

RATIONALE FOR IN-PERSON ASAM TRAINING 1-2-2018

As our substance use disorder (SUD) treatment system transitions from the Pennsylvania Client Placement Criteria (PCPC) to the American Society of Addiction Medicine (ASAM) Criteria, the Department of Drug and Alcohol Programs (DDAP) has been asked to reconsider its decision for in-person training of The ASAM Criteria. DDAP has contemplated the issue from various positions, including the effectiveness of in-person versus web-based education as well as considerations related to successful system transformation. DDAP understands the initial concern providers may have regarding the in-person, two-day training as it relates to cost and loss of revenue. After careful consideration, DDAP has concluded that at this time of transition, the in-person training will be the most effective option to increase the opportunities of skill acquisition and application of The ASAM Criteria principles and for increasing the likelihood of successful system transformation overall.

The rationale in support of an in-person training experience is detailed below, both regarding knowledge transfer and skill acquisition, as well as issues related to system transformation. Considering cost, DDAP strongly encourages the Single County Authorities (SCAs) to assist providers by sharing or supporting the expense incurred for training. The department also suggests collaboration among all SUD stakeholders to engage in cost-sharing; thereby, minimizing the burden incurred by a single provider/organization.

LIVE TRAINING VERSUS DISTANCE LEARNING:

DDAP continues to investigate new and innovative strategies to provide engaging and effective trainings that minimize cost and burden to systems and individuals. For example, DDAP's future training plan includes the engagement of remote participation of live training events and the use of web-module software for on-demand viewing. While these approaches are pragmatic for some course material, in other cases, live trainings are our best or only option. This is particularly the case for topics such as The ASAM Criteria, which is highly skills-based and often requires tailoring for unique patient or provider populations.

Below are several empirical and conceptual arguments for the superiority of live training on The ASAM Criteria while suggesting potential next steps for the providers of ASAM Criteria training. Any decisions about ideal training modalities should be evidence-based, and although there are limited data comparing different training approaches on The ASAM Criteria specifically, the larger adult learning field provides several insights.

1) With the exception of travel time for highly remote participants, training time needed for e-training versus live trainings is comparable.

While any training endeavor should involve a careful needs assessment to determine the amount of time needed to meet educational objectives, there is no evidence to suggest that e-training modalities allow for abbreviated training time. While we do not have research comparing training length to learning outcome measures for The ASAM Criteria training, most trainings range in length from 12-13 contact hours or credits.

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E-training can be provided in many formats. One important distinction is whether a format is synchronous or asynchronous. Synchronous e-training creates environments such as virtual classrooms, in which learners and facilitators come together at a common day and time with opportunities for interactivity such as chat, videoconferencing, and instant messaging that show to facilitate learning (Proske et al. 2007). To date, there are no synchronous training options available on The ASAM Criteria, though this may be an important direction to explore in the future.

Asynchronous e-training involves creating a pre-recorded video, narrated PowerPoint, or other online learning opportunities that can be completed on-demand. While this allows for flexibility, i.e., a person could complete a module of the training during down time, it does not allow for interactivity between participants. While there are asynchronous training options available on The ASAM Criteria, they require comparable amounts of time and have several other limitations that are explored below.

2) Evidence suggests that if tiered learning is employed, asynchronous e-training is ideal for establishing foundational knowledge, and live training is preferable for more advanced learners to apply knowledge.

Substance use disorder (SUD) treatment providers come to training with a range of skills and tailoring training to their individual needs could certainly optimize engagement and facilitate cost efficiency. Recent discussions explore allowing those who are trained in the Pennsylvania's Client Placement Criteria (PCPC) and knowledgeable in its application to complete training via e-training. While tiered learning options should be explored in any implementation effort, there is significant evidence to suggest that an inverse of this proposal may be more promising. One such evidence-based approach that uses tiered learning is known as the flipped classroom. This model employs asynchronous video lectures and practice problems as preparatory work followed by active, group-based problem-solving activities in a live training environment (Bishop et al., 2013). In a recent review of 24 studies that investigated the effectiveness of a flipped classroom, results consistently revealed high levels of learner satisfaction and significant increases in performance when compared with traditional methods. While a flipped classroom approach could be a promising avenue to explore in training The ASAM Criteria, to date, no clear criteria exists for determining which participants might be appropriate for foregoing important preparatory work. Additionally, a tiered approach relative to The ASAM Criteria has not been well evaluated by The Change Companies or Train for Change Inc. These types of curriculum improvements will be proposed to the providers of The ASAM Criteria training.

3) Proficiency with The ASAM Criteria is a skill and skill learning requires practice with feedback.

Performance feedback is applied to many fields (Ende, 1983), including SUD treatment provider training (Hettema et al., 2012). Similar to other professions, SUD professionals are typically not the best judge of their own clinical skillfulness (Miller, 2004), making

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feedback from outside sources a critical ingredient to modify behavior. Didactic or instructional methods can only take a student so far. DDAP feels it is beneficial to practice with a coach who can provide feedback and suggest improved strategies. The same is true for learning to apply The ASAM Criteria with Motivational Interviewing skills, which involves a complex set of decision rules, interpersonal style components, and behavioral responses (Hetteema, 2012). Live training on The ASAM Criteria allows for opportunities to practice necessary skills and receive feedback from peers and expert facilitators. Research comparing different modalities for teaching skills, including communication about SUDs, clearly favors approaches that allow for practice feedback (Schwalbe et al., 2014). Without objective feedback, initial gains in skillfulness observed following training quickly diminish (Miller, 2004).

Improved technology is enhancing our ability to provide feedback and coaching remotely, but DDAP feels that skills involving communication training still require the presence of a trained facilitator. While synchronous training options on The ASAM Criteria aren't currently available, it is DDAP's hope that Train for Change Inc. explore developing an e-learning program that allows trained facilitators to remotely observe participants and provide feedback. However, we are told there is preliminary evidence to suggest that, even if such an option becomes technologically feasible for training The ASAM Criteria, it still may have some limitations when compared to live training. For example, in a study in which direct patient encounters were observed remotely via web conferencing, students and facilitators tended to prefer in-person supervision. In this study, students who received live training were more satisfied on every measure of training satisfaction, when compared to students who received feedback via web facilitation. For example, while 11 percent of live training participants said communication was a barrier, 40 percent of web facilitation students reported communication barriers. Similarly, web facilitation participants were less comfortable with the session, were less likely to report that they would participate in the future, reported learning fewer skills, and reported having a poorer understanding of the case (Hayden et al., 2012).

4) Live trainings allow for active, multi-modal learning and are more engaging than e-training.

When participants are engaged in e-training, they are often distracted by other work or environmental tasks and become tempted to multi-task in ways that inhibit learning. Research demonstrates that participants have better focus and attention when attending a live training.

Active learning approaches that engage students in the learning process are almost always superior to passive learning in research on adult education (Freeman, 2014). Live trainings allow for active learning using an array of multi-modality strategies, such as discussion, small group work, and simulation that is not feasible in most e-training modalities. For learning to be engaging, participants need opportunities for interaction and students of web-based training often report feeling isolated (Wilkinson et al., 2004).

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5) Live training allows for tailoring and consideration of unique cultural and motivational elements of implementation.

Across a large and diverse commonwealth like Pennsylvania, there are many unique SUD treatment providers and settings within our system of care. Live training allows for flexibility that allows the facilitator to tailor training content and format to the needs and learning styles of the group. The presence of a trained facilitator increases the chance that participants will think about and apply learned concepts to their own unique setting and role. Instructional tools might include the introduction of specific background material, focused discussion on applications that are unique to the groups' clinical population, or the sharing of experiences from peers with similar backgrounds.

Additionally, it is very common for learners to experience some ambivalence about modifying or changing their current practice behaviors. Facilitation style can dramatically impact whether participants engage in learning (Hettema, 2009; Hettema, 2014). The presence of a skilled facilitator can give participants an opportunity to express and work through concerns or questions about implementation in a productive manner. These managements option simply aren't possible in e-training environments where participants who have motivational barriers may fall through the cracks.

EDUCATION VERSUS TRANSFORMATION:

The change from PCPC to The ASAM Criteria is not simply the switch from one placement tool to another; rather, it is an opportunity to more fully transform our system of SUD care from an acute model of service to a chronic, recovery-management focus of care. It is the opportunity to become more client-centered and person-driven. It will require improved clinical skill in areas such as motivational interviewing and assessing stages of change. It will require a paradigm shift in the way individuals are seen and treated including a move from defining treatment as something "done" to individuals to an opportunity to have them participate in their care and empower individuals to engage in the process. It will move us from identifying resistant clients to professional self-examination and identification of personal biases that keep us from giving clients personal ownership and choice in their recovery process.

Because of the factors identified above, it is not sufficient to compare in-person training of The ASAM Criteria with online training because we are not talking about standard education, rather we are talking about the need to embrace "system transformation." Therefore, it is not standard relaying of information that is discussed in studies comparing online versus in-person education. It involves changing perspective and a paradigm shift. Since the basic concept is to change the way business is conducted, rather than a straightforward exchange of information, the comparison and argument for similar effectiveness of the two training modalities is not likely applicable. A number of things allow transformation to be more successful:

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- Studies show that transformation efforts generally fail or produce an unsatisfactory result when essential steps are skipped in an effort to save time (Kotter, 1995), such as establishing a sense of urgency. The need to assist individuals out of their comfort zones is an important factor that is often overlooked. This requires identifying and discussing challenges. Discussion cannot occur in an online process.
- Kotter also stresses the need to create and communicate the vision and remove obstacles to change. While DDAP can mandate the use of The ASAM Criteria, this will not necessarily result in the overall systemic, transformational clinical re-positioning that is desired without the opportunity to dialogue the vision and emphasize what will be gained by making the transition to The ASAM Criteria.
- The exchange that can occur through in-person training is more likely to lend itself to relaying the credibility of system change and provide opportunity to clarify the questions and concerns that exist and remain for some individuals. The in-person training is not only an information exchange, but a strategy for establishing and increasing buy-in for the advantages of making the switch.
- Armenakis and Harris (2002) indicate that active participation, persuasive communication, and management of information helps to create readiness for change and reorganization. This exchange cannot occur in online relaying of information.
- In a 2015 article regarding transformation in the mental health system, Kathryn Powers indicates that building the information base is essential to coordinating and establishing a foundation for change. While DDAP, SCAs, providers, etc. must utilize additional measures beyond the training experience to communicate the expectations, values, and mission of this transformation, the training experience will be an essential ingredient for setting the stage for this overall system transformation.

When the transition to The ASAM Criteria and the transformation to a more Recovery Oriented System of Care occurs, the training in the use of The ASAM Criteria can be seen more as an educational transfer of knowledge and skill building. Until that time, it is necessary to engage in a didactic process that allows for an *exchange* of information, dialogue, and question and answer experiences. When this has been accomplished and most of the existing field has begun to apply The ASAM Criteria and we are substantially on the way to system transformation, then the argument in favor of online training for the purpose of training and not transformation will apply. DDAP will at that point consider this training option. However, during this initial phase of transition from the PCPC to The ASAM Criteria, the department feels that those who have primary responsibility for the use and application of The ASAM Criteria should engage in the in-person, two-day trainings.

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