

NIATx Workshop

***Lynn Madden, PhD, MPA
Assistant Professor, Yale University School of Medicine
CEO, APT Foundation, Inc.***

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Summer Bootcamp in Implementation Science and Biostatistics
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Introduction to NIATx

- A deep dive in the principles of NIATX
- Discussion and practice with NIATX tools and exercises
- Starting change teams and change projects
- Specific discussion of coaching and coaching strategies
- Recognizing and managing resistance



NIATX WAS ORIGINALLY A PARTNERSHIP OF TWO GRANT PROGRAMS IN 2003

SAMHSA/CSAT

Strengthening Treatment Access and Retention

The Robert Wood Johnson Foundation

Paths to Recovery

It has since been deployed extensively in the **US**, across many areas of healthcare and in the carceral system.

International deployment includes extensive work in Ukraine, Tajikistan, Kazakhstan, Kyrgyzstan and more recently developed work in Peru, Moldova and Georgia.



NIATx Settings

NIATx has been **deployed extensively in the US**, across many areas of healthcare and more recently in carceral settings and in integrated care.

*NIATx is in the evaluation phase of a JCOIN study in which 55 jails in the US were recruited regarding efforts to increase Medications for Opioid Use Disorder.

*A NIDA funded grant in West Virginia aimed at scaling up and integrating care for OUD, HIV and HCV in 20 primary care settings. (Altice, Madden, Feinberg, MPIs)



NIATx as an Evidence-based Practice

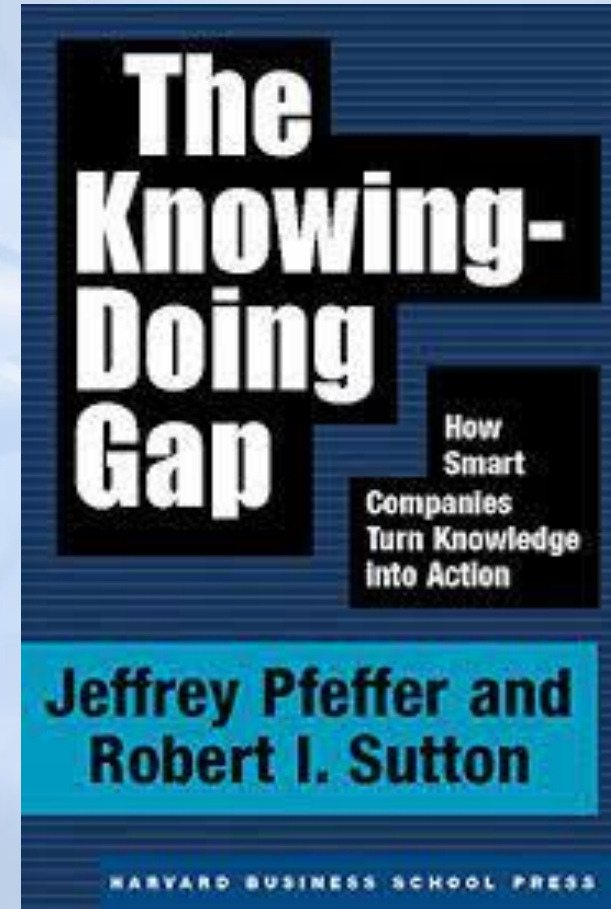
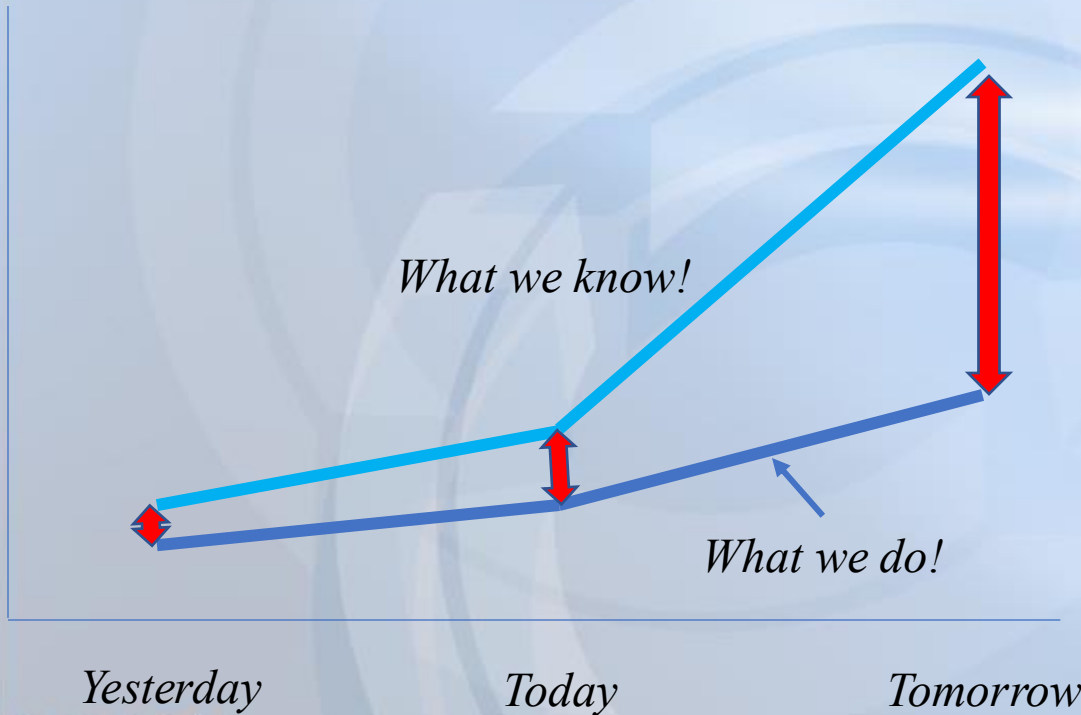
The NIATx Model was originally developed as a demonstration project supported by the Robert Wood Johnson Foundation (RWJF) and the US Substance Abuse and Mental Health Administration (SAMHSA). The seminal article that emerged from this demonstration pilot was authored by McCarty et al., (2007), and described the impact of the NIATx model on access and retention in addiction treatment settings.

Since then, more than 60 peer-reviewed publications support the effectiveness of the NIATx model. The model has expanded to include use in adopting evidence-based practices and in mental health, child welfare, criminal justice, gerontology, integrated care, mobile technologies and other human service settings.

<https://niatx.wisc.edu/niatx-as-an-evidence-based-practice/>



WHY NIATx? -- The Know-Do Gap



Crossing the Quality Chasm

Focuses on closing the gap between what we know to be good health care and the health care that people actually receive.

(2001). Crossing the quality chasm: a new health system for the 21st century. Washington, D.C.: National Academy Press



In response - Social Psychology and Engineering team up

- NIATx tools were developed by engineers and social scientists (primarily psychologists and public policy experts) and clinical practitioners attempting to mediate clinical/organizational process to short circuit the dreaded 17-year evidence to practice gap.
- David Gustafson, PhD, Professor Emeritus, University of Wisconsin, Madison is the key architect. He also is the founder of CHESS – the Center for Health Enhancement Systems Studies at UW.



Based on the Principles of Adult Learning

- 1. Need to know (purpose/relevance)
- 2. Self –concept or Autonomy
- 3. Prior experience
- 4. Readiness to Learn
- 5. Orientation to Learning (problem centered and goal oriented)
Experiential or “hands on”
- 6. Motivation to Learn



What could go right today?



A Systems Thinking Orientation

Starting Assumptions

- Everyone is acting as they should, given the system they are in.
- Your current system is perfectly designed to produce the results it is currently producing.
 - *To produce different results you must change the system. (THE PROCESSES)*
- We all contribute to the system that we are a part of, both positively and negatively.

W. Edwards Deming



- NIATx Tools and Coaching along with Learning Collaboratives move teams toward the AIM that is...

EXPECTED
SUPPORTED
REWARDED

Key concept - Co-production of knowledge

- Principles of Knowledge that is developed by change teams and coaches
 - Context based
 - Pluralistic
 - Goal orientated
 - Interactive
 - Four elements of working with co-production approach
 - Equality
 - Diversity
 - Accessibility
 - Reciprocity
- (Albert Norstrom, et al. Nature Sustainability, 2020)

NIATx is primarily focused on process or DOING implementation

- Actions that encourage people/organizations/systems to adopt evidenced based practices are **implementation strategies**. NIATx is a bundle of implementation strategies that encompasses AND operationalizes both site specific pre-implementation and implementation of an evidenced based practice.
- Key to the NIATx approach is an understanding that implementation and especially the scale up of EBPs is generally undertaken by non-academics/non-scientists who need methods to evaluate their efforts to scale up/implement in real time. Allows their learning to improve process in an iterative way

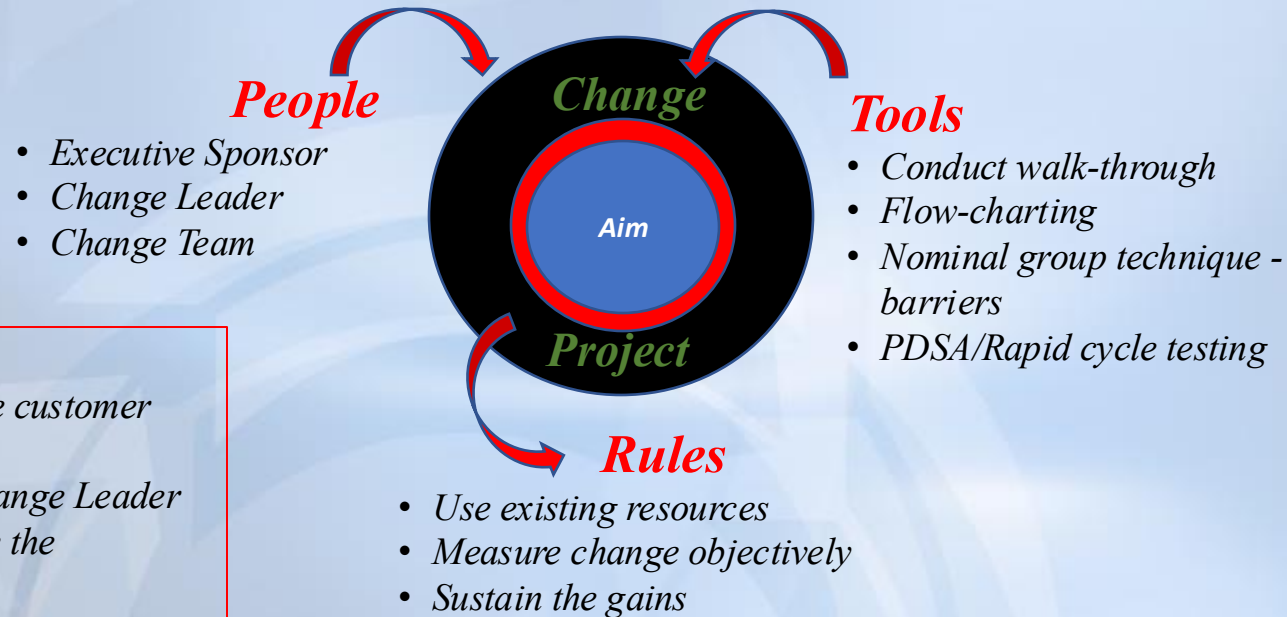


Why A Process Model?

- Customers are served by processes.
- 85% of customer related *problems* are caused by organizational processes.
- To better serve customers, organizations must improve processes.
- THE MODEL ASSUMES GOOD INTENTIONS



The NIATx Model



Five Principles

- Understand/Involve the customer
- Fix Key Problems
- Choose a Powerful Change Leader
- Get Ideas from Outside the Organization
- Use Rapid-Cycle Testing

When AIM setting, build urgency! Why is this important?

People with OUD have a number of medical and psychiatric co-morbidities and are often disenfranchised from care for HIV, HCV, depression track with OUD

When treated in specialty treatment centers, they are significantly more likely to die 10-20 years earlier than those without OUD – PRIMARILY from chronic medical conditions (e.g., hypertension, cardiovascular disease, etc.)

Treating patients for OUD, another chronic, relapsing condition, provides an opportunity to better engage patients in all aspects of medical care. MOUD is EBP for OUD

Five Key Principles

Evidence-based predictors of change

- 1) Understand and involve the customer
- 2) Focus on key problems
- 3) Select the right change agent
- 4) Seek ideas from outside the field and organization
- 5) Do rapid-cycle testing



Conducting a Rapid Cycle Change Exercise

PDSA cycles

Plan the change

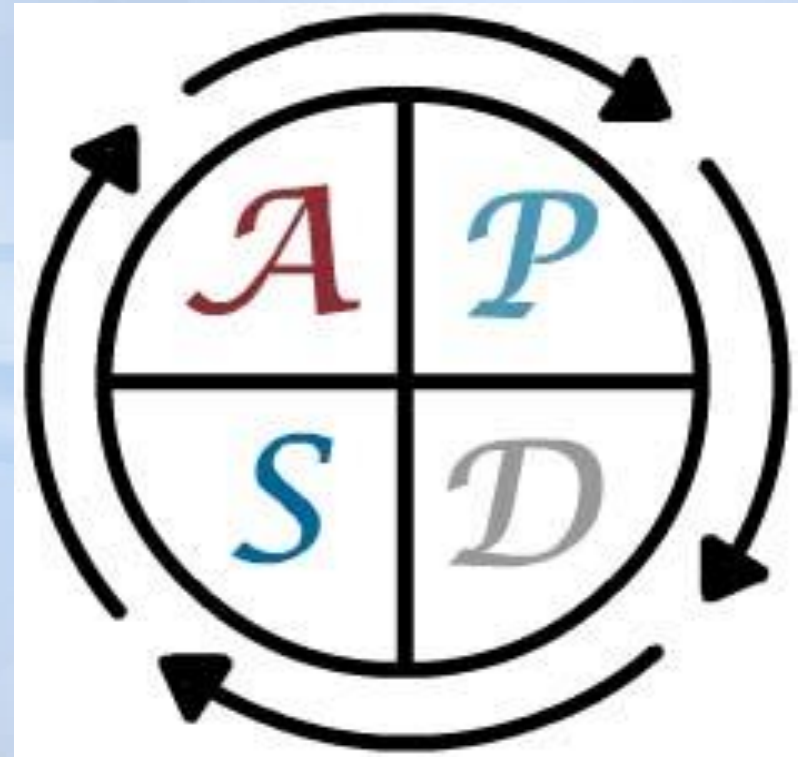
Do the plan

Study the results

Act on the new knowledge

Rapid cycle changes

Changes should be doable in
2 -4 weeks



PDSA Steps Explained

Plan¹

- Plan a change or test, aimed at improvement
- Include how you will collect data
- What is your prediction for the test?

Do

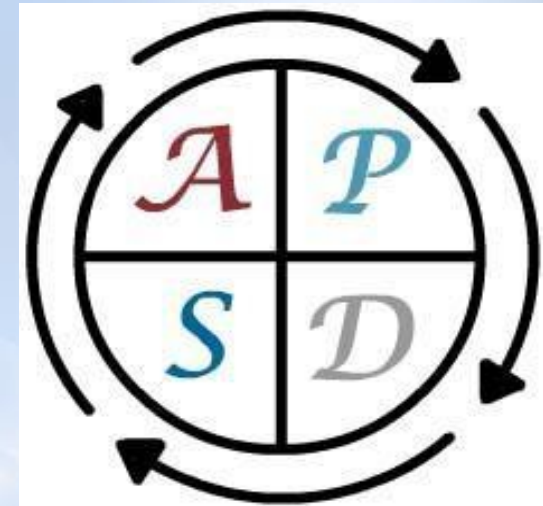
- Carry out the change or test, preferably on a small scale
- Document your observations
- Record data

Study

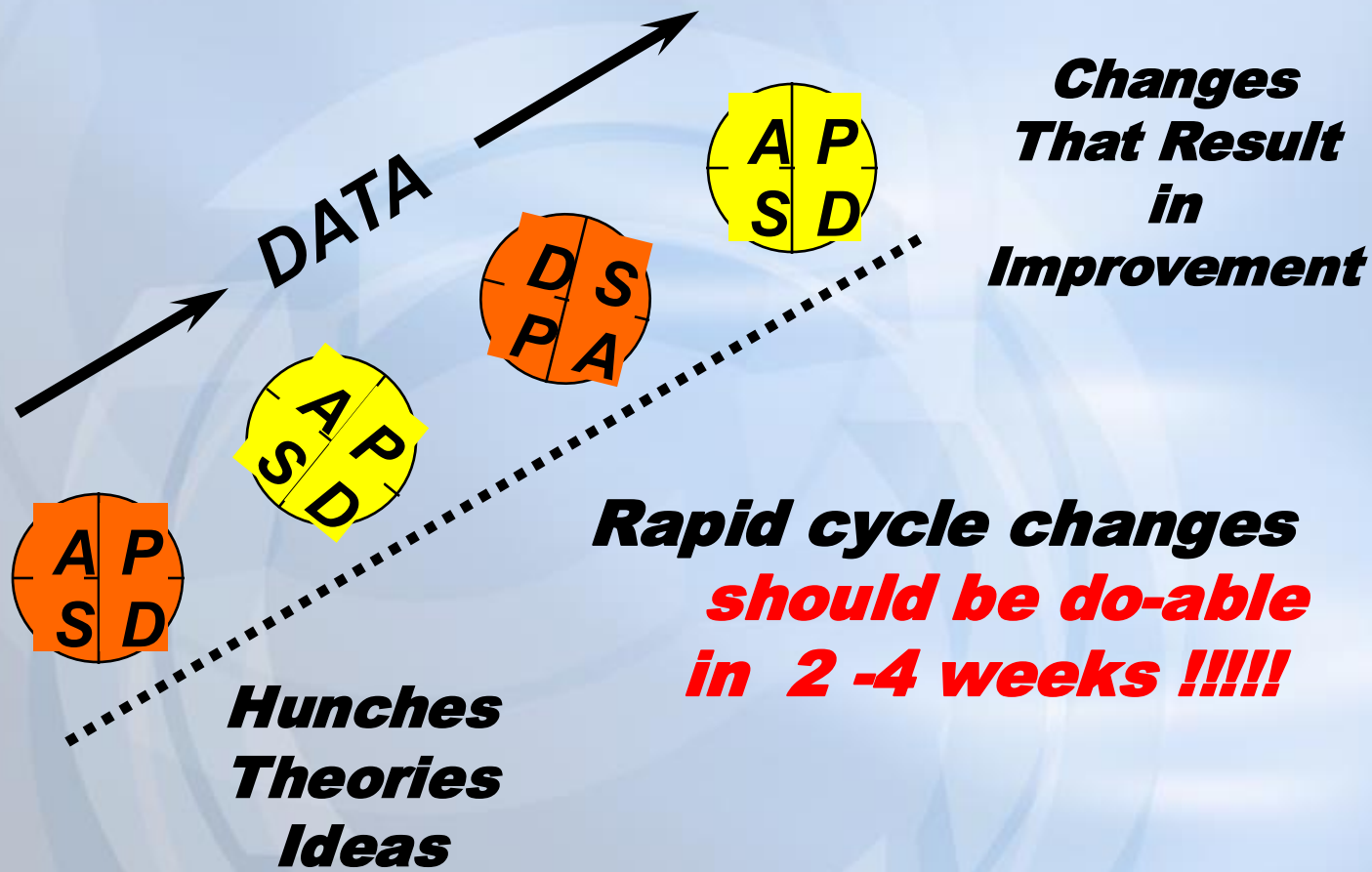
- Study the results. Was your prediction correct?
- What worked and what went wrong
- Summarize what was learned

Act

- Adopt change (or) abandon change (or) adapt change and run another cycle
- Move on to next cycle



Change Cycles PDSA - Sustain



Essential Learning Collaborative Components

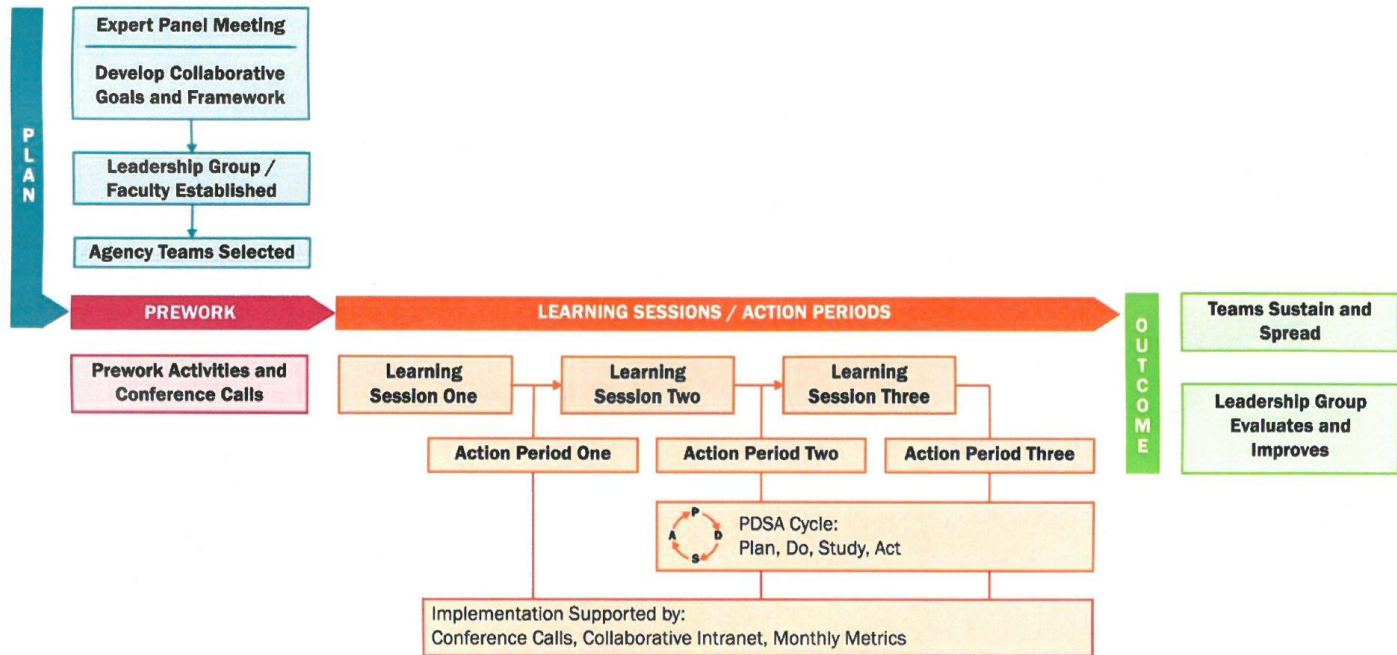
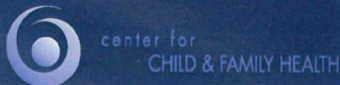


Figure adapted from Institute for Healthcare Improvement (IHI), 2003

Markiewicz, J., 08



NCCTS



Institute for Healthcare Improvement (IHI), 2003



www.NIATx.net

Reduce Waiting & No-Shows • Increase Admissions & Continuation

Measuring Process - Four 'simple' NIATx AIMS

- Reduce Waiting Time
- Reduce No-Shows
- Increase Continuation
- Increase Admissions



NIATx Toolkit

- **AIM setting and Coaching/Facilitation**
- Change teams – Executive Sponsor, Change Leader, Data manager. Change teams are ‘coached’, generally externally at first
- Rapid Cycle PDSAs (all data is useful. Fail fast) A change must be doable in a 2 – 4 weeks.

PDSAs are guided by the following facilitated tools:

- the Walk Through
- Nominal Group Technique
- Flowcharting
- The development of SMART goals (Specific, Measurable, Attainable, Relevant, and Time bound) and simple pre-post metrics



Understanding the Context and Collecting Local Baseline Data

- Flowcharting
- Nominal Group Technique
- Walk Through
- Patient level data (cascades, census, waiting time, lab results)
- SMART goal setting

One of the benefits of NIATx is that it is a way to involve staff, improve morale, and move toward creating new opportunities.

NIATx sees change as a regular and ongoing element of our work. How do you determine what to change?

How do you find new ideas? And generate baseline data?

One important way is found in the **Nominal Group Technique**

Delbecq, A. L., Van de Ven, A. H., & Gustafson, D. H. (1975).
Group techniques for program planning



Identifying Barriers and Facilitators and change ideas Using NGT

- **Nominal Group Technique (NGT)** is a structured facilitation tool to help the change team brainstorm a list of ideas/changes and reach a consensus on what change to test first. Mixed methods approach.
- **Benefits**
 - Promotes group participation in the decision-making process.
 - Engages both extroverted and introverted team members.
 - Uses priorities of each team member to discover the overall priorities of the group.
- **Time**
 - An NGT Exercise can be completed as quick as 15-20 mins.
- ***In our time together, you will have the opportunity to conduct a NGT exercise.***



Steps in conducting an NGT

STEP 1: Silent idea generation

STEP 2: Round-robin recording of ideas

STEP 3: Serial discussion of ideas

STEP 4: Final voting





Conducting a Walk-through

- Play the role of a client and a client's family member or friend seeking treatment at your agency. Create a legitimate scenario. If it is walk-through at your own organization, it is not a secret.
- Try to think and feel as the client/family member would, and think about what they would want changed.
- Ask staff what changes would make the process better for clients and for staff.
- Compile a list of client and staff needs and possible improvements that could address these needs.

Walk Through Exercise



After the walk through

- What surprised you the most during your walk-through?
- What two things that you observed during the walk through would you change?



Why Flowchart?

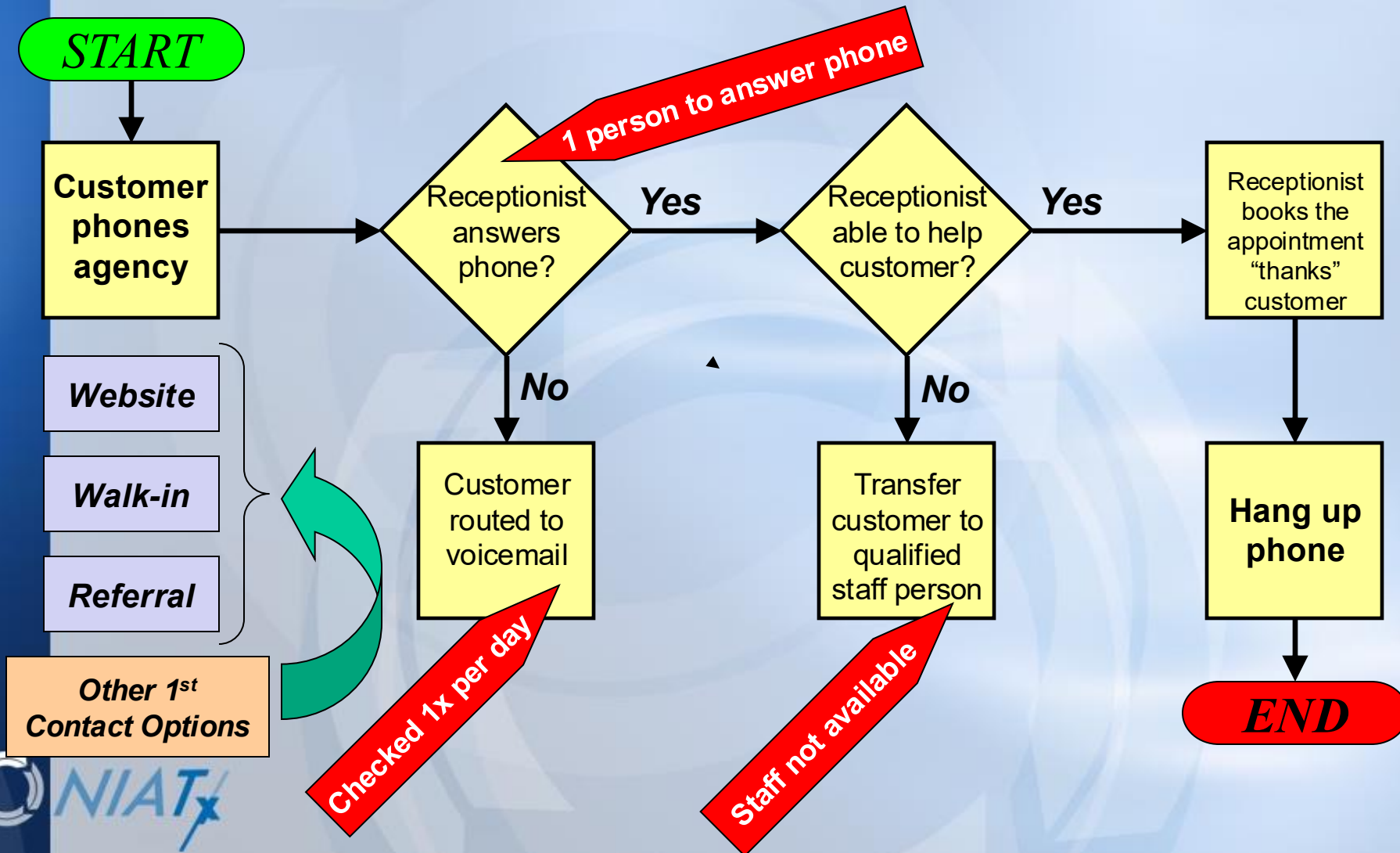
Flowcharting is useful for:

1. Providing a starting point to understand the process as it is today.
2. Identifying key problems/bottlenecks
3. Showing where to test ideas for most impact
4. Adding interactivity - gets the team together
5. Creating a simple & succinct visual process overview- enhances adult learning



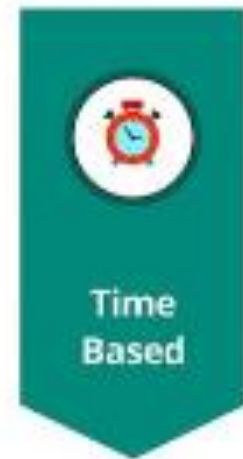
Sample Flowchart

Process name: *Customer 1st Contact (phone call) to Agency Response*



Developing SMART Goals

SMART



NIATx™

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Reduce Waiting Times & No-shows • Increase Admissions & Continuation

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NIATx – Breakthrough Innovations

- AIM Setting – issues are complex, but can be approached by evidenced based AIM setting.
- Rapid Cycle Change – appeals to both logic and emotion.
- Implementation is guided with simple approaches that emphasize coaching and relationship building. Teams gain implementation/performance improvement capacity and ownership of solutions.
- The Walk-through – an opening experience.
- Business case and/ or clinical outcome – change is tied to strategic advantage – right now. The advantage is tied to population level health outcomes AND ultimately to the organization/field.



Starting a Change Project

- Set the AIM and select a change team – name a change leader, an executive sponsor, and data person.
- Conduct a walk-through. (local context)
- Collect baseline data. (Nominal Group Technique, Flowcharting, local data)
- Review baseline data and walk-through.
- Suggest a process change that might move toward the desired aim.

NIATX strategies in Implementation

Start by asking five questions:

1. What's it like to be an individual in our care?
2. What are we trying to accomplish?
3. How will we know if a change is an improvement?
4. What changes can we test that may result in an improvement?
5. How can we sustain the improvement?



CASE EXAMPLES



Promising Practices



Rhode Island Department of Corrections



Small sequential changes, big impact

Rhode Island Department of Corrections

- Change #1 Continuing all persons entering incarceration on their existing MOUD
- Change #2 Screening ALL others for OUD (SISQ – Wakeman)
- Change #3 offering all who screened positive induction to MOUD as indicated.
- Change #4 active discharge planning with community agencies that included introductions prior to release

- Outcome: reduced post incarceration overdose death in Rhode Island by **63% in one year.**
- Initial evaluations that included explicit questions regarding OUD and warm hand-offs post incarceration were key components in this approach – **“promising practices”**



Moldova - Probation



Overview of Activities Done in Probation

March – June 2025

- Implementation of monthly coaching sessions with territorial teams.
- Strengthening inter-institutional collaboration (with police, local public authorities, NGOs).
- Introduction of screening for opioid drug use upon entering probation.
- Focus on individualizing interventions and early identification of beneficiaries' vulnerabilities.
- Increased internal awareness regarding inclusive approaches.

Examples of Change Activities in Probation

March – June 2025

- Asking every new person about opioid drug use.
- Repeating the question at each monitoring visit, especially for those with drug-related offenses.
- Extending the duration of counseling sessions and providing informative sessions on drugs/addiction/therapies (emphasis on methadone/buprenorphine therapy).
- Collaboration agreements and signed contracts with NGOs and the narcological office.
- Referrals to the narcologist.
- Referrals to NGOs for services.
- Qualitative data (from coaching) shows progress.

Activities Completed for Each Probation Office (March – June 2025)

Location	New Entries to Probation	Number Released	Number Screened	Screened Positive	Linked to Treatment
Chisinau	190	149	149	20	0
Balti	105	139	106	2	0
Cahul	120	122	102	0	0
Orhei	122	149	111	2	1
Ungheni	113	74	105	3	1
Comrat (Gagauzia)	40	31	40	1	0
Calarasi	83	92	89	3	0
Anenii Noi	21	31	26	0	0
Edinet	6	3	22	2	1
Falesti	92	106	120	6	0
Total	913	893	899 (100%)	34 (3,7%)	3 (8,8%)

Moldova - Prisons



Activities in Prisons (March – June 2025)

- Monthly coaching sessions with territorial teams.
- Strengthening inter-institutional collaboration (with police, local public authorities, NGOs).
- Introduction of single-item opioid drug use screening upon entry.
- Focus on tailoring interventions and early identification.
- Increased internal awareness regarding inclusive approaches.
- Active participation of teams in thematic training (diversity, human rights, reintegration).
- Initiation of collaborations with local NGOs for post-detention assistance.
- Absence of standardized procedures for case management.

Overview of Activities in Prison (March – June 2025)

- Active participation of teams in thematic training (diversity, human rights, reintegration).
- Initiation of collaborations with local NGOs for post-detention assistance.
- Screen for opioid use for every new entrant.
- Repetition of the opioid use question, especially for those with drug-related offenses.
- Qualitative data (from coaching) shows progress (increase in the number of people included in treatment in some institutions).

Activities Completed in Prison (March – June 2025)

Location	Number Entered	Number Released	Number Screened	Number Screened (+)	Number Started on Treatment
Leova nr. 3	47	N/D	33	5	0
Cricova nr. 4	220	N/D	569	443	22
Cahul nr. 5	136	N/D	94	11	0
Soroca nr. 6	170	N/D	141	97	3
Rusca nr. 7	18	N/D	47	4	1
Pruncul nr. 9	39	N/D	59	12	0
Balti nr. 11	349	N/D	349	140	6
Chisinau nr. 13	730	N/D	308	132	13
Cricova nr. 15	10	N/D	211	106	1
Pruncul nr. 16	490	N/D	264	40	4
Rezina nr. 17	58	N/D	131	118	2
Branesti nr. 18	81	N/D	501	162	6
Total	2344	N/D	2755 (100%)	1274 (46,2%)	61 (4,8%)

APT Foundation

Yale SCHOOL OF MEDICINE



AIM: Reducing wait time – a known barrier to treatment access

- APT Foundation, an organization that serves persons with substance use disorders and mental health needs wanted to improve both access to care and retention in care as the first steps in improving both clinical and financial performance. Benefits to the person, public health and the organization.
- Wait time is endorsed as the key reason that people don't enter SUD treatment. (Andrews, Molfenter) INITIAL WAIT TIME to TREATMENT WAS OVER THREE WEEKS.



AIM: Reducing wait time – a known barrier to treatment access

- Methods proven to increase access to treatment are informed by identifying and eliminating the barriers that prevent people from readily accessing services. This is true across all health services.
- Retention is improved by shifting programs in ways that reduce program level demand on patients. People/patients come back if the program is engaging to them and includes evidenced based care. Both aims are achieved by making changes based on consumer feedback – gained through organization level data.



A series of process level changes were introduced over a two-year period

- A change team was formed
- Walk throughs were conducted
- NGTs were performed with ALL staff
- Initial changes included both sequencing admission process steps and task shifting (promising practices)

• (Madden, Farnum, et al. *Addiction*. 2018)



Table 1. Summary of phase 1 change projects to improve wait time and access.¹

Identified Barriers	Change Project to Address Barriers
<ul style="list-style-type: none"> Admission occurred only after results from purified protein derivative (PPD) for tuberculosis were read. 	<ul style="list-style-type: none"> PPD was placed (but not read) before admission since positive findings are not a contraindication for beginning methadone maintenance
<ul style="list-style-type: none"> Patients required to provide documentation or contact information to verify addiction history and/or treatment failure. Information had to be received in writing prior to admission 	<ul style="list-style-type: none"> Modified requirement for external documentation of addiction history
<ul style="list-style-type: none"> Patients required to pay back balances and upfront fees to cover administrative costs, physical exam (PE), and tapering (in case of discontinuation of methadone maintenance) 	<ul style="list-style-type: none"> Discontinued back-balance payment requirement and upfront administrative, PE, and tapering fees
<ul style="list-style-type: none"> Patients admitted only if self-pay or with insurance coverage 	<ul style="list-style-type: none"> Eligible patients admitted irrespective of insurance coverage or ability to self-pay. Following admission, patients without insurance were assisted in procuring it (e.g. Medicaid, etc.)

¹Phase 1 barriers to wait time (interval between first face-to-face appointment and first dose of methadone) and access were identified following an initial walk-through of extant intake procedures.

Table 2. Summary of phase 2 change projects to reduce potential barriers to treatment access or retention.¹

Identified Barriers	Change Projects to Address Barriers
<p>Long wait time:</p> <ul style="list-style-type: none"> Admission process divided into screening, intake, physical exam (PE) and methadone initiation--all conducted on different days by appointment Full physical exam needed prior to admission 	<ul style="list-style-type: none"> Regularly scheduled walk-in screening, intake, medical screening, and methadone initiation available on same day Medical screening for contraindications conducted prior to admission; PE performed on walk-in basis after admission
<p>Counseling:</p> <ul style="list-style-type: none"> Patients were assigned a counselor whom they met with one-on-one by appointment only and sometimes assigned to a scheduled treatment group 	<ul style="list-style-type: none"> Primary mode of counseling changed to “drop-in” groups; walk-in individual counseling available on request or as-needed
<p>Methadone dosing:</p> <ul style="list-style-type: none"> Non-standardized dosing protocol Sub-therapeutic maintenance dosing 	<ul style="list-style-type: none"> Standardized dosing protocol implemented Therapeutic maintenance target dose within a maximum of 30 days (i.e., ≥ 90 mg daily)

¹Phase 2 barriers to access, retention, and capacity were identified by change team members.

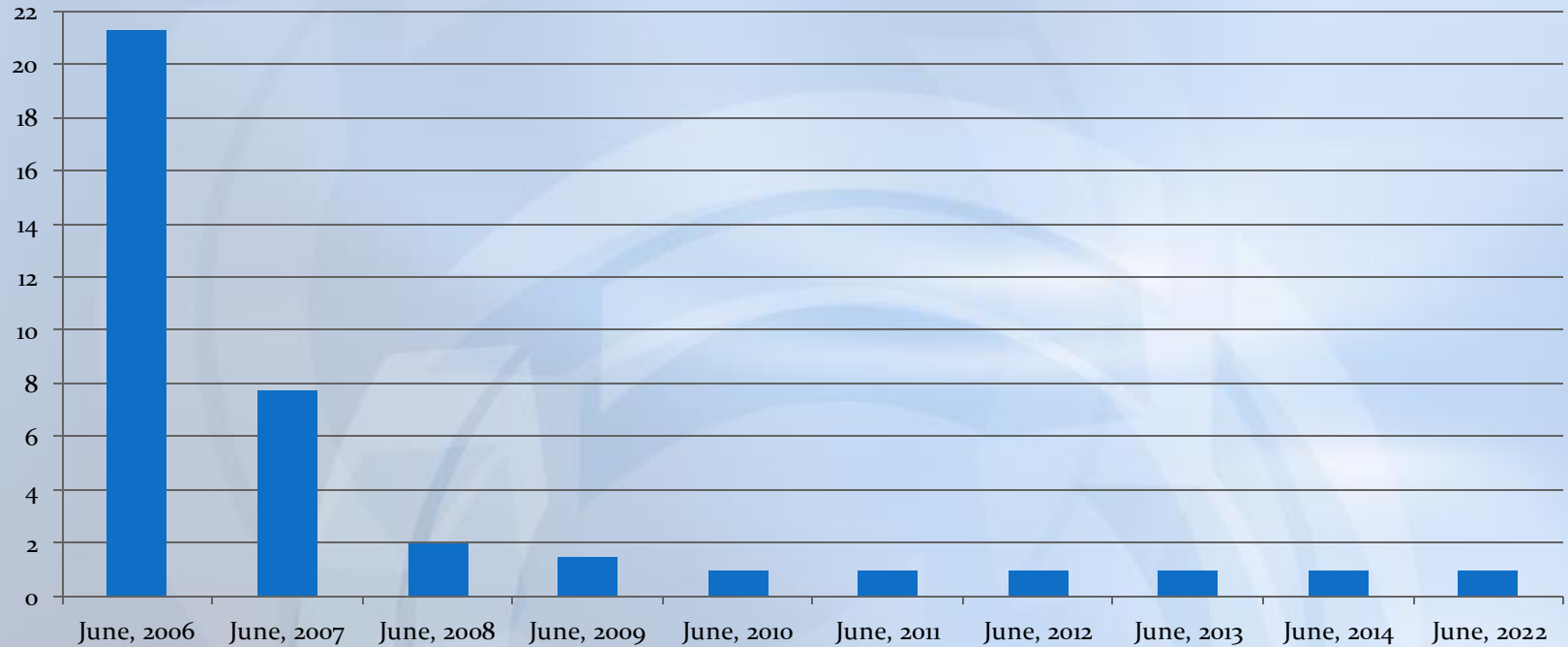


Table 2. Summary of phase 2 change projects to reduce potential barriers to treatment access or retention.¹

Identified Barriers	Change Projects to Address Barriers
<p>Take-home methadone doses:</p> <ul style="list-style-type: none"> • Eligible patients not receiving take-home medication • Reliance on patient request 	<ul style="list-style-type: none"> • Routine review of patients' take-home dose eligibility performed by clinical teams • Eligible patients were contacted to review criteria and complete relevant paperwork
<p>Administrative discharge criteria:</p> <ul style="list-style-type: none"> • Inability to pay for services • Ongoing substance use • Behaviors deemed "inappropriate" by providers such as arguments or non-attendance • No standardized protocol 	<ul style="list-style-type: none"> • Inability to pay no longer a criterion for discharge • Ongoing substance use (unless unsafe) no longer a discharge criterion • Inappropriate behaviors (unless a risk to patient or staff safety) no longer a discharge criterion • Patients discharged only after review by clinical team and approval of chief executive officer confirming safety risk or absence of treatment efficacy

¹Phase 2 barriers to access, retention, and capacity were identified by change team members.

Waiting Days to Admission



CENSUS

MMT Services

Census: Methadone Services



Was rapid access working? Some staff were skeptical

Behavior and Symptom Identification Scale (BASIS-24

Copyright; Eisen, et al 2004, 2006)

- Brief, efficient client-centered self-report of symptoms and problems with web-scoring and benchmarking
- Inform and monitor the impact of client-treatment and program-improvement changes
- Domains: 1) Depression/Functioning;
2) Relationships;
3) Self-Harm;
4) Emotional Lability;
5) Psychosis;
6) Substance Abuse;
7) Total Score

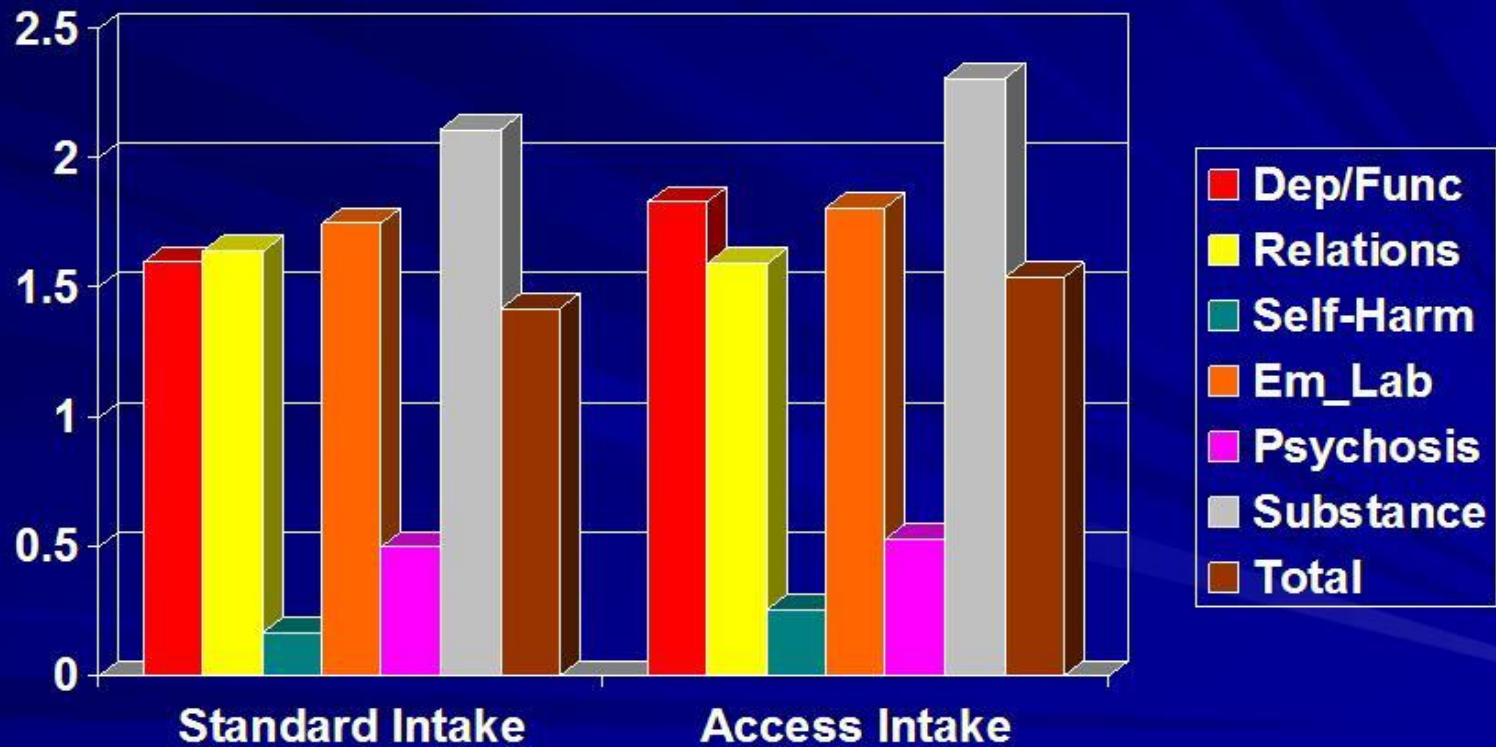


PARTICIPANT CHARACTERISTICS

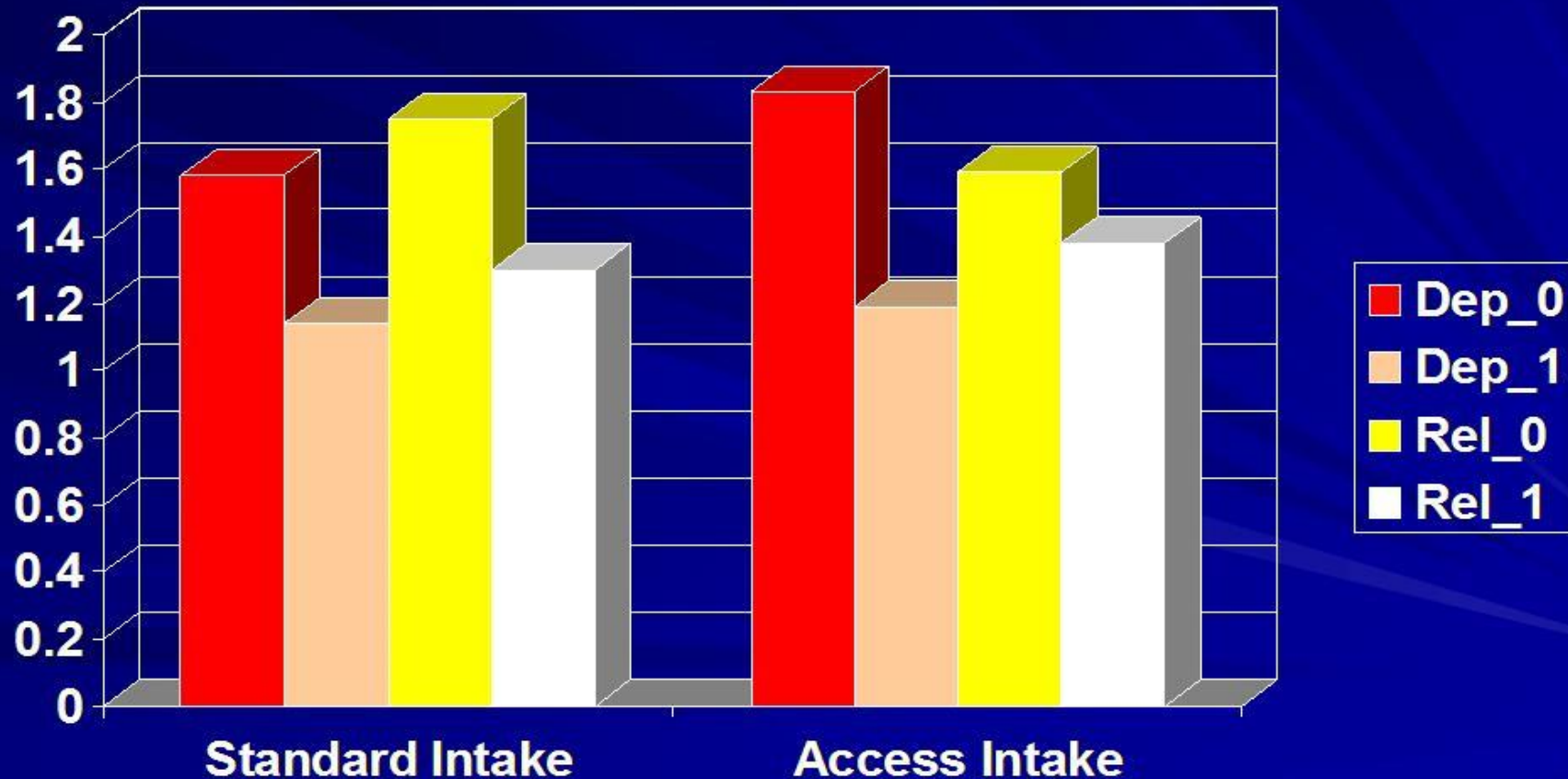
Age	34.08 (10.53) Years (range 16-66)
Education	74% High School graduates
Employment	30% FT or PT
Gender	63% Men; 37% Women
Ethnicity/Race	67% European American 15% African American 14% Hispanic American 4% Other/Multi-ethnic
Marital	12% Married, 65% Single, 23% s/w/d



BASIS-24 Subscale Differences with Changes in Intake Procedures



Depression and Relationship Problems over Time Across Intake Procedures



BASIS-24 Differences and Intake Changes

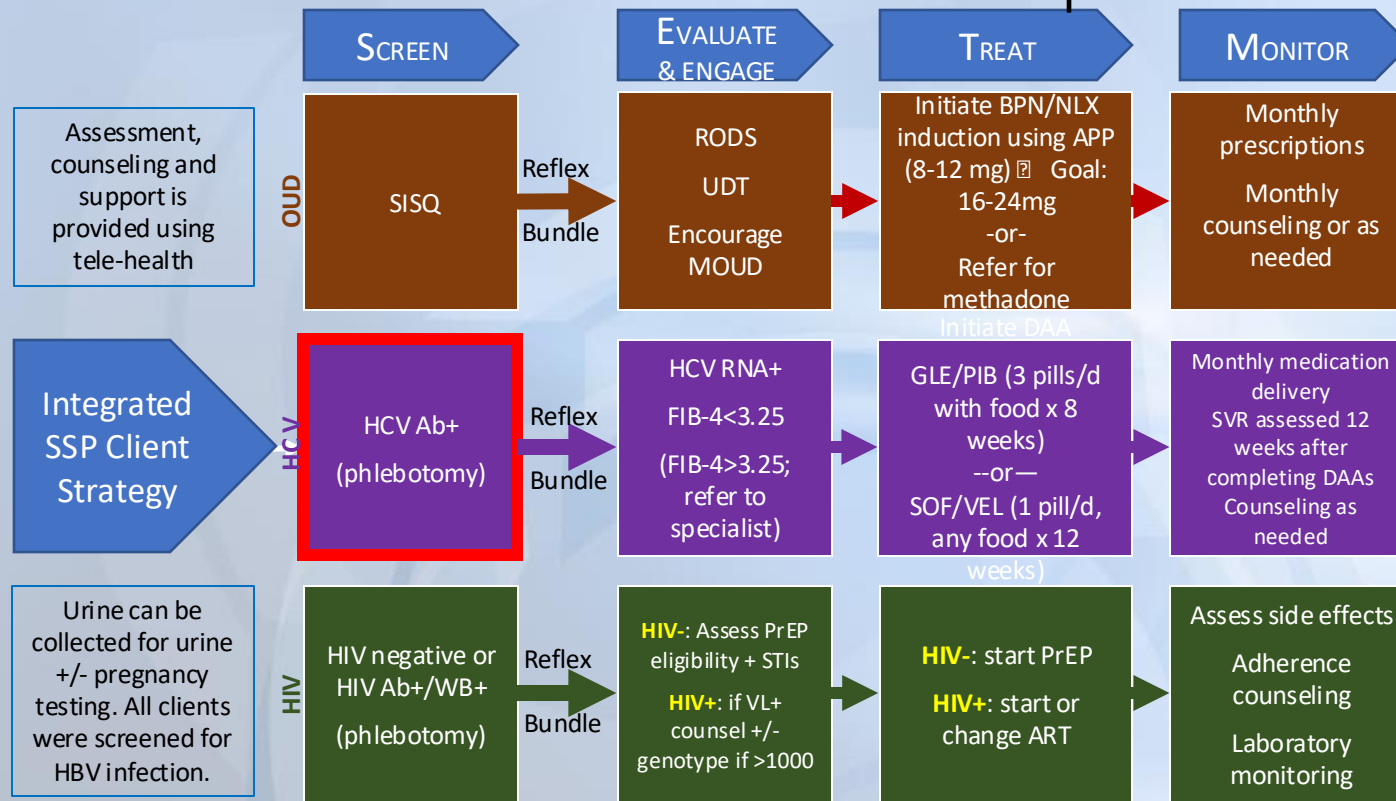
- Change to Open Access Intake related to higher severity of Total score, $t(2519)=3.4$, $p<.001$, and Depression/Functioning ($t=4.5$), Self-Harm ($t=3.7$), and Substance Abuse ($t=3.6$) than Standard Intake
- Significant reduction in severity from admission to midpoint assessment for Total score, $F(1,721)=191.6$, $p<.0001$, and all 6 BASIS-24 subscales
- Open Access Intake had higher admission Depression scores than Standard Intake, but no differences at midpoint assessment, $F(1,730)=5.9$, $p<.015$
- Standard Intake had higher admission Relationship scores than open Access Intake, but no differences at midpoint assessment, $F(1,730)=5.7$, $p<.008$

Good for clients/Good for APT/ Good for community

- As time to treatment declined more clients entered treatment. Barriers to access were systematically addressed and ultimately included 'bundling' all services needed for admission and diagnosis on the same visit. We did more than ten change cycles to move toward our aim.
- Though those who entered more quickly were more acutely ill, they gained as much improvement as their less acute peers. In other words, more people got more better as APT improved access.
- As the census grew, APT reduced its reliance on grant dollars from 53.4% to 22% and achieved an increasingly positive margin which supports patient care and is shared with staff. Today that number is less than 5%.

Differentiated Care Model – Focus on HCV

Screen – Evaluate – Treat with NO In-person Visits



Sivakumar A, UDP, 2022



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Reduce Waiting & No-Shows • Increase Admissions & Continuation

Differentiated Care Outcomes

66 underwent laboratory testing (the only in-person visit)

Outreach workers managed most of the communication with patients using texting or calls

HCV outcomes

- 35 had **chronic HCV** and 31 started pan-genotypic DAA treatment (2 lost and 2 incarcerated)
- 12 were unstably housed and 8 used stimulants
- Implementation: timing from first tele-health visit
 - Phlebotomy: 6.9 days
 - DAA initiation: 9.9 days
- Efficacy outcomes: 29 of 31 (**93.5%**) achieved SVR

MOUD outcomes [?] 26 of 31 (84%) ended up on MOUD; 6 at baseline

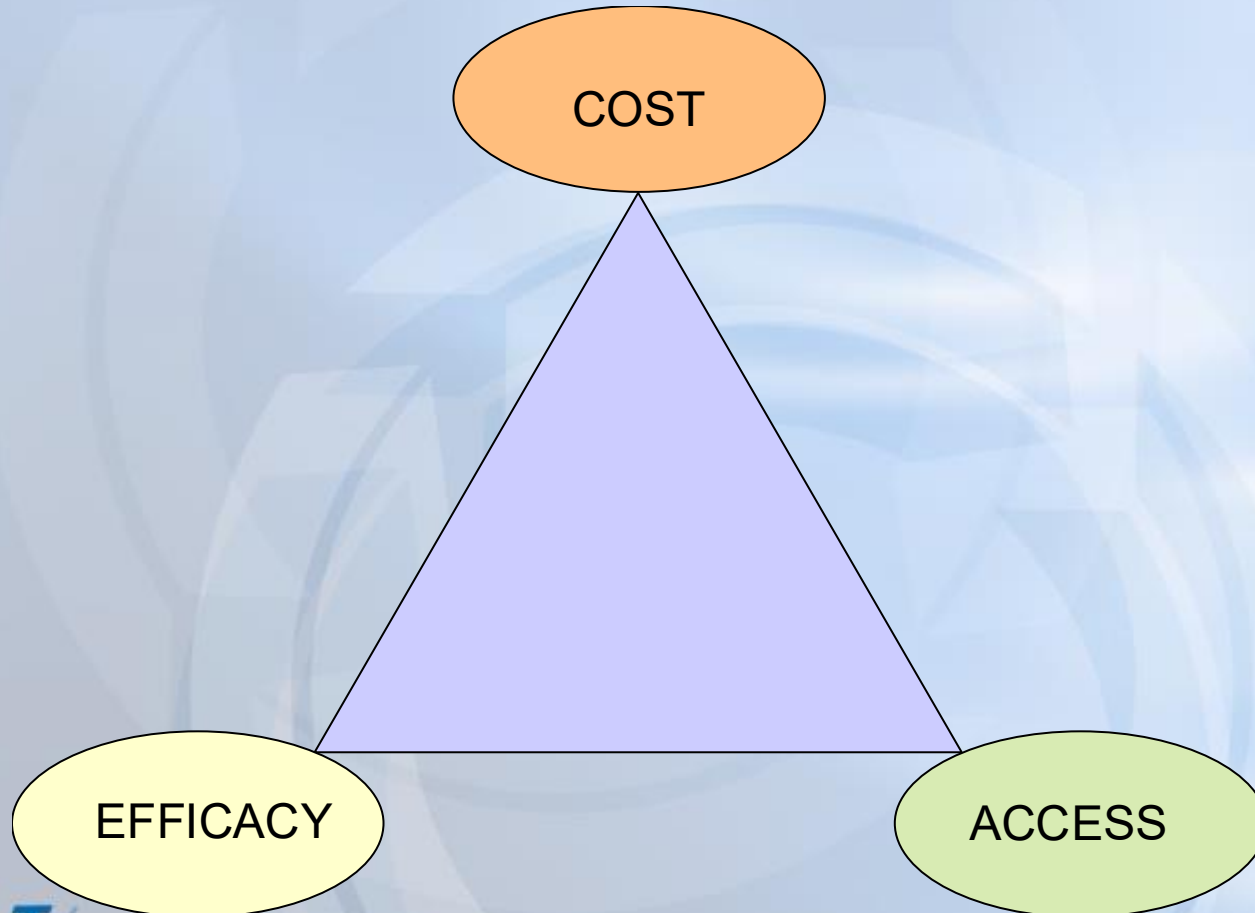
- New initiations (N=20): BPN (N=14) and methadone (N=6)

HIV outcomes [?] no new diagnoses

- All 6 were prescribed ART [?] the two without VS became suppressed when the SVR was assessed

Performance Management Metric

Services that people can and will come to, that we can pay for, and that work.



CONCLUSIONS

- People will engage in services if we reduce demands on the process. They will stay if it works for them and is easy to stay. **What do we know about what people actually want and about what they think they need?**
- It is important to use transparent metrics understandable to payers, clinical staff and patients to evaluate service offerings and improvements.
- Building Implementation/Change Capacity leads to sustainability

10 Steps of NIATx & Creating a Change Project

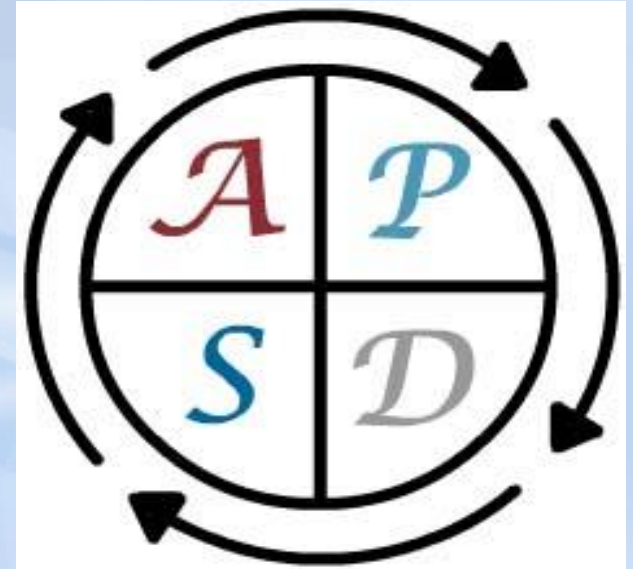


Making Changes

- **PDSA Cycles**

- **P**lan the change
- **D**o the plan
- **S**tudy the results
- **A**ct on the new knowledge
 - Adapt
 - Adopt
 - Abandon

- Two to four week cycles



The Four NIATx Aims

- **Reduce Waiting Times**
- **Reduce No-Shows**
- **Increase Continuation**
- **Increase Admissions**



Leading Change Teams

- Establish direction with a clear aim
- Create a sense of urgency – articulate how baseline data shows the need for important improvements
- Provide accountability and stay organized
- Involve the right staff
- Communicate, communicate, communicate
- Engage senior leaders
- Motivate and inspire
- Commit to empowerment
- Create a process for short term wins
- Use Tools



STAY ORGANIZED

USING Coaching and NIATx tools record who attended the meeting, the date, the discussion highlights, ideas that come up AND most importantly

THE PLAN

What will the group do?

When will they do it? And who?

What is the measure?

How will you know if a change is an improvement?

What is the date of the next meeting?



Detours

- Projects not related to goals
- No feedback
- Insufficient leadership
- No business case/strategic advantage
- Large change cycles

DON'T FORGET

- Small changes really matter!
- For support, go to the website – NIATx.net (in English)
- For questions – email colleagues and networks, including me.
- lynn.madden@yale.edu



Selected Peer Reviewed Publications



NIATx as an Evidence-based Practice

The following is a partial list of NIATx-related research published in peer-reviewed publications:

- Fleddermann, K., Jacobson, N., Horst, J., Madden, L. M., Haram, E., & Molfenter, T. (2023). Opening the “black box” of organizational coaching for implementation. *BMC health services research*, 23(1), 106.
<https://doi.org/10.1186/s12913-022-08948-6>
- Chokron Garneau, H., Assefa, M. T., Jo, B., Ford, J. H., 2nd, Saldana, L., & McGovern, M. P. (2022). Sustainment of Integrated Care in Addiction Treatment Settings: Primary Outcomes From a Cluster-Randomized Controlled Trial. *Psychiatric services (Washington, D.C.)*, 73(3), 280–286.
<https://doi.org/10.1176/appi.ps.202000293>



NIATx as an Evidence-based Practice

- White, V. M., Molfenter, T., Gustafson, D. H., Horst, J., Greller, R., Gustafson, D. H., Jr, Kim, J. S., Preuss, E., Cody, O., Pisitthakarm, P., & Toy, A. (2020). NIATx-TI versus typical product training on e-health technology implementation: a clustered randomized controlled trial study protocol. *Implementation science : IS*, 15(1), 94.
- Ford, J. H., Osborne, E. L., Assefa, M. T., McIlvaine, A. M., King, A. M., Campbell, K., & McGovern, M. P. (2018). Using NIATx strategies to implement integrated services in routine care: a study protocol. *BMC Health Services Research*, 18(1), 431.
- Freese, T. E., Padwa, H., Oeser, B. T., Rutkowski, B. A., & Schulte, M. T. (2017). Real-world strategies to engage and retain racial-ethnic minority young men who have sex with men in HIV prevention services. *AIDS Patient Care and STDs*, 31(6), 275–



NIATx as an Evidence-based Practice

- Madden, L., Bojko, M. J., Farnum, S., Mazhnaya, A., Fomenko, T., Marcus, R., ... & Dvoryak, S. (2017). Using nominal group technique among clinical providers to identify barriers and prioritize solutions to scaling up opioid agonist therapies in Ukraine. *International Journal of Drug Policy*, 49, 48–
- Gustafson Jr, D. H., Maus, A., Judkins, J., Dinauer, S., Isham, A., Johnson, R., ... & Atwood, A. K. (2016). Using the NIATx model to implement user-centered design of technology for older adults. *JMIR Human Factors*, 3(1), e2.
- Pearson, F. S., Shafer, M. S., Dembo, R., del Mar Vega-Debién, G., Pankow, J., Duvall, J. L., ... & Patterson, Y. (2014). Efficacy of a process improvement intervention on delivery of HIV services to offenders: a multisite trial. *American Journal of Public Health*, 104(12), 2385-2391.



NIATx as an Evidence-based Practice

- Gustafson, D. H., Quanbeck, A. R., Robinson, J. M., Ford II, J. H., Pulvermacher, A., French, M. T., ... McCarty, D. (2013). Which elements of improvement collaboratives are most effective? A cluster-randomized trial. *Addiction*, 108(6):1145-57. PMID: PMC3651751. doi: 10.1111/add.12117
- Quanbeck, A. R., Madden, L., Edmundson, E., Ford, J. H., McConnell, K. J., McCarty, D., & Gustafson, D. H. (2012). A business case for quality improvement in addiction treatment: evidence from the NIATx collaborative. *The Journal of Behavioral Health Services & Research*, 39(1), 91–
- McCarty D, Gustafson DH, Wisdom JP, Ford J, Choi D, Molfenter T, Capoccia V, Cotter F. (2007). The Network for the Improvement of Addiction Treatment (NIATx): enhancing access and retention. *Drug and Alcohol Dependence*, 88(2-3):138– PMID: PMC1896099



Coaching and Facilitation as a Discrete Implementation Strategy: How to Support and Drive Better Implementation





We cannot change the way the world is, but by opening ourselves to the world as it is, we may find that gentleness, decency and bravery are available—not only to us but to all human beings.

Chögyam Trungpa, Buddhist teacher

Learning Objectives

- Review the evidence for facilitation as an important strategy in implementation
- Discuss different ideas about facilitation
- Discuss approaches to facilitation
- Explore the importance of selecting facilitation tools that suit your implementation strategy



ERIC

- The Expert Recommendations for Implementing Change study, or ERIC, compiled and described implementation strategies, resulting in 73 discrete strategies.

A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change. Powell, B.J., Waltz, T.J., Chinman, M.J. et al. *Implementation Sci* 10, 21 (2015).

Defining Facilitation of Implementation

- ERIC defines **facilitation** as a process of interactive problem solving and support that occurs in a context of a recognized need for improvement and a supportive interpersonal relationship.
- **Coaching** is a common term to describe the same process



Facilitation as a key element of implementation

- Coaching or facilitation has been cited as the most important or among the most important tools for successful implementation. Coaching can take many forms but is most commonly organized (initially) as external support.



Implementation Science: The Key To Successful Implementation is Facilitation

		IMPLEMENTATION TEAM	
		YES	No
INTERVENTION	Effective	80%, 3 Yrs	14%, 17 Yrs
	Facilitation	Effective use of Implementation Science & Practice	Letting it Happen Helping it Happen

Fixsen, Blase, Timbers,
& Wolf, 2001

Balas & Boren, 2000



Learning Collaboratives

- *Which elements of improvement collaboratives are most effective? A cluster-randomized trial*

David H Gustafson, et al. (2013) Addiction

An RCT with 201 substance use treatment sites across five US States. Conclusions: Coaching and the combination of collaborative components were about equally effective in achieving study aims, but coaching was substantially more cost-effective.



- A 2019 systematic review of successful facilitation strategies included the following attributes: “goal-setting, assessing progress and outcomes, and providing tools and resources.”

Change Facilitation Strategies Used in the Implementation of Innovations in Healthcare Practice: A Systematic Review. Lydia Moussa, 2019. Journal of Change Management.



How does facilitation work?

- As is common in implementation science, we sometimes know that certain strategies show evidence of working, but we don't know how, exactly. “Healthcare facilitation, an implementation strategy....has produced promising yet mixed results in randomized implementation trials and has not been fully researched across different contexts.”

Amy M. Kilbourne, et al Implement Sci Commun.2023: 4:53.



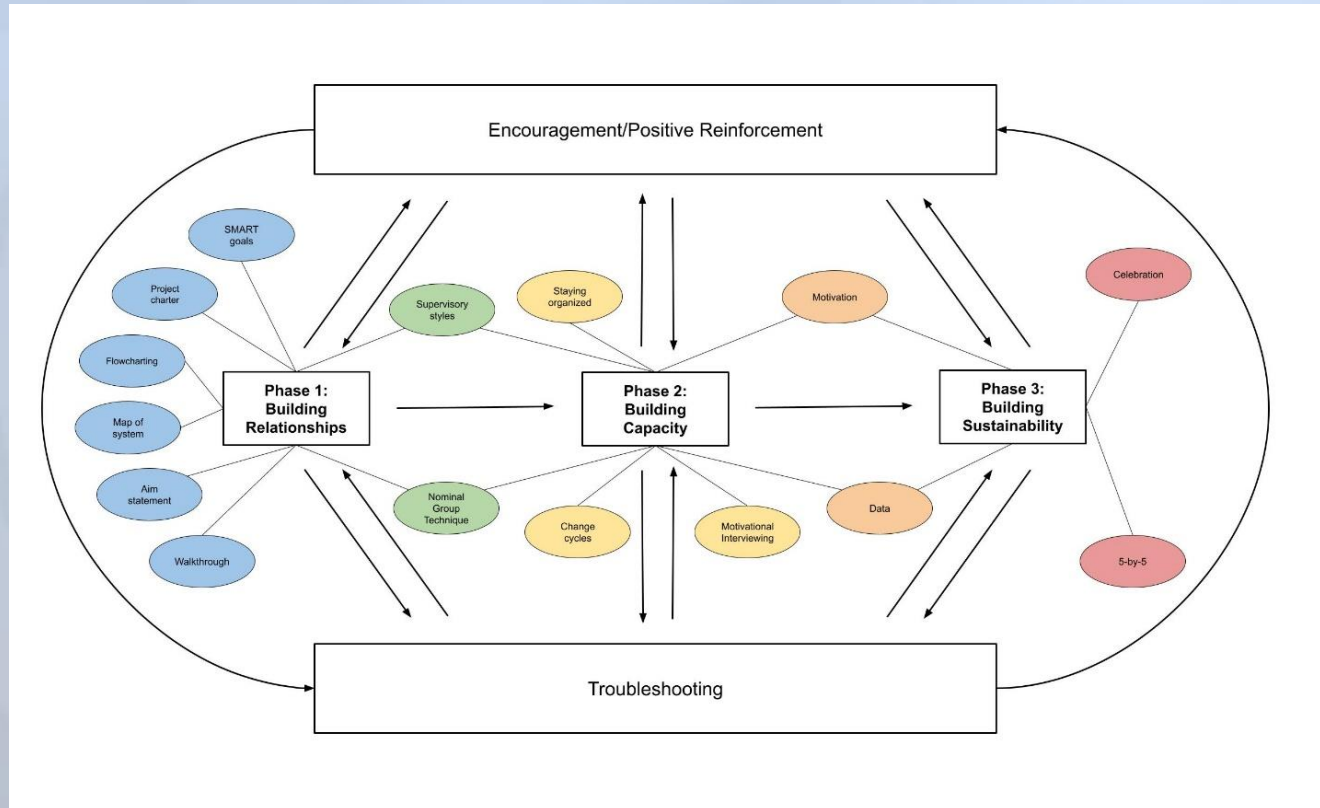
The Black Box of Coaching for Implementation

- Qualitative interviews with 9 coaches were inductively coded to develop a model of coaching for implementation. Forty previously recorded coaching calls underwent directed content analysis using a priori codes based on the model to test for rigor and utility.
- Analysis resulted in a 3-phase model of **what happens** when coaching for implementation: building relationships, building capacity and building sustainability. Various tools were associated with each phase.



Opening the Black Box of Organizational coaching for implementation. Fledderman K, Jacobson N, Horst J, Madden LM, Haram E, Molfenter T. BMC Health Serv Res. 2023 Feb

A Coaching Model



Another look at the black box of facilitation

- This study used a modified Delphi consensus method to determine **how** facilitation works in different contexts.
- Three thematic areas emerged: facilitator characteristics, organizational human and material resources and contextual factors. Each area is described by facilitator actions/selected tools and organizational sense making.

How does facilitation in healthcare work? Using mechanism mapping to illuminate the black box of a meta-implementation strategy.
Amy M. Kilbourne, et al Implement Sci Commun.2023: 4:53. online May 2023



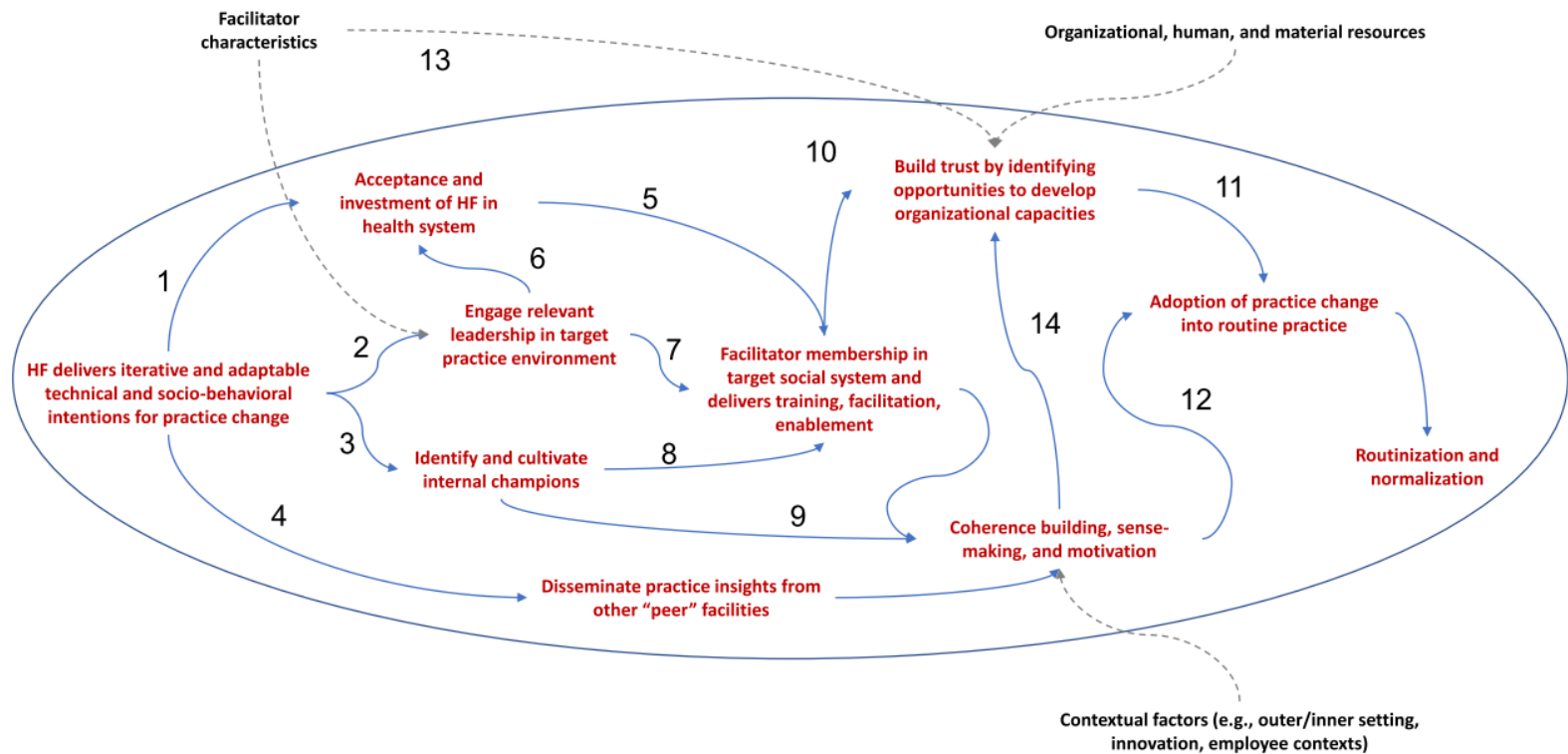


Fig. 2 Healthcare facilitation (HF) mechanism map using directed acyclic graphs

Other ERIC strategies that some consider 'coaching'

- **Audit and Feedback** – collect and summarize clinical performance data over a specified time period and give it to clinicians and administrators to monitor, evaluate and modify provider behavior
- **Facilitate relay of clinical data to providers** – Provide as close to real-time data as possible about key measures of process/outcomes using integrated modes/channels of communication in a way that promotes the use of the targeted intervention



- **Organize clinician implementation team meetings**
 - Develop and support teams of clinicians who are implementing the innovation and give them time to reflect on the implementation effort, share lessons learned, and support one another's learning
- **Provide ongoing consulting** – provide ongoing consulting with one or more experts in the strategies used to support implementing the innovation
- **Use an implementation adviser** – seek guidance from experts in implementation



Facilitation techniques- Motivational Interviewing

- Motivational interviewing was initially a counseling approach developed primarily by William Miller and Stephen Rollnick. It is designed to elicit behavior change by helping to recognize, explore and resolve ambivalence.

Rollnick, Stephen; Miller, William R. (October 1995). *What is Motivational Interviewing*” Behavioral and Cognitive Psychotherapy. 23 (4)



Motivational Interviewing principles

- Resist the righting reflex
- Understand the person's (organization's) own motivations
- Listen with empathy
- Empower the person (organization)



Motivational Interviewing Processes

- Engaging – aligning with empathy
- Focusing – what?
- Evoking – why?
- Planning - how?

These processes are not necessarily linear, or definitive of facilitation

Appreciative inquiry

- **Appreciative Inquiry** is an asset-based approach to dialogue and engagement that can be utilized by communities, organizations, and teams. It builds on the idea that we can best improve human/organizational systems by a focus on what is going well and a shared vision of a positive future versus cataloguing deficits.



Practicing Appreciative Inquiry or positive framing

- **A simple way to practice Appreciative Inquiry is to employ 3 key approaches:**
 1. Practice asking positive questions.
 2. Find and share positive stories of when you, other people, the organization is its best.
 3. Practice playing different roles and inspiring others to become champions of positive questions.

-



Appreciative Inquiry Exercise

1. BREAK INTO PAIRS

2. ASK YOUR EXERCISE PARTNER

- What motivates you to do the work that you do?
- What is it really like to do your work?
- What does a good day look like?

3. TALK TO EACH OTHER FOR ABOUT THREE MINUTES

4. **Report back** to the room tell the group something you learned about the person you interviewed.



Choosing facilitation tools/approaches

- One key challenge to selecting tools to drive implementation is that **context** is so critical.
- Understanding context sometimes does not occur before implementation approaches are theoretically conceptualized or funded.
- Choosing families of strategies as a preliminary step can be helpful.
- Be prepared to pivot as context becomes more clear or shifts.



THE CFIR – ERIC tool

- This tool identifies which ERIC implementation strategy might best address specific contextual barriers as delineated by the Consolidated Framework for Implementation Research (CFIR).
- Logically based justification of discrete implementation strategies is increasingly necessary for funding and for obtaining stakeholder support.

Choosing implementation strategies to address contextual barriers: diversity in recommendations and future directions. Waltz, T.J., Powell, B.J., Fernandez, M.E., et al. *Implementation Sci* 14, 42 (2019).



Rolling with Resistance

Lynn Madden, PhD, MPA

CEO, APT Foundation

Assistant Professor, Yale University School of
Medicine

A series of four parallel white lines that start from the bottom right and extend towards the top right, creating a sense of movement and direction.

RESISTANCE IS NORMAL

- Resistance is a natural part of change.
- It doesn't mean someone is unmotivated.
- Most of us feel challenged by making changes—pulled in different directions.

DIFFUSION OF INNOVATION

The Diffusion of Innovation theory, developed by Everett Rogers, explains how new ideas, products, or technologies spread through a population over time. It highlights that adoption doesn't happen instantly but follows a predictable pattern across different adopter groups. The theory focuses on the innovation itself, the communication channels, time, and the social system.

KEY ELEMENTS

Innovation: The new idea, product, or technology being introduced.

Communication Channels: The means by which information about the innovation is spread (e.g., mass media, interpersonal communication).

Time: The period over which the innovation diffuses through the population.

Social System: The group or organization within which the innovation is being adopted.

INNOVATION CHARACTERISTICS

Relative advantage: How the innovation is perceived as better than existing alternatives.

Compatibility: How well the innovation aligns with the values, needs, and experiences of potential adopters.

Complexity: How difficult the innovation is to understand and use.

Trialability: How easy it is to experiment with the innovation on a limited basis.

Observability: How easily the results of the innovation are visible to others.

ADOPTER CATEGORIES

Innovators: The first to adopt an innovation, often risk-takers.

Early Adopters: Opinion leaders who adopt relatively early and influence others.

Early Majority: Adopters who adopt after the early adopters, influenced by social norms and peer pressure.

Late Majority: Adopters who adopt after the majority have already adopted, often due to necessity or peer pressure.

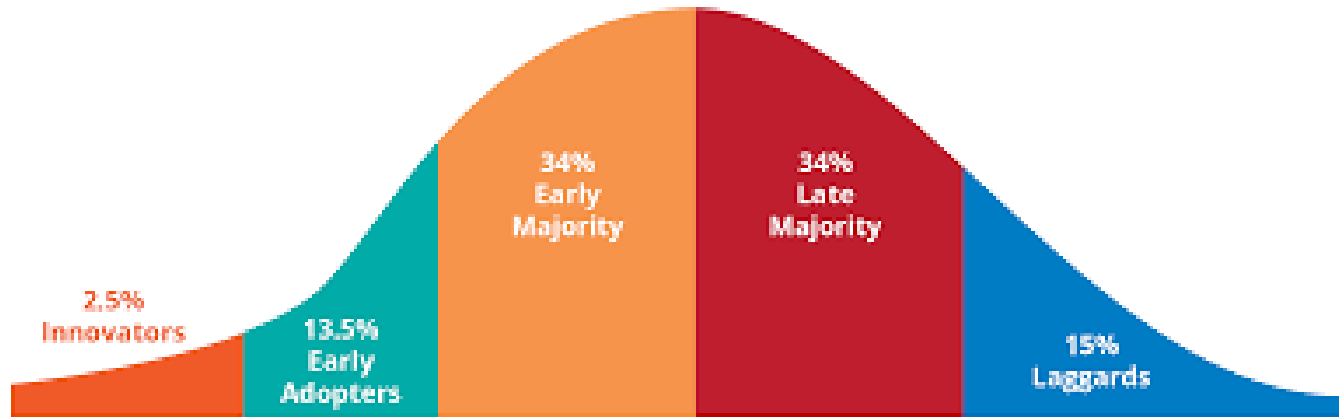
Laggards: The last to adopt an innovation, often resistant to change and influenced by tradition.

THE S-SHAPED CURVE

The adoption of an innovation often follows an S-shaped curve, with slow initial adoption, a period of rapid growth, and then a slowing down as the innovation reaches saturation.

The tipping point, or critical mass, is the point where the innovation's adoption rate accelerates dramatically.

In essence, Diffusion of Innovation theory helps us understand how and why new ideas and technologies spread within a population, considering both the characteristics of the innovation and the characteristics of the adopters.



DIFFUSION OF INNOVATION

RESISTANCE MANAGEMENT

It's a proactive approach that aims to ensure a smoother transition during times of organizational transformation by addressing potential resistance and fostering support for the change.

Basically, resistance management is a strategic approach to navigating the human side of change, ensuring that individuals are supported and engaged in the transformation process, ultimately leading to more successful outcomes.

MANAGING RESISTANCE TO CHANGE

Proactive Approach: Resistance management is not just about dealing with resistance after it emerges; it is about anticipating and planning for it.

Focus on Support: The goal is to increase the level of support for the change initiative among stakeholders.

Addressing Underlying Concerns: It involves understanding the reasons behind resistance and addressing those concerns through clear communication, engagement, and support.

Facilitating Adoption: Resistance management aims to help individuals adopt new processes, technologies or behaviors with minimal friction.

WHY IT'S IMPORTANT

Successful Change Implementation: Resistance to change can derail projects and hinder organizational goals.

Employee Engagement: By addressing resistance proactively, organizations can foster a more engaged and motivated workforce.

Improved Outcomes: Effective resistance management can lead to better project outcomes and increased organizational benefits.

KEY STRATEGIES

Communication: Clear and transparent communication about the need for change, its impact, and the benefits is crucial.

Engagement: Involving stakeholders in the change process and addressing their concerns can help build support.

Education and Training: Providing necessary training and support can help individuals adapt to the change.

KEY STRATEGIES

Removing Barriers: Identifying and removing obstacles that hinder the implementation of change can facilitate adoption.

Empathy and Understanding: Approaching resistance with empathy and understanding, rather than blame, can be effective in addressing concerns.

Incentives and Recognition: Offering incentives or recognition for successful adaptation to change can motivate individuals.

WHAT IS “ROLLING WITH RESISTANCE”?

- Don't push—**go with it.**
- Like judo: use the energy, don't fight it.
- Find the opening, not the obstacle.

CHANGE MANAGEMENT EXERCISE - 4P'S

- Create a chart with four quadrants labeled Project, Process, People and Product.
- For each quadrant, brainstorm the potential impacts of the change:
 - Project: What tasks, timelines, and resources are required?
 - Process: How will workflows and operations change?
 - People: Who will be affected, and how can they be supported?
 - Product: Will the change influence the quality or delivery of products/services?
- Identify specific actions to address impacts in each area.
- Discuss and prioritize these actions as part of the change plan.

QUESTIONS?

Thank you!

Please feel free to contact me:
lynn.madden@yale.edu

