed skepticism about the value of EBPs: “I know IMR is an EBP, but what will it do for my veterans?” (Site 13). Several respondents indicated that although they valued EBPs, this was in contrast with the overall culture of their programs: “Not everybody cares that they have an evidence-based practice. That's terrible to say” (Site 4).

Fit: Structure/programming. IMR was perceived to fit well within the clinical structure of all IMR sites and most non-IMR sites. For instance, IMR sites tended to view IMR as a “gateway class” (Site 8) to expose people to the ideas of recovery or as a “linchpin” (Site 7) to their recovery-oriented programming. Non-IMR sites generally thought IMR could fit within their current structure and programming. For instance, one respondent stated, “based on the psycho-ed group that I'm doing now, it would be something that would fit right into that” (Site 13). To that end, both IMR and non-IMR sites reported offering programs they viewed as similar to IMR. IMR sites generally viewed IMR as working synergistically with other programs, and many non-IMR sites anticipated that IMR would work similarly. However, non-

IMR sites sometimes viewed IMR as redundant and therefore superfluous: “We have classes that are the same model but I guess that what we kind of, you know, we don't call it that... we do stress management, helping to reduce relapses and building social supports, and we talk about the stress vulnerability model and stuff ... we haven't really called it IMR” (Site 16).

Staff time. IMR sites and non-IMR sites frequently cited a lack of staff time as a serious barrier to implementing programs. This barrier particularly impairs a site’s ability to allocate staff time to training and other implementation supports (certification, consultation, etc.). The lack of time made “importer-champions” particularly valuable to IMR sites, since they are already trained:

I think it was seen as very progressive, and you know the other thing is, you have someone who comes in with the training, who can do it, and I think that's some of the bias when you bring new things in. People think it's great and all, but they don't wanna do it. I think they don't have a good sense of being able to guide that and direct it. But, they're all for other people doing it. I think this was a good thing to do. (Site 4)

Discussion

Our study sought to identify factors affecting the implementation of IMR within the VHA. Initially, we aimed to examine factors associated with successful IMR adoption or rejection. However, very few sites either contemplated IMR adoption and chose not to adopt the program or attempted to adopt the program and failed. Instead, sites without IMR generally had, at best, a cursory knowledge of IMR. Nonetheless, data from sites with IMR provided a rich understanding of the factors stakeholders believe affect their implementation of IMR and can be contrasted with themes from non-IMR sites.

Awareness of IMR is essential to implementing the program; however, the converse is more informative—there were few cases of site staff knowing of IMR and choosing not to implement it. This phenomenon speaks to the acceptability of the program, at least from a clinician’s perspective and suggests that IMR implementation would be greatly aided by efforts to disseminate information about the program more widely. In addition, awareness of IMR at IMR sites was generally based upon first-hand experience with IMR and may be construed as “evidence” of the effectiveness of IMR (Kitson, Harvey, & McCormack, 1998). Knowledge may be essential, but not sufficient, and other themes were clearly important to implementation success.

Site champions have been highlighted in previous literature (Curley & Gremillion, 1983; Damschroder, Banaszak-Holl, et al., 2009); however, what was unique in our analyses was a specific type of champion—the importer champion, that most of the champions in this sample came from outside their current VAMC. Importer champions appeared to play key roles in the implementation of IMR within these VAMCs. Their preexistent familiarity with IMR may obviate the need for training. Moreover, they can educate their colleagues about the model (thus providing awareness of IMR) and advocate for its implementation. Importer champions may be especially effective in settings with autonomy-supporting leadership. In such a context, importer champions may be empowered to implement programming they believe would best serve Veterans. Conversely, in settings in which staff view programming as “flowing from the top,” potential importer champions may not be activated or supported, thereby stifling potential implementers.

The importance of leadership in the implementation of practices is well-established (Greenhalgh et al., 2004). In our analyses, sites with IMR generally viewed site leadership as

providing implementers (often importer-champions) with the latitude to implement needed programs and adapt programming as they saw fit. Participants described work environments that could be termed “autonomy-supporting environments” in which they perceive that supervisors understand employees, communicate information clearly, value employee input and initiative, and offer employees choices (Deci, Eghrari, Patrick, & Leone, 1994). Autonomy-supporting environments have been associated with perceived competence (Baard, Deci, & Ryan, 2004) and given the role of autonomy support in fostering change in consumer outcomes (Williams, Freedman, & Deci, 1998), these environments merit further exploration regarding their role in the implementation of EBPs. This view of leadership contrasts with the “strong and active leadership,” which was found to facilitate IMR implementation in community mental health centers (Whitley et al., 2009). The difference may be attributable to organizational factors between VA and community sites and/or the type of leadership that supports initial adoption versus high-fidelity implementation. Regarding the latter, initial adoption of IMR may be fairly straightforward without requiring hands-on leadership involvement; however sustainability and support of high-fidelity IMR may require more structure and accountability.

Respondents generally viewed IMR as fitting (or potentially fitting) within the programmatic structure of their setting. Many IMR sites viewed IMR as central to their mission, and even non-IMR sites had few concerns about the fit (mostly regarding the overlap of IMR with other groups already offered). This is particularly true for PRRCs, which generally structure programming to include skills-based groups and individual services. Staff time was viewed as a barrier at both IMR and non-IMR sites, but this barrier was obviously surmounted at IMR sites. The fit of IMR within extant program structures may also explain the relative passivity of leadership support necessary to implement IMR. However, it is important to note

that structural changes not commonly observed in the current study—namely IMR-specific supervision and adapting policies, procedures, and documentation—were found to affect IMR fidelity and quality in previous studies (Bartholomew & Kensler, 2010; Bond et al., 2009; Rychener et al., 2009), rather than adoption. Practically nothing is known regarding the fidelity of IMR within VHA and these factors may still prove relevant to fidelity.

Our results should be viewed with caution, though, given several limitations. Although sites were selected via stratified random sampling, they do not necessarily represent all VAMCs or broader sampling from psychosocial rehabilitation and recovery centers. Also, our study focused on the adoption of IMR—whether IMR was present or absent—and did not assess quality of implementation (i.e., fidelity) or sustainability. Future research should focus on these implementation outcomes and factors that support success in these areas.

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Table

Respondent/Site Type x IMR/PRRC Status

IMR/PRRC Status	Sites (n=22)	Local Recovery Coordinators (LRC) (n=20)	Local IMR Experts (n=16)	PRRC Coordinators (n=2)
Current IMR/Certified PRRC	6	6	7	2
Current IMR/Planning PRRC	4	3	1	0
Current IMR/No PRRC Plans	1	1	3	0
No IMR/Certified PRRC	1	1	0	0
No IMR/Planning PRRC	4	5	3	0
No IMR/No PRRC Plans	6	4	2	0