The Charles and Helen Schwab Foundation
BUILDING EFFECTIVE SUBSTANCEABUSE TREATMENT (BEST)
FINAL EVALUATION REPORT

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INTRODUCTION

This is the final evaluation report for the Building Effective Substance Abuse Treatment (BEST) initiative funded by the Charles and Helen Schwab Foundation (CHSF) and designed to support capacity building in community-based drug abuse treatment programs located in the San Francisco Bay Area Region.

Understanding organizational change in substance abuse treatment systems is helped by understanding the financing of these systems. Building on prior work (Rice et al., 1990, 1991), Harwood, Fountain and Livermore (1998) estimated total economic costs associated with substance abuse at $276 billion in 1995. They further estimated that 42% of these costs are borne by federal, state and local government, reflecting the federal-state-local partnership in supporting substance abuse treatment. Using figures from 1992, Harwood et al. (1998) estimated that $10 billion dollars were expended for specialized services related to substance abuse treatment, prevention, training and research. Two-thirds of all substance abuse treatment is provided in the public sector (Mechanic et al., 1995). These public sector funds come from a variety of sources, each having specific eligibility criteria and reimbursable services. In 2003, the federal Substance Abuse Prevention and Treatment Block Grant allocation to states was $1.75 billion (www.samhsa.gov/budget/B2005/spending/cj_48.aspx). Special federal programs, which change over time, supplement block grant funding. States provide additional treatment funding. The National Center on Addiction and Substance Abuse (CASA, 2001) reported that states spent $2.5 billion, in 1998, directly on treatment of alcohol, drug, and nicotine addiction. Federal block grant and state funds are passed onto local governments, where local funds are sometimes added in. Other sources of public sector substance abuse treatment funding include Medicaid, Medicare in smaller amounts, and the criminal justice system. The Department of Veteran's Affairs spent $400 million on substance abuse treatment in 1998 (Chen et al., 2001).

These issues related to system financing are evident when an individual seeks treatment. At the community-level, the mix of treatment funding is administered by Departments of Public Health or similar agencies, which in turn contract with community-based providers. The collection of agencies in the local treatment system is often not well integrated into other medical or mental health services. Individual programs in such systems may share a common funding source and contractual requirements, but have little incentive for inter-agency coordination. They have a primary mission of providing direct services, and limited resources for building, improving, and evaluating agency activities. The result is often a fragmented system of care, with inefficiencies in service provision, limitations in the continuum of care, and barriers to access for persons seeking treatment.

As a strategy for improving treatment and treatment systems, organizational development deals most directly with the needs of treatment agencies. Organizational development involves a review of organizational practices, identification of organizational priorities where efficiency may be gained, and reorganization of practices to improve efficiency. In substance abuse treatment agencies, organizational development will move the agency toward greater access and effectiveness of care. The largest organizational intervention in drug abuse may be the combined Robert Wood Johnson Foundation (RWJF) Paths to Recovery and Center for Substance Abuse Treatment Strengthening Access to Treatment. Combined into the Network for Improvement of Addiction Treatment (NIATx), these yoked initiatives work with 44 programs (Victor Capoccia, personal communication), implementing system change to increase access and retention (Gustafson, 2002).

In 2001 the Charles and Helen Schwab Foundation (CHSF) planned an initiative designed to support capacity building and infrastructure development in substance abuse treatment. The Building Effective Substance Abuse Treatment (BEST) initiative first included treatment programs in San Mateo County, CA, and was later extended to include additional programs in the San Francisco Bay Area region. This paper reports on an evaluation of the BEST initiative. Using qualitative interviews and survey procedures, the evaluation sought to determine whether organizational interventions supported by BEST would affect change in the organizational climate, practices, and functioning of participating agencies. We hypothesized that there would be significant improvements in organizational functioning as measured by instruments designed to assess organizational factors related to implementing new technologies.

The Building Effective Substance Abuse Treatment (BEST) Initiative

The BEST initiative was designed to improve substance abuse treatment through investment in organizational development. The BEST initiative reflects a model for involving private foundations in the traditional federal-state-local partnership that supports substance abuse treatment. Treatment agencies emphasize direct services, often at the expense of organizational and infrastructure development. This is driven partly by agencies themselves, and partly by public sector funding sources, both of which place the highest value on client service. The presence of foundations in the partnership empowers both the public sector agencies and their funders to engage in organizational activities that are only indirectly related to the mission of client service. The rationale behind this effort is that improving organizational practices and infrastructure can move agencies toward increasing access and effectiveness of care.

Design of the BEST Initiative. At the time that CHSF was planning the BEST initiative, RWJF was planning its Paths to Recovery initiative (later renamed NIATx). Both Foundations had prior experience with capacity building, which was instrumental in shaping BEST. CHSF had previously implemented a capacity building initiative targeting a range of regional human service agencies (Blair, Irie & Moore, 2002). RWJF also had a prior organizational capacity building effort, the Darwin Project, which was designed to assess and overhaul the business practices of a large service agency in order to improve program effectiveness (Sallade, 2001).

In 2001 the Foundation convened a BEST design team, coordinated by BTW Consultants and in partnership with RWJF, and including members of the county drug abuse treatment Provider's Coalition (BTW Consultants, 2002). Partnership with RWJF added value due to their experience in grant-making in the substance abuse area. While planning for the BEST initiative was collaborative and linked with the RWJF Paths to Recovery initiative, the final design of these projects differed. BEST was designed to focus on broad areas of organizational assessment and intervention (e.g., clinical care, quality management, governance and leadership), while Paths to Recovery focused more narrowly on practices related to client admission and retention.

In 2002 the Foundation contracted with BTW Consultants to provide management support, and selected the American Institutes for Research (AIR) as the Assessment and Planning Team. Near the end of the Design Phase (November 2001), CHSF added a Substance Abuse Program Officer with overall responsibility for the initiative, and a Director of Evaluation who provided oversight for evaluation component. Following an extended market downturn, these positions were eliminated (October 2004), although the Initiative continued through June 2005.

Description of the BEST Initiative. The BEST Initiative includes two models with successively modified approaches to supporting organizational change (see Table 1). The two models, BEST I and II, differed in a number of ways. BEST I included a Coordinating Team and a Learning Community, components that were eliminated from BEST II. Further, the period of agency funding was decreased from 2 years (BEST I) to 1 year (BEST II). Last, the geographical reach of the model was changed from multiple programs in a single county (BEST I) and included most provider agencies in the county, to a small number of programs in different locations within the San Francisco Bay Area (BEST II).

BEST I, involving 12 substance abuse treatment agencies in San Mateo County, CA, began in May 2002 and provided two years of agency funding. BEST II, involving 9 treatment providers located throughout the Bay Area, began in December 2002 and was provided one year of agency funding.

Through a consultant-facilitated Assessment and Planning (AP) process, all agencies identified system improvement interventions designed to increase efficiency, increase numbers of persons served, and increase number and quality of services provided. Participating agencies then implemented improvements in one or more of six areas: clinical care, quality management, governance and leadership, business operations, staff development, or administration.

Table 1. Comparison of Initiatives for BEST I and II.

	BEST I	**BEST II****
Start of Initiative	May 2002	December 2002
Start of Intervention Funding	December 2002	July 2003
Number of Programs	12	9
Geography	San Mateo County	Bay Area
Length of Intervention	2 Years	1 Year
Assessment Funding	$20,000-40,000*	$20,000-40,000**
Intervention Funding	$50,000 per year	$50,000 per year
Assessment and Planning Process	X	X
Self Assessment	X	X
Learning Community	X	
Coordinating Committee	X	
Evaluation	X	X

* Assessment funding ranged from $20,000 to $40,000.

** Six programs were funded in December 2002 and 3 programs were funded in March 2004. The first 6 programs received assessment funding, and the last 3 programs did not.

For BEST I, the design was to focus on a single area of human services agencies (substance abuse providers) located in a single county (San Mateo County). This geographic clustering enabled the Learning Community, since providers would not have to travel distances to participate in face to face Learning Community meetings. Agencies participating in BEST II were selected by the CHSF Program Officer, following the Foundation's intention to expand capacity building to all Bay Area substance abuse providers, but with a scaled back intervention model eliminating the coordinating team and the Learning Community. Foundation resources restricted the number of agencies that could be included in the BEST II initiative, and participating agencies were selected by the CHSF Program Officer based on knowledge of the treatment system and through consultation with potential participant agencies.

Implementation of the BEST Initiative. BEST I and II shared a similar implementation strategy. For BEST I, thirteen agencies participated in an orientation meeting in May 2002. One agency did not continue their involvement in the Initiative due to significant organizational challenges it experienced at the time, but participated later in BEST II. Twelve agencies participated in the Assessment and Planning phase beginning in June 2002 (BTW Consultants, 2003). Following the AP process each agency received a consultant report recommending one or more areas where a system improvement intervention may be most needed. Each agency then prepared a proposal reflecting how they themselves would like to direct their system improvement effort. These proposals were negotiated between the Foundation and the agency, and the system improvement projects were funded in December 2002. Agencies received funding support in two stages. First, each agency received $20,000 to $40,000 to support their participation in the AP process (BTW Consultants, 2003). After their proposal had been accepted, each agency received $50,000 per year for two years, to implement the system intervention they had proposed.

Implementation of BEST II followed the same trajectory. Participants met with foundation staff, assessment team members and a few BEST I participants for an orientation meeting in November 2002. They participated in the AP process with Foundation funding to offset costs of participation, prepared a proposal to the Foundation, and received one-year of funding of $50,000 to support implementation of their intervention.

Assessment and Planning (AP) Process. The American Institute for Research (AIR) performed assessment and planning activities in each agency. The aim of the AP process was to conduct a collaborative and in-depth assessment of organizational abilities and needs, and to prioritize areas for capacity building. For each agency, AIR met with the Executive Director, collected and reviewed agency documents, conducted a two-day site visit including interviews with six to eight individuals or groups, and developed and distributed a Provider Self-Assessment tool. To support their participation in this process, and to offset any costs associated with participation, each agency received $20,000 to $40, 000 depending on the size of the agency (BTW Consultants, 2003). AIR prepared a report to each agency, met with the Executive Director to review the report and, where indicated, revised a final report for the Foundation. For BEST I, the AP process was concurrent in multiple agencies at the same time, with site visits in May to July 2002, and final reports completed in October 2002 (Burling, Shore & Lahey, 2002).

For BEST II, the AP process was modified in a number of ways. First, more information about the AP process was provided at the Orientation Meeting of the Initiative, an extensive

introductory packet was mailed to each participating agency, and initial planning meetings with the agency were conducted by phone rather than in person. The timing of activities changed to include an extended period for document collection, site visits ranging from one to three days depending on the agency size, and a longer time to complete the provider self-assessment prior to the site visit. In addition, AIR processing meetings focused on one rather than multiple agencies, and AIR staged their work so that no more than three agencies were being assessed simultaneously.

System Improvement Projects (SIPs). The AP report to each agency contained recommendations for system improvement in one or more areas (see Table 2). These included, for example, recommendations that the agency engage a consultant to support strategic planning efforts, or that a clinical administrator develop a standard curriculum for staff training. Agencies usually used these recommendations in designing the intervention proposed for funding.

Table 2. Examples of System Improvement Projects

Organizational Capacity Area	**Description of System Improvement Projects**
Purpose and Goal Attainment	Organizational consultant for strategic planning
Governance and Leadership	Consultant to aid in organizational restructuring; management and board training
Staff Development and Human Resources	Consultant to develop standard drug abuse treatment training curriculum and provide staff training
Business Operations	Consultant to aid in developing fundraising plan, business plan
Infrastructure	Consultant to develop/install new computer systems; train staff with new system
Communications	Trainer/facilitator to provide in-service training to acquire new skills and improve communication between staff

Understanding of the BEST project may be supported by additional discussion of the nature of system improvement projects. As an example, several agencies sought to improve governance and leadership and depending on the specific needs of the agency this could be implemented in different ways. Specific system improvement efforts related to government and leadership could include:

- A process of restructuring of the current management team in order to decentralize responsibility
- Creating or eliminating leadership staff positions or
- Specific leadership training for the Executive Director and or top managers
- Consultation to the Executive Director concerning further development of the board
- Consultation and training for the board to build needed capacity such as strategic planning or fundraising support, or developing board committees with specific tasks.

As a second example, several agencies elected to build capacity in the area of infrastructure related to data and data systems. Specific interventions included:

- Agency wide assessment of data system needs
- Purchase and installation of servers for data and communication across sites
- Selection and installment of new or upgraded financial billing systems
- Developing email communication and web access throughout an agency
- Unifying multiple data entry systems onto a single platform with increased retrieval capability.
- Where changes were made to computer or other electronic systems, staff training to support broader use of new tools within the agency.

Role of the Foundation. CHSF holds partnership as a core value. In BEST, this translated into active participation of the Foundation's Substance Abuse Program Officer and Director of Evaluation in the workings of the initiative. Foundation staff were involved in the BEST design team, and in developing the AP process and the evaluation. The Program Officer negotiated funding and scope of work for the selected system improvement projects, and monitored their progress. Foundation staff also participated in the Learning Community, and in the oversight and management functions of the Coordinating Committee and Evaluation Advisory Team. The Foundation, consequently, offered an active presence in the life of the initiative, both as a funder and as a partner. The role of the Foundation was reduced in BEST II because the Learning Community, in which they participated, was not included in this initiative.

Learning Community (LC). Occurring in BEST I only, the LC was intended as a forum for sharing experiences and resources, for building collaboration, and for discussions or presentations in areas of mutual concern. Meeting in quarterly half-day sessions, the LC included the Executive Director and/or key leadership staff from each participating agency, and representatives of the Foundation and the collaborating consultants. Meetings typically focused on specific topics such as the assessment and planning process, leadership, communication, organizational capacity, agency boards, and sustainability of the learning community. Much of the meeting time was reserved for discussions and sharing among peers.

Other LC activities include e-mail communication and distribution of other materials (e.g., list of communication resources and a bibliography on leadership). Input about timing, content and format of LC meetings was solicited from participants through two surveys, during LC meeting discussions and by e-mail. Initially meetings were going to be held bi-monthly. However, participant feedback was that quarterly meetings were preferred due to time demands. The desire for smaller gatherings to address specific topics was also expressed. In response, two interest groups were formed to focus on data systems and fund development. These groups each met from one to three times. Executive Directors as well as other staff (e.g., staff person in charge of information technology issues) attended.

Management and Coordination. In BEST I the activities of the Foundation, consultant partners, and community stakeholders were organized through a Coordinating Committee. This committee included representatives from the Foundation, AIR, BTW Consultants, and the UCSF evaluation team. BTW Consultants coordinated activities of the design team, the Coordinating Committee, and the LC. Evaluation efforts had oversight through an Evaluation Advisory Team including the same stakeholders, with additional representation from two participating programs.

In BEST II, both the LC and Coordinating Committee were eliminated. Management and coordination functions were centralized with CHSF staff.

METHODS

Overview of the Evaluation Design

The goals of the evaluation were to identify effective capacity building models and to increase organizational learning about capacity building strategies within the Foundation, the LC and the substance abuse field. The evaluation plan included assessment strategies at the system level (the agency system targeted for change), the agency level, and the LC level.

BEST is a multi-component intervention and any of the components alone or in combination may contribute to BEST outcomes. These components include the AP process and the system improvement project that occur at each agency, the role of the Foundation in shaping and monitoring the Initiative, the LC, and the management and coordination of the Initiative. Evaluation procedures included a combination of structured interviews, review of agency documents, staff surveys, and treatment services administrative datasets. In this report, we include findings from the baseline, 12 and 24-month follow-up interviews and surveys. We also include findings from our review of administrative datasets.

Participating Agencies

Organizational Characteristics of BEST I Agencies. A total of 10 out of 11 agencies completed the Organization Survey, and altogether these agencies operated 67 treatment units. All agencies identified themselves as a private not-for-profit organization. Regarding the composition of the board of directors, 80% reported that more than half of the members of the board were from racial/ethnic minority backgrounds, 60% reported that more than half of the board comprised women members, and 22% reported that more than half of the board members were in recovery for addiction problems. The average annual revenues for the nine agencies that responded to this question was $1,716,000 (range = $392,000 to $4,400,000). Public funding comprised 70% (range = 25% to 99%) of all revenues. Agencies provided services in all major modalities including outpatient drug free (100%), outreach support services (75%), prevention services (57%), inpatient/residential services (50%), medication services (25%), and medical care (15%). In terms of information and technology resources, agencies had an average of 15.9 computers onsite (range = 7 to 42), and most had internet access (mean = 12.5; range = 1 to 30). In most agencies (7 out of 10), clinical staff had access to computers with internet capabilities.

In BEST I only, we used the San Mateo Office of Alcohol and Drug Services database to describe the service population for the 12 agencies participating in the initiative. From our review of this administrative dataset for calendar year 2002, we found that, there were 3,686 clients in treatment across the 12 agencies. The majority of clients were male (70%) and seeking treatment for alcohol and drug abuse with a mean age of 34 years. Overall, clients were 48% Caucasian, 25% Hispanic, 20% African-American, 6% Asian/Pacific Islander, and 1% Native American. Thirty-five percent were being treated in an outpatient setting, 31% in a non-hospital detoxification setting, and 24% in a long-term (> 30 days) residential treatment setting. Relatively few were being treated in other settings (e.g., hospital detoxification, intensive outpatient, or < 30 day residential treatment).

Organizational Characteristics of BEST II Agencies. Nine agencies completed the Organization Survey, however, some providers chose not to answer all of the questions in the survey, so that complete data are not available for all agencies. A total of 55 treatment units were operated by 8 agencies (treatment unit data was available for 8 out of the 9 agencies surveyed). All agencies identified themselves as private not-for-profit organizations. The composition of the board of directors was diverse with 63% (5 out of 8) of agencies reporting that more than half of the members were from minority racial/ethnic backgrounds, 75% (6 out of 8) reported that more than half of the board comprised women members, and 25% (2 out of 8) reported that more than half of the board members were in recovery for addiction problems. In terms of their annual substance abuse revenues, the average annual revenues for 8 agencies that responded to this question was $4,100,000 (range = $260,000 to $17,700,000). The majority of the substance abuse revenues were obtained from public sources (mean = 93%; range = 70% to 100%). Agencies provided services in all major modalities including outpatient drug free (67%; 6 out of 9), outreach support services (89%; 8 out of 9), prevention services (67%; 6 out of 9), inpatient/residential services (67%; 6 out of 9), medication services (44%; 4 out of 9), and medical care (67%; 6 out of 9). Regarding computer resources, agencies had an average of 73 personal computers onsite (range = 21 to 250) dedicated for staff use, and access to internet services varied widely (mean = 42; range = 5 to 100). Fifty six percent of the agencies (5 out of 9) provided access to computers with internet capabilities for all clinical staff.

Procedures

Structured interviews were conducted at baseline, and at 12 and 24 months from the date of the baseline interview. Interviews were conducted with key stakeholders including foundation representatives, a county administrator of alcohol and drug treatment programs, consultants with the Initiative, and agency directors to describe the implementation of BEST as well as assess its impact at the system, agency, and LC level. Interviews with agency staff assessed the organization's health including organizational aspirations, resources, priorities, needs, and planned system improvement projects, as well as their experiences to date with the Initiative. Interview guides appear in Appendix A.

Staff surveys were used to characterize programs and to assess the impact of system improvement projects. Executive Directors assisted the evaluation team in identifying key personnel and board members to complete the surveys. With consent from program staff, surveys were either mailed or distributed during site visits. Surveys were given to board members and agency personnel during the first six months of the implementation phase, and then again approximately 12 and 24 months later (for BEST II, at 12 months only). Survey items, grouped within scales, are included in Appendix B.

Agency documents were reviewed to develop contextual and baseline information. Documents reviewed included reports from the assessment and planning process completed at each agency, and grant proposals submitted by each agency to the Foundation. As described above, the San Mateo Office of Alcohol and Drug Services database was used to describe the service population for the 12 agencies participating in BEST I.

Measures

Structured interviews. A total of 12 Executive Directors were interviewed at baseline, and two programs later merged into one giving 11 Executive Director interviews at 12 months. One Executive Director did not respond to follow up efforts at 24 months, so that 10 Directors were interviewed at this wave. Interviews with the other stakeholders (funders and consultants) focused on the nature of the planning process for the initiative and their perceptions about its effectiveness, challenges of the initiative, and its policy implications. Most participants were interviewed in person, but a small number were interviewed by phone due to constraints of time or distance. The numbers of other stakeholders interviewed was 7 at baseline, 5 at 12 months and 4 at 24 months. Interviews lasted approximately 60 to 90 minutes, and their content follows separate interview guides developed for Executive Directors and other stakeholders.

For BEST II, we modified the interview guides to reflect changes in the design of the initiative: 1) eliminating the involvement of a coordinating team and LC; and 2) decreasing intervention and funding periods to 1 year. Nine executive directors were interviewed for BEST II at baseline, and 8 were re-interviewed at 12 months.

Staff Surveys. Surveys of agency staff and board members were used to characterize participating agencies and to assess the impact of system improvement projects. Three instruments were adapted for use in the evaluation (see below). In each agency, staff in key positions were included in the survey: Executive Director, Directors of individual treatment units, the Fiscal Services Manager, Data Manager, and two counseling line staff. Board members were identified as potential survey respondents in consultation with the Executive Director, and varied according to the size of the board. In BEST I, this translated into 5 to 13 staff surveys and 3 to 13 board surveys distributed per agency. With participant consent, surveys were either mailed or distributed to staff during site visits, and were mailed to board members. In BEST I, these surveys were distributed to board members and agency personnel during the first 6 months of the implementation phase of the initiative, and then again approximately 12 and 24 months later. At each time point, approximately 90 staff surveys and 70 board surveys were distributed across 11 participating agencies.

In BEST II, surveys were collected at baseline only, with participant selection following the same general procedures as those in BEST I. In BEST II, 5 to 9 staff surveys and 1 to11 board surveys were distributed per agency. Across the 9 participating agencies, a total of 61 staff surveys and 55 board surveys were distributed. Survey distribution and return rates, broken out by staff and Board membership, are seen in Table 3.

Table 3. Number of Surveys Distributed and Response Rates.

BEST I Surveys	Staff			Board Members		
	Distributed	Received	% Rate	Distributed	Received	% Rate
Baseline	90	81	90%	74	57	77%
12 months	90	77	86%	76	51	67%
24 months	87	65	75%	70	36	51%
BEST II Surveys						
Baseline	61	45	74%	55	29	53%

Survey instruments, listed below, are discussed in more detail in a previous report (Guydish et al., 2003).

Organizational and Treatment Unit Surveys. These surveys, developed at the Oregon Health Services University (Dennis McCarty, personal communication), were designed to assess organizational characteristics of substance abuse treatment programs. They characterize treatment organizations, treatment units, and treatment staff in participating agencies.

Organizational Readiness for Change (ORC) Survey. The ORC, developed at Texas Christian University, was designed to assess motivation and personality attributes of program leaders and staff, institutional resources, and the organizational climate as a first step in understanding organizational factors related to implementing new technologies into a program (Lehman, Greener, & Simpson, 2002). Items for each of the subscales are rated on a 5-point "Strongly Disagree-Strongly Agree" scale, with "Strongly Disagree" at the low end (score of 1) and "Strongly Agree" at the high end (score of 5).

System Improvement Project (SIP) Survey. The SIP survey was developed by the evaluation team to assess the effects of system improvement projects. The survey instrument addressed 4 areas commonly selected for improvement (data systems, governance and leadership, staff development, and fund development). SIP survey items are rated on a 5-point "Strongly Disagree" (score of 1) to "Strongly Agree" (score of 5) scale.

Data Analysis

Qualitative Interview Data. Interviews with program Executive Directors were audiotaped and transcribed. Interviews with other stakeholders (e.g., Foundation staff or other consultants) were recorded using written notes during the interview, and these notes were transcribed shortly following the interview. Transcriptions were sent to 4 evaluation team members who reviewed them, extracted themes or other observations, and discussed these in team meetings.

Quantitative Survey Data. We examined the effect of SIPs on organizational measures (ORC and SIP subscales) over time (Appendix C). We first assigned the BEST I agencies into four groups based on the types of organizational interventions selected: 1) financial resources (6 agencies); 2) governance and leadership; (5 agencies) 3) computer and data management system (6 agencies); and 4) staff development and human resources (5 agencies). Several agencies appear in more than one grouping because their organizational intervention addressed more than one area. In this analysis, the unit of analysis is the participant who completed the survey. The main outcome variables included subscales of the ORC and SIP surveys. A mixed effects ANOVA model for each outcome variable was estimated and tested via maximum likelihood with SIP intervention group (agency that focused on specific SIP area versus agency that did not), assessment point (baseline, 12 month, and 24 month follow up), and interaction of the two (SIP x assessment point) as effects in the model. All analyses were performed using SAS version 9.0 (SAS Institute Inc., Cary NC).

RESULTS

Below, we present our evaluation findings based on interview and survey data collected for BEST I and II cohorts. As mentioned above, interview guides and instruments that are designed to measure organizational readiness for change and effects of system improvement projects are included in Appendix A and B. In addition, more detailed information about the survey results and graphical representations of the survey findings are included in Appendix C and E.

Interview Findings: BEST I

Assessment and Planning Process. Most respondents were positive about the AP process, their participation in the process, and the expertise and sensitivity of the AP team. The intention of the AP process was a comprehensive assessment of each agency's organizational capacity with multiple recommendations offered as a menu from which the agency might choose to intervene. Respondents reported that the AP process helped validate and sharpen work in which the agency was already interested. In this positive context, however, there were some challenges. Some agency directors voiced concern about the short timeline given to complete a full evaluation of the agency. They reported that sufficient time was not given to complete self-assessment surveys, participate in face-to-face interviews, and to discuss and respond to evaluation findings documented in the AP report, including errors or misstatements. In addition, there was confusion among some participants about the purpose of the AP process, the intended scope of recommendations, the amount of available funding that could be dedicated to SIP implementation (within the range of $50,000 to $100,000 per agency per year for two years), and how many recommendations agencies were expected to address in their proposals. Moreover, many of the recommendations made by the AP team involved seeking and contracting for consultant services in specialized areas, such as board development, fundraising, and information technologies. Some respondents, however, were unsure where to find the type of consultation recommended, expressed concern that the consultant should be familiar with 501c3 operations, as well as knowledgeable in a specific area such as board development. For many respondents the self-assessment tool seemed redundant. Respondents commented that the tool came to them after the initial meeting with the Executive Director and the AP team, and after the AP site visits, when much of the information covered in the self-assessment tool had already been discussed.

During both of the follow up interviews, most providers reaffirmed the value of the AP process. They restated how their assessment confirmed what they already knew and helped them to focus their efforts. Most providers used their assessment to develop their SIP implementation plan. Approximately two years after having participated in the assessment process, many of the providers continued to report ways in which the assessment report influenced their work. They used the report in different ways including: strategic planning, their own internal monitoring (e.g., through satisfaction surveys), a tool for agency board members to reflect and better understand the agency, and to develop a management team approach to decrease the executive director's workload and burden. Some of the agencies used the report to address organizational capacity needs separate from their Schwab-funded primary projects. For example, one agency improved communication between senior and middle level management; another agency improved their substance abuse treatment services.

System Improvement Project. A total of 23 organizational capacity areas were selected by BEST I agencies (Table 3). The top two organizational capacity areas chosen for investment were business operations and infrastructure. Six out of the 12 agencies (50%) applied funds to improve their organization in these two areas. Although the AP team identified one top priority investment area for most agencies (10 out of 12; 83%), the majority decided to design and implement system improvement projects focusing on more than one organizational area (8 out of 12; 67%). Twenty-five percent of the agencies did not accept the top organizational area recommended, but instead chose one of the other projects recommended by the AP team. In 10 out of 12 agencies (83%), the lead recommendation involved hiring a consultant to assist in the implementation of the system improvement project. Although providers stated that they were knowledgeable about how to measure the outcomes of system improvement projects, in some cases, system improvement projects were not well-defined. As a result, the measurement of outcomes was also not well-defined.

Table 4: BEST I Areas of Organizational Capacity Investment

Organizational Capacity Area	No. of Priority Recommendations in each Area	No. of Selected Interventions in each Area
Purpose and Goal Attainment	2	1
Clinical Care/Services	2	0
Governance and Leadership	4	5
Staff Development and Human Resources	2	4
Business Operations	2	6
Infrastructure	1	6
Community Context/Connectedness	0	0
Structure and Communication	1	1
Total	14	23

At the 24 month follow up interview, most agency directors reported that they had completed implementation of their system improvement projects. However, providers also reported that some projects had limited impacts or their potential had not been fully realized during the two-year project implementation period. Agency directors identified a number of products that resulted from these projects including:

- Forming a board of directors
- Developing a strategic plan
- Creating a fully operational website for the program
- Developing a fiscal policy and procedures manual
- Developing agency procedures to ensure compliance with HIPAA regulations
- Creating benchmarks to use in decisions regarding promotions and compensation
- Re-organizing the leadership structure
- Developing a donor database
- Creating and integrating data management systems
- Upgrading computer systems and software

Positive outcomes identified by providers included:

- Improved communication
- Greater staff cohesion and a sense of purpose/mission
- Improved fund development systems
- More efficient data gathering and reporting systems
- Improved staff morale
- Increases in staff retention and completion
- Greater acceptance of innovation, and increases in revenues.

Although across many of these agencies system improvement projects produced positive outcomes, in some cases these projects produced unintended consequences. For example, one agency director reported a 50% turnover in members serving on the board of directors.

The majority of directors did not make significant modifications to the design system of improvement projects. Several agency directors reported that their system improvement project objectives and timetable were overly ambitious; and a number of agencies used funding from other sources to support the implementation of system improvement projects. In one case a system improvement project objective was dropped, and in another a project goal had not been accomplished.

Throughout the two-year implementation period, providers were faced with many challenges including:

- high staff turnover
- anticipated and unanticipated reductions in funding support from public and private sources
- dedicating time for staff to become involved in implementing and maintaining system changes
- re-organizing leadership and management structures within agencies
- developing effective reporting systems to meet reporting requirements from funding agencies
- staff resistance to change
- low staff functioning in the areas of organizational and leadership skills
- Anticipated difficulty in sustaining changes resulting from these system improvement projects.

Providers identified a number of critical elements needed for the successful implementation of system improvement projects. Most commonly providers identified hiring consultants with necessary skills and knowledge about the system improvement project, and having a "champion" involved who can effectively lead the agency through the change process. Overall, providers were satisfied with consultants that they hired to assist in designing and implementing system improvement projects.

Learning Community. At the time of the baseline interviews, providers had only initial experience with the Learning Community, but understood its promise as tool for sharing information and building collaboration. In this general positive context, some providers expressed dissatisfaction with the amount of time spent in introductions and trust-building exercises in the Learning Community meetings. These respondents noted that the County already had a Provider's Coalition, and most participants were known to each other in that

context. At the time of the 12 month interview providers reported valuing the Learning Community as a place to reflect, learn from each other, and serve as a source of support. The LC was seen as adding value to the pre-existing Provider's Coalition, helping the coalition be more confident in dealing with county-related issues, and broadening the focus of coalition meetings. Respondents also reported increasing collaboration outside the LC, such as joint collaboration on grant proposals. At this stage, a disconnect existed between some of the participants' desires for input into the LC meetings and the request for such input from BTW. Although BTW asked for input when planning LC meetings and offered an opportunity to debrief at the end of LC meetings, some providers seemed not to recall these opportunities for input. One criticism was that material presented in the LC was interesting but not applicable to participating agencies, and participants recommended that more time should be spent on skill building and sharing experience about their SIP interventions. Examples of LC topics are included in Appendix D.

At the time of the 24 month interview providers expressed broad satisfaction with the Learning Community. The support, networking and sharing of information remained important for them and their staff members (the latter typically through participation in the fundraising and IT subgroups of the Learning Community). Many providers spoke about the ways in which their Learning Community participation positively impacted their system improvement project and the functioning of the county provider coalition (in which most of them participate). For some, it also provided new contacts and information to benefit other aspects of their agency's work (e.g., the start of a new adolescent treatment project with another Bay Area treatment agency).

Many of the suggestions for improvement of the Learning Community were addressed overtime as they surfaced (e.g., less outside speakers and more peer learning). However, some suggestions, due to their timing, could not be addressed for this Learning Community but may inform future ones (e.g., include more staff in the Learning Community meetings and start the special issue subgroups earlier in the Initiative). New recommendations related to the Learning Community include: the introduction of homework and individual consultation in-between group meetings, efforts to combine resources among agencies, and Learning Community participants that represent broader content and geographical foci. A number of BEST II providers stated their desire to participate in a Learning Community.

Looking forward, almost without exception, providers desired to continue the Learning Community. One provider questioned his own feasibility and interest in ongoing participation due to available time and a shift in the agency's priorities; another provider questioned the level of honesty among some of the providers and its impact for sustainability. At the time of our interviews, the Learning Community participants had submitted a proposal to the Schwab Foundation to obtain additional funds to continue to support the convening of the group; the subgroup focused on IT issues plans to meet on its own and had met once since the Initiative ended.

Interview Findings: BEST II

Assessment and Planning Process. Most providers reported that the AP process was positive and thorough. In general, providers reported that taking part in the AP process helped them to reflect on long-term goals and validated their beliefs about where the agency should focus their SIP. For some it added a new perspective that resulted in changed priorities. However, providers reported that the self-assessment tool seemed redundant with information collected during face-to-face interviews. Providers recommended that the self-assessment

instrument be used as a platform to develop new questions and then gather secondary information from face-to-face interviews; they also expressed the need to tailor the self-assessment tool to take into account the size of the agency; for some of the smaller agencies the questions did not seem relevant. When agencies reviewed the APP report to guide the selection and design of system improvement projects, the level and type of staff involvement varied. At some agencies the executive directors choose the focus of system improvement projects themselves; decisions at other agencies involved varying degrees of staff and board input.

When reflecting on the assessment process approximately one year after its completion, BEST II providers' voiced thoughts similar to those when asked one year earlier. However, with more time having elapsed, they provided additional examples of ways they use the assessment report: to collaboratively write and submit a grant with AIR, to enhance community support for their clinic's work, to inform agency reorganization, and for strategic planning. One agency described how they use their assessment report to aide the operation of the entire agency. They review and reference the report regularly in management and program team meetings and assign different staff the responsibility to address identified organizational capacity areas for improvement. Although the AP process was generally viewed as positive, one agency director reported that a "check in" with the agency regarding their selection of a system improvement project, implementation methods, or measurement of outcomes would have been helpful.

Implementation Process. In most cases, the APP team identified one top priority recommendation for agencies. However, they also identified related areas of investment and provided a list of other acceptable projects. The time frame set by the funder for the completion of system improvement projects and amount of the grant funds awarded strongly influenced the selection of projects in BEST II. Additionally, for 8 out of 9 agencies (89%), the APP team recommended that agencies hire consultants to assist in the design and implementation of system improvement projects.

Table 5: BEST II Areas of Organizational Capacity Investment

Organizational Capacity Area	No. of Priority Recommendations in each Area	No. of Selected Interventions in each Area
Purpose and Goal Attainment	3	3
Clinical Care/Services	1	1
Governance and Leadership	3	3
Staff Development and Human Resources	1	0
Business Operations	1	3
Infrastructure	1	2
Community Context/Connectedness	0	0
Structure and Communication	0	0
Total	10	12

The focus of the priority recommendations coming out of the AP process were on six major areas, and there was a total of 10 priority recommendations across the 9 BEST II participating agencies (see Table 4). Only two agencies did not follow the top priority recommendation proposed by the AP team. In one case, the agency proposed to focus on more than one organizational capacity area, however, this decision was based on a recommendation made by the AP team.

While the majority of agency directors selected the top priority recommendation made by the AP team, most also chose to take on more than one SIP. In general, system improvement projects focused on areas that the agency was already invested in and sought to expand through use of BEST funds. In many cases agency directors did not provide a clear explanation as to how SIP outcomes were measured, but reported that SIPs led to improvements in organizational structures and functioning evidenced by:

- Having a more effective leadership structure in place
- Creating a more effective treatment team and delivery system
- Developing long-term strategic plans
- Increasing use of computers
- Improving communication among staff
- Improving staff morale, cohesion and efficiency
- Improving the operation of finance and accounting systems
- More effective data gathering and reporting systems.

One agency director also reported improved client outcomes including reductions in early treatment drop out and improved substance use and psychosocial functioning among clients. At the 12-month follow up, almost all agencies reported that they had completed implementation of their system improvement projects, with the exception of one agency. The director of this agency reported that the system improvement project had not been fully implemented due to budgetary problems resulting from a major theft at the agency.

During the period that agencies implemented their system improvement project, they were faced with a number of challenges including not having an adequate number of management staff to meet agency needs, restructuring of clinical programs and services, and staff turnover which in one case was directly related to the implementation of their SIP (i.e, re-organization of service delivery programs and priorities required a higher level of professionalism). Other challenges included meeting staff training needs to allow staff to access computer resources, reductions in funding support from public sources, dedicating time to the implementation of SIPs, and staff resistance (e.g., to new technologies, difficulty in acceptance of new leadership structures).

Critical elements identified as necessary for the successful implementation of projects included having knowledgeable consultants, staff acceptance of SIP goals and commitment to change, and having existing resources at the agency that facilitated the implementation of the SIP (i.e., staff knowledgeable about computer technology).

Survey Findings: Organizational Readiness for Change and System Improvement Project Surveys

Based on survey responses, we found that agency staff had more favorable perceptions over time regarding their agency's functioning. With a few exceptions, our results did not support the hypothesis that investment in system improvement projects (e.g., Computer and Data Management Systems) would result in improvements in organizational functioning related to that area for the intervention group, but not the comparison group (i.e., agencies that did not select the SIP). In general, across SIP investment areas staff reported significant improvements in organizational functioning over time such as reductions in program and training needs, increased awareness and understanding of the agency's long-term goals, improved staff solidarity and cooperation, improved communication among staff, increased access to computers, e-communications, and data management systems, and a greater awareness of the importance of training and staff development and involvement in training activities. As expected, we also found that agencies that invested in governance and leadership interventions had greater improvements in the performance of managerial/leadership systems over time than agencies that did not select this intervention area. Surprisingly, we found that agencies that invested in computer and data management systems had less access to computers than the comparison group (i.e., agencies that did not invest funds in computer systems). This finding may reflect the fact that comparison agencies had greater access to computer resources than intervention agencies, and that to observe significant improvements in access to computers resources for the intervention group may have required a larger investment of funds than was possible through the BEST Initiative. We also found that agencies that invested in staff development and human resources activities exhibited higher program needs than the comparison group. Higher program needs for the intervention group most likely reflects a greater need for program resources than could be addressed by the system improvement project selected. Contrary to predictions, we found that agencies that selected a staff development and human resources intervention had lower scores on the SIP staff development subscale indicating that staff had more negative perceptions about the agency's commitment to career development issues and improving staff job performance. Additional findings suggest similar patterns of responses on measures of perceived commitment to improving clinical skills and involvement in professional growth activities and openness and ability to change for the staff development and human resources and comparison group at the baseline and 12-month follow up. However, at the 24-month assessment, the comparison group had higher scores on these measures.

DISCUSSION

Assessment and Planning Process

Satisfaction with the Assessment and Planning (AP) Process. Overall, respondents were positive about the AP process, their participation in the process, and the expertise and sensitivity of the AP team. However, a number of factors may have influenced satisfaction with the AP process including the program's readiness for the organizational assessment. Some Executive Directors were interested to receive and consider external feedback, while others had definite ideas about program needs and how to use BEST funds in advance of the organizational assessment. This may frame a consideration in future initiatives, such that programs having definite priorities for funding in advance of the organizational assessment may be less satisfied

with a broad assessment process or recommendations unrelated to those priorities. Furthermore, it is important to note that while nearly all BEST I and II agencies spoke positively about the AP process; there were some negative reactions including those related to the content and process of the AP process. We did find that several concerns expressed by BEST I participants were not expressed by BEST II participants. For example, in BEST II the timeline seemed more relaxed and less pressured, and Executive Directors had few complaints about the content and review of AP reports they received. The evaluation team believes this reflects improvements to the AP process made between BEST I and BEST II, such that the BEST II timeline was more generous, allowing the AP process to proceed sequentially rather than simultaneously in programs, and shifting distribution of the self-assessment tool to before rather than after the site visits. The AP team also reported that they had been sensitive to problems experienced in BEST I, and had modified their AP procedures.

While identified problems with the AP process may have interfered with an otherwise positive process, and contributed to a loss of the sense of partnership for some participants, criticisms almost always occurred in a broader context where most respondents regarded the AP process as positive and helpful to the agency. In future initiatives, agencies may benefit from an assessment approach that tailors the AP process to each agency, provides generous timelines for data gathering, assessment, and feedback and obtains input from the agency about what they hope to gain from the AP process. Furthermore, Executive Directors might be forewarned that the AP process report, may be critical and may reflect misunderstandings or misstatements, and that they would have the opportunity to discuss and modify the report where appropriate before it went on to the Foundation. Restructuring the AP process in these ways might prevent or minimize problems in future organizational initiatives using an AP process.

In terms of the AP process, several issues bear comment: a) the self-assessment tool, b) adjusting the AP process to the size or complexity of the agency, c) ownership of the AP process, and d) use of consultants.

Self-Assessment Tool. BEST I providers sometimes experienced this tool as redundant, coming as it did in some cases after the site visit had been completed and revisiting information provided in the site visits. This was understandable since, in BEST, part of the goal was to develop and pilot a self-assessment tool that might later be used by programs not receiving intensive site visits. The goal was to develop a self-assessment tool that many drug abuse treatment programs could use to review agency systems and operations.

While the timing of the self assessment tool was earlier in BEST II, coming prior to the site visits, some respondents still complained about redundancy, noting that the site visitors asked for some of the same information that had been provided in the written self assessment. Some BEST II respondents were uncertain whether the site visitors had read the self-assessment responses, because they asked some of the same questions that were included in the self-assessment survey.

On reflection, it seems that the self-assessment tool may be more useful where there are no follow-up site visits, or where site visits are used to clarify and further develop information provided in the self-assessment. Future organizational initiatives using an AP process may consider using either site visit or self-assessment procedures, or if both are applied, minimizing overlap.

Adjusting the AP Process to Size or Complexity of the Agency. Across the 20 agencies participating in BEST were large agencies with multi-million dollar annual budgets and service sites spread throughout California, and small agencies serving specialized populations in a single site. Respondents from the largest and smallest agencies commented that the AP process seemed to be a "one size fits all" model. Respondents from larger agencies expressed concern that the AP process did not adequately assess the agency as a whole, while those in smaller agencies felt a more modest AP process may have worked better for them. Understanding that the AP process is innovative and involved learning for those both conducting the process and participating in it, and was generally highly valued by respondents, one reflection is that future AP efforts may be suitably modified to account for the size and complexity of the program being assessed.

Ownership of the AP Process. The BEST Initiative was structured so that the Foundation paid for the AP process, and in this sense "owned" the AP report. BEST agencies had limited ability to control information or conclusions in the report. Insofar as AP recommendations agree with the Director's understanding of their agency or expectations about what they might change, this arrangement may cause few problems. However, in cases where AP recommendations do not agree with the Director's assessment or priorities, the Director potentially faces negative choices: either find in the recommendations something with which they agree, or reject the recommendations and justify an alternative area of investment.

The advantage of the approach used in BEST was having an independent assessment, where observations or recommendations at odds with the agency director could be considered. The disadvantage was that agencies may not openly disagree with the report because of their concern that they could risk of loss of funding, even if the funder stated that this would not occur. The situation may be different if the report went only to the agency. Then the Director could privately disagree with the report and frame a proposal based on their understanding or priorities.

In future similar initiatives it may be helpful to consider the competing gains of these different approaches. If the Foundation is interested to use independent assessments to encourage agencies to work in areas not always of their choosing, and willing to use funding as a lever, then the current BEST approach may be suitable. If the Foundation does not intend to use funding as a lever to direct agency selection of its intervention, then organizational assessment reports to the Director may be helpful to the agency and not involve perceived risk of loss of funding. In either case, it seems important that these issues are understood in advance: who owns the report, whether participants offer proposals that are consistent with recommendations in the report, and whether failure to do so may mean that a proposal will not be funded.

Use of Consultants. Many of the recommendations provided by the AP team, and the proposed intervention projects, suggested work with consultants. Participating agencies did work with consultants, particularly in the areas of data systems and governance and board development. Participants had mixed success with consultants initially, and expressed concerns about finding consultants having the specialized expertise needed (e.g., in board development or data systems), and also being knowledgeable about non-profit service systems. At the two-year follow up, participants generally reported positive experiences working with consultants. One organizational capacity improvement in the local treatment system may have been gaining experience, for agencies both individually and collectively, in how to find and use consultant services, an impact that may be expected to extend in time beyond the BEST Initiative.

If use of consultants is a likely outcome of the assessment process in future initiatives, it

is important to consider the best ways to support agencies in finding consultants with the desired mix of skills and experience, without having the Foundation endorse specific consultants. One strategy, applied in BEST was to have participants share information about consultants in a Learning Community meeting, although this seemed to occur too late in the Initiative to be useful to most participating agencies. Another strategy may be to provide a training session dedicated to effective collaboration with consultants which, if offered by a party outside the Foundation, may include a list of potential consultants.

Funding in the BEST Initiative.

The BEST Initiative provided $20,000 to $40,000 per agency to offset costs associated with completing the AP process, after which the agency proposed a specific organizational change intervention. Once the proposals were approved by the CHSF Program Officer, all agencies received $50,000 per year to implement the proposed changes. One important distinction was that BEST I agencies received $50,000 per year for 2 years, while BEST II agencies received $50,000 for one year only. Based on respondent interviews, the evaluation team has considered reflections related to BEST funding including: a) clarity about the amount of funding available to agencies, b) the balance of assessment vs. intervention funding, c) the relationship between AP recommendations, agency proposals and the available funding, d) one vs. two years of intervention funding, and e) the adequacy of funding in terms of the work proposed.

Clarity about the Amount of Funding Available to Agencies. Early in the BEST Initiative and before agencies had received any funding, the amount intended per agency was described as an average of $50,000 per year for two years. This was in consideration of the varying size and complexity of participating agencies and the nature of the chosen system improvement project. Although unstated, it also left open the expectation that more ambitious proposals by any agency may result in greater funding. After proposals were submitted to the foundation, it was made clear that the funding amount was fixed at $50,000 per agency per year. Had this level of support been known in advance, both the assessment team and agency Directors could have framed their recommendations and proposals with this amount in mind.

In stating an ambiguous funding level at the start, the Foundation may have encouraged proposals larger and more varied in scope and, although not a stated strategy, may work to maximize effort and increase overall gain of the Initiative. At the same time, the absence of a clear funding level may encourage recommendations and proposals that are outsized in comparison with funds eventually committed. Funders aim to maximize the gain of their community investments, and programs aim to maximize funding received as well as positive accomplishments that may accrue. It is predictable that agencies will propose projects and budgets consistent with the maximum funds available. In an effort to win competitive funding, grantees may also, and perhaps typically, envision leveraging grant funds so as to offer work and accomplishments not achievable with grant funds alone.

This leveraging approach, by both grantor and grantee, can result in ambitious proposals. The advantage, which everyone hopes for, is gain beyond the funding amount. The accompanying risk is that parts of the proposed work may be later dropped or only addressed nominally. The evaluation team suggests that the amount of funding per agency is better made clear at the start, so that proposals can be framed with these amounts in mind. Beyond this, the Foundation and initiative planners may wish to consider the balance between a conservative

strategy that works to limit proposals directly to available funding, and the leveraging strategy that encourages agencies to propose broad or multiple objectives. Broad leveraging objectives, while desirable, are difficult to measure and more difficult to attribute to the Initiative directly.

Balance of Assessment vs. Intervention Funding. BEST agencies received $20,000 to $40,000 for participating in the AP process, followed by $50,000 per year to implement the selected system change. Importantly, BEST I agencies received the $50,000 per year implementation funding for two years, while BEST II agencies received this amount for only one year. In BEST I the total available to any agency was approximately $120,000 ($20,000 APP, $50,000 intervention in year 01, $50,000 intervention in Year 02). In Best I, then, AP funding to the agency represented 17% of all funds provided. In BEST II, because there was only one year of intervention funding, this proportion was 40%.

Supporting agencies to participate in the AP process helps defray costs of participation. Funding agencies to participate in the AP process may also be helpful if incentives are needed to garner their agreement to participate, or if those participating in the process are not assured of receiving subsequent intervention funding. At the same time the proportionate funding for participating in the AP process in relation to that for the system change intervention, may have been unnecessarily high. Some respondents report that they would have participated in the AP process for less, because it had organizational value. No respondents expressed that AP funding was too low to support participation, and some reported applying "leftover" AP funds to their intervention phase. As the BEST Initiative was structured, all agencies participating in the AP process were intended to receive subsequent intervention funding if they submitted a reasonable proposal. Given these considerations, shifting agency funding partly from the AP phase to the intervention phase may offer increased intervention support without affecting AP participation.

Relationship between Recommendations, Proposals and Funding. The AP process was designed as a complete organizational review intended to guide the agency proposal, but without regard to the amount of funding available. That is, AP recommendations were framed without consideration of the funding limit placed on the intervention. This strategy offered agencies feedback and recommendations in a number of areas, helped agencies consider a range of possible program improvements, and may have supported leveraging of other funds. A different approach may be to conduct the complete organizational review, and even offer broad recommendations, but then suggest actions that might be accomplished with the available funds. The general issue is how to make meaningful recommendations in the context of available funding, both directing the agency to achievable objectives and retaining the value added by a complete organizational assessment.

One vs. Two Years of Intervention Funding. Comparing follow-up interviews with BEST I and BEST II projects, we observe that one year of intervention provided in BEST II may not support envisioned system changes.

In future similar initiatives, participating agencies may benefit from individual consultation about which project would be most appropriate for the agency given the available funding, length of funding period, potential impact, and sustainability. Whether the funding provided is small or large, it is important to know at the outset that funding available will support the aims of the SIP to be implemented in programs. To assist in this, it may be helpful for providers to have a section in the AP report that discusses cost. For example, an outline of major components of

the intervention and estimates of short and long-term costs (that is, costs associated with sustaining system changes) may inform the design of more focused projects.

System Improvement Project (SIP) Implementation

Design and Implementation of System Improvement Projects (SIPs). Some providers were unclear as to how to pursue their SIP; others were unsure how to measure the impact of their project. In general, providers did not receive assistance from BEST partners in designing system improvement projects or determining how to measure impacts. While providers may have benefited from consultation of the AP team or outside consultants in designing their SIP, this did not occur formally or systematically. The evaluation found, for example, that agencies commonly included more than one capacity building area in their proposal. Asked about this, participants sometimes offered that they understood the scope exceeded the funds available, but that they planned to leverage funds from other sources. In some cases they did, but in other cases one or more objectives were later dropped or received minimal attention.

During follow up interviews, most agency Directors perceived higher efficiency as a result of implementing their SIP. For example, providers reported becoming more efficient in tracking units of service, communicating with staff members using email systems, managing fund development departments, monitoring fiscal systems and managing clinical and administrative systems. Providers also reported that SIPs had led to unplanned positive outcomes in systems operations (e.g., staff development, tracking units of service and budgets). Although some agency directors thought the SIP projects may have been implemented at these agencies without BEST funding, this process was accelerated due to BEST.

A number of BEST I participants experienced slow progress at the outset in terms of selecting and working with consultants in different areas. Some participants also reported that the intervention they were implementing grew in complexity or cost, or required more time than first envisioned. Specific examples were efforts to improve, upgrade or integrate computer and data systems where, for example, creating unified electronic communication across separate sites within one agency may require certain specification and investments. Similarly, integrating into this system common communication, financial, or data gathering software required additional specification and investment. A second example described by respondents was the amount of time that it took for the costs of the fundraising position to become cost-effective and bring additional return to the agency. Agencies found that it took more time to do such things as find and hire the fundraising staff person, develop fundraising strategies, build a donor base, and write successful funding proposals. Building or rebuilding Boards of Directors, and often focusing board activities on fund development activities, likewise took time, and tended to occur by attrition of existing members and recruitment of new board members who understood and accepted the fund development as part of their mission. If these lessons seem plain enough in retrospect, they were not known or expressed early in the course of the BEST Initiative, where the time and funding available seemed at first sufficient to all of these tasks. The longer time needed to accomplish these systemic changes also means that observation of the effects of capacity building may be delayed.

In future similar initiatives, similar to the design of projects, participant agencies may benefit from assistance to revise project objectives so that they are achievable given the timeline and budget, and to help ensure the availability of measurable data. This could have included more proactive and regular check-ins by Foundation staff, the AP team or other persons with

experience in organizational change efforts. For agencies not experienced in capacity building, collaboration with an experienced agency may be helpful. This type of input may enhance the impact of the initiative by increasing the long-term capacity of agencies to design, implement and evaluate their work. Issues helpful to consider include: who is most appropriate to assist agencies (e.g., Foundation staff, AP team, evaluation team), whether this type of input is recommended or required, and the relationship between evaluation and program monitoring.

Impacts of SIPs. Both interview findings and survey results indicated that programs experienced positive changes as a consequence of participating in the BEST Initiative. Specifically, agency directors attributed a number of positive changes to their involvement in the BEST Initiative and implementation of SIPS including higher efficiency among staff and operational systems. Additionally, survey results indicated that staff had more favorable perceptions about how their agency functioned after involvement in the Initiative; and few group differences emerged. Although survey findings suggested improved organizational functioning across agencies over time, our findings must be interpreted within the context of the evaluation's limitations including a small sample size, missing data, and observational nature of this evaluation. Therefore, replication of the evaluation's findings using larger samples and a randomized controlled trial design is desirable. Nonetheless, the combined results of executive directors interviews and staff surveys suggest that participation in the BEST Initiative had a positive impact on organizational functioning at these agencies.

Monitoring the System Improvement Project (SIP). Oversight of SIP implementation in any given agency was generally left to the responsibility of the Agency Director. While Directors reported that the Foundation program officer was accessible, and some had sought his assistance on program questions, monitoring of SIP implementation either by the Foundation or by the Agency was variable. A high level of monitoring had the drawbacks of taking agency time away from other activities and may be experienced as unhelpful. At the same time, some level of monitoring may remind agencies that progress is important to the funder, may organize agency efforts toward periodic reporting requirements, and may offer opportunity to discuss and address any problems encountered.

Learning Community (LC).

Comments on the LC refer only to BEST I participants, all of whom were located in a shared geographic area in San Mateo County. BEST II agencies were geographically dispersed throughout the Bay Area, and the BEST II initiative did not include an LC.

In BEST I the pre-existing Provider Coalition set the stage for the LC because trust had already been built among participants through the work of the coalition. Unlike the coalition, which focused heavily on relationships between the providers and the County funding agency, the LC focused on areas of interest to, and chosen by the members, and generally unrelated to County issues. Some respondents commented that the work of the LC might have been accelerated by briefer focus on building trust, which already existed in this group, and earlier focus on more substantive issues. One key suggestion from participants early in the initiative was to develop smaller groups based on common BEST capacity building projects, as a way to further enhance the impact of the LC. This suggestion was followed later in the course of the BEST initiative.

The LC seemed to enhance participant involvement in the Initiative as well as their

organizational work. The goals of the Learning Community - to serve as a forum for sharing experiences and resources related to capacity building, for building trust and collaboration among Initiative partners, and for discussions or presentations concerning areas of mutual concern - were met to some extent. The outcomes that occurred most frequently among LC members required less commitment and involvement (e.g., sharing SIP experiences during LC meetings) as compared to those outcomes that occurred less frequently (e.g., collaboration to submit a joint grant proposal).

The flexibility of the LC to evolve and change to meet the needs of the participants was a particular strength. Some of the challenges that the LC experienced such as meeting the expectations of all participants, obtaining input from members, and how to continue the LC once funds cease remain challenges but are not unique to this effort.

LCs can add value to organizational capacity building initiatives such as BEST. In this case, due to the existing relationships among most of the participants and their close geographic proximity, the cost of the LC was relatively low and, although not insignificant, the time commitment for providers was relatively small. This may not be the case for other LCs in which participants do not know each other, or need to travel significant distances for meetings. In thinking about future Learning Communities as part of an Initiative such as BEST, we would recommend considering inclusion of the following elements:

- An individual or group to manage the LC
- A flexible design that allows the LC to evolve according to the input of its participants
- Utilization of peers as much as possible for planning and as resources
- Involvement of other agency staff who work closely on the SIP (besides the Executive Director) as part of the larger LC meetings
- Formation of smaller groups that focus on specific SIP areas at the start of the Initiative
- Discussion and plans for sustainability of LC post-funding early in the Initiative process.

Role of the Foundation.

Providers from the BEST I and BEST II initiatives had positive comments about the foundation staff and the process in which they worked.

- Avoidance of competition among BEST I providers since all providers could participate
- Inclusion of substance abuse treatment providers in the design process of the Initiative
- Uniqueness of project with few “strings attached,” easy reporting, and a broad range of system improvement areas to focus on
- Openness and flexibility regarding how funds were used (e.g., one agency was allowed to use surplus funds from the AP process for their SIP project)
- Accessibility of Foundation staff.
- Able to use as a resource to call with questions or receive referrals
- Passionate about substance abuse treatment
- Updates on the substance abuse treatment field (e.g., through the Foundation’s substance abuse treatment weekly e-mail update and through updates from the field at LC meetings)

- Tangible support provided for BEST I's county coalition efforts (e.g., funding for BTW consultant to lead a coalition retreat)

Suggestions to improve the role of the foundation centered on communication. Some of the providers weren't sure how much communication with the foundation staff was appropriate and would have liked some more information about the project timeline, reporting, and feedback on their foundation reports.

In the Fall of 2004, near the end of the BEST I initiative and about midway through BEST II, and in the context of an extended market downturn, the Charles and Helen Schwab Foundation retrenched, dramatically reducing its focus on substance abuse services and retaining its longstanding core focus on learning disability. This change did not affect funding for participating agencies, all of which received funding to their established project end date. However, providers commented on the asset that CHSF and the BEST initiative had brought to the substance abuse provider community, by expanding the existing federal-state-local funding partnership, by focusing energy on organizational development, and through a demonstration of understanding of and concern for the improvement of community-based treatment systems. Providers commented on the subsequent loss to the substance abuse treatment system that would follow the withdrawal of CHSF from this program area. The intention of the BEST initiative, as expressed by the CHSF Substance Abuse Program Officer, had been to involve all Bay Area substance abuse treatment agencies in the initiative over time, supporting a broader movement toward organizational assessment and organizational development in these treatment systems. Providers hoped that leadership shown by CHSF in partnering with substance abuse treatment systems may encourage other foundations to take a more active role in this area, expanding the base of support and opportunity for innovation in treatment programs and treatment systems. In final process evaluation interviews, key informants expressed disappointment with the loss of these real and potential supports.

CONCLUSIONS

The BEST Initiative provides important support for substance abuse treatment organizations to focus on improvements to their agency's organizational capacity. At the 24 month follow up, providers report positive impacts on themselves and their organizations as a result of their involvement. Most agency directors reported that they had completed implementation of their system improvement projects. However, providers also reported that some projects had limited impacts or their potential had not been fully realized during the two-year project implementation period. The other components of the Initiative, the AP process and the Learning Community seem to have provided a good opportunity for agency reflection and input related to system improvement projects and other aspects of their work (e.g., county level substance abuse policies). While positive impacts as a result of BEST system improvement projects are reported in interviews and group discussions, the survey data only weakly show this type of evidence. As mentioned above, this may result from a number of Initiative design and methodological reasons including the relatively short period of time since the implementation of the intervention, the amount of funding, and the number of individuals and agencies surveyed.

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Appendix A
Interview Guide for Executive Directors and Other Key Stakeholders

Questions for Executive Directors

We would like to know why your agency decided to participate in the BEST Initiative.

1. What is your understanding of the goals of the BEST Initiative?

2. What are the main reasons that you want to be involved in this Initiative? (Probe: What changes/impact do you expect as a result of being part of this Initiative? At the individual and organizational level)

We are interested in learning about your agency's experience with the assessment and planning phase of the BEST Initiative.

3. Can you describe how your organization selected individuals to participate in the assessment and planning phase of the BEST initiative? (Probe: To what extent are you satisfied with the procedures involved in selecting representatives of your agency to participate in the assessment and planning phase of the BEST initiative? Number of individuals involved? Match between your agency's needs and expertise of those selected within your agency to participate in the APC process?)

4. Did you participate in the planning process, and if so, how? At the beginning of the assessment process, did you have some area or areas identified for the system intervention; what were they? Did your thinking about the needs of the organization, or how those needs were prioritized, change during the course of the assessment process? How well did the final recommendations made by the assessment and planning team reflect your perception of agency needs?

5. Can you tell me how your organization decided to focus on [state their specific long-term system improvement project]? (Probe: who was involved, decision-making process, pros and cons of different options, etc.). What role did the Schwab Foundation play in helping you to identify a system improvement project? (Probe: negotiation process).

6. What do you think was most useful about the assessment and planning process? What was most challenging? * (Probe: What are your thoughts on the self-assessment tool? What are your thoughts on the timeline for completion of tasks during the assessment and planning phase? What did you learn about your agency that you did not know before you participated in the assessment and planning phase? What was surprising or unexpected?)

7. To what extent do you think that the assessment and planning team had appropriate backgrounds, skills, and expertise to assist your organization?* (Probe: ability to create a safe environment, expertise related to organizational capacity issues of interest, sensitivity to cultural and diversity issues, etc.)

8. What recommendations would you make to improve the assessment and planning process?

9. What current services or support are you receiving from AIR or BTW? (Probe: If yes, what services?)

We are interested in gaining a better understanding of your agency's system improvement project and the unique challenges you think you will face.

10. How would you summarize your organization's system improvement project? (Probe: What are the project's short-term goals? What are the project's long-term goals?)

11. What do you think are critical elements to make your project a success? (Probe: infrastructure, organizational practices, resources, staffing issues, etc.)

12. What are the main challenges you think you will face in implementing your project? (Probe: infrastructure, organizational practices, resources, staffing issues, etc.)

13. How will your agency assess the effects/outcomes of your system improvement project? (Probe: What systems does your agency have in place to assess the impact of your system improvement project?)

We are interested in obtaining your views on the Learning Community.

14. What is your understanding of the purpose of the Learning Community?

15. What is appealing to you about being part of this community? What concerns you?

16. What do you hope this community accomplishes? (Probe: personal impact as well as group impact)

17. What do you think are critical elements to make the Learning Community a success?

18. To what extent are the leaders (i.e., BTW consultants) of the Learning Community addressing the needs of providers?

19. As you probably know, BTW consultants are providing ongoing planning and support for the BEST Initiative. This includes facilitating communication among BEST Initiative participants and organizing and convening the Learning Community meetings. To what extent is BTW effective in this role? To what extent are they addressing the needs of providers who are involved in the BEST Initiative? (Probe: What is most successful? What could be improved?)"

20. Is there anything else that you would like to discuss?

Thank you for your participation in this interview.
***Without exception, all program participants should be asked these questions.**

Interview Questions for Other Stakeholders

We are interested in gaining a better understanding about the goals of the BEST Initiative, and your experiences with the planning process of the initiative.

1. What is your understanding of the goals of the BEST Initiative?

2. What is the history of this initiative and how did this come about?

3. What was the nature of the planning process for the BEST Initiative?

4. Please describe your specific role and responsibility in this initiative?

5. What do you hope this initiative accomplishes? (Probe: for yourself, your agency, and the broader initiative?).

6. What aspects of the initiative have gone especially well, and why?

7. What have been the most important challenges you have confronted working on this initiative so far? How have you dealt with those challenges? (Probe: how addressed or how should they be addressed, reasons occurred, etc.).

8. Can you describe your experience with other participants of the BEST Initiative? (Probe: What went well? What were the main challenges? What was surprising or unexpected?).

9. What are the policy implications of this initiative? (Probe: What impact do you think that this initiative will have on the substance abuse treatment system in San Mateo County or nationally?)

10. Given your experiences with this initiative to date, what would you do differently (or do you plan to do differently) in the future? (Probe: Are there things, that given further reflection, you wish you had done differently?).

11. What are the most important things you have learned during this process so far?

12. What do you hope the Learning Community accomplishes? (Probe: personal impact as well as group impact)

13. To what extent is BTW effective in their role as project coordinator? To what extent are they addressing the needs of the Schwab Foundation? To what extent are they meeting the needs of providers involved in the BEST Initiative?

Thank you for your participation in this interview.

Appendix B
Organizational Readiness for Change Survey

The Organizational Readiness for Change (ORC) is a copyrighted instrument developed at the Institute for Behavioral Research, Texas Christian University, TCU Box 298740, Fort Worth, Texas, 76129. Survey forms and scoring criteria may be retrieved at www.ibr.tcu.edu.

The ORC includes 115 items representing 18 subscales designed to measure organizational factors believed to influence the adoption of new technologies. Two versions of the survey (i.e., directors and clinical staff) capture these different perspectives. Higher scores on each scale represent "more" of the attribute represented.

The 18 subscales can be grouped into four categories: Motivation for Change, Program Resources, Staff Attributes and Organizational Climate. Below is a list of survey scale items within scales. We analyzed data at the subscale level and did use the superordinate categories. Each item was answered on a scale ranging from 1 (disagree strongly) to 5 (agree strongly). Higher scores on the Motivation for Change scales indicate greater perceived need for change. Higher scores on the remaining scales (Program Resources, Staff Attributes and Organizational Climate) indicate favorable perception of the agency in that area. The single exception is the Stress subscale, in which higher scores indicate higher perception of stress within the agency.

MOTIVATION FOR CHANGE (Needs/Pressure)

Program Needs

Your program needs additional guidance in (Staff Version)–

- assessing client needs.
- matching needs with services.
- increasing program participation by clients.
- measuring client performance.
- developing more effective group sessions.
- raising overall quality of counseling.
- using client assessments to guide clinical and program decisions.
- using client assessments to document program effectiveness.

Your program needs additional guidance in (Program Director Version) –

- documenting service needs of clients for making treatment placements.
- tracking and evaluating performance of clients over time.
- obtaining information that can document program effectiveness.
- automating client records for billing and financial applications.
- evaluating staff performance and organizational functioning.
- selecting new treatment interventions and strategies for which staff need training.
- improving the recording and retrieval of financial information.
- generating timely "management" reports on clinical, financial, and outcome data.

Training Needs

You/your counseling staff need(s) more training for –

- assessing client problems and needs.
- increasing client participation in treatment.
- monitoring client progress.
- improving rapport with clients.
- improving client thinking and problem solving skills.
- improving behavioral management of clients.
- improving cognitive focus of clients during group counseling.
- using computerized client assessments.

Pressures for Change

Current pressures to make program changes come from –

- clients in the program.
- program staff members.
- program supervisors or managers.
- agency board members.
- community action groups.
- funding and oversight agencies.
- accreditation or licensing authorities.

RESOURCES

Offices

- Your offices and equipment are adequate.
- Facilities here are adequate for conducting group counseling.
- Offices here allow the privacy needed for individual counseling.
- This program provides a comfortable reception/waiting area for clients.

Staffing

- There are enough counselors here to meet current client needs.
- A larger support staff is needed to help meet program needs.
- Frequent staff turnover is a problem for this program.
- Counselors here are able to spend enough time with clients.
- Support staff here have the skills they need to do their jobs.
- Clinical staff here are well-trained.

Training

- Staff training and continuing education are priorities at this program.
- You learned new skills or techniques at a professional conference in the past year.
- The budget here allows staff to attend professional conferences each year.
- This program holds regular in-service training.

Computer Access

- Client assessments here are usually conducted using a computer.
- Computer problems are usually repaired promptly at this program.
- Most client records here are computerized.
- You have a computer to use in your personal office space at work.
- Computer equipment at this program is mostly old and outdated.
- Staff here feels comfortable using computers.
- More computers are needed in this program for staff to use.

e-Communications

- You used the Internet (World Wide Web) to communicate with other treatment professionals (e.g., list serves, bulletin boards, chat rooms) in the past month.
- You have easy access for using the Internet at work.
- You used the Internet (World Wide Web) to access drug treatment information in the past month.
- You have convenient access to e-mail at work.

STAFF ATTRIBUTES

Growth

- This program encourages and supports professional growth.
- You read about new techniques and treatment information each month.
- You have enough opportunities to keep your counseling skills up-to-date.
- You regularly read professional journal articles or books on drug abuse treatment.
- You do a good job of regularly updating and improving your skills.

Efficacy

- You have the skills needed to conduct effective group counseling.
- You consistently plan ahead and carry out your plans.
- You usually accomplish whatever you set your mind on.
- You are effective and confident in doing your job.
- You have the skills needed to conduct effective individual counseling.

Influence

- You frequently share your knowledge of new counseling ideas with other staff.
- Staff generally regard you as a valuable source of information.
- Other staff often ask your advice about program procedures.
- Other staff often ask for your opinions about counseling and treatment issues.
- You often influence the decisions of other staff here.
- You are viewed as a leader by other staff here.

Orientation (scale not computed)

- Psychodynamic theory is commonly used in your counseling here.
- Pharmacotherapy and medications are important parts of this program.
- Behavior modification (contingency management) is used with many of your clients here.
- 12-step theory (AA/NA) is followed by many of the counselors here.
- Cognitive theory (RET, RBT, Gorski) guides much of your counseling here.

Adaptability

- You are willing to try new ideas even if some staff members are reluctant.
- Learning and using new procedures are easy for you.
- You are sometimes too cautious or slow to make changes.
- You are able to adapt quickly when you have to shift focus.

ORGANIZATIONAL CLIMATE

Mission

- Some staff get confused about the main goals for this program.
- Program staff understand how this program fits as part of the treatment system in your community.
- Your duties are clearly related to the goals of this program.
- This program operates with clear goals and objectives.
- Management here has a clear plan for this program.

Cohesion

- Staff here all get along very well.
- There is too much friction among staff members.
- The staff here always work together as a team.
- Staff here are always quick to help one another when needed.
- Mutual trust and cooperation among staff in this program are strong.
- Some staff here do not do their fair share of work.

Autonomy

- Treatment planning decisions for clients here often have to be revised by a counselor supervisor.
- Management here fully trusts your professional judgment.
- Counselors here are given broad authority in treating their own clients.
- Counselors here often try out different techniques to improve their effectiveness.
- Staff members are given too many rules here.

Communication

- Ideas and suggestions from staff get fair consideration by program management.
- The formal and informal communication channels here work very well.
- Program staff are always kept well informed.
- More open discussions about program issues are needed here.
- Staff members always feel free to ask questions and express concerns in this program.

Stress

- You are under too many pressures to do your job effectively.
- Staff members often show signs of stress and strain.
- The heavy workload here reduces program effectiveness.
- Staff frustration is common here.

Change

- Novel treatment ideas by staff are discouraged.
- It is easy to change procedures here to meet new conditions.
- You frequently hear good staff ideas for improving treatment.
- The general attitude here is to use new and changing technology.
- You are encouraged here to try new and different technique.

Appendix B
BEST SIP Outcomes Survey

This survey asks questions about your role as executive director and board member and the various activities, management and functions of the board and agency. These questions apply to the last 6 months. Please answer and mark the appropriate box for each question.

Governance and Leadership	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1. Senior management has the leadership skills to run this agency effectively.					
2. This agency has the appropriate number and composition of senior staff.					
3. It is difficult to fill open senior staff positions.					
4. Succession planning occurs for senior management positions.					
5. Senior management effectively collaborates with board members.					
6. Senior management meetings take place on a regular basis.					
7. Senior management agrees on the mission and goals of the agency.					
8. Senior management works effectively with each other.					
9. Senior management can articulate the mission and goals of the agency to others.					
10. This agency has a formal governance structure and process.					
11. This agency has staff input on its visions and goals.					
12. This agency has a written procedure manual.					

Comment Box: Governance and Leadership

Staff development	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
13. Staff receives adequate supervision.					
14. A performance appraisal system is regularly used (e.g., to review performance, salary and benefits).					
15. The agency invests in career development from the entry level and up.					
16. The agency has a policy of promotion from within the organization.					

Comment Box: Staff Development

Financial Resources	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
17. This agency needs guidance in developing strategies to diversify funding.					
18. This agency is effective in working with funding and oversight agencies.					
19. This agency has easy access to information on funding opportunities/sources.					
20. This agency has a fund developer who is charged with identifying grant opportunities and grant writing.					
21. This agency has a long-term financial/business plan.					
22. Board members are involved in making decisions regarding grant submissions, and contribute to fundraising.					
23. Staff is involved in generating ideas to improve fund diversity.					
24. This agency is effective in meeting grant submission deadlines.					
25. This agency uses the service of a fund developer to assist in the submission of grant applications.					
26. This agency has systems and controls in place to manage finances.					
27. This agency has stable funding.					

28. Outside of grants, contracts, this agency engages in revenue-generating activities.					

Comment Box: Financial Resources

Data Systems	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
29. This agency has a dedicated Data Manager.					
30. This agency reviews client demographic characteristics of its client population (e.g., average age, gender, ethnicity) at least annually.					
31. This agency reviews treatment outcomes of its client population (e.g., average time in treatment) at least annually.					
32. This agency uses client-level data in grant proposals and other fund raising efforts.					
33. Information about our client population (age, gender, ethnicity, time in treatment) is easily accessible within the agency.					
34. Information about our client population is easily accessible from County or State databases.					
35. Client data collected and reported to county is useful to this agency.					
36. Client-level data must be entered into multiple databases to address the reporting requirements of multiple funders.					
37. Computer technical support for staff is adequate.					

Comment Box: Data Systems

Appendix C
Organizational Readiness for Change and System Improvement Project Subscales Detailed Remarks

Financial Resources Intervention Group: Contrary to predictions, there were no significant group ($p = 0.18$) or group by time ($p = 0.25$) interaction effects for the Program Needs ORC subscale. However, there was a significant main effect for assessment period ($p < .05$); ORC program needs subscale scores tended to decrease over time. Regarding the SIP Financial Resources subscale, we found no significant effects for time, group, or a group by time interaction.

ORC and SIP Mean Subscale Scores and Standard Deviations at Each Assessment for Financial Resources Intervention and Comparison Groups

	Assessment					
	Baseline		12 Month		24 Month	
Variable						
ORC Program Needs	M	SD	M	SD	M	SD
Financial Resources Intervention Group	3.25	.63	3.00	.75	2.79	.69
Comparison Group	3.26	.74	3.12	.72	3.17	.53
SIP Financial Resources						
Financial Resources Intervention Group	3.29	.56	3.39	.48	3.34	.57
Comparison Group	3.21	.57	3.31	.44	3.35	.47

Governance and Leadership Intervention Group: For the ORC Mission subscale, there was a significant main effect for assessment period ($p < .0001$); ORC Mission subscale scores increased over time suggesting that staff increased their awareness and understanding about their agency's goals. There were no significant group or group by assessment interaction effects.

We found a significant main effect for assessment period for the ORC Cohesion subscale ($p < .01$), reflecting that staff perceived interpersonal interactions among staff members in a more favorable light over time. No other significant effects were observed.

Similarly, a significant main effect for assessment was observed for the ORC Communication subscale ($p < .05$). The ORC Communication subscale scores tended to increase over time suggesting improved communication among staff. A significant main effect for group or group by assessment interaction for the ORC Communication subscale failed to emerge.

There was a significant interaction effect for the SIP Governance and Leadership subscale ($p < .05$). As figure 1 shows (see Appendix E), SIP Governance and Leadership scores for respondents in the intervention group increased steadily from baseline to the 24-month follow up assessment, while scores for the comparison group initially decreased, but stabilized by the 24-month assessment. This significant interaction effect indicates that the intervention group had more favorable impressions regarding the

business management and leadership skills of their senior staff over the course of the follow up period than the comparison group.

ORC and SIP Mean Subscale Scores and Standard Deviations At Each Assessment for Governance and Leadership Intervention and Comparison Groups

	Assessment					
	Baseline		12 Month		24 Month	
Variable						
ORC Mission	M	SD	M	SD	M	SD
Governance and Leadership Intervention Group	3.53	.67	3.77 3.78	.50	3.84	.43
Comparison Group	3.66	.50	3.89	.51	3.78	.46
ORC Cohesion						
Governance and Leadership Intervention Group	3.81	.72	4.02	.71	3.91	.70
Comparison Group	3.75	.42	3.91	.53	3.82	.48
ORC Communication						
Governance and Leadership Intervention Group	3.54	.60	3.80	.57	3.79	.66
Comparison Group	3.57	.53	3.71	.58	3.69	.44
SIP Governance and Leadership						
Governance and Leadership Intervention Group	3.73	.56	3.86	.48	4.08	.38
Comparison Group	3.87	.47	3.81	.40	3.78	.48

4.2.2.c Computer and Data Management Intervention Group. A significant main effect for group was found for the ORC Program Needs subscale ($p < .05$); Program Needs scores were higher for the comparison group. (see Figure 2 in Appendix E). There was also a significant main effect for assessment ($p < .05$), indicating a decrease in program needs over time. The group by assessment interaction was not significant.

As shown in Figure 3 (see Appendix E), the ORC Computer Access subscale scores for the comparison group were significantly higher than the intervention group suggesting greater use of computers and satisfaction with the level of access to computers and data management systems at these agencies ($p < .01$). There was also a main effect for assessment ($p <.0001$) with ORC Computer Access subscale scores increasing over time ($p < .0001$). A significant group by assessment interaction was not observed.

Similarly, we found a significant assessment effect for the ORC E-communications subscale ($p < .01$). Agencies reported having greater access to e-communications over time. No other significant effects were observed.

SIP Computer and Data Management subscale scores significantly increased from baseline to the 24-month follow-up assessment suggesting greater accessibility and use of client level data as well as greater use of data management systems at agencies ($p < .01$). No other significant effects were observed.

ORC and SIP Mean Subscale Scores and Standard Deviations At Each Assessment for Computer and Data Management Intervention and Comparison Groups

	Assessment					
	Baseline		12 Month		24 Month	
Variable						
ORC Program Needs	M	SD	M	SD	M	SD
Computer and Data Management Intervention Group	3.14	.67	2.83	.71	2.92	.73
Comparison Group	3.39	.67	3.33	.68	2.99	.50
ORC Computer Access						
Computer and Data Management Intervention Group	2.79	.64	3.10	.43	3.11	.50
Comparison Group	3.01	.57	3.40	.58	3.30	.48
ORC E-Communications						
Computer and Data Management Intervention Group	3.04	1.02	3.59	1.00	3.62	.96
Comparison Group	3.61	.89	3.86	.66	3.85	.63
SIP Computer and Data Management Systems						
Computer and Data Management Intervention Group	3.20	.53	3.40	.52	3.38	.52
Comparison Group	3.29	.42	3.44	44	3.58	.49

4.2.2.d Staff Development and Human Resources Intervention Group. As shown in Figure 4 (see Appendix E), we found a significant effect for group ($p < .01$) indicating higher program needs for the intervention group than the comparison group, and this effect endured over the follow up period. We also found a significant effect for assessment period ($p < .05$); Program Needs subscale scores decreased over time. The group by assessment interaction effect was not significant.

A significant main effect for assessment period for the ORC Training Needs subscales was found ($p < .001$), indicating a steady reduction in training needs from baseline to the 24-month follow-up period. No other significant effects were observed.

We also found a significant increase in the Training Resources subscale scores ($p < .01$) over time, indicating a greater awareness of the importance of training and staff development and involvement in training activities over the follow up period. No other significant effects emerged.

As shown in Figure 5 (see Appendix E), a significant interaction effect was found for the ORC Growth subscale ($p < .05$). These results show similar levels of perceived commitment to improving clinical skills and involvement in professional growth activities among the intervention and comparison groups at the baseline and 12-month follow up assessment; however the comparison group had higher ORC Growth subscale scores than the intervention group at the at the 24 -month assessment point.

For the ORC Cohesion subscale, we found a significant main effect for assessment period ($p < .01$). Staff perceptions about how well staff work together (i.e., staff solidarity) at the agency improved from baseline to the 24 month assessment point. No group or group by time interaction effects were found.

We observed a significant main effect for assessment period ($p < .05$) for the ORC Communication subscale suggesting improved communication among staff over time at these agencies. No other significant effects were found.

As shown in Figure 6 (see Appendix E), there was a significant interaction effect for the ORC Change subscale ($p < .05$). Both intervention and comparison groups had similar scores on this scale at the baseline and 12-month assessment point suggesting that staff had similar views about their openness and ability to adapt to change. However, the comparison group had higher ORC Change scores than the intervention group at the 24-month assessment point.

We found no significant main or interaction effects for the ORC Efficacy subscale.

For the SIP Staff Development subscale, we found a significant main effect for group ($p < .05$). As seen in Figure 7 (see Appendix E), the intervention group had lower scores on the Staff Development subscale at baseline and over the follow up period than the comparison group. We also found a significant effect for time ($p < .01$). Staff Development scores tended to increase from baseline to the 24-month follow-up assessment suggesting that staff had more favorable perceptions over time about their agency's commitment to career development among staff and improving staff job performance. There was no significant group by time interaction effect.

ORC and SIP Mean Subscale Scores and Standard Deviations At Each Assessment for Staff Development and Human Resources Intervention and Comparison Groups

	Assessment					
	Baseline		12 Month		24 Month	
Variable						
ORC Program Needs	M	SD	M	SD	M	SD
Staff Development and Human Resources Intervention Group	3.48	.67	3.31	.74	3.12	.39
Comparison Group	3.09	.64	2.87	.67	2.84	.76
ORC Training Needs						
Staff Development and Human Resources Intervention Group	3.37	.70	3.10	.81	2.89	.73
Comparison Group	3.07	.76	2.90	.72	2.67	.80
ORC Training Resources						
Staff Development and Human Resources Intervention Group	3.22	.70	3.54	.69	3.58	.66
Comparison Group	3.36	.74	3.49	.73	3.78	.59
ORC Growth						
Staff Development and Human Resources Intervention Group	3.44	.54	3.48	.44	3.54	.63
Comparison Group	3.41	.50	3.53	.62	3.80	.59
ORC Cohesion						
Staff Development and Human Resources Intervention Group	3.61	.60	3.80	.55	3.81	.49
Comparison Group	3.89	.50	4.05	.63	3.88	.61
ORC Communication						
Staff Development and Human	3.37	.60	3.66	.50	3.71	.54

Resources Intervention Group						
Comparison Group	3.70	.47	3.81	.62	3.74	.52
ORC Change						
Staff Development and Human Resources Intervention Group	3.62	.51	3.67	.55	3.53	.53
Comparison Group	3.66	.46	3.64	.55	3.82	.45
ORC Efficacy						
Staff Development and Human Resources Intervention Group	3.74	.56	3.83	.42	3.87	.37
Comparison Group	3.97	.34	3.93	.53	4.03	.49
SIP Staff Development and Human Resources						
Staff Development and Human Resources Intervention Group	3.48	.77	3.68	.54	3.66	.46
Comparison Group	3.75	.69	3.86	.47	3.99	.53

Appendix D
List of BEST I Learning Community Topics

- Debrief on the AP process and build a common vision for the LC (October 25, 2002)
- Build trust among members and discuss common challenges and opportunities for cross-organizational learning by area of investment (December 6, 2003)
- Discuss leadership challenges and experiences and share leadership strategies informed by BEST I participant experiences (February 28, 2003)
- Discuss communication strategies for external audiences and share internal communications challenges and solutions (May 16, 2003).
- Discuss BEST project opportunities and challenges with peers working on similar projects, and develop a shared understanding of the use of consultants (September 5, 2003)
- Presentation and discussion about an organizational capacity effort, The Darwin Project (November 21, 2003)
- Describe progress on SIP and organizational lessons learned (March 5, 2004)
- Discuss board structures and current challenges related to staffing the board (June 4, 2004)
- Reflect on the LC and plan for sustainability (September 30 and October 1, 2004).

Appendix E
Graphs showing main and interaction effects for Organizational Readiness for Change and System Improvement Project Subscales

Figure 1. SIP Governance and Leadership Subscale Scores at each Assessment for the Governance and Leadership Intervention and Comparison Group

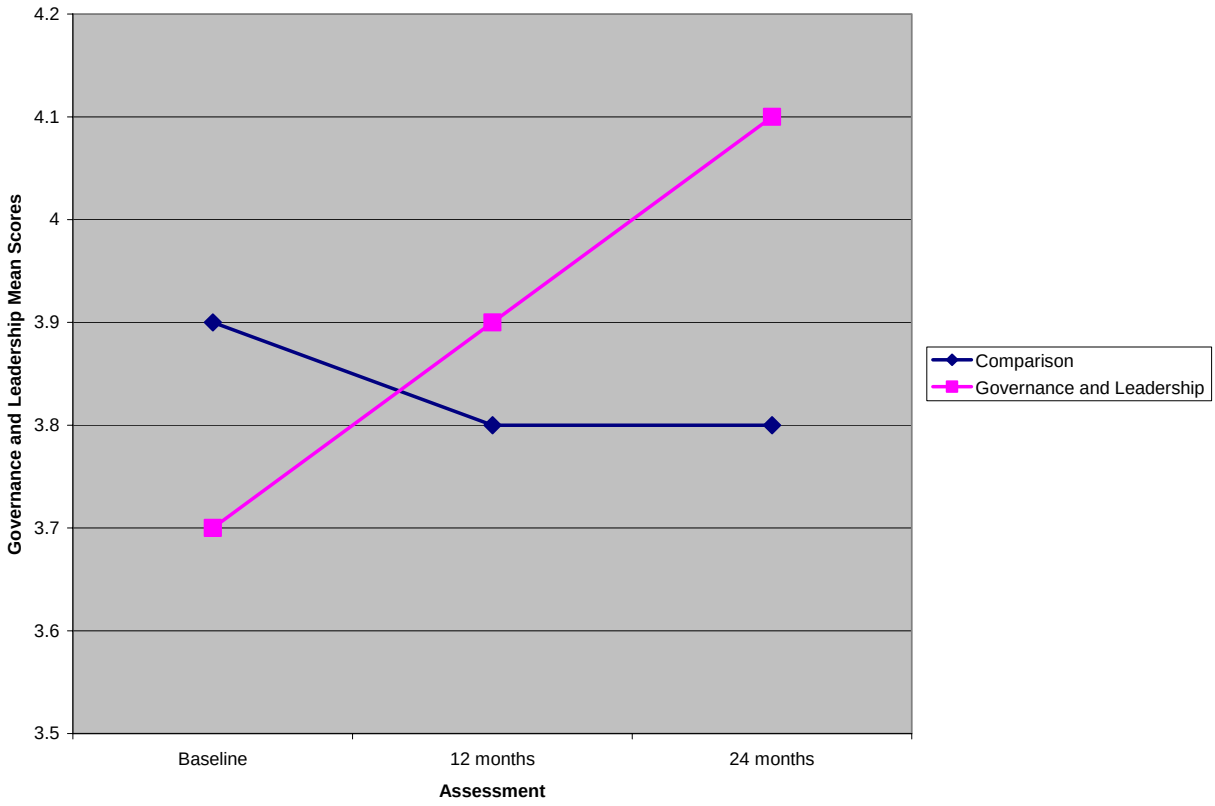

Figure 2. ORC Program Needs Subscale Scores at each Assessment for the Computer and Data Management Intervention and Comparison Group

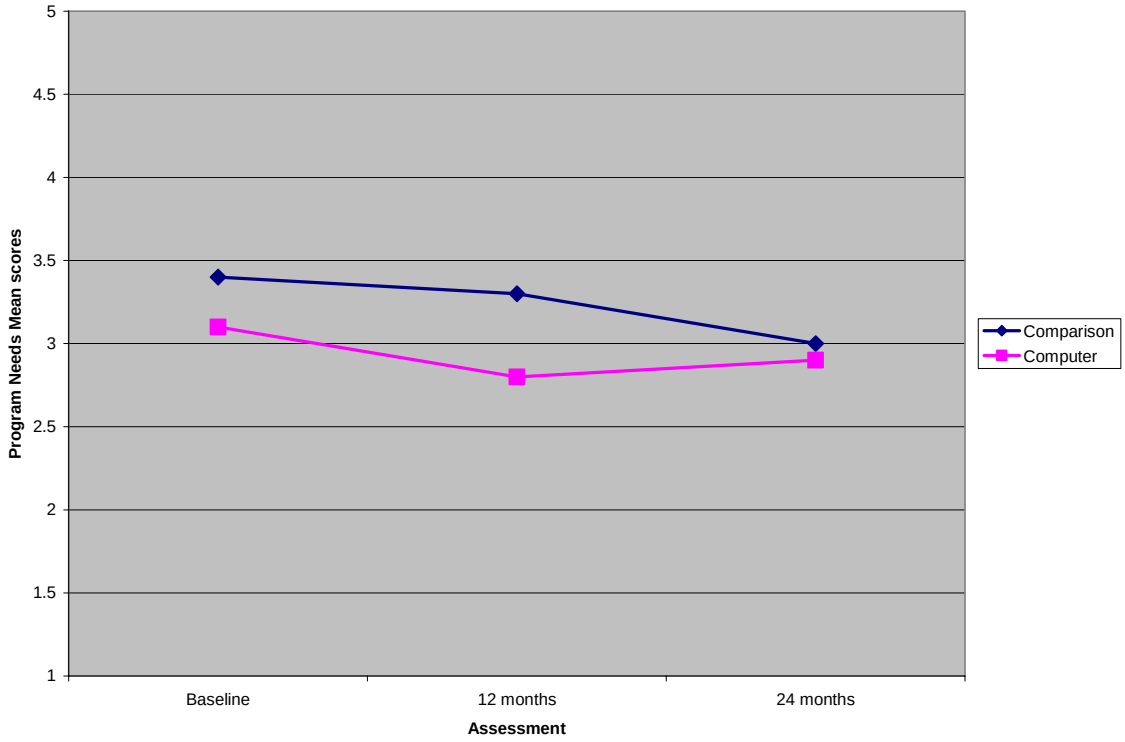

Figure 3. ORC Computer Access Subscale Scores at each Assessment for the Computer and Data Management Intervention and Comparison Group

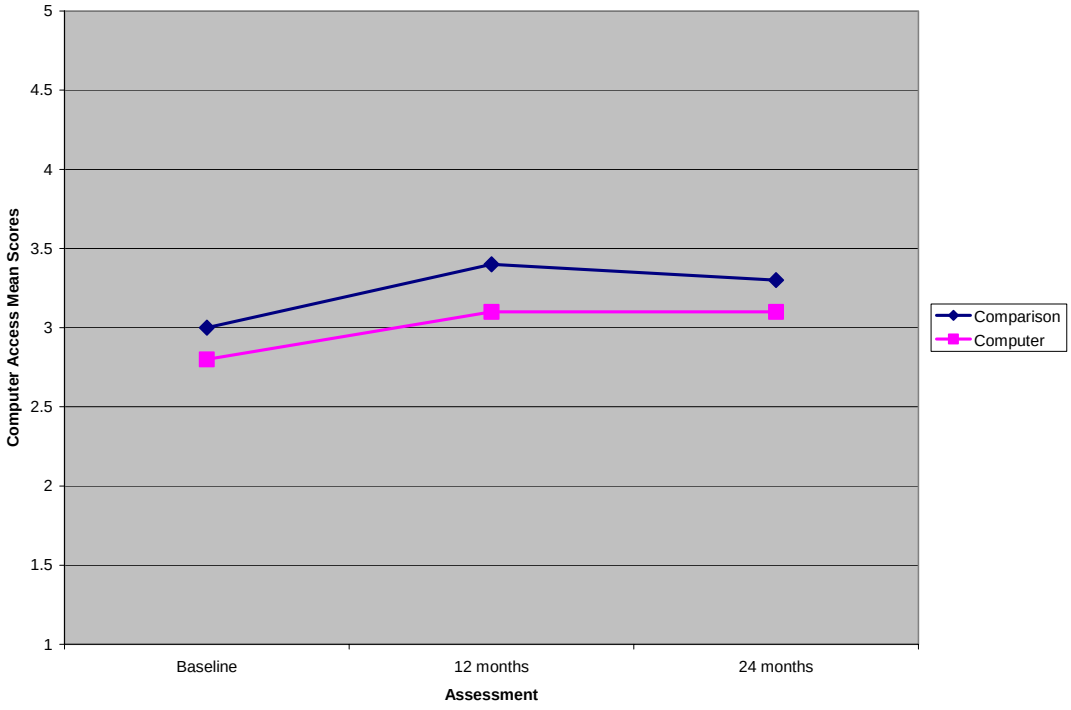

Figure 4. ORC Program Needs Subscale Scores at each Assessment for the Staff Development and Human Resources Intervention and Comparison Group

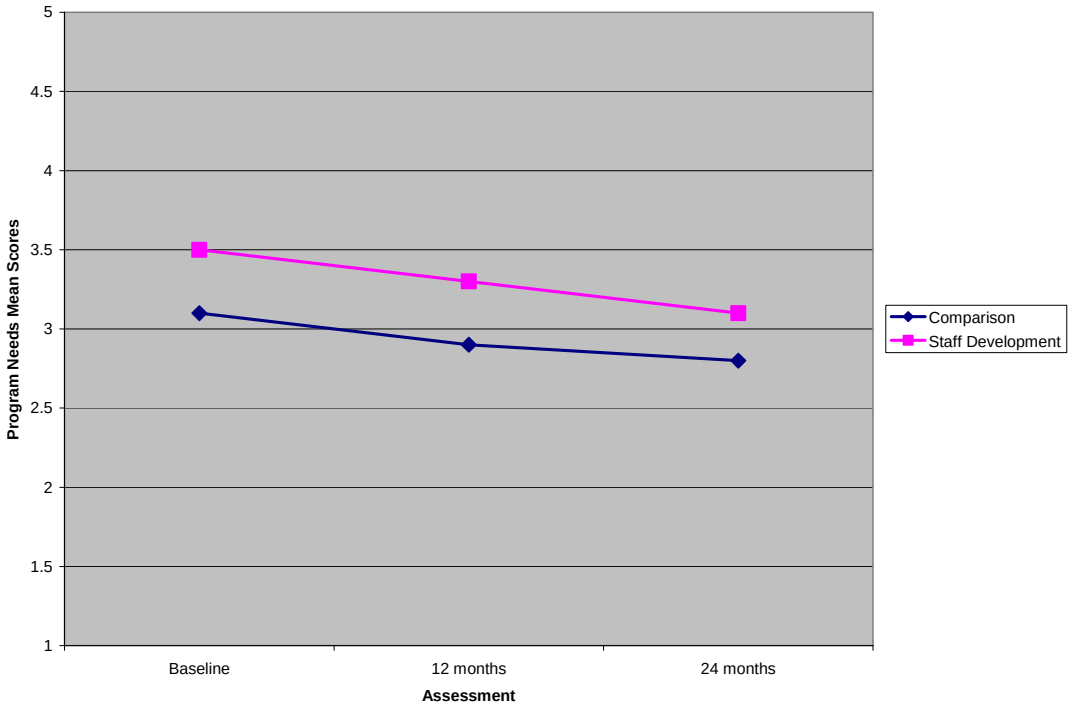

Figure 5. ORC Growth Subscale Scores at each Assessment for the Staff Development and Human Resources Intervention and Comparison Group

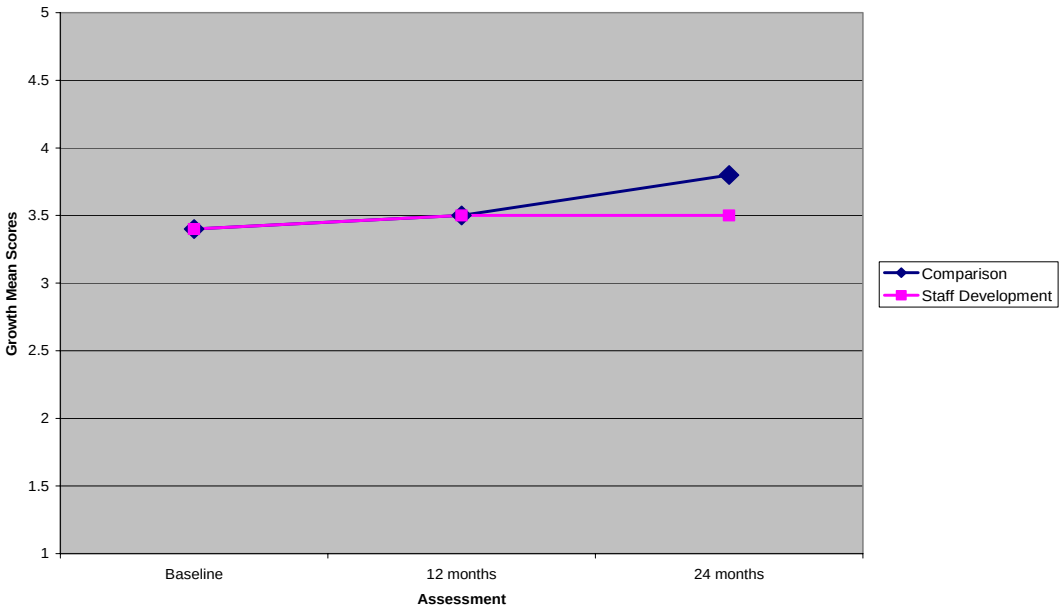

Figure 6. ORC Change Subscale Scores at each Assessment for the Staff Development and Human Resources Intervention and Comparison Group

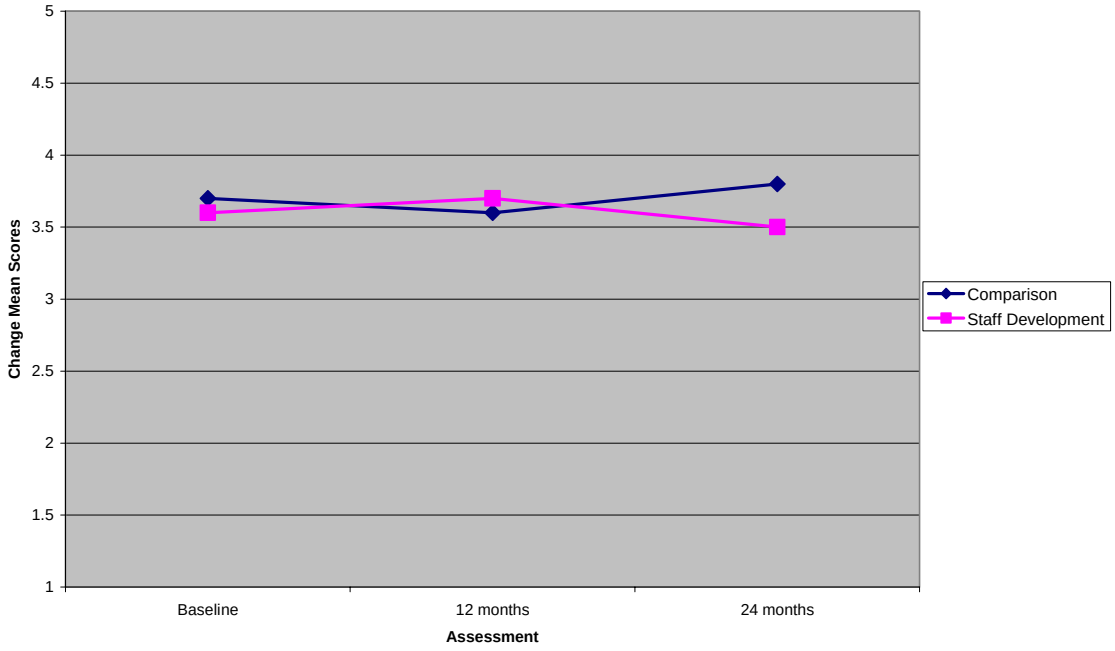

Figure 7. SIP Staff Development Subscale Scores at each Assessment for the Staff Development Intervention and Comparison Group