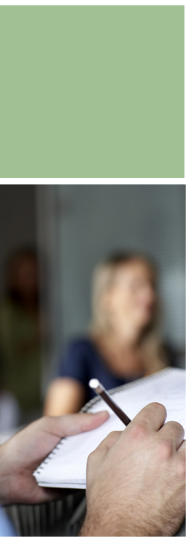



Manual 6

Implementing Feedback-Informed Work in Agencies and Systems of Care

ICCE Manuals on Feedback-Informed Treatment (FIT)

INTERNATIONAL CENTER
FOR CLINICAL EXCELLENCE

The ICCE Manuals on Feedback-Informed Treatment (FIT)

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The ICCE Manuals on FIT were a collaborative effort. The development team included: Rob Axsen, Susanne Bargmann, Robbie Babbins-Wagner, Bob Bertolino, Cynthia Maeschalck, Scott D. Miller, Bill Robinson, Jason Seidel, and Julie Tilsen.

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Manual 1: What Works in Therapy: A Primer
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Manual 2: Feedback-Informed Clinical Work: The Basics
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Manual 3: Feedback-Informed Supervision
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Manual 4: Documenting Change: A Primer on Measurement, Analysis, and Reporting
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Manual 5: Feedback-Informed Clinical Work: specific populations and service settings
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Introduction to the Series of Manuals

The International Center for Clinical Excellence (ICCE)

The International Center for Clinical Excellence (ICCE) is an international online community designed to support helping professionals, agency directors, researchers, and policy makers improve the quality and outcome of behavioral health service via the use of ongoing consumer feedback and the best available scientific evidence. The ICCE launched in December 2009 and is the fastest growing online community dedicated to excellence in clinical practice. Membership in ICCE is free. To join, go to: www.centerforclinicalexcellence.com.

The ICCE Manuals on Feedback-Informed Treatment (FIT)

The ICCE Manuals on Feedback-Informed Treatment (FIT) consist of a series of six guides covering the most important information for practitioners and agencies implementing FIT as part of routine care. The goal for the series is to provide practitioners with a thorough grounding in the knowledge and skills associated with outstanding clinical performance, also known as the ICCE Core Competencies. ICCE practitioners are proficient in the following four areas:

Competency 1: Research Foundations

Competency 2: Implementation

Competency 3: Measurement and Reporting

Competency 4: Continuous Professional Improvement

The ICCE Manuals on FIT cover the following content areas:

- Manual 1: What Works in Therapy: A Primer
- Manual 2: Feedback-Informed Clinical Work: The Basics
- Manual 3: Feedback-Informed Supervision
- Manual 4: Documenting Change: A Primer on Measurement, Analysis, and Reporting
- Manual 5: Feedback-Informed Clinical Work: Specific Populations and Service Settings
- Manual 6: Implementing Feedback-Informed Work in Agencies and Systems of Care

Feedback-Informed Treatment (FIT) Defined

Feedback-Informed Treatment is a pantheoretical approach for evaluating and improving the quality and effectiveness of behavioral health services. It involves routinely and formally soliciting feedback from consumers regarding the therapeutic alliance and outcome of care and using the resulting information to inform and tailor service delivery. Feedback-Informed Treatment (FIT), as described and detailed in the ICCE manuals, is not only consistent with but also operationalizes the American Psychological Association's (APA) definition of evidence-based practice. To wit, FIT involves "the integration of the best available research…and monitoring of patient progress (and of changes in the patient's circumstances – e.g., job loss, major illness) that may suggest the need to adjust the treatment…(e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment)" (APA Task Force on Evidence-Based Practice, 2006, pp. 273, 276-277).

Manual 6
Introduction

In this manual the implementation of Feedback-Informed Treatment (FIT) in agencies and healthcare systems is explored. The objective is to guide organizational staff through the process of implementation. Practical strategies will be provided for each stage, including: preparation, planning, and sustainability. This manual also includes exploration and discussion of potential challenges as well as suggestions for resolving the most common difficulties encountered when implementing FIT in real world clinical settings. The manual concludes with: (1) a brief quiz; (2) Frequently Asked Questions (FAQ); and (3) a list of references for the sources cited.

Overview

Successful implementation of FIT requires time and planning. A plan demonstrates commitment to accountability, stewardship, and return on investment. Although the benefits have been documented in a number of randomized clinical trials, implementing FIT in real world clinical settings presents a number of challenges. Research and experience provide a great deal of insight about the process as well as practical strategies for ensuring success. The challenges and solutions are addressed in five different sections:

1. Overview of Agency Implementation
2. Exploration
3. Installation
4. Initial Implementation
5. Full Implementation

Each section represents an important component of implementation. Agencies are encouraged to be thorough in their review of the sections, taking the time to fully consider the background information and recommendations, and the commitment necessary for both successful implementation and long-term sustainability.

1) Overview of Agency Implementation

Implementation relates to a specified set of purposeful activities at the practice, program, and system level designed to put into place a program or intervention of known dimensions with fidelity. Implementation frequently involves the establishment, redefinition, and shift in culture. In agencies, shifting from the status quo can be difficult, but is necessary in order to successfully implement any innovation (Bertolino, 2011). Successful implementation of FIT is a process which requires planning, patience, commitment, and support. Referencing implementation in Public Behavioral Health care (PBH), Bohanske and Franczak (2010) stated, "Think evolution not revolution. PBH agencies are among the most regulated and controlled entities in health care. They are beholden to numerous stakeholders and regulatory bodies. Wholesale changes in programs and procedures are, consequently, likely to provoke resistance from top to bottom" (p. 313).

The work of Rogers (2003) provides a path to understanding how new ideas or practices (innovations) are adopted in organizations (social systems). He identifies five attributes of new ideas or practices that affect the "rate of adoption." Successful agencies consider these qualities when designing an implementation plan.

Rogers' five attributes follow, along with examples of how each informs planning and implementation of FIT:

1) Relative Advantage:

The degree to which the new idea/practice is perceived to be better than the idea/practice it is replacing. Planning documents and implementation processes should address shortcomings of current practice (e.g., dropout rates, inconsistent outcome measurement, outcome measures that detract from clinical work or lack feasibility, etc.) and describe how adoption of FIT practice will contribute to improvements. Agency staff (i.e., managers, supervisors, clinicians) seeing the relative advantage of the new practice is positively correlated with adoption of the new practice.

2) Compatibility:

The congruency of the new practice with current organizational and individual values, and with perceived needs. Planning documents and implementation processes should address the extent to which the FIT practice is congruent with current mandates, mission and/or vision statements, strategic plans, current trends in global behavioral healthcare practice, professional ethics, professional development initiatives, accreditation/licensing requirements, and enhanced outcomes (effectiveness) for clients. The stronger the degree to which the new practice is perceived to be compatible with current values and to address perceived needs, the greater the likelihood of adoption.

3) Complexity:

New practices that are perceived as too complex are less likely to be adopted. Planning documents and implementation processes related to FIT practice need to address issues related to similarities to current practices, adequacy of training and integration supports (e.g., coaching, competency-based supervision, etc.), reasonableness of timelines for implementation, sequences for implementation across an organization to maximize training and resources, opportunities for providing formal feedback related to implementation processes, access to "communities of practice" (i.e., groups of people who share a common concern or a passion for something they do and how to do it better as they interact regularly), and access to training materials (e.g., videos, manuals, research documents, published resource articles, etc.).

4) Trialability:

The degree to which the new practice can be experimented with and "tried out" is positively correlated with the success of its eventual adoption. Planning documents and implementation processes related to FIT practice should address specific training and integration support processes that will be in place to ensure there are practice opportunities to develop skills and abilities before clinicians are expected to administer and integrate outcome and alliance measures, as well as the opportunities to address emerging practice issues through competency-based supervision and "communities of practice."

5) Observability:

Whether or not the results of new practice are visible to self and others affects eventual adoption. Both clients and clinicians need to see the utility of the outcome and alliance measures in improving service delivery in order to ensure that clients provide valid responses. Planning documents and implementation processes should address how FIT practice contributes to improved outcomes including identification of cases at risk of null or negative outcome in real time, allows for feasible outcome management data-gathering, provides real-time reports (dependent on data-reporting system being implemented) to guide clinical practice and program development/evaluation, and is able to compare outcomes to normative databases.

Rogers' five attributes make clear the resources, depth of commitment, and time required for creating a change in culture to FIT. Successful implementation is rarely, if ever, accomplished in weeks or months. Neither is attendance at a workshop or training – however long or comprehensive it may be – sufficient. Fixsen et al. (2005) describe the process as occurring in five stages, generally spanning several years, which can be used as a roadmap to successful implementation:

1) Exploration:

Primary Question: *"Are these the right measures, at the right time?"*

Exploration involves actively considering change: gathering information about the innovation, assessing capacity, building consensus, and making decisions.

2) Installation:

Primary Question: *"How do we set this up to be successful?"*

Installation involves preparing to implement the new practice: making necessary adjustments to agency infrastructure, developing training and integration supports, and running small pilot projects.

3) Initial implementation:

Primary Question: *"How do we make this work in the 'real world?'"*

As the name implies, initial implementation is when effort is aimed at learning to use and support the new practice, where all are expected to be using the new practice, and when structures are in place to support the new practice and solve any issues that arise.

4) Full implementation:

Primary Question: *"How do we communicate the new 'normal?'"*

In full implementation, changes in policy and practice are reflected at all levels (management, supervisors, practitioners), mechanisms are in place for monitoring and ensuring fidelity, staying current with and integrating new developments related to the new practice.

5) Sustainability:

Primary Question: *"How do we keep it going and avoid 'drift?'"*

Sustainability involves an ongoing commitment to fidelity and positive outcomes. Once considered a separate stage, it is now generally recognized that sustainability must be addressed at each of the above stages (Blase, 2008; Duda, 2008).

Duda (2008) emphasizes that the five stages do not necessarily occur in a stepwise fashion. Agencies and systems of care may find it necessary at times to back up. Few implementation plans are able to identify and address all the challenges associated with a particular stage the first time round. Most, for example, must revisit consensus-building and

installation, several times before succeeding.

Keeping Rogers' (2003) and Fixsen's (2005) work in mind, the following recommendations are made based on the experiences of ICCE Associates and Members implementing FIT in diverse service settings around the world:

1. In virtually all settings, at least three years were required in order to fully implement FIT and operationalize the sustainability mechanisms.
2. Modeling of FIT principles by agency leadership and implementation teams, especially the creation of an agency-wide culture of feedback (see Manual 2), is essential for creating goodwill and reducing defensiveness during the exploration and installation stages.
3. Reluctance to change, or inertia, can be very powerful in organizations. A decision to move forward with the full and sustainable implementation of FIT practice requires unwavering leadership and a willingness to make alterations to the implementation plan along the way.
4. Implementation of FIT practice needs to be resourced and funded as an ongoing core agency practice, not as a time-limited project. Of critical importance is anticipating the need to reconsider the roles, schedules, and time commitments of some staff during the installation, training, and initial implementation stages. Doing so can provide time for clinicians to receive training and integration supports–both of these will require funding support and/or workload adjustment
5. Once a decision has been made to proceed with implementation, a written plan must be developed outlining: (1) perceived needs and concerns about the status quo; (2) anticipated benefits of FIT practice directly related to the needs and concerns; (3) descriptions of how FIT practice will support improved services (i.e., clinical and outcome management); (4) intended implementation processes; and (5) intended sustainability mechanisms.
6. Train the clinical leadership (i.e., supervisors) and management team first so that each is familiar and proficient with the ICCE Core Competencies (see Appendix B).
7. Integrating clinical leaders into training and coaching roles greatly facilitates adoption of practice.
8. Addressing the ICCE Core Competencies (see Appendix B) regularly through competency-based supervision models, including clinical consultations, coaching sessions and formal supervision sessions, supports the adoption of FIT practices.
9. System wide implementations are rarely successful. Middle to large agencies are more likely to succeed with a sequenced implementation (also called a "staged roll out"), ensuring that training and supervision are adequately resourced and difficulties are identified and addressed in real time. Typically, training groups of up to 15–20 clinicians is best, followed by three months of biweekly supervision, and periodic booster trainings.
10. Clear, agencywide communication strategies are a must. Ensure that a plan is in place for keeping everyone informed throughout the implementation process, including teams not currently preparing to implement FIT practice.
11. Use the FRIFM to assess readiness to implement, progress made, and fidelity to FIT practice.

The Feedback Readiness Index and Fidelity Measure (FRIFM)

The Feedback Readiness Index and Fidelity Measure (FRIFM) is an organizational readiness checklist and evaluation tool for behavioral health agencies, services and/or systems of care specifically designed to assist in the implementation of FIT. The FRIFM addresses six realms, each of which is an important organizational component in evaluating a system's readiness to implement or fidelity to a feedback-informed approach to services. The six realms are:

Realm 1 – Clinical Implications: Components related to counselors/therapists; supervision of clinicians; training of staff

Realm 2 – Administrative: Components related to the agency's structures and levels of commitment

Realm 3 – Information Systems/Paperwork/ Documentation/IT: Components related to modalities for data collection

Realm 4 – Regulatory and Accreditation: Components related to regulatory and accreditation entities

Realm 5 – Consumers: Components related to consumers as stakeholders

Realm 6 – Funders: Components related to funding agencies

The FRIFM provides detailed indicators of issues likely to impede successful implementation of FIT practice. By completing the tool, agency managers are able to quickly and easily:

(1) identify a system's strengths and weaknesses important to using the FIT approach;

(2) prioritize realms in need of consultation and training;

(3) set specific objectives and goals necessary for successful implementation of FIT; and

(4) measure progress of and identify barriers during implementation.

Administering and then comparing the responses of the clinical staff, supervisors, and managers, can help identify and foster discussion regarding the successes, challenges, and barriers to implementing FIT. It is recommended that the FRIFM be used not only as a tool to assess readiness for FIT implementation but also as a means of evaluating whether all necessary steps and structures are in place to support FIT in the agency throughout the installation and implementation stages. The FRIFM document provides a clear picture of an agency in "full and sustainable operation." The FRIFM and detailed instructions for using the FRIFM tool are located in Appendix A.

2) Exploration

Readiness Assessment and Strategic Planning (Mapping the Territory)

Implementing FIT begins with an exploration and assessment of the agency's readiness and motivations. Multiple factors impact the implementation of any new practice, including social, economic and political issues and influences (Bohanske & Franczak, 2010; Fixsen et al., 2005). Understanding the agency's current conditions and culture will assist in strategic planning. As noted earlier, research and experience make clear that successful implementation of FIT requires not only a shift in practice but agency culture (Bertolino, 2011). The more thorough the plan the greater the chances of success.

The following sections cover the key information to be considered during the exploration stage of implementing FIT. The FRIFM is used to structure the discussion and highlight important factors likely to affect implementation during this stage.

Role of FRIFM in the Exploration Stage

Recall that the exploration stage is characterized by gathering information about the innovation, building consensus, and making decisions. During this period, the focus is on exploring the reasons for change (e.g., considering community/consumer needs, program needs, professional practice needs, resources, stakeholder support, etc.), identifying the anticipated benefits and potential barriers of the new practice, and assessing the capacity for change. It concludes with a decision being made on whether or not to embrace the new practice. In most instances, the activities involved in the exploration stage are carried out by a small group of people (Initial Implementation Team [IIT]), who share a keen interest in or knowledge about the new practice, are intimately involved in agency operations, possess strategic vision, or all of the above.

During this initial stage, having the IIT complete and review the FRIFM, especially in consultation with staff members from the different programs within the agency or system of care, helps by:

- Providing indicators of all the components and processes that need to be in place for the successful adoption of FIT practice (a "map" of full and sustainable operation);
- Providing a template for identifying current resource gaps that will need to be addressed (and funded) in order to achieve full and sustainable implementation;
- Identifying areas which could benefit from the involvement of a consultant/trainer (i.e., knowledge specialist) related specifically to assisting agencies with full and sustainable FIT implementation;
- Identifying agency policies, mission statements, and business plans that may need to be changed;
- Clarifying expectations that may need to be addressed in discussions with funders, accreditation and regulatory bodies, and other stakeholders;
- Clarifying the agency's rationale for adopting FIT practice, with specific reference to identifying deficits in or dissatisfaction with the quality and outcome of current service delivery.

In the material that follows, suggestions are provided for addressing the critical tasks of the exploration stage (information gathering, consensus building) for each realm of the FRIFM.

Realm 1: Clinical Implications

Implementation of FIT is more successful, when the IIT:

- Consults with clinicians and supervisors about FIT, especially as it relates to clinical workflow;
- Explores the attitudes of supervisors and clinicians regarding routine outcome measurement and FIT. Understanding can vary within an agency. Traditional methods (i.e., pre- and post-measurement, periodic follow-up) are quite different from using real-time feedback processes to guide service delivery and the possibility of measuring and comparing the outcomes of staff members;
- Becomes familiar with the ICCE Core Competencies (Appendix B) so that they can provide meaningful input regarding the implications of integrating FIT into agency practice;
- Involves any natural clinical leaders and/or

internal trainers in the exploration process.

- Solicits staff experience about prior implementation projects, demonstrating an openness to feedback and willingness to learn from the past mistakes;
- Begins identifying potential practice "champions" – supervisors and clinicians that may facilitate later implementation efforts.
- Consults with agencies that have implemented FIT either in person or via the community practice network available on the ICCE website (www.centerforclinicalexcellence.com).
- Explores the changes in agency culture that will be required for successful implementation of FIT. Too often, implementation efforts are derailed during the exploration stage when the intervention is adapted in order to fit with existing agency practices and structure. The FRIFM can help avoid this common error by keeping the focus on exploring the actions required for ensuring fidelity to FIT practice.

Realm 2: Administrative

Creating an environment conducive to FIT practice requires change at all organizational levels. During the exploration stage, it is crucial that the IIT:

- Includes members of the management team with decision making authority;
- Includes managers and directors from all programs within the agency or system;
- Develop a written document identifying the rationale and goals for implementing FIT across the entire agency or system of care;
- Develop a written document comparing FIT practice with the current agency vision or mission statement;
- Explore the financial costs associated with implementation and available resources;
- Review any prior attempts to implement FIT (or other outcome management, CQI initiatives);
- Consider how implementation of FIT may facilitate or compete with other organizational change initiatives.

Realm 3: Information Systems/ Paperwork/Documentation/IT

Research indicates that clinicians spend as much as 30% of their available time completing the documentation required by regulatory and funding bodies. During the exploration stage, the successful IIT:

- Develops a thorough understanding of clinician

workload, including documentation and productivity requirements;

- Explores clinicians attitudes and concerns regarding the addition of FIT to current workload, documentation, and productivity requirements;
- Investigates agency capacity for taking on the additional documentation and workload related to implementing FIT practices (e.g., administration, scoring, interpretation of measures, data collection and aggregation, etc.);
- Considers options (i.e., software, webware, integration with electronic health record) for data collection and management related to FIT;
- Consults with other agencies using FIT practice and/or a trainer consultant familiar with impact of FIT on clinician workload as well as data collection and management options.
- It is usually helpful to consult with other agencies providing services using FIT practice and/or a trainer/consultant who is familiar with various options.

Realm 4: Regulatory and Accreditation

Regulatory and accreditation bodies have a large impact on behavioral health practice. Most such entities are in strong support of involving consumers in the provision and evaluation of services. Indeed, agencies involved with FIT practice that have gone through an accreditation process typically find few conflicts and most often exceed standards and regulatory requirements. Nonetheless, during the exploration stage, the successful IIT:

- Ensures members have a sound understanding of current standards, expectations, and requirements;
- Uses the FRIFM to explore areas of conflict and congruence between current regulation and accreditation standards and fully implemented FIT practice (This will often entail examining the standards and requirements of several regulatory entities when multiple disciplines are involved in implementation);
- Solicits staff input regarding potential conflicts between FIT and current regulatory and accreditation standards;
- Consults with and seeks input from regulatory and accreditation bodies to resolve any conflicts between current standards and FIT practice;

Realm 5: Consumers

Involvement of consumers in the development and evaluation of services is a global trend in healthcare in general and behavioral health in particular. FIT practice is at the forefront of this movement. Most agencies and systems of care have policies and practices in place for soliciting consumer feedback and dealing with complaints, including a formal consumer rights document, discharge summaries,

end-of-service satisfaction surveys, or a consumer advocate or group. In truth, few objections have been reported by consumers in agencies adopting FIT. Nonetheless, given the central role that service users play in FIT, the successful IIT:

- Includes consumers or a consumer representative in the exploration process;
- Reviews current policies and practices for soliciting feedback, identifying areas of overlap and potential conflict.
- Uses existing consumer feedback mechanisms to identify strengths, needs, and areas for potential improvement that, in turn, are used to refine the agency's rationale for adopting FIT practice. When no formal practices are in place for soliciting consumer-feedback, informal interviews, focus groups, surveys, and discharge summaries can be used.
- Considers any accommodations that may need to be made in order to implement FIT (solicit feedback) with all consumers served by the agency (e.g., children, visually impaired, cognitively or educationally challenged, etc.).

Realm 6: Funders

Funders, like accreditation and regulatory entities, exert a significant influence on agency policy, practice, and culture. Typically, funders are interested in measures of performance, including the number of consumers served and the efficiency and effectiveness of services offered. Such data is generated and available in real time when FIT is implemented. As such, FIT is a generally attractive option as it provides a value-based metric on which funding decisions can be based.

During the exploration stage, the successful IIT:

- Invites and includes representatives from various funding bodies;
- Reviews the costs and benefits of FIT with funders;
- Explores the value-based metrics made possible by the data collection and aggregation central to FIT (e.g., effect size, comparison of outcomes between and among providers and programs, outcome per dollar spent, etc.);
- Solicits input from the funders regarding potential obstacles and conflicts between FIT practice and documentation requirements (e.g., needing to change standardized reporting formats, etc.);
- Considers, together with funders, any adjustments that may need to be made to "contracted deliverables" (outcomes and outputs) during the installation and implementation stages. Adopting FIT is likely to impact productivity in the short run, taking some staff and other resources away from direct service provision.

3) Installation

Once the decision has been made to proceed with adoption of a new practice, the installation phase begins. During this stage, the IIT and agency are in the preparation mode, setting up the infrastructure necessary to support implementation. Installation is often the costliest stage of the process. Productivity can and often does suffer and resources must be expended for planning, training, and organizational development. Although frequently attempted, such expenditures cannot be avoided as it is during this stage that the groundwork is laid for FIT implementation. Indeed, most implementation failures can be directly traced to inadequate preparations occurring during the installation stage of implementation.

Common activities of the installation stage include:

- Policy development and revisions;
- Organization of a "Transition Oversight Group" (TOG) to provide leadership throughout the implementation and sustainment stages;
- Securing of funding for training initiatives;
- Organizing coverage for staff involved in implementation;
- Creation of initial FIT practice guidelines for clinicians, supervisors, and managers;
- Review of human resources;
- Intensive training for the clinical leaders (i.e., supervisors, practice champions [clinicians with high interest in FIT], and managers responsible for specific programs);
- Conducting focus groups of agency staff;
- Development of communication strategies for dissemination about FIT and implementation efforts;
- Development and implementation of training materials for line clinicians;
- Development of a detailed implementation plan identifying objectives, tasks, timelines, and reporting and accountability frameworks;
- Establishment of necessary IT supports;
- Meetings with stakeholders to review progress and manage potential risks, and;
- Running demonstration/pilot projects.

Establishing a Transition Oversight Group

Once there is a clear commitment by management to adopt FIT, it is important to establish a "Transition Oversight Group" (TOG). Typically, the TOG consists of members of the IIT, line staff, supervisors, quality assurance personnel, agency

administrators (or representative with executive decision-making power), advisors within and outside of the organization, and any stakeholders with an interest in FIT practice. The TOG meets on a regular and frequent basis throughout the installment and initial implementation stages and is responsible for developing and overseeing the formal implementation plan. Said another way, the job of the TOG is to plan, organize, oversee, problem-solve, and coordinate communication about all aspects of the implementation and sustainment of FIT practice within the agency or organization (see Appendix C). The TOG is also responsible for: (1) making recommendations to decision makers regarding changes to existing organizational and practice policies and structures for supporting FIT and; (2) monitoring the completion of tasks by individuals and groups within the agency. Once the TOG is organized and operational, the job of the IIT is finished.

Role of the FRIFM in the Installation Stage

Recall that installation involves laying the groundwork for successful implementation. During this stage, adjustments are made to agency infrastructure, training and integration supports are identified and/or developed, and small pilot projects are started. By providing indicators of specific tasks that need to be accomplished and structures that need to be in place, the FRIFM simultaneously serves as a guide to preparation efforts and method for assessing progress.

Realm 1: Clinical Implications

During the installation stage:

- Clinicians are trained in FIT:
    - Introductory and advanced level workshops are conducted multiple times a year by the ICCE (for more information, go to: www.centerforclinicalexcellence.com). Agencies can send staff to these intensive trainings or invite an ICCE "Certified Trainer" (CT) to provide consultation and training onsite, telephonically, or via an e-learning platform. ICCE CTs are well versed in the FIT Core Competencies, have passed an exam, and demonstrated competency in delivering FIT training and assisting implementation. They are also familiar with and able to use the FRIFM to guide and support implementation efforts.
    - A five-day, intensive "training of trainers" workshop is available that prepares participants to provide training and supervise implementation in larger agencies and systems of care (for more information, go to: www.centerforclinicalexcellence.com).
- Training materials are created to support FIT practice and implementation. Those responsible can use the ICCE Core Competencies and "Sample FIT Training" as guides (see Appendices B and F);
- Formal processes are established for monitoring the integration of FIT practices into ongoing service provision by clinicians (e.g., supervision, quality assurance, etc.);
- Clinical leadership and/or supervisors receive advanced training and/or ongoing consultation in FIT supervision; in particular, the interpretation of feedback data (i.e., client graphs, statistical

indices [see Manuals 2 and 4]). As indicated in Manual 3, supervisors play a key role in FIT implementation. When supervisors demonstrate confidence and competence in FIT they are able to better use competency-based supervision models to guide and support the development of FIT practice with clinicians.

- Clinical supervisors integrate FIT practices into all discussions regarding client care ([staff meetings, case reviews, employee evaluations] see Manual 3). Experience makes clear that clinical leaders are more likely to be successful when they not only possess advanced knowledge regarding FIT and the interpretation of feedback data but also use FIT practices to guide their own work;
- Regular opportunities are provided for reviewing the fundamentals of FIT practice with pilot project members (i.e., in-services, case presentations);
- Data collection systems are put in place for monitoring the administration, scoring, interpretation, and aggregation of information from routine administration of outcome and alliance measures, including integration once implementation with clients begins.

Realm 2: Administrative

During installation:

- The TOG reviews agency vision and/or mission statements, policies and procedures, documentation requirements, and quality assurance practices (i.e., paperwork) to ensure congruence with FIT:
  - The components of FIT practice identified in the FRIFM may simply be incorporated into existing policy and procedure documents or new ones may be created.
  - Sample documentation (progress note, service delivery plan) congruent with FIT practice can be found in Appendices D and E.
- The TOG develops clear written policies regarding FIT, including:
  - Expectations regarding the use of outcome and alliance measures in clinical practice;
  - The purposes and use of data generated by routine outcome monitoring.
- The TOG and management develop a provisional budget for covering:
  - Staff time spent on the TOG and related duties (training, consultation, development of policy and clinical practice guidelines);
  - Training of staff in FIT;
  - Decreased productivity of staff involved in piloting the implementation of FIT;
  - Development/use/training in data collection and management systems;
- The TOG develops formal clinical practice guidelines that provide direction for using FIT in the agency as well as specific programs:
  - Providing the rationale, administration procedures, and programs and staff affected. For example, if clients meet with multiple service providers in the agency, the guidelines will need to identify which will administer and record outcome and alliance scores.
  - Giving detailed instructions for integrating data into clinical practice and informing clinical decision making.
- The TOG solicits feedback from staff and program managers involved in piloting FIT to

ensure that policies, procedures, and guidelines are understandable and feasible.

- The TOG reviews and revises clinical and administrative workflow:
  - Streamlining paperwork;
  - Eliminating unnecessary reporting requirements;
- The TOG establishes a framework for keeping staff and management informed about implementation. Poor communication is a serious threat during installment. To avoid the negative feelings, discouragement, and suspicion that can result, the following communication strategies should be employed:
  - Hold regular meetings with clinicians, allowing ample opportunity for discussion of successes and challenges;
  - Remain open to and encourage sharing of clinician fears and concerns about FIT;
  - Provide a clear statement of intent about the objectives for implementing FIT(i.e., improving outcomes not performance appraisal);
  - Provide regular updates throughout implementation (e.g., weekly emails, newsletters, bulletins, column on the agency intranet site, etc.);
  - Schedule ongoing consultation with a knowledge expert/consultant from outside the agency during which time concerns and challenges may be addressed;
  - Assign a TOG member to be responsible for seeking critical feedback from staff and program managers regarding implementation;
  - Keep FIT at the forefront of clinical discussion by offering an in-service once a month on a topic or challenge central to FIT practice by a line staff member.

Realm 3: Information Systems/ Paperwork/Documentation/IT

A significant benefit of FIT is the ability to monitor progress and engagement of services in real time as well as determine and compare outcomes of clinicians and programs. Deciding how data will be gathered, tracked, aggregated, and reported is part of the installation stage of implementation. The FRIFM provides indicators of the preferred components of a data management system, with the aim of ensuring utility for clients and clinicians. There are a number of different options to consider:

- Collecting ORS and SRS scores from paper and pencil administrations and enter them into a spreadsheet program for tracking, aggregation, and analysis (i.e., average intake scores, calculation of individual, program, and agency effect sizes). While simple and inexpensive, this approach is also labor-intensive. The inability to compare results to normative data samples or generate expected treatment response (ETR) trajectories is a significant limitation (see Manuals 2 and 4).
- Subscribing to a web-based application. Such systems are accessible wherever the internet is available. They can be used on a desktop, laptop, tablet, or smartphone. The number of available systems is growing. All allow clients or clinicians to complete the ORS and SRS, plot scores on a graph, compare progress to the ETR, aggregate data at the practitioner, program, and agency level, identify and warn clinicians and supervisors of "at risk" clients, and provide a number of helpful statistical indices (effectiveness, dropout rate, etc.). Most agencies and systems of care take advantage of such services. Subscriptions typically include technical support and web-

based training. The systems are user-friendly and generally there are no issues with compatibility with existing computer systems in agencies. Of course, choosing this option means factoring in the annual cost of the subscription in the implementation plan. No matter which data management system is selected, the TOG will need to identify individuals to oversee the system. Tasks for the person(s) include:

* Liaising with the vendor;
* Setting up different levels of access for practitioners, supervisors, and managers;
* Adding new users to the system;
* Deactivating clinicians when they leave the agency;
* Ensuring annual subscription contracts are renewed;
* Assisting in the transfer of client data from one program site to another;
* Reporting aggregate data on a regular basis to the TOG and management.

Realm 4: Regulatory and Accreditation

During the installation stage, any conflicts identified during the exploration stage between FIT and regulatory and accreditation standards are addressed and resolved. The TOG:

- Invites representatives of regulatory and/or accreditation bodies to join the TOG;
- Shares information with regulatory and accreditation bodies documenting how FIT meets or exceeds current expectations and standards;
- Works with representatives from regulatory and accreditation bodies to resolve any conflicts;
- Creates formal agreements to ensure clear understanding of proposed resolutions;
- Seeks any necessary waivers from regulatory and accreditation entities for the duration of the installation and initial implementation stages.

Realm 5: Consumers

During installation, FRIFM indicators related to consumers are used:

- To develop consumer-oriented clinical practice guidelines (see Realm 2 above);
- To inform revisions of agency policy, vision, and mission statement to reflect the central role of consumers in a feedback-informed treatment system.

Realm 6: Funders

During the installation stage, implementation of FIT may impact contracted deliverables. The TOG:

- Invites funders to join the TOG;
- Shares information with funders documenting the cost savings and improved efficiency associated with full FIT implementation;
- Develops a clear understanding of and plan for addressing the potential impact that FIT practices will have on contracted deliverables in the short run;
- Works with representatives from funding bodies to negotiate a formal agreement regarding any anticipated difficulties in meeting service targets.

Conducting a Pilot of FIT

Running a "pilot project" helps identify potential barriers to implementation. A group or program within a treatment system agrees to fully implement FIT. Problems are identified by project members and reported to the TOG. Solutions are developed and sent back to the pilot group for testing. Large and clinically diverse systems may benefit from running pilots in several programs simultaneously. Although the length of pilots is variable most medium to large size agencies require 6-12 months to identify the system-specific issues likely to impede full implementation. During this phase, the key to success is maintaining open communication so that problems and conflicts can be identified and resolved.

The TOG must be ready to and capable of:

- Revising agency mission, policy, and/or quality assurance standards and expectations;
- Revising workflow and traditional measures of productivity;
- Communicating updates to all agency staff regarding findings of the pilot project.

4) Initial Implementation

During initial implementation, FIT is implemented across the entire agency or treatment system. Staff members (clinicians, supervisors, managers) have been trained, infrastructure supporting FIT practice is in place, and pilot project findings have been incorporated into the implementation plan (see Appendix C). Of the four stages, this one is the most resource and labor-intensive. Significant effort must be extended by everyone involved (TOG members, program managers, supervisors, administration [known collectively as, "integration supports"]) to ensure that the new practice is being consistently used. The FRIFM and competency-based supervision methods can be used to ensure: (1) fidelity to the clinical practice guidelines; and (2) utilization of data generated by FIT practices to inform clinical work and program evaluation.

Communication, problem-solving, and ongoing training and skill development are key. Fixsen et al. (2005) cite numerous studies showing that access to and interaction with all of integration supports, top management, and technical assistance from knowledge experts during this stage are directly related to implementation outcomes. Research and experience make clear that initial implementation takes time. Clinicians and supervisors go through varying degrees of struggle to integrate FIT practice into clinical care. Although the amount varies some, few agencies complete initial implementation in less than 9-12 months. If an agency is using a sequenced implementation approach, it is expected that programs will be at different stages, with some in installation and others in initial and full implementation.

Role of the FRIFM in the Initial Implementation Stage

A central task of initial implementation is monitoring individual and organization performance. Fixsen et al. (2005) suggest that monitoring efforts fall into three different categories: (1) context measures (ensuring necessary supports are in place and installation tasks are complete); (2) compliance measures (ensuring practitioners use the core components and avoid proscribed practices); and (3) competence measures (evaluating level of skill demonstrated during service provision). The FRIFM provides a structure for monitoring performance in all three categories, quickly and efficiently assessing fidelity to FIT practice and the quality and effectiveness of agency infrastructure and integration supports. Regular review of the tool by members of the TOG, integration supports, and clinical staff also helps

maintain focus on core tasks of implementation, thereby preventing the drift that can occur during this stage.

Realm 1: Clinical Implications

During initial implementation, all practitioners are expected to use the skills and tasks associated with FIT practice, including administering outcome and alliance measures and integrating the client feedback into service planning and delivery. During this period, supervision is critical to success. The TOG ensures that supervisors:

- Have access to consultation and training in FIT practice and competency-based supervision approaches with knowledge experts;
- Model openness to feedback;
- Use FIT in their own clinical practice;
- Help clinicians incorporate FIT in their practice;
- Monitor practice of clinicians to ensure fidelity to FIT practice;
- Address any difficulties clinicians experience with using outcome and alliance measures, and interpreting and adjusting services in response to client feedback;
- Use the ICCE Core Competencies to identify and address any deficits in clinician knowledge and skill level;
- Provide regular opportunities for reviewing clinical practice guidelines and agency training materials related to FIT practice;
- Facilitate regular small group discussions and peer supervision sessions among clinical staff regarding FIT practice;
- Use individual client data and aggregate clinician data to guide supervision. (Note: supervisors must exercise caution when interpreting clinician aggregate data [i.e., effect size, percentage of clients reaching benchmarks] in this stage as scores are subject to a significant amount of random variation when the number of cases in the data management systems is small [see Manuals 2 and 4]);
- Use the data management system to identify and address cases "at risk" for dropout and poor or negative outcome that require supervision;
- Remain alert to the need for making adjustments to clinician workload and productivity requirements to facilitate the integration of FIT into practice.

Realm 2: Administrative

Adopting a new practice is rarely a linear process. Once implementation begins, most agencies will need to revisit tasks from prior stages. For this reason, it is essential to maintain a functioning TOG during the initial installation stage. As FIT is rolled out across programs, the TOG:

- Uses all means (training, supervision, ongoing communication, etc.) available to maintain full commitment to implementing all components of FIT;
- Ensures that structures are in place for supporting implementation (e.g., supervision, data management, quality assurance/compliance methods, case review, etc.), including explicit policies and practices for assisting clinicians and supervisors who are not meeting competency requirements (i.e., training, mentoring);
- Liaises between the clinical supervision functions and managers/administrators responsible for adapting agency policies or clinical practice guidelines.

- Regularly seeks feedback from clinicians and supervisors regarding the implementation process and addresses roadblocks and/or procedural issues that may arise;
- Oversees agency policies and processes regarding cases at risk for negative or null outcome or dropout;
- Works with administration to adjust its business plan and secure any additional resources needed for successful implementation.

Realm 3: Information Systems/ Paperwork/Documentation/IT

Initial implementation is the first opportunity to fully test data collection and management processes. The TOG has a significant role to continue playing in this realm:

- Addressing issues related to workflow and data reporting;
- Ensuring that meaningful data is provided to clinicians, supervisors, and program managers in real time;
- Ensuring that required documentation supports rather than hinders FIT practice (see Appendices D and E).

Realm 4: Regulatory and Accreditation

During initial implementation, the TOG:

- Creates summary reports of agency outcome data;
- Documents how the agency is meeting and exceeding expectations and requirements;
- Develops a plan for improving agency outcomes (i.e., percentage of clients reaching baseline, effect size);
- Shares outcome reports and improvement plan with regulatory and accreditation bodies.

Realm 5: Consumers

During initial implementation, the TOG:

- Uses existing consumer feedback mechanisms to obtain consumer feedback related to the implementation process and experience with FIT practice;
- Conducts community development activities (focus groups, surveys, discharge interviews, etc.) to obtain consumer feedback related to the implementation process and experience with FIT practice;
- Processes consumer feedback and incorporates resulting information in future training and clinical practice guidelines.

Realm 6: Funders

During initial implementation, the TOG:

- Creates and shares summary reports of agency outcome data with funders;
- Documents how the agency is improving effectiveness, efficiency, and return on funder investment;
- Develops and shares a plan for improving agency outcomes (i.e., percentage of clients reaching baseline, effect size, outcome per dollar spent/ invested) with funders;
- Use the outcome report and improvement plan to seek changes/waivers to any funder documentation and reporting requirements that impede FIT practice.

5) Full Implementation

In the full implementation, all tasks associated with prior stages are complete. FIT is fully integrated into agency vision, culture, policy, and practice. Results of the newly implemented practice should now be approximating that of the original evidence-based program.

The major activities during this stage involve:

- Continued performance monitoring at both the individual and organizational levels;
- Using outcome data for program and professional development initiatives;
- Incorporation of ongoing developments of the new practice into existing practice and policies;
- Consideration of potential adaptations (or innovations) for specialized programs/ populations.

Role of FRIFM in the Full Implementation Stage

A primary challenge of the full implementation stage is maintaining engagement. Since, in most agencies, the TOG disbands at this point, it is critical that structures are in place for monitoring performance. Implementation can easily deteriorate when such monitoring focuses on clinical performance to the exclusion of administrative, technical, and systems supports. Periodic review of the FRIFM ensures that all pertinent realms for supporting FIT practice remain in place and effective. Once FIT is fully implemented, attention can turn to innovation and sustainment.

Realm 1: Clinical Implications

During full implementation:

- Any productivity standards that were relaxed or waived during prior stages are resumed;
- Clinicians are once again carrying full caseloads and using the ORS and SRS with the majority of clients. Research and experience indicate that it is reasonable to expect the measures to be administered with 95% of clients;
- Compliance and competency monitoring processes are a routine part of supervision and management practices (The ICCE Core Competencies [Appendix B] should be used to guide determinations of competency in FIT practice; the FRIFM can be used as a checklist to audit clinician, supervisor, and training program compliance with FIT practice).

Realm 2: Administrative; Realm 3: Information Systems/Paperwork/ Documentation/IT; Realm 4: Regulatory and Accreditation; Realm 5: Consumers; and Realm 6: Funders

During full implementation:

- Performance monitoring in realms 2 through 6 is taken over by the agency's quality assurance personnel. The FRIFM easily serves as a guide for monitoring;
- Overall agency outcome data is continuously tracked by managers and administrators and used to develop performance improvement plans;
- Through a continuous cycle of making adjustments and evaluating the results (deliberate practice), agencies strive toward clinical excellence;
- Agency outcomes and performance improvement plans are shared with funders, regulatory and accreditation bodies, consumers, and other stakeholders.

Innovation

Innovation refers to adapting FIT – making "desirable changes" – for specialized programs or populations. Planned changes to established clinical guidelines and FIT protocol must be distinguished from drift, where alterations occur piecemeal and may reflect attempts to maintain the status quo, avoid making necessary changes to policy and structure, or a lack of competence. In order to minimize threats to anticipated beneficial outcomes, alterations to established protocol should be piloted on a small scale prior to full implementation. Fixsen et al. (2005) cite research showing that adaptations made after a new practice has been fully implemented are more successful than modifications made during earlier stages.

Sustainment

A practice is sustainable when policies, practices, and structures are in place that ensure: (1) ongoing adherence to protocol; and (2) responsiveness to new developments and/or expectations in the practice environment (e.g., development of a program for new staff, supervisors, and program managers; open communication regarding new social, political, and economic pressures, etc.). Ongoing use of the FRIFM by quality assurance personnel can help identify and address common threats to fidelity (e.g., avoiding the new practice; competency concerns; potential conflicts with implementation processes for other clinical practices and/or funder requirements; changes in leadership). It also provides clear performance expectations for new managers, clinicians, and supervisors.

FIT practice is more likely to be sustained when:

- Practice champions are identified, supported, and used as mentors and trainers. Such staff could participate in advanced intensive and training of trainers courses (for more information, go to: www.centerforclinicalexcellence.com);
- FIT practices are introduced to potential new staff during the hiring and evaluation process;
- New staff are trained to use FIT during orientation and paired with practice champions for mentoring;
- Agency in-service meetings are conducted on specific aspects of FIT practice;
- Tip sheets and FAQs are created and distributed to staff for easy reference;
- Opportunities are provided for staff members to participate in a "community of practice" where knowledge, skills, references, and emerging information about FIT are shared. On this regard, the ICCE provides an opportunity for agencies to create private online discussion groups exclusively for their staff and also opportunities for staff to engage in knowledge exchange and discussion with FIT clinicians from around the globe. Membership is free at: www.centerforclinicalexcellence.com.
- A mechanism is in place for reviewing and updating policies and practice guidelines regarding FIT. Through ongoing evaluation and monitoring, agencies can identify changes that need to be made at the organization level in order to support FIT, including:
    * Developing (if not already in place) and continuing to refine processes for managing outcome data (i.e., identify someone to oversee administrative functions such as data management);
    * Creating staff evaluations for performance improvement based on FIT;
    * Implementing organizational fidelity evaluations to monitor adherence to FIT;
    * Ensuring that data is relevant to practice at program level (i.e., program evaluation and planning).

Manual 6 Quiz

Research indicates that people retain knowledge better when tested. Take a few moments and answer the following 10 questions. If you miss more than a couple, go back and reread the applicable sections. One week from now, complete the quiz again as a way of reviewing and refreshing what you have learned. Refer to page 27 for the answers.

1. Feedback-Informed Treatment is:

a) A way of thinking of therapy

b) A new model of therapy

c) A pantheoretical approach for evaluating and improving the quality and effectiveness of behavioral health services

d) All of the above

2. Which are the most important steps for implementing and ensuring the sustainability of FIT?

a) Funding support

b) Securing administrative buy-in and ensuring agency or system-wide implementation

c) Designing and executing a pilot project

d) Exposing front-line clinicians, supervisors, and managers to the empirical foundation and practices of FIT with ongoing consultation and support

e) B, C & D

3. The Feedback Readiness Index and Fidelity Measure (FRIFM) will help behavioral health agencies, services, and/or systems:

a) Assess readiness for change

b) Determine if you should use feedback-informed treatment (FIT)

c) Provide a case for support for funding bodies

d) Meet state regulatory standards

e) Evaluate a system's fidelity or readiness to implement a feedback-informed (FIT) approach to services

4. What are the core elements in creating a culture of feedback?

a) Documenting a counselor's success rates

b) Using outcome and alliance measures at each counseling session

c) Sharing the outcome and alliance graphs with consumers

d) B & C

e) All of the above

5. What is the most important criteria for a successful pilot project?

a) Ensure that management expectations for the pilot are clear

b) Start small with one or two teams

c) Notes should be recorded at each meeting so that the internal process can be recorded and reviewed

d) Develop a plan to track and monitor data

e) All of the above

6. For successful agency wide or system wide implementation, administrators must be mindful of:

a) The cost of the roll-out

b) The attitudes of the staff

c) Media awareness

d) Practicum opportunities for students

e) Providing sufficient support to agency staff through the transition to FIT

7. How can agencies support a FIT culture?

a) Mandate FIT

b) Provide group follow-up consults on a routine and ongoing basis

c) Provide individual support and consultation

d) A & C

e) B & C

8. Web based data management systems are recommended for large and multi-site agencies because:

a) They are cheaper than the other options

b) They provide better data

c) They require a wide bandwidth

d) They are easily accessible by multiple users via the internet

9. The TOG is responsible for:

a) Training clinicians

b) Maintaining the data management system

c) Troubleshooting

d) Managing the agency budget

10. A FIT training for staff should:

a) Include opportunities to practice FIT skills

b) Include follow-up or booster sessions

c) Involve training supervisors first

d) All of the above

Answer Key

1. c	6. e
2. e	7. e
3. e	8. d
4. d	9. c
5. e	10. d

FAQ

Question:

Can't our agency implement FIT without doing the Feedback Readiness Index and Fidelity Measure (FRIFM) gap assessment?

Answer:

Using FRIFM will ensure that you have done the assessment in advance and can develop an implementation plan that meets the specific needs of your agency. The absence of this assessment and good advanced planning makes your agency more likely to fail. The assessment will provide your agency with a good understanding of staff readiness to implement a feedback-informed (FIT) approach to services. The six realms assess clinical implications, administrative issues, information systems and IT readiness and capability, paperwork and documentation, regulatory and accreditation issues, consumer issues, and funding issues. The comprehensiveness of the assessment will prepare you and your agency for successful implementation.

Question:

How do we implement FIT at the same time the agency is engaged in other organization change projects?

Answer:

In a word, by planning. Change is a constant in the world of behavioral health. If an agency is not conducting multiple change projects at the same time when implementation of FIT begins, most will be forced to take on other organizational development efforts along the way. Careful preparation and planning, establishing and empowering a TOG, and following through are the keys to success.

Question:

What if the staff is unhappy about the use of FIT?

Answer:

Be prepared. Adopting FIT requires a change in organization culture and practice. At a minimum, the implementation process described in this manual takes three years. It will take time for the changes to occur and for staff to adjust. Following the recommendations outlined in the manual (running pilots, establishing open communication, etc.) will resolve most objections and challenges. At the same time, administrators and managers need to be clear about expectations. Moving from the exploration to installation stage means that a commitment has been made to fully implement. Agency policy must reflect this commitment and identify the remedial steps and consequences taken for noncompliance.

Question:

Is FIT a new model of therapy?

Answer:

FIT is not a model of therapy, it is a pantheoretical approach for evaluating and improving the quality and effectiveness of behavioral health services. It involves routinely and formally soliciting feedback from consumers regarding the therapeutic alliance and outcome of care and using the resulting information to inform and tailor service delivery. One of the benefits of adopting FIT is that it does not dictate the type of treatment offered.

Question:

Our counselors believe that they have to give up their model of therapy in order to adopt FIT. Is this correct?

Answer:

As mentioned above, FIT is not a model of therapy and counselors do not have to give up their own models of therapy in order to work within a feedback-informed culture. It is important that counselors have a well-informed practice framework, or model of practice, that they adhere to and can describe and deliver in a coherent and reliable manner. At the same time, practicing FIT will quickly challenge clinicians to alter their usual way of working when client feedback indicates that the therapeutic alliance or outcomes are at risk.

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Appendix A - Part 1

Feedback Readiness Index and Fidelity Measure (FRIFM)
Realm 1 CLINICAL IMPLICATIONS
(Version 1.0)

Not Applicable	No, None, Never	Very Limited, Not Often	Partially. Frequently	Mostly, Regularly	Yes, Fully Always
N/A	1	2	3	4	5

Write in the score that best applies

Counselors/ therapists:

1. Administer and score the Outcome Rating Scale (ORS) each visit or "unit of service." ☐ Score
2. Administer and score the Session Rating Scale (SRS) each visit or "unit of service." ☐ Score
3. Adjust the level or type of care in response to client feedback on the ORS and SRS.
4. Use outcome (ORS) data to develop an "expected treatment response" (ETR) for each client. ☐ Score
5. Plot client progress (ORS scores) on individualized graphs from session to session to determine which clients are making progress and which are at risk for a negative or null outcome. ☐ Score
6. Use the ORS and SRS to adjust the level or type of care and to determine whether the service is addressing the client's focus of treatment. ☐ Score
7. Modify the "service delivery plan" in response to formal client feedback on objective measurement tools. ☐ Score
8. Use the SRS to discuss whether the service matches the client's goals for treatment. ☐ Score

Appendix A - Part 1 (continued)

Feedback Readiness Index and Fidelity Measure (FRIFM)
Realm 1 CLINICAL IMPLICATIONS
(Version 1.0)

Not Applicable	No, None, Never	Very Limited, Not Often	Partially. Frequently	Mostly, Regularly	Yes, Fully Always
N/A	1	2	3	4	5

Write in the score that best applies

9. Use the SRS to discuss whether the service matches the client's culture, worldview, and preferences. ☐ Score

Supervision of Clinicians:

10. Relates to the "Core Competencies" of a feedback-informed (FIT) approach to treatment services. ☐ Score

11. Is based on and targeted by outcome data aggregated over clinician's caseload rather than on theoretical knowledge or technical expertise. ☐ Score

12. Is evaluated for impact on effectiveness via aggregated ORS data over time. ☐ Score

13. Is available when ORS data identifies cases at risk for negative or null outcomes. ☐ Score

14. Encourages diversity in thinking and treatment approach to match individual client culture, preferences, and worldview. ☐ Score

Training of Staff:

15. Ongoing training is oriented toward and structured core competencies of feedback-informed treatment (FIT). ☐ Score

16. Is based on identified deficits in core competencies of feedback-informed treatment (FIT). ☐ Score

17. Is targeted to clinicians whose outcomes fall below clinic, agency, or state norms as determined by aggregated ORS and SRS data. ☐ Score

Feedback Readiness Index and Fidelity Measure (FRIFM)
Realm 2 - ADMINISTRATIVE
(Version 1.0)

Not Applicable	No, None, Never	Very Limited, Not Often	Partially. Frequently	Mostly, Regularly	Yes, Fully Always
N/A	1	2	3	4	5

Write in the score that best applies

The Agency

1. The agency uses the ORS and SRS to facilitate individualized treatment planning. ☐ Score

2. The agency has a formal, continuous, automatic system to collect client outcome data that is integrated into the service delivery process. ☐ Score

3. The agency has infrastructure to support the collection and analysis of ORS and SRS data on each individual consumer with real time feedback to the therapist. ☐ Score

4. The agency has a training plan for all staff that supports feedback informed treatment (FIT). ☐ Score

5. The agency has written admission, transfer, and discharge policies that are based on "expected treatment response" trajectories derived from individual client ORS data. ☐ Score

6. The agency's Mission Statement and strategic plan incorporates client outcome data as a central feature of its service delivery system. ☐ Score

7. The agency uses client outcome data to identify under-performing therapists or programs. ☐ Score

8. The agency has a structure for using outcome data to develop norms for determining the dose of treatment required to achieve statistically and clinically significant change. ☐ Score

9. The agency has a structure for identifying which clients are at risk for a negative or null outcome based on aggregated ORS data. ☐ Score

Appendix A - Part 1 (continued)

Feedback Readiness Index and Fidelity Measure (FRIFM)
Realm 2 - ADMINISTRATIVE
(Version 1.0)

Not Applicable	No, None, Never	Very Limited, Not Often	Partially. Frequently	Mostly, Regularly	Yes, Fully Always
N/A	1	2	3	4	5

Write in the score that best applies

10. The agency has a structure and policy for addressing clients who are not progressing that insures continuity of care. ☐ Score

11. The agency has policies and procedures for informing funders and/or referral sources in real time of individual client progress. ☐ Score

12. The agency has policies that integrate support staff functions with the collection of client/consumer outcome and alliance data. ☐ Score

13. The agency has consensus amongst senior managers that the client feedback via the ORS and SRS are the central drivers of service delivery of the agency. ☐ Score

14. The agency has policies that reflect a commitment to therapist accountability and use of client feedback to guide and inform client service delivery ☐ Score

15. The agency "Client Rights and Responsibilities policy" includes a statement regarding the use of formal client feedback to guide treatment planning. ☐ Score

16. The agency director has developed consensus with the agency's Board of Directors on the application of an outcome informed and consumer directed service delivery system. ☐ Score

17. The agency communicates regularly with funding entities and referral sources about agency effectiveness and outcome data. ☐ Score

18. The agency uses outcome data to guide therapist/staff training programs. ☐ Score

Feedback Readiness Index and Fidelity Measure (FRIFM)
Realm 2 - ADMINISTRATIVE
(Version 1.0)

Not Applicable	No, None, Never	Very Limited, Not Often	Partially. Frequently	Mostly, Regularly	Yes, Fully Always
N/A	1	2	3	4	5

Write in the score that best applies

19. The agency's board of directors, supervisors and line staff receive ongoing outcome data regarding therapist/program performance relative to agency and state norms. ☐ Score

20. The agency is committed to providing individual lengths of service for each client/consumer based on ORS outcome data. ☐ Score

21. The agency has an automatic and scalable data collection and analysis system. ☐ Score

22. The agency has a clearly articulated business plan that supports feedback informed service delivery. ☐ Score

23. The agency has a human resource development plan that supports primary and continuing education of staff in feedback-informed service delivery at all levels. ☐ Score

Appendix A - Part 1 (continued)

Feedback Readiness Index and Fidelity Measure (FRIFM)
Realm 3 - INFO SYSTEMS/PAPERWORK/DOCUMENTATION/ IT
(Version 1.0)

Not Applicable	No, None, Never	Very Limited, Not Often	Partially. Frequently	Mostly, Regularly	Yes, Fully Always
N/A	1	2	3	4	5

Write in the score that best applies

1. Data collection (outcome, alliance, intake) is done in a collaborative manner with clients. ☐ Score
2. Data collection relates to client service and progress. ☐ Score
3. Data collection facilitates easy management of client service & progress. ☐ Score
4. Information systems provide reliable, efficient data that is used in real time to prevent dropout/improve retention. ☐ Score
5. Data collection is continuous, and provides usable data in real time for quality improvement purposes. ☐ Score
6. Information systems respect and encourage innovation and diversity. ☐ Score
7. Data collection is transtheoretical as regards treatment modality. ☐ Score
8. The information system provides feedback in real-time. ☐ Score
9. Feedback system and paperwork is automated. ☐ Score
10. Information systems allow for comparisons in real-time for effectiveness of different providers, groups, agencies and treatment systems. ☐ Score

Feedback Readiness Index and Fidelity Measure (FRIFM)
Realm 4 - REGULATORY and ACCREDITATION
(Version 1.0)

Not Applicable	No, None, Never	Very Limited, Not Often	Partially. Frequently	Mostly, Regularly	Yes, Fully Always
N/A	1	2	3	4	5

Write in the score that best applies

1. Regulatory and accrediting entities have clear standards and expectations that facilitate implementation of a feedback-informed treatment (FIT). ☐ Score

2. Regulatory and accrediting entities are able to identify which programs achieve below, average or above average outcomes according to national norms. ☐ Score

3. Regulatory and accrediting entities monitor programs around dynamic, real-time measures of outcome, alliance, and consumer satisfaction. ☐ Score

4. Regulatory and accrediting entities expect programs to have a real-time system for informing the program and practitioners when their outcomes are outside national norms. ☐ Score

5. Regulatory and accrediting entities expect programs to have a real-time system for identifying when particular consumers are not satisfied with the type, level or provider of care. ☐ Score

6. Regulatory and accrediting entities monitor programs' system for identifying cases at risk proactively (in real time) rather than relying on a reactive system of problem management. ☐ Score

7. Regulatory and accrediting entities expect programs to have an actuarial approach, which predicts which clients need a change in the type, level of provider of care. ☐ Score

8. Regulatory/accrediting entities establish information systems that allow consumers to identify where to receive the most effective care. ☐ Score

Appendix A - Part 1 (continued)

Feedback Readiness Index and Fidelity Measure (FRIFM)
Realm 4 - REGULATORY and ACCREDITATION
(Version 1.0)

Not Applicable	No, None, Never	Very Limited, Not Often	Partially. Frequently	Mostly, Regularly	Yes, Fully Always
N/A	1	2	3	4	5

Write in the score that best applies

9. Regulatory and accrediting entities can compare programs by comparative aggregate outcomes. ☐ Score

10. Regulatory and accrediting entities establish information systems to ensure 100% client participation in and responsivity to client preferences in choice of treatment. ☐ Score

Feedback Readiness Index and Fidelity Measure (FRIFM)
Realm 5 – CONSUMERS
(Version 1.0)

Not Applicable	No, None, Never	Very Limited, Not Often	Partially. Frequently	Mostly, Regularly	Yes, Fully Always
N/A	1	2	3	4	5

Write in the score that best applies

1. Consumers have complete and unfettered access to their records. ☐ Score
2. Consumers participate actively in the creation of their records as demonstrated by their ability to discuss specific aspects of their service plan. ☐ Score
3. Consumers' treatment plans are structured by their priorities, goals, preferences, and progress. ☐ Score
4. Level and type of care offered to consumers is informed by initial score on the ORS. ☐ Score
5. Consumer feedback via the ORS and SRS is taken seriously, and used to alter/modify the course of treatment in real time. ☐ Score
6. Consumers are informed of the formal process and timeframe for dealing with treatment that is ineffective or undesired. ☐ Score
7. Consumer feedback on the SRS is used for tailoring treatment to the consumer's preferences, desires and needs. ☐ Score
8. Consumers have ready access to valid results and measurements of the effectiveness of programs and therapists. ☐ Score

Feedback Readiness Index and Fidelity Measure (FRIFM)
Realm 6 – FUNDERS
(Version 1.0)

Not Applicable	No, None, Never	Very Limited, Not Often	Partially. Frequently	Mostly, Regularly	Yes, Fully Always
N/A	1	2	3	4	5

Write in the score that best applies

1. Funding agency has policies that reward superior performing participating agencies. ☐ Score

2. Funding agency has a direct data link with participating service agencies that reimburses therapists/agencies for positive outcomes ☐ Score

3. Funding agency and participating agencies have polices that allow for a transtheoretical approach to services. ☐ Score

4. Funding agency and participating agencies link reimbursement to positive outcomes for individual clients using integrated and continuous assessment of client response to services rendered to the client. ☐ Score

5. Funding agency provides outcome data to consumers. ☐ Score

6. Funding agency determines continuing service needs based upon outcome and process data measures. ☐ Score

7. Funding agency uses outcome data to compare treatment programs on a regular basis and make value-based funding decisions ☐ Score

Appendix A - Part 2

Feedback Readiness Index and Fidelity Measure Instructions

The Feedback Readiness Index and Fidelity Measure (FRIFM) is an organizational readiness checklist and evaluation tool for behavioral health agencies, services and/or systems. The FRIFM addresses six realms, each of which is an important organizational component in evaluating a system's fidelity or readiness to implement a feedback-informed (FIT) approach to services. The six realms are:

Realm 1 - Clinical Implications
Realm 2 - Administrative
Realm 3 – Information Systems/Paperwork/Documentation/IT
Realm 4 – Regulatory and Accreditation
Realm 5 - Consumers
Realm 6 - Funders

Each realm consists of a series of statements that serve to:

1. Identify a system's strengths and weaknesses important to using a FIT approach.

2. Enhance a strategic planning process that will assist an organization to:

    a. Identify initial steps necessary to transition to FIT services;
    b. Prioritize which realms need consultation and training to adjust;
    c. Project timelines, strategic objectives and goals to implement formal client feedback on the quality and outcome of services.

3. Determine what resources, training and consultation would be helpful to:

    a. Implement systems driven by client feedback and outcomes data;
    b. Identify and provide necessary areas of staff development;
    c. Establish documentation and information policies and procedures to achieve a FIT approach while reducing time spent in documentation tasks.

How to Use the FRIFM:

The checklist and self-evaluation can be used in a number of ways:

1. As a tool for generating discussion among the clinical and administrative staff regarding the challenges or shortfalls in implementing FIT:

    a. Staff and administration could meet and work through each realm. Current realities, attitudes, opportunities or obstacles are raised and discussed as the team rates each item as Not Applicable; or from 1 to 5 with rating 5 representing full agreement.

Appendix A - Part 2 (continued)

b. Relevant personnel for each realm could rate each section in separate meetings. Final evaluation scores could then be discussed with the whole group.

2. In conjunction with onsite training and consultation to clarify and address whatever challenges are shortfalls are identified in process of completing the form:

    a. Telephone or onsite consultation clarifies with the executive team of the organization what priorities, resources, and strategies are needed to initiate action for change in the system;
    b. Timelines, deliverables and responsibilities are delineated from this interactive consultation process.

3. As an organizing tool to engage and enlist the input, planning and change strategies of relevant team members for each FRIFM realm.

    a. The importance of administration support and buy-in to successful implementation of FIT is, for example, highlighted as management addresses the items in realm 2.
    b. Either alone or with consultation assistance, the organization uses the realms and resulting ratings to plan implementation strategies for each segment of the organization and for each stakeholder area.

4. As a fidelity and progress measure, the FRIFM can be completed as implementation occurs:
    a. Re-evaluation and rating of items provides a measure of progress to help modify the plan based on the results of organizational change

Appendix B

Core Competencies for ICCE Clinicians

The ICCE is a worldwide community of clinicians, educators, researchers, and policymakers promoting excellence in behavioral health services.

The core competencies identify the knowledge and skills associated with outstanding clinical performance. Accreditation as an ICCE clinician requires proficiency in all four competency areas.

Competency 1: Research Foundations

- Clinicians are familiar with research on the therapeutic alliance.
- Clinicians are familiar with research on behavioral healthcare outcomes.
- Clinicians are familiar with general research on expert performance and its application to clinical practice.
- Clinicians are familiar with the properties of valid, reliable, and feasible alliance and outcome measures

Competency 2: Implementation

- Clinicians integrate consumer-reported outcome and alliance data into clinical work.
- Clinicians collaborate and are transparent in their interactions with consumers about collecting feedback regarding alliance and outcome.
- Clinicians ensure that the course and outcome of behavioral healthcare services are informed by consumer preferences.

Competency 3: Measurement and Reporting

- Clinicians measure and document the therapeutic alliance and outcome of clinical services on an ongoing basis with consumers.
- Clinicians provide details in reporting outcomes sufficient to assess the accuracy and generalizability of the results.

Competency 4: Continuous Professional Improvement

- Clinicians determine their baseline level of performance
- Clinicians compare their baseline level of performance to the best available norms, standards, or benchmarks
- Clinicians develop and execute a plan for improving baseline performance
- Clinicians seek performance excellence by developing and executing a plan of deliberate practice for improving performance to levels superior to national norms, standards, and benchmarks

Appendix B (continued)

Competency 1: Research Foundations

- Clinicians are familiar with research on the therapeutic alliance.
    - The alliance is made up of four empirically established components (consumer preferences, agreement on the goals, agreement on methods, and bond)
    - Next to consumer level of functioning at intake, the consumer's rating of the alliance is the best predictor of treatment outcome.
    - A significant portion of the variability in outcome between clinicians is due to differences in the therapeutic alliance.
    - Monitoring alliance allows clinicians to identify and reduce risk of early dropout or null or negative change
    - Consumer ratings of alliance are more highly correlated with outcome than clinician ratings
    - Improvements in alliance (intake to termination) are associated with positive outcomes

- Clinicians are familiar with research on behavioral health (e.g., mental health, substance misuse, disease management) outcomes.
    - Psychotherapy is generally effective.
    - There are no meaningful differences in outcome between competing approaches when the following factors are taken into account:
        - Researcher or clinician allegiance
        - Dosing, training, and clinician effects
        - Comparison treatments are "bona fide," intended to be effective
        - Meta-analytic versus single study results
    - Therapy works in large part because of certain shared factors that are expressed in variable proportions through the interactions between clinicians and consumers.
        - Allegiance and commitment to approach by consumer and clinician
        - Working alliance between consumer and clinician
        - Agreement on goals
        - Agreement on methods
        - Relational bond
        - Consumer preferences
        - Healing rituals/practices (model and technique)
        - Extratherapeutic factors: A greater proportion of variance in outcomes is due to non-therapy or non-identifiable variables than is due to specific or non-specific therapeutic factors
    - There is substantial variation in outcomes between clinicians.
    - Clinicians understand general outcome statistics (overall success rates, effect size, corrected effect size), deterioration rates, dropout, etc.

Appendix B (continued)

- Clinician effectiveness tends to plateau over time in the absence of concerted efforts to improve it.

- Clinicians can identify the differences and similarities between the terms "evidence based practice," "empirically supported treatments," and "practice based evidence."
- Clinicians are not accurate at subjectively assessing risk of poor outcome, drop out, and deterioration.
- Clinicians are familiar with the normative differences in special client populations such as youth and children and understand how to apply outcome measurement appropriately with these populations.
- Monitoring outcomes allows clinicians to identify consumers at risk of early dropout or not improving.
- Clinicians who have access to outcomes data generally have fewer early dropouts and fewer poor outcomes.
- Predictors of outcome are:

    - Duration of therapy without positive change (negative predictor)
    - Early positive change
    - Consumer rating of alliance
    - Level of consumer engagement (consumer's active participation in the creation and maintenance of the alliance)
    - Improvement of alliance over course of treatment
    - Use of outcome and alliance measures
    - Severity of distress at intake
    - Clinician allegiance to their choice of treatment approach
    - Bona fide treatment that is intended to be effective
    - Clinician's previous effectiveness rate (Brown's research on the stability of clinician ratings over time)

- Non-predictors and weak/absent predictors of outcome are:

    - Consumer age, consumer gender, clinician age, clinician gender
    - Consumer diagnosis, previous treatment history
    - Clinician licensure, discipline, training, degrees, personal therapy, certifications, clinical supervision
    - Model/technique of therapy or matching therapy to diagnosis
    - Adherence/fidelity/competence to a particular treatment approach

- Clinicians are familiar with general research on expert performance.

    - Multiple domains (music, sports, chess, and mathematics) share common factors that are associated with expert performance.
    - Knowing baseline
    - Ongoing feedback
    - Deliberate, reflective practice

- Clinicians are familiar with the properties of valid, reliable, and feasible alliance and outcome measures:

Appendix B (continued)

- Clinicians understand and can articulate the trade-offs between feasibility and the reliability and validity of psychometric measures

    - Longer outcome measures provide little additional predictive information if instrument measures single-factor general distress (as opposed to multifactor instruments)
    - Longer outcome measures result in low rates of compliance in real-world clinical settings

- Clinicians understand the importance of an outcome measure's sensitivity to change

Competency 2: Implementation

- Clinicians integrate consumer-reported outcome and alliance data into clinical work.

    - Use valid, reliable, and feasible measures of outcome and alliance to guide services throughout the therapy process.
    - Understand and communicate the statistical properties and results of the outcome and alliance measures to consumers in a clinically meaningful way (i.e., clinical cut-off, norms, trajectories, reliable change index).
    - Can integrate outcome and alliance data with consumer preferences and other clinically meaningful information (i.e., clinician judgement and observation, other consumer-reported and collateral data).

- Clinicians collaborate and are transparent in their interactions with consumers about collecting feedback regarding alliance and outcome.

    - Use an alliance measure to identify problems/concerns in the therapeutic relationship.
    - Understand the importance of creating a "culture of feedback" (i.e., to optimize chances for catching and repairing alliance breaches, to prevent drop out, to correct deviations from optimal treatment experiences).
    - Can identify systemic factors (e.g., organizational, management, government, program, billing, funding, information technology) and therapeutic practices that facilitate or hinder a culture of feedback.
    - Know a range of strategies/options for adjusting service delivery in response to alliance feedback (e.g., discussion with client, consultation with peers, supervision, team meetings).

- Clinicians ensure that the course and outcome of behavioural healthcare services are informed by consumer preferences.

    - Clinicians ask consumers about their preferences regarding treatment.
    - Consumer feedback is used to monitor and clarify consumer's preferences (focus, type, length, intensity, location, and provider).

Appendix B (continued)

Competency 3: Measurement and Reporting

- Clinicians measure and document the therapeutic alliance and outcome of clinical services by keeping complete and organized records of outcome and alliance data for the consumers they serve

- Clinicians provide details in reporting outcomes sufficient to enable others to assess the accuracy and generalizability of their results. Clinicians use a consistent and transparent system of data collection, analysis, and reporting that accounts for:

    - Data being systematically included or excluded from collection, analysis, and reporting
    - Missing data
    - Demographic and descriptive data (e.g., age, gender, culture, treatment setting)
    - Psychometric properties of the instruments (e.g., reliability, validity, norming)
    - Formulas and methods used to calculate and report effectiveness (e.g., reliable change index, corrected versus uncorrected effect size, percentage reaching performance targets or benchmarks, etc.)

Competency 4: Continuous Professional Improvement

- Clinicians determine their baseline level of performance by calculating their overall effectiveness (e.g., reliable change index, corrected and/or uncorrected effect size, percentage of consumers reaching performance targets or benchmarks, etc.)

- Clinicians compare their baseline level of performance to the best available norms, standards, or benchmarks representative of client populations similar to their own

- Clinicians develop and execute a plan of deliberate practice to reach the best available norms, standards and benchmarks

    - Identify areas of practice (i.e., retention, alliance, outcome) that fall short of national norms, standards, or benchmarks;
    - Develop and execute a specific plan for meeting national norms, standards, and benchmarks;
    - Obtain training (supervision, consultation, coaching) targeted to areas of practice that fall short of national norms, standards, or benchmarks;
    - Monitor improvements in baseline performance and adjust their plan for improvement as needed.

- Clinicians seek performance excellence by developing and executing a plan of deliberate practice for improving performance to levels superior to national norms, standards, and benchmarks

    - Identify specific goals for performance improvement (i.e., outcome, retention, specialties);
    - Develop and execute a specific plan for reaching performance improvement objectives;
    - Reflect on the results and adjust plan for continued professional improvement.

Appendix C

Components of a Sample Implementation Plan

Developing a detailed plan keeps the implementation process organized and moving forward. The ideal work plan: (1) lays out all tasks to be achieved at each stage of implementation; (2) sets specific timelines for the completion of tasks and stages; and (3) identifies the person(s) responsible and accountable.

An example of tasks to be included in a FIT implementation plan include:

Initial Preparation:

- Develop a written document identifying the rationale and goals for implementing FIT across the entire agency or system of care
- Gain consensus regarding scope of implementation of FIT
- Establish TOG
- Create a draft protocol or guidelines for using FIT

Financing/Resources:

- Identify costs and write budget
- Finalize budget
- Secure resources to purchase data management system
- Arrange clinical and management coverage for administrators, trainers, supervisors, and practitioners participating in the pilot
- Orient staff that will be providing coverage for managers, trainers, and pilot project members
- Identify fund-raising opportunities
- Conduct fund-raising events

Appendix C (continued)

Data Management:

- Identify data management needs
- Identify staff responsible for overseeing data management and reporting
- Negotiate contract and acquire data management system
- Set up data management system
- Test data management system

Training:

- Develop training plan
- Finalize training curriculum
- Secure training space and schedule training for supervisors
- Conduct basic FIT training for supervisors
- Coaching of supervisors using FIT in practice
- Conduct training for supervisors in FIT supervision
- Conduct basic FIT training with clinicians
- Coach clinicians using FIT in practice
- Create training plan for use of data management system
- Finalize data management and analysis training curriculum and materials
- Schedule data management and analysis training and book computer training room for the training
- Conduct data management and analysis training
- Develop sustainability plan for ongoing FIT training

Communications:

- Develop communications plan
- Create communications material (FAQs, articles, newsletters, etc.)
- Inform teams of milestones achieved and upcoming events
- Communicate outcomes to staff and management

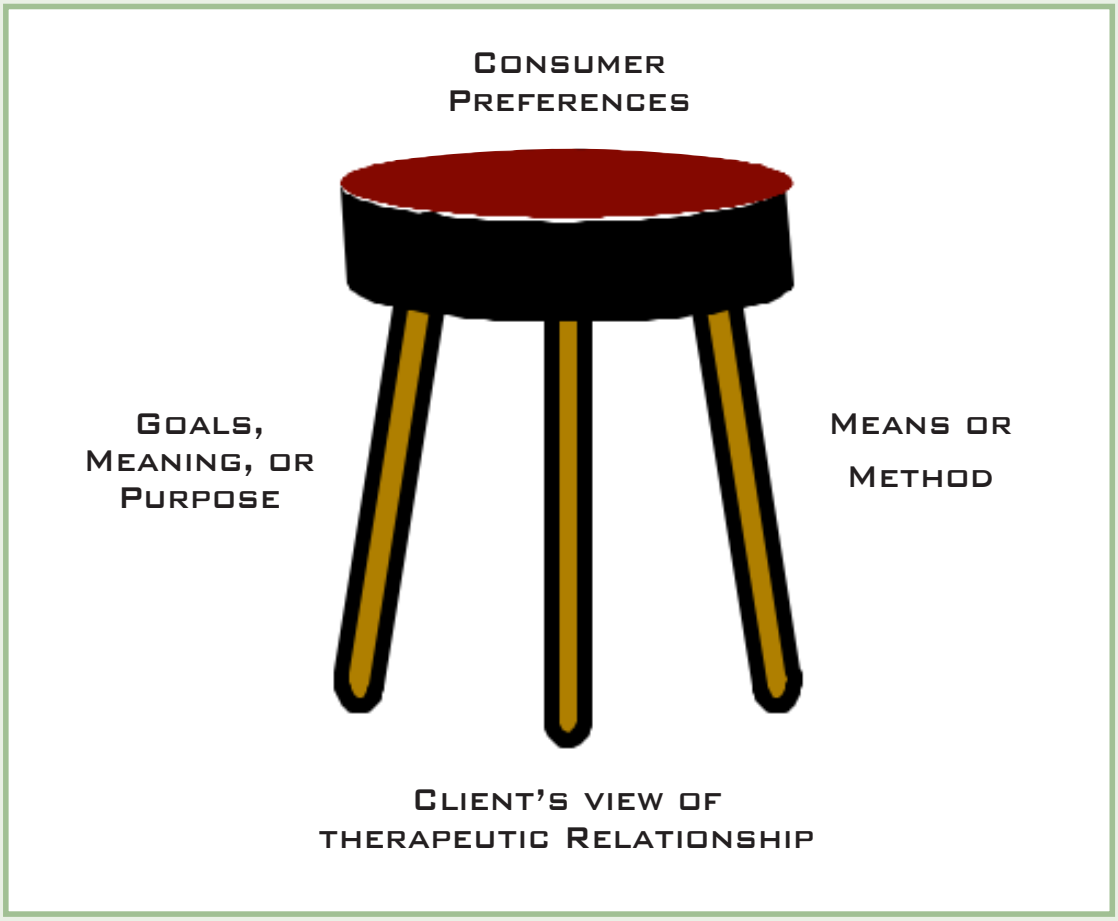
Evaluation:

- Complete evaluation plan for process and outcomes
- Collect data during implementation
- Compile evaluation data into report
- Implement recommendations from report

Appendix D

Sample FIT Service Delivery Plan and Instructions

Feedback-Informed Concurrent Service Delivery Agreement



Appendix D (continued)

Name:	
Date:	
Consumer's stated reasons/motivation for seeking services:	
Agreed upon goals/meaning/purpose/preferences for services:	
Agreed upon means/methods (including type, frequency, provider):	
Feedback-Informed process explained (Outcome & Alliance Tracking):	Yes No
Clinician signature:	Consumer signature:

Appendix D (continued)

The FIT-SDA

Consistent with the principles of FIT, the purpose of the FIT-SDA is to ensure that treatment is organized around the interests, motivations, goals, and preferences of the person seeking services.

Fill in the name of the person and date the agreement is being completed:

NAME:
DATE:

Fill in the person's stated reasons/motivations for seeking services. Take care to use the language and words of the person in treatment, avoiding diagnostic and treatment terms or jargon:

CONSUMER'S STATED REASONS/MOTIVATION FOR SEEKING SERVICES:

As an example, consider a man who presents for treatment because his partner has threatened to leave if he does not quit drinking. When asked, he readily admits that drinking is a problem. At the same time, his stated reason/motivation for seeking services is to "keep his wife from leaving him." Therefore, in the box above, the helping professional would write, "To keep his wife from leaving" or "To maintain his marriage."

Appendix D (continued)

Fill in goals/meaning/purpose of the services the person and helper have agreed to, highlighting the specific way the treatment offered fits with the preferences of the person:

Agreed upon goals/meaning/purpose/preferences for services:

Using the example of the man presenting for treatment because his partner has threatened to leave if he does not quit drinking, a potential goal could be "decrease drinking to an amount that is acceptable to my wife." In this statement, the goal is directly related to the man's stated motivation for services.

Fill in the means and methods the person and therapist agree to use to achieve the agreed upon goals:

Agreed upon means/methods (including type, frequency, provider):

Returning once again to the example of the man hoping to save his marriage, the helper would write the specific services that will constitute treatment. For example, "Weekly individual sessions focused on harm reduction and controlled drinking strategies," or "Attendance at three Alcoholics Anonymous meetings per week."

Appendix D (continued)

Explain the purpose of seeking feedback via the ORS and SRS, thereby creating a culture of feedback:

When introducing the ORS, the therapist should say:

"I/We work a little differently at this (agency/practice). My/our first priority is making sure that you get the results you want. For this reason, it is very important that you are involved in monitoring the progress of services from beginning to end. I/We like to do this formally by using a short paper and pencil measure called the ORS. It takes about a minute. Basically, you fill it out at the beginning of each session and then we talk about the results. A fair amount of research shows that if we are going to be successful in our work together, we should see signs of improvement earlier rather than later. If what we're doing works, then we'll continue. If not, then I/we will try to change or modify the services. If things still don't improve, then I'll work with you to find someone or someplace else for you to get the help you want. Does this make sense to you?"

When introducing the SRS, the therapist should say:

"I'd like to ask you to fill out one additional form. This is called the SRS. Basically, this is a tool that you and I will use at each session to adjust and improve the way we work together. A great deal of research shows that your experience of our work together—did you feel understood, did we focus on what was important to you, did the way we worked make sense and feel right—is a good predictor of whether we'll be successful. I want to emphasize that I'm not aiming for a perfect score—a 10 out of 10. Life isn't perfect and neither am I. What I'm aiming for is your feedback about even the smallest of things—even if it seems unimportant—so we can

Appendix D (continued)

adjust our work and make sure we don't steer off course. I won't take it personally. I'm always learning and am curious about what I can learn from getting this feedback from you that will in time help me improve my skills. Does that make sense?"

In the box, the helper indicates whether time was taken during the visit to explain the feedback-informed process:

Feedback-Informed process explained (Outcome & Alliance Tracking):	Yes	No

Once completed, the FIT-SDA is signed by both the service provider and person seeking treatment:

Clinician signature:	Consumer signature:

Appendix E

Sample FIT Progress Note and Instructions

Feedback-Informed Progress Note

NAME:	
DATE:	
ORS ADMINISTERED: YES NO COLLATERAL SCORE:	PROGRESS: → ↑ ↓
PROGRESS ADDRESSED IN SESSION BY:	
BETWEEN SESSION PLAN: MAINTAIN & CONSOLIDATE GAINS/ADDRESS DETERIORATION/REVISE APPROACH	
SRS ADMINISTERED: YES NO	ABOVE 36 BELOW 36 INCREASING SAME DECREASING
SRS ADDRESSED DIRECTLY: YES NO	
CLINICIAN SIGNATURE:	CONSUMER SIGNATURE:

Appendix E (continued)

Sample FIT Progress Note and Instructions (continued)

The FIT Progress Note

Consistent with the principles of FIT, the purpose of the FIT Progress Note is designed to ensure that any services offered are informed by ongoing feedback about the outcome of treatment and the alliance between the provider and recipient of services.

Fill in the name of the person and date the agreement is being completed:

NAME:
DATE:

In the box on the left, indicate whether the ORS was administered at the beginning of the visit. In the box to the right, circle the arrow indicating whether the scores on the ORS stayed the same, improved, or deteriorated as compared to the prior measurement:

ORS ADMINISTERED: YES NO COLLATERAL SCORE:	PROGRESS: → ↑ ↓

Determining whether services are working is fundamental to feedback-informed treatment. As a result, the ORS must be administered at or near the beginning of each and every session or "unit of service." The helping professional must also determine whether or not the scores on the ORS indicate that the person in care is making progress.

Appendix E (continued)

Describe how the outcome since the prior measurement was specifically addressed during the visit (if the ORS was not administered, indicate why and then describe how progress was assessed and addressed during the service):

Progress addressed in session by:

Scores on the ORS can go up, down, or stay the same, indicating improvement, deterioration, or maintenance of progress, respectively. If scores have gone up since the prior measurement, the provider details the nature of the improvement and how the progress was addressed during the visit. In the case of improved scores in the treatment of a person with depression, for example, the therapist might write, "Client stated she got up rather than lying in bed by setting her alarm clock." In the case of deterioration, the therapist might write, "Client reports that lower scores are the result of experiencing more isolation during the week" or "of having been unable to get up and out of bed despite having set the alarm clock as recommended in the last visit." The key is documenting the reason for the results in as concrete and specific terms as possible.

Describe the plan developed during the visit for addressing the progress reported in the current visit:

Between session plan: Maintain & Consolidate gains/Address Deterioration/Revise approach

In this box, the plan developed by the provider and recipient of services during the visit aimed at reinforcing progress, maintaining gains, or addressing deterioration is summarized. Here again, the key is to provide concrete and specific actions that will be taken by the person, provider, or both. In the case of the depressed person whose ORS scores were worse than in the prior visit, the therapist might write, "An appointment will be made with the (physician, psychologist, nutritionist, etc.) to evaluate for potential (physical illness,

Appendix E (continued)

medications, psychological assessment, etc.)." Should progress have been made, the therapist would detail what the person in care will do between visits to maintain or consolidate changes and avoid setbacks.

In the box on the left, indicate whether the SRS was administered at the end of the visit. In the box to the right, indicate whether the total score was above or below 36 and if the score increased, decreased, or was the same as compared to the prior measurement:

SRS Administered: Yes No	Above 36 Below 36 Increasing Same Decreasing

Tracking the status of the relationship between the provider and recipient of treatment services is a critical component of feedback-informed treatment. As a result, the SRS must be administered at the end of each and every session or "unit of service." The helping professional must also determine whether or not the scores on the SRS indicate a problem exists in the relationship. Scores below 36 should always be discussed as well as scores that have decreased (even by a single point) as compared to the prior measurement. As a result, the provider should also:

Indicate whether scores below 36 or those which have decreased (even by a single point) as compared to the prior measurement were addressed directly prior to ending the session:

SRS Addressed directly: Yes No

Once completed, the FIT Progress Note is signed by both the service provider and person seeking treatment:

Clinician signature:	Consumer signature:

Appendix F

Sample Training Plan

Training Supervisors

Basic training for supervisors should include not only the content but also opportunities to practice FIT skills through demonstration and role-playing. Following the basic training, supervisors should, whenever possible, integrate FIT practice into their work. If supervisors do not provide direct service to clients this can present a challenge to developing the necessary level of understanding and skill for them to obtain the confidence and competence they will need with FIT for supervision of clinicians in FIT practice. In this case, agencies may need to identify interested clinicians and train them as "champions" who can mentor their colleagues.

A basic FIT training covers the following material:

- Rationale for measuring outcome and alliance
- Key research underpinnings of FIT
- The psychometrics of the Outcome Rating Scale (ORS) and Session Rating Scale (SRS)
- Administration and scoring of the ORS and SRS
- How to track ORS and SRS scores
- How to use the measures to inform practice and collaborative planning
- Using outcome and alliance data for continual professional improvement
- Special applications of ORS and SRS including different treatment modalities and settings (covered in Manual 5)

Following their basic training, regular coaching should be provided to supervisors. A one-day training is not sufficient to develop mastery in FIT practice. It is through the process of integrating FIT into practice that questions and challenges emerge. Coaching can assist clinicians through this awkward phase of integrating FIT into practice. Group consultation/coaching sessions are particularly helpful in this phase. Sharing successes and challenges provides a Community of Practice and opportunities for learning from one another. If a pilot project was undertaken, participants of the pilot can play a valuable role in these follow-up "booster" sessions by sharing what they have learned during the pilot.

Appendix F (continued)

Example

Following a one-day training, the trainers set up biweekly consultation sessions with the participants. They invite peer champions who participated in the pilot of FIT to participate in the meeting. At the first session only one of the participants had tried to use the measures with their clients. None of the others had tried it. The trainer asks about what got in the way of the other participants using the measures. A few of the participants mentioned that they had forgotten as this was not their usual practice. The peer champion tells them that when he started he forgot too but what helped him remember to administer the measures was to attach the ORS and SRS to the clients' charts. Another participant admitted that he was hesitant to administer the measures to his clients because he was afraid of the feedback his clients might have and how he would be able to handle it if the feedback on the SRS was negative. The peer champion validates the participant's experience sharing that he too had had similar fears in the beginning but he decided it was not about his feelings but whether the treatment was the right fit for his client. Once he tried it, he was surprised at how generous the clients were with their feedback. He added that what really convinced him that it was important to administer the measures was when he thought he had had a great session with a client but to his surprise, when he administered the SRS the score was really low. He realized he would have never picked up the issues the client was having with the alliance had he not administered the measures. The peer champion's willingness to share about this less than successful session gave permission to the other participants to try using the measures and showed them it is okay to make mistakes and learn from them.

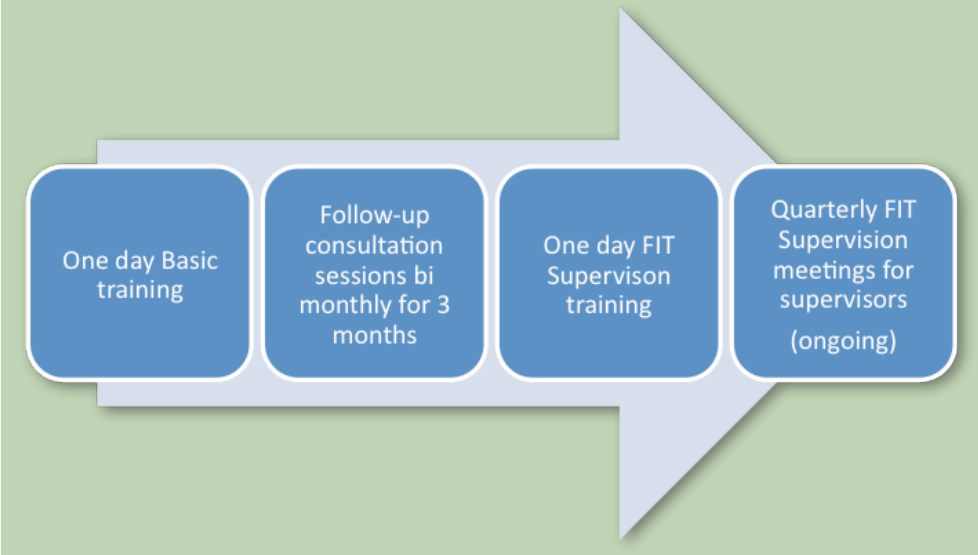
Following the basic training and a period of practice and consultation (3-6 months is suggested), supervisors should then be additionally trained in the principles and practices unique to FIT supervision including:

- Key tasks for FIT supervisors
- Practical applications of FIT practice in supervision:
  * How FIT supervisors integrate client outcome and alliance feedback into supervision
  * How FIT supervisors ensure client preferences are elicited and addressed
  * How FIT supervisors can integrate aggregate outcome statistics into supervision

Appendix F (continued)

- Identifying and addressing obstacles to clinician implementation
- Reviewing cases at risk of null or negative outcome with clinicians
- Reviewing successful cases with clinicians
- Using FIT to assist clinicians in striving to improve outcomes and achieve clinical excellence

It is important to provide ongoing opportunities for supervisors to obtain support and consultation following their training and as they embark on the task of supervising clinicians in FIT supervision. For example, FIT supervision can be made a standing item at supervisor meetings or regular FIT supervision consultation meetings can be held.



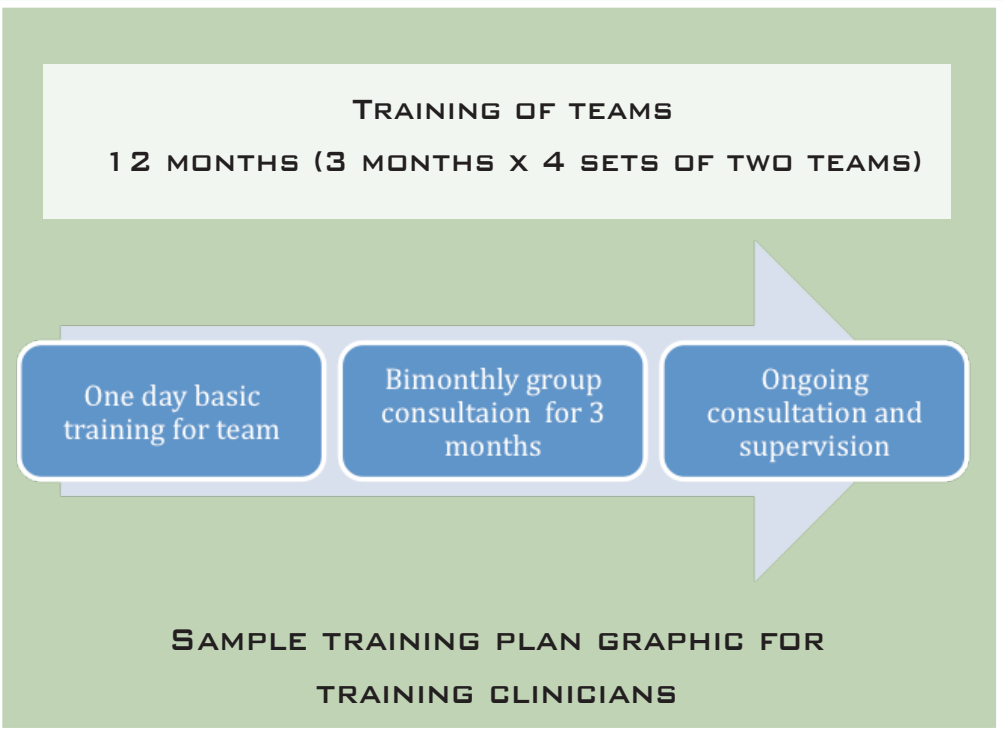
Sample training plan graphic for training supervisors

Appendix F (continued)

Training Clinicians

After supervisors are trained in FIT practices and FIT supervision, clinicians can be given the same basic FIT training and follow-up consultation or "booster" sessions that their supervisors went through (see above). As a show of support and to provide supervisors with an awareness of any issues clinicians may have as they are introduced to FIT, it is recommended that supervisors attend the basic training and follow-up consultation sessions with the clinicians that they supervise.

In large agencies, it is recommended that training and integration of FIT be done in waves so that one or two teams are trained and assisted with integration via consultation meetings of clinicians. It is best that clinicians integrate FIT into their practice immediately following their training so that their knowledge and skills are not lost.



Sample training plan graphic for training clinicians

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