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ORIGINAL PAPER

Implanting Rhizomes in Vermont: a Qualitative Study of How the Open Dialogue Approach was Adapted and Implemented

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Abstract
The Open Dialogue approach was developed in Finland in the 1980s as a form of psychotherapy and a way to organize mental health systems. It has been adapted and implemented in several countries in recent years. This qualitative study sought to explore staff and developers' experiences with one adaptation of the Open Dialogue approach in the state of Vermont called the Collaborative Network Approach. In total twenty two staff members from two agencies participated in focus groups and three developers of the approach were interviewed. Three dominant topics emerged in the analysis process: impact of training; buy-in across levels; and shift in organizational culture. Findings revealed that 1) participants experienced the Collaborative Network Approach as positively impacting their clinical work, relationship with clients and families, and with colleagues; 2) buy-in across levels – colleagues, management and department of mental health - was perceived as crucial to the development and implementation of the approach; 3) the main challenges to full implementation were: inadequate billing structures, costly and lengthy training, and resistance to shift organizational culture to integrate the Collaborative Network Approach into agencies. We hope to have contributed to the field in a way that will support further efforts to develop and implement Open Dialogue-informed approaches by pointing to potential successes and challenges future program developers may face.

Keywords Open dialogue · Qualitative research · Psychosis · Mental health

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Introduction

The Open Dialogue (OD) approach was developed in the 1980s in Finland as a form of psychotherapy inspired by systemic family therapy and a way to organize mental health systems [1]. OD emphasizes a social network perspective and conceives of mental health problems as relational. With a focus on creating meaning through language, psychosis and other mental health crises are understood as extreme experiences not-yet-spoken about, and the goal of the treatment is to generate therapeutic dialogue by bringing all the voices to a shared forum where meaning can be created jointly [2]. Accordingly, treatment is structured around network meetings with the person at the center of concern and others who are part of their support network. During network meetings, a series of techniques are employed to foster a type of dialogue that allows the network to create new language and meaning to deal with difficult experiences. The seven principles of open dialogue are: immediate help (i.e., a network meeting should be set up no later than 48 h after request for care), social network perspective (i.e., meetings should include the client's support network), flexibility and mobility (i.e., teams meet as often as needed and preferably in people's homes), responsibility (i.e., the team should follow through with families once help is sought), psychological continuity (i.e., the same team should stay with the family for the entire duration of treatment), tolerance of uncertainty (i.e., taking time to make decisions and slowing the process down), and dialogue and polyphony (i.e., encourage meaning making and creating new language to talk about experiences) [1].

Von Peter and colleagues have argued that OD is aligned with the human rights paradigm that has increasingly been informing global mental health [3]. The authors argued that the principles and practices of OD foster a contextualized understanding of mental health needs; balance power differentials during treatment; and reduce the risk of over medicalizing mental health problems. In addition, since OD is a largely non-institutional response to mental health problems, it is well-suited to prevent violence and coercion in treatments and systems [3].

The Collaborative Network Approach (CNA) is an adaptation of the OD approach that was developed in the 2010s in the state of Vermont. Developers created a training curriculum that encompasses core techniques and principles that guide OD, and held several other modalities of shorter trainings such as seminars, workshops and talks through the years inviting trainers from Europe and the US. Some of the skills and principles that guide the CNA are reflection; listening without an agenda; slowing down and taking time before making decisions; avoiding interpretations and explanations in favor of listening with curiosity; inviting all the voices to be heard during the meetings; and guaranteeing safety for the network. The CNA incorporates these principles, skills and techniques to a varying degree throughout the agencies where it is practiced. Some clinicians may implement the entire CNA with clients and families and structure all treatment around network meetings. However, most clinicians practice the CNA to the degree that it fits with their on-going clinical work. For instance, they may incorporate certain elements of the CNA into case management; individual therapy sessions; team supervision; crisis support and other practices.

Findings from key studies in Finland revealed that recovery rates (symptom remission combined with a return to social and educational/occupational roles) for people experiencing a first episode psychosis who received OD were 83% after 5 years [4]. Additionally, people who received OD were less likely to be hospitalized and had fewer hospital stays at follow-up [5]. A review of the evidence on OD concluded that more research is needed to determine the effectiveness of the approach, support implementation efforts and generate better tools to assess structural level changes [6]. Nevertheless, the existing literature points to favorable

results and has prompted several adaptations and implementation efforts of OD throughout the world in UK, Austria, Italy, Germany, Poland, Norway, Denmark, Japan and in the United States, however, descriptions of the implementation process are lacking.

Open Dialogue was introduced and adapted in Scandinavian countries in the early 2000s and a scoping review of the evidence showed great variation in how the OD was adapted outside of Finland [7]. According to the authors, one possible reason was the attitude of Finnish developers toward manualizing the approach, creating standardized measures or prescriptive practices, which have been avoided. This attitude is consistent with the approach itself but created challenges for researchers to assess to what degree practices reflected the OD principles and how to measure them. The evidence showed that from an implementation standpoint, challenges often came from practitioners who resisted abandoning traditional clinical roles [7].

The UK is currently comparing peer supported OD to treatment as usual in a large randomized clinical trial. A qualitative study of how this OD variation was experienced by clinicians and service users in a mental health center in the UK reported that participants experienced an openness in meetings, a sense of authenticity, and a space for different perspectives; and clients reported mixed reactions to the technique of reflection [8]. From an organizational perspective, clinicians reported a need for broad organizational restructuring to accommodate the introduction of OD-informed practices, as they were viewed by participants as challenging hierarchical structures on multiple levels [8]. Additionally, participants reported that colleagues who were not trained in the approach often resisted its implementation.

In the United States, adaptations of the OD approach have been implemented in Massachusetts, Vermont, New York and Atlanta. However, there is limited research describing implementation strategies, outcomes, and experiences with the approach. One mixed methods study examining the feasibility of OD in Massachusetts was conducted. The study included a sample of 16 individuals experiencing psychotic symptoms over a 12-month period when they received an adaptation of OD called Collaborative Pathways [9]. Results showed an improvement in symptomatology and functional outcomes following the intervention. Additionally, the authors reported that their OD intervention was feasible, but that adaptation and implementation of the approach still faced multiple barriers including funding and billing structures, training cost and length, and logistical challenges (e.g., home visits, 24/7 availability).

The Parachute Program in New York City, launched in 2012, was designed to incorporate OD principles and peer support work into crisis response services through mobile crisis teams and respite centers. An implementation analysis of the launch and first three years of the program's existence provided a thorough description of the process and presented the main implementation challenges [10]. Hopper and colleagues described Parachute as counterhegemonic because it challenged institutional and professional interests [11], and pointed to suboptimal systemic readiness; lack of buy in from agencies; difficulties associated with training; and the insufficient social supports to meet participants' basic material needs as the main challenges in the implementation of Parachute [11].

There are few studies describing the adaptation and implementation of the OD approach both in Finland and in other countries. The existing evidence suggests that OD has generally been well received by staff, clients and family members. The key implementation challenges found in the literature were related to lack of systemic readiness (organizational culture, funding and billing structures, buy-in) and resistance across levels due to the counterhegemonic nature of the approach.

The current paucity of research describing the implementation of OD outside of Finland limits our understanding of the perceived benefits and challenges to fully implementing OD-informed services, which may reduce the capacity for mental health systems to implement OD-informed approaches successfully. The current study addressed this knowledge gap by investigating the Vermont case of the CNA implementation from the perspectives of staff and developers.

Objective: To describe the case of OD adaptation and implementation in two agencies in Vermont.

Methods

This study is epistemologically positioned within the social constructivist tradition [12] and used qualitative description [13] as a method. Qualitative description is well-suited to guide the collection of accounts of experiences and events in a way that remains close to the data, keeping interpretations to a minimum. Thus, no pre-determined theoretical framework guided this study.

Reflexivity

The first author kept a journal of all field visits and compiled impressions, thoughts and relevant interactions with participants that were not captured in the interviews and focus groups. Notes and observations shaped how data were approached and small adjustments in how questions were framed for participants.

Setting

This study was conducted at two agencies that had implemented the CNA in the state of Vermont. Both provide services to people with mental health needs (e.g., inpatient, outpatient, crisis support, residential), substance use problems and developmental needs. Recipients of care include people who are insured by Medicaid and Medicare; in addition, the services provide care for those without insurance.

Participants

22 staff members and three CNA developers participated in this study. Staff members were mental health professionals (psychologists, psychiatrists, nurses, social workers and case managers) with CNA training working in one of the two research sites. Developers were people who were directly involved in the initial and current efforts to implement the CNA. 16 staff members and two developers were women, and six staff and one developer were men.

Recruitment

A social worker, a psychiatrist and a program director from the agencies invited trained staff to be part of the study by providing information about the study's aims and procedures. Developers of the CNA were directly contacted by the first author through email and invited to participate.

A purposeful sampling method was used to recruit people who were information rich about the topic under investigation.

Data Collection

Data were collected using four focus groups – two at each site with five to six participants each - and three unstructured interviews. One focus group was composed of supervisors and directors, while the other three were composed of staff providing direct services. Focus groups were conducted to uncover a shared understanding of how the CNA was implemented; gather a broad range of information about the subject; and capture interactions and contrasting perspectives between participants. A focus group guide was not used; instead, broad questions were asked to elicit stories about the development and implementation of the CNA. Example questions included: how did you become involved with OD? how has OD affected your work? and what are the difficult parts about this work? Participants' answers prompted new questions that were discussed within the group. Focus groups were conducted by the first author and lasted approximately 60 min.

Individual, unstructured qualitative interviews were conducted with developers of the CNA by the first author. The purpose of the interviews was to elicit perspectives about the development and implementation of the OD approach. Interviews were unstructured in order to allow for greater flexibility of topics to be discussed. Participants were asked open ended questions about how they became involved with OD; what role they played in the adaptation and implementation processes in Vermont; and the main challenges of developing and implementing OD. Each interview lasted between 30 to 60 min.

All focus groups and interviews were audio recorded and transcribed verbatim by the first author.

Data Analysis

Data were analyzed using a phenomenological approach developed by the senior author [14]. Each transcript was summarized and reduced to a one-page narrative using the words of participants. Several readings of the narratives were performed and allowed for topics to emerge. After recurring topics within the narratives were identified, topics were organized into a central narrative that described the findings using words of participants themselves.

Ethics

This study was approved by the Yale University School of Medicine IRB (HIC/HSC # 2000024372). Informed consent was obtained in writing from all participants of the study.

Results

Stories about the inception, development and challenges of implementing the CNA were identified in all interviews with developers and recounted the exact same events with very little variation. Training impact, organizational culture and buy-in were common throughout all interviews and focus groups.

Inception

The developers expressed that the organizational culture in both agencies was favorable to the incorporation of the OD principles, because the set of humanistic values that underlie the OD approach were important for agencies well before the CNA was developed. One of the agencies had worked with systemic family therapy for many years prior to the CNA development in Vermont, according to two developers. According to one developer, in 2012, with the active participation of a member of the community with lived experience with the mental health system, the Vermont Department of Mental Health agreed to start funding training. The cost and length of OD training combined with the need to adapt the original OD approach to the context of Vermont led developers to create trainings inhouse.

The realization that OD, as a form of psychotherapy and a way to organize mental health systems, was very hard to replicate reinforced the need to create a version of OD that suited the characteristics of the agencies and the people who were served in a way that would be feasible within the existing mental health system. For one developer "there are substantial ways people live differently in different parts of the world, you have to respect and match the way people live, I think it's restrictive and perhaps self-destructive to insist that people respect the practices of another culture". The training development was described as an ongoing process that involved multiple discussions with experienced trainers from Europe and the United States and changes from year to year.

Impact of CNA Training

For the majority of participants, the techniques learned in training were useful in a broad sense, influencing their relationships with clients, families and colleagues. Along with the impact in relationships, staff described how principles and techniques they learned impacted their work beyond facilitating network meetings, as exemplified by one participant: "even in my individual therapy sessions I'm finding that I'm using some of the principles, so I am a part of networks where I facilitate at and use full CNA, but then I feel like in my work it becomes a way of being, so it kind of oozes out everywhere". Managers, directors and supervisors reported incorporating the CNA principles in how they conducted team meetings, case discussions and supervision. For instance, one case manager described her experience: "I work in a case management function and I supervise other case managers, so I think it has impacted how I supervise people, certainly, and what that time is like that I spend with my staff".

The versatility of the CNA principles and how they can be integrated in various contexts of clinical work seemed to be key in the success of the gradual implementation process adopted in Vermont. For one clinician: "the word eclectic stuck out to me, I feel like this model has plenty of room for collaboration with other therapeutic approaches". Participants in one focus group agreed that fidelity criteria may not be helpful in the implementation process of the CNA, according to one participant "don't let great get in the way of good, if we try to stick to all these fidelity measures and all of the principles we might not be able to do as much as we're doing".

A rich discussion about the use of medication in treatment and how the CNA has changed how clinicians and psychiatrists approach this issue took place in one focus group. One psychiatrist mentioned that the CNA philosophy fit well with his concerns about long-term use of medications and side effects, and has allowed for further discussions with the networks about introducing or increasing medications before making decisions. Other clinicians in the group weighed in and pointed that a moment of crisis is when people are most vulnerable, and

offering a diagnosis and medication may not be that helpful “in terms of a person’s ability to develop meaning for who they are and finding purpose in life”. Another participant, who was a psychiatrist, stated: “I didn’t have any skills for working with people in acute psychosis other than offering them medications and support”. In the original Finnish model, avoiding the introduction of a neuroleptic medication early in the treatment was important; however, it is not clear how adaptations of OD outside Finland have approached the issue.

Staff reported a shift towards a more collaborative way of working with colleagues after training in the CNA and the majority of participants referred feeling less burnout. As expressed by one staff member: “I think a lot of the reason why I would get burned out was just being involved in things that didn’t feel good, that were inhumane, or that were taking people’s freedom away, or autonomy away and just watching the system be so cruel to the people that I am getting paid to help, year after year, it’s just horrible. And this work is probably the most humane way of work that I’ve ever done.” For another participant: “I think that that is a big shift for me, thinking that the answer lies within the client and the network, so not feeling that burden I think that that has led to me to feel less burned out”.

Challenges related to training included finding time for staff to be trained; receiving approval from managers to participate in the trainings; and developing a curriculum that effectively teaches the core principles of this practice and provides the necessary clinical experience. As expressed by a manager: “it really did get to be a challenge in terms of time away from here [the agency]”. Another manager also described how “my supervisor was not really on board with [a colleague] and I getting involved with OD, because it felt like we were never going to be facilitators”. Finally, staff turnover is a reality in mental health services, as mentioned by one participant: “people get trained, and they leave too”. Part of the implementation process in Finland, Germany and in the Parachute Program was to train everyone in the service regardless of whether they would facilitate network meetings or not. One participant, who was relatively new to the agency, found that being trained in the CNA was useful to feel more heard among colleagues even though she was not directly facilitating meetings.

Offering the trainings was described by developers as challenging as they have attempted to create an OD-informed practice that is suitable to the specific characteristics of Vermont while having highly experienced trainers come from Europe. According to one of the developers: “the people who have the most experience with this live far away and it’s expensive to have them come”. In summary, CNA training is time consuming and costly, however, the experience of being trained was perceived by all participants as generally positive, and they reported powerful changes in clinical practice, such as being more curious to listen, not having an agenda, realizing the answer to problems lie within the network, slowing things down and generating more dialogue. Additionally, participants reported improvement in the relationship with clients and families, and among colleagues, while also feeling less burnout.

Buy-in Across Levels

The involvement of high-level management in the implementation of the CNA within the agencies had been crucial to the development of strategies to effectively incorporate the CNA. One developer stated: “I’ve been in Vermont a really long time and it’s a small state and I think having buy-in from someone in my position may have helped to some extent”. Clinical directors described their involvement in creating solutions that would allow the CNA to be conducted and paid for through the existing billing structures. As expressed by one participant: “With the system being tied to units and medical necessity and treatment plans and things like

that, our system of care is not set up inherently to do this. And yet I think even with all of that there's an openness and support throughout our organization".

According to developers, Medicaid – and most insurances – will not pay for more than one therapist in the room, posing a challenge to the formal uptake and scaling up of the CNA in agencies. This systemic constraint directly affected how clinicians were able to practice CNA in their daily work schedules. According to one staff member, the CNA work has to be built into their regular workload and most of it is not billable, and "our clinicians, their requirement is 65 percept of their time is direct service, then we have referrals coming in constantly, we do 15 assessments a week or so, how do you balance that when you want to dedicate 2 hours [to a network meeting]?"

Some programs within the agencies had more flexibility with how to allocate funds, which had allowed for certain areas to start working with the CNA more than others. A specific area where the CNA has been reported to thrive is in Developmental Services, where funding is not fee for service, and according to one staff "there is opportunity and flexibility to incorporate [the CNA] in a more formal way throughout our days". Most research into the OD approach has focused on psychosis, however, in Vermont, the principles of CNA have been informing practices with other populations such as children and their families. For a developer: "so basically what we're doing right now is to offer this to the extent that we can fit it into our usual processes. We have areas, if you're doing this in a purely fee for service basis that's very hard to do, because fee for service will only pay for one therapist in the room.".

While buy-in from upper levels of management was described as important, Vermont had chosen a bottom up approach in developing this work. A developer described it: "the rhizomes are part of the roots, like grasses that go underneath and spread out, and then the grass is what you see on the surface it's just a really small part of it that is all the connections. And that image has really stayed with me for some reason. And so, I'm trying to implant the rhizomes, and have it embedded in there and have it be more of a culture shift. So, it's a beautiful idea." For another developer: "I think these practices are more likely to be broadly adapted if it works from the ground up". The combination of working from the ground up, determining how to incorporate network meetings within agencies and having support from the system more broadly were described by participants as the key features of the Vermont experience.

For participants in one focus group, not having buy-in from their colleagues meant that working alongside clinicians who were not interested in the CNA posed a challenge. Some clinicians reported that colleagues refused to participate in network meetings, were averse to the technique of reflection and were not interested in using the CNA approach with clients and families. On that subject, one clinician stated: "you know, they're pretty vocal about saying that they find this a very weird way of working".

Finally, buy-in from clients and families themselves was perceived as crucial. Staff reported that some families felt like the structure of the meeting felt like an intervention and were not comfortable with having so many people in the room. One staff member recounted a case in which the meetings were difficult to handle and seemed ineffective, or, "as far as the groups at the center I've tried to incorporate [CNA] we ran into some big problems".

Shifts in the Organizational Culture

The CNA was perceived as disrupting traditional roles practitioners were used to playing in treatment. For instance, one staff member stated that: "I think sometimes some of our colleagues, myself even, come in and think you're going to fix things, control things, and in

many ways I think you have to step back and verbally say that I'm not controlling this and we don't know the plan, but we'll see where we go. For some people that's comfortable and for some people it's not". This sentiment resonated with other participants of the focus group.

Participants also expressed further challenges to incorporating the CNA more broadly in agencies. In one focus groups, all participants reported a cult-like culture around the CNA. They reported that growing interest in the agency in having people trained to expand the use of the approach has left some clinicians who did not want to be trained feeling left out. Participants referred to this cult-like culture in two ways: first, as a not quite permeable group of people who were trained and worked together setting themselves apart from the rest of the agency; and second, as a power dynamic that was described as being unspoken of within the agency. The first characteristic was reported to get better with time as more people were trained. The power dynamics was described by participants as still existing in the agency, and one practitioner reported that colleagues with extensive training in OD and CNA held a higher status and were given more space to speak and be heard in the organization. In the same focus group, one participant pointed out that this power issue was surprising, given that OD and CNA often challenge and try to balance out power differentials. Nevertheless, it was reported that many felt discouraged to become more involved because of the aforementioned issues.

Some participants felt that being in the agency for a long time and having seen other approaches come and go may discourage people to get trained in the CNA. One staff member reported hearing from a colleague that CNA was "just another flavor of potato chips". Several staff also reported they felt that some clinicians were not comfortable with the structure of the network meetings. One clinician stated: "I think what rocks a lot of people is that they are scared, or they have a worry, or they have an agenda that needs to be met, or if that can't be met or spoken about, then this way of working is just too foreign for them".

While most staff reported that giving up power within the treatment setting was liberating and had a positive impact on their clinical work, some staff described how disorienting the CNA may be at first. For instance, one clinician felt that "and I know that was my experience, at least, I felt way more comfortable reflecting and very nervous to facilitate [meetings] in the beginning". Another concern was voiced by a manager as "how do you address suicidality in the moment, how do you combine open dialogue with best practices for suicide intervention?". In that sense, it seemed important for staff to integrate different approaches within the agency, as expressed by one staff who said: "I think that there is a part of our agency that is more OD focused, there is a part of our agency that has other clinical initiatives, so how do we as an agency work together in kind of pulling these approaches together?"

Discussion

The purpose of this study was to describe how OD was adapted and implemented in two community mental health centers in Vermont as the CNA. Overall, findings revealed that 1) participants experienced the CNA as positively impacting their clinical work, relationship with clients and families and with colleagues; 2) buy-in across levels – colleagues, management and department of mental health - was perceived as crucial to the development and implementation of the CNA; 3) the main challenges to full implementation were: inadequate billing structures, costly and lengthy training, and resistance to shift organizational culture to integrate the CNA into agencies.

This study addressed several important knowledge gaps about the development and implementation of OD in the United States. First, it addressed the lack of systematized accounts of implementation efforts throughout the country. Second, it did so using a qualitative approach to provide a rich description of the Vermont case. And, finally, we hope to have contributed to the field in a way that will support further efforts to develop and implement OD-informed approaches by pointing to potential successes and challenges future OD program developers may face.

The study findings are consistent with a previous study evaluating the implementation of OD in Massachusetts [9]. Both studies found that challenges to implementing OD were related to the length and cost of providing training and inadequate billing structures. Our findings are also consistent with the process of adaptation and implementation of the OD approach in Scandinavia. A scoping review [7] showed that the lack of standardized measures to determine fidelity to the original model and the general adaptability of the principles in different contexts make it difficult to determine to what degree the adaptations resemble the Finnish model. In the case of the CNA, the system was not completely changed to incorporate the OD approach fully, but rather, principles and techniques were incorporated throughout a myriad of existing clinical modalities and some network meetings were facilitated by staff when possible. In the scoping review, authors pointed to a resistance of the OD model to fidelity criteria and standardization, that was also the case in Vermont, where fidelity was seen by staff as a barrier to a more organic process of incorporating the CNA into day to day work in the agencies. Developers were also very clear in stating that the CNA is not a replication of the original Finnish OD model, hence the change in the approach's name.

Findings from clinicians in Vermont are consistent with those reported in a qualitative investigation of peer-supported OD implementation in the UK [8]. Clinicians in the UK reported similar experiences to those we reported in our study, including the possibility to slow down, listen attentively, not have an agenda and be able to practice in better conformity to their values. In the Vermont and the UK case, resistance to the model was reported to come from staff who were not trained but worked side by side with staff who were practicing OD-informed approaches.

A recent paper about the implementation challenges of the Parachute Program in New York City [11] identified OD training as especially difficult because it involved unlearning traditional understanding of mental health problems and adopting a clinical attitude that is dramatically different from traditional roles in mental health. In the Vermont case, our findings show that while staff recognized that training was intense and time consuming, their experiences of letting go of the expert roles were described as a relief, and resistance to embracing the CNA was reported as coming from colleagues who did not receive training. In that sense, more research is warranted to better understand what elements of the training process may contribute to generate resistance or acceptance of the model among clinicians. In the Vermont case, the very elements that brought discomfort in the Parachute Program were viewed as providing relief and reducing burnout.

Hopper and colleagues also pointed to lack of buy-in from the agencies involved in the Parachute project, which was not the case in Vermont. The difficulty in finding ways to bill within the insurance structures of the health system was experienced in the New York project more acutely than it has been in Vermont. In the case of Parachute, not finding ways to successfully move from a grant-based program to a Medicaid billable program meant the demise of the entire project. In Vermont, while

doing this work on top of regular caseloads was reported as far from ideal, certain programs within agencies, with more flexibility as to how money is spent, have been allowing for a gradual expansion of practices. Meanwhile, according to participants, upper management and the Department of Mental Health in Vermont have been working together to find solutions to better deal with billing structures.

Finally, Vermont has opted for a bottom-up implementation strategy, as opposed to the one Parachute employed. Slowly growing rhizomes, as one participant described, may have been crucial to the overall sustainability of the project in the state and may contribute to its future expansion. Also worth mentioning is the difference between metropolitan New York City and rural Vermont. Hopper and colleagues identified precarious livelihoods [11] as a difficult problem to deal with in New York, which is something we did not find in Vermont. The limited literature available about this theme in the US makes this one of the few studies describing the adaptation and implementation of the model in this context. The Vermont experience of adapting and implementing the OD approach shows one possible route that may support others who are interested in implementing OD informed approaches. We hope this study will inform future research and public policy development.

Strengths

This study was the first to explore the implementation of OD-informed practices in Vermont. Focus groups and interviews revealed rich details of the specific context of Vermont, generalizations to other localities are not intended.

Limitations

This study did not include staff members who did not receive training in the CNA to better understand how the implementation of the approach affected the organizations more broadly.

Despite this, we hope that this study will serve as a starting point to systematize the CNA; to develop implementation strategies to consolidate and expand the use of the CNA in Vermont and elsewhere; and to generate the necessary evidence to assess the approach's clinical and cost-effectiveness.

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Compliance with Ethical Standards

Conflicts of Interest/Competing Interests Authors report no conflicts of interest.

Ethics Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. This study was approved by the Yale University School of Medicine Institutional Review Board (HIC/HSC # 2000024372).

Consent to Participate Informed consent was obtained in writing from all participants of the study.

Consent for Publication Not applicable.

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